183725

Exhibit A

2010-11 City of Portland Health Plan

183725

CITY OF PORTLAND

HEALTH PLAN DOCUMENT

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CHAPTER 1

1.0 GENERAL PROVISIONS

1.01 Establishment of Plan

1.01.010 The City of Portland hereby establishes the City of Portland Health Plan (the "Plan") which includes component plans of the Plan, effective July 1, 2010 (the "Effective Date"). Capitalized terms used in this Plan that are not otherwise defined shall have the meanings set forth in Chapter 2.

1.01.020 This Plan is designed to permit an Eligible Employee to elect various benefit components, and to pay for those components with a combination of Employer and Employee contributions. Employee contributions may be paid on a pre-tax Salary Reduction basis or with after-tax deductions, as permitted under the Internal Revenue Code and the City's Cafeteria Plan's applicable components.

1.02 Governing Law

Except to the extent that this Plan is governed by federal law, this Health Plan shall be construed, administered, enforced and governed by and in accordance with the applicable laws of the State of Oregon, even if Oregon's choice of laws otherwise would require application of the law of a different jurisdiction.

1.03 Plan Year

Plan year shall mean the l2 month period beginning July 1 and ending June 30 each year.

1.04 Plan Limitations

1.04.010 Nothing contained in this Plan shall be deemed to give any participant the right to be retained in the service of the City or to interfere with the right of the City to discharge any participant at any time regardless of the effect which such discharge shall have upon such employee as a participant under this plan.

1.04.020 The City of Portland does not guarantee benefits payable under any insurance policy or other similar contract described or referred to herein, and any benefits thereunder shall be the exclusive responsibility of the insurer or other entity that is required to provide such benefits under such policy or contract.

1.05 Plan Amendments and Termination

The Plan was established with the bona fide intention that it will be continued indefinitely, but the City has no obligation to maintain the Plan or any component, and reserves the right to amend, change, terminate or cancel the Plan described herein, and provisions, in any manner at any time, subject to the City's obligations under the Public Employees Collective Bargaining Act, provided, however, that no amendment, change or termination shall reduce or eliminate benefits retroactively. If the Plan is amended or terminated it will not affect coverage for services provided prior to the effective date of the change.

1.06 Non-Assignability

Except as otherwise provided by law, the benefits provided hereunder shall not be subject to assignment, anticipation, alienation, attachment, levy or transfer and any attempt to do so shall not be recognized.

1.07 Administrator

1.07.010 The Plan and its Components shall be administered by the Administrator described in Chapter 2. The Administrator shall have responsibility for the general operation of the Plan and shall have the power and duty to decide all questions arising in connection with the administration, interpretation and application of the Plan and shall take all actions and make all decisions that shall be necessary to carry out the provisions of these Component Plans, including but not limited to:

1.07.020 Determining an employee's eligibility to participate in any plan components authorized by the Plan;

1.07.030 Promulgating rules of procedure and keeping records necessary for the proper and efficient administration of the Plan;

1.07.040 Advising the insurers and third party administrators with respect to participating employees and with respect to contributions made on behalf of participating employees;

1.07.050 Furnishing the City Council, participants and insurers with information they may require;

1.07.060 Engaging the service of such agents as the administrator may deem advisable to assist or perform the administrator's duties;

1.07.070 Consulting with the City Attorney with respect to the meaning or construction of the Health Plan and its component plans and the administrator's duties thereunder; and

1.07.080 Assuming responsibility for all applicable reporting and disclosure requirements, and engaging the service of agents to assist with reporting and disclosure requirements.

1.07.090 The Plan Administrator will be deemed to have properly exercised such discretionary authority unless the Plan Administrator has abused his or her discretion hereunder by acting arbitrarily and capriciously.

1.08 Plan Notification

Reasonable notification of the availability and terms of the Plan shall be provided to all Employees of the City by the Administrator.

1.09 Tax Effects

Neither the Employer nor the Plan Administrator makes any warranty or other representation as to whether any pre-tax contributions made to or on behalf of any Participant hereunder will be treated as excludable from gross income for local, state, or federal income tax purposes. If for any reason it is determined that any amount paid for the benefits of a Participant or Beneficiary is includible in an Employee's gross income for local, federal, or state income tax purposes, then under no circumstances shall the recipient have any recourse against the Plan Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as the result thereof.

1.10 Social Security Impact

Participation in the Plan may reduce the amount of a Participant's taxable compensation. Accordingly, there could be a decrease in the Participant's Social Security benefits.

1.11 Type of Plan

This is an employee welfare plan which provides medical benefits to eligible Participants and their beneficiaries. The CityCore Medical Plan, the Economy - High Deductible Health Plan, the SMW Plan for Seasonal Maintenance Workers and the Medicare Supplement Plan are self-insured plans. The City shall determine, from time to time, what portion of the benefits shall be paid directly by the Employer and what portion shall be paid by the eligible employees subject to the City's obligations under the Public Employees Collective Bargaining Act. Any amounts paid by the Employer on behalf of the plans shall be paid out of the City Health Funds unless otherwise required.

CHAPTER 2

2.0 DEFINITIONS

2.01 Definitions. As used in the City of Portland Health Plan and any of its component plans.

2.01.010 "Administrator" shall mean the Manager, Benefits of the City of Portland.

2.01.020 "Annual Enrollment Period" shall mean the period immediately preceding the period of benefit coverage, generally the last two weeks in May of each year, designated by the Administrator during which an employee may file or amend his or her benefit election form.

2.01.030 "Benefits" means for Eligible Employees of BOEC, COPPEA, DCTU, PFFA, PPCOA and Recreation employees for the Plan Year commencing on July 1, 2010, and subsequent plan years.

A. The Kaiser NW Health Plan of Oregon, group medical and hospital service agreement, including Kaiser optical plan, as amended from time to time.

B. The City of Portland CityCore medical plan and Vision Service Plan as amended from time to time.

C. The Kaiser NW Foundation Health Plan of Oregon group dental services plan, as amended from time to time.

D. Oregon Dental Service Plan, as amended from time to time.

2.01.040 Benefits" mean for Eligible Employees of the PPA for the Plan Year commencing on July 1, 2010 and subsequent plan years.

A. The Kaiser Health Plan of Oregon, group medical and hospital service agreement, including the Kaiser optical plan as amended from time to time.

B. The City of Portland CityNet and Vision Service Plan as amended from time to time.

C. The ODS Health Plan Inc., CityNet medical plan and Vision Service Plan, as amended from time to time.

D. The Kaiser Foundation Health Plan of Oregon group dental services plan, as amended from time to time.

E. Oregon Dental Service Plan, as amended from time to time.

2.01.050 "Benefits" mean for Eligible non-represented Employees for the Plan Year commencing on July 1, 2010 and subsequent plan years.

A. The Kaiser NW Health Plan of Oregon, group medical and hospital service agreement, including Kaiser optical plan, as amended from time to time.

B. The City of Portland CityCore medical plan and Vision Service Plan as amended from time to time.

C. The City of Portland Economy, High Deductible medical plan and Vision Service Plan as amended from time to time.

D.. The Kaiser NW Foundation Health Plan of Oregon group dental services plan, as amended from time to time.

E.. Oregon Dental Service Plan, as amended from time to time.

2.01.060 "Benefits" mean for Eligible Employees of the Laborer's Local 483 Seasonal Maintenance Workers for the Plan Year commencing on July 1, 2010 and subsequent plan years.

A. The City of Portland Seasonal Maintenance Worker medical plan as amended form time to time.

2.01.070 "Benefit Election Form" shall mean the forms, including electronic enrollment forms, promulgated by the Administrator by which an eligible employee elects the plans of his or her choice pursuant to this Benefit Plan.

2.01.080 "Change In Status" means an event that allows a Participant to make changes in his or her benefit elections as defined in Chapter 3. Changes made to coverage and elections must be consistent with and on account of the specific family status changes.

2.01.090 "City" shall mean the City of Portland, Oregon.

2.02.010 "Code" shall mean the Internal Revenue Code of 1986, as amended, and the regulations issued thereunder. References to a

Code section shall be deemed to be to that section as it now exists and to any successor provision.

2.02.011 "Council" shall mean the members of the City Council of the City of Portland, Oregon.

2.02.012 "Dependent," for purposes of the CityCore, Economy - High Deductible, Seasonal Maintenance Worker medical plans and the Medicare Supplement plan shall mean as defined below. Proof of a dependent's initial eligibility and continued eligibility may be requested at any time. Enrollees must be able to provide proof of eligibility for continued coverage. Failure to provide proof of dependent status will result in loss of dependent coverage.

A. Legal spouse as recognized by the employee's state of residence. A divorced or legally separated spouse is not eligible for City paid coverage;

B. Domestic partner as defined and declared in the City of Portland's Domestic Partner Affidavit or who is a registered domestic partner as per the Oregon Family Fairness Act of 2007.

C. Unmarried child under the age of 19 (age 21 for Kaiser plans) including the participant's:

1. Natural child,

2. Stepchild, if the employee's spouse is primarily responsible for financial support,

3. Child who is required to be covered by participant or participant's spouse as a result of divorce decree or court order to provide coverage.

4. Adopted child or child placed for adoption, or

5. Eligible child of an enrolled domestic partner (as declared on the Domestic Partner Affidavit) if the domestic partner is primarily responsible for financial support or is required by divorce decree or court order to provide coverage.

6. The child cannot be in active military status and be eligible under the Plan.

D. Coverage may continue to age 23 if the child is a full-time student (as defined by the school) in an Educational Institution. (A paid registrar's receipt from the school in attendance or a signed document with the school registrar's signature and seal will be required.) Coverage will end on the last day of the month in which the student graduates or otherwise stops attending school and

notification to the City's Benefits and Wellness Office must be made within 60 days of the event.

E. Incapacitated and dependent children may be covered past the qualifying age of 19 (age 21 for Kaiser plans) if the incapacitating condition existed prior to the child's first birthday after the qualifying age. An incapacitated child is one who is incapable of self-support because of developmental or physical disability. The disabled child will be covered as long as the child has a Determination of Disability under the Social Security Act, continues to reside with and be primarily supported by the employee.

F. Grandchild or other child if the employee and/or spouse or domestic partner has been granted custody and has been appointed the child's legal guardian.

G. Child of an eligible dependent child who is currently covered under the plan. Coverage for the child will be provided only so long as the dependent child continues to be covered under the plan, and as long as the child of the dependent child is living at the enrollee's residence.

H. Any dependent child or adult child of an employee as defined under the Health Care and Education Affordabilty Reconcilation Act of 2010 upon the required effective date.

2.02.013 "Earned income" shall have the meaning given such term in Code Section 32(c)(2).

2.02.014 "Educational Institution" means college, university or trade school accredited by the Council for Higher Education Accreditation that maintains a regular faculty and curriculum and has a regularly enrolled body of students in attendance at the place where its educational activities are regularly presented.

2.02.015 "Effective Date" of this amendment and restatement is July 1, 2010.

2.02.016 "Eligible Employee" means a full-time permanent or temporary employee appointed form an eligible list or appointed to an exempt position in a budgeted full-time position who is regularly scheduled to work at least 72 hours in a biweekly payroll period; a permanent part-time employee appointed from an eligible list or appointed to an exempt position who is regularly scheduled to work at least 40 hours but less than 72 hours in a biweekly payroll period, or a Laborers' Local 483 seasonal maintenance worker who is paid at least 40 hours in a month excluding any hours paid

from a third pay period in a month and otherwise meets the eligibility requirements in Chapter 3 . The term Employee does not include an independent contractor.

2.02.017 "Employee" shall mean an elected official of the City, a non-represented employee of the City of Portland, a City employee in the bargaining unit represented by the City of Portland Professional Employees Association (COPPEA), a member of the Bureau of Police in the bargaining unit represented by the Portland Police Commanding Officers Association (PPCOA), those members of the Bureau of Fire, Rescue and Emergency Services in the bargaining unit represented by the Portland Fire Fighters Association (PFFA), those members of the Bureau of Police in the bargaining unit represented by the Portland Police Association (PPA), those members of the Bureau of Emergency Communications in the bargaining unit represented by AFSCME Council 75 Local 189, those members of the District Council of Trade Unions, those members in the bargaining unit represented by Laborers' Local 483 Recreation Employees and those members in the bargaining unit represented by Laborers' Local 483 Seasonal Maintenance Workers. The term "Employee" does not include an independent contractor.

2.02.018 "Employee Contribution" shall mean the portion of the plan costs paid by the Employee or other eligible participant.

2.02.019 "Employer Contribution" shall mean the portion of the plan costs paid by the Employer.

2.02.020 "FMLA" means the Family Medical Leave Act of 1993, as amended.

2.02.021 "Full-time Employee" shall mean for purposes of this Plan, a permanent or temporary employee in a budgeted full time position in a benefit eligible employee status and job class or equivalent designation and who is regularly scheduled to work the Standard Hours Designation of at least 72 hours in a biweekly payroll period.

2.02.022 "Full-Time Student" shall mean a student enrolled in an Educational Institution as a full-time student as defined by the Educational Institution.

2.02.023 "Insurer" shall mean an insurance company duly licensed to do business in Oregon.

2.02.024 "HIPAA" means the Health Insurance Portability and Accountability Act of 1996, as amended.

2.02.025 "Initial Enrollment" means the period immediately preceding the date on which the Participant commences participation in the Plan.

2.02.026 "Medical Expenses" means the amounts paid for medical care as defined in Code Section213(d) for the Participant, his or her spouse or domestic partner and/or Dependents.

2.02.027 "Participant" shall mean an Employee who currently meets the eligibility requirements of Chapter 3 of this document and enrolls in the Benefit Plan or a component plan.

2.02.028 "Part-Time Employee" shall mean for purposes of this Plan in a benefit eligible employee status and job class or equivalent designation and who is regularly scheduled to work the Standard Hours Designation of at least 40 hours but less than 72 hours in a biweekly payroll period.

2.02.029 "Plan" shall mean City of Portland Health Plan.

2.02.030 "Plan Year" means the 12 month period beginning July 1 and ending June 30 each year.

2.02.031 "Third Party Administrator" a company the City contracts to provide customer service and claims payment or reimbursement for the City's self-insured medical plans.

CHAPTER 3

3.0 ELIGIBILITY AND PARTICIPATION

3.01 General

All Eligible Employees will become Participants during an Annual Enrollment Period or upon initially becoming eligible. If an Eligible Employee does not enroll within thirty-one (31) days of first becoming eligible, the Employee will be assigned default benefits as provided under Section 4.02, except on the occurrence of an applicable Change in Status event

3.02 Initial Eligibility

3.02.010 Full-time and part-time non-represented, BOEC, COPPEA, DCTU, and Recreation employees shall become eligible to participate in the Plan the first day of the month following the date of hire.

3.02.020 Full-time members of the PFFA, PPA and PPCOA shall become eligible to participate in the Plan the first day of the month following 30 days of eligible service.

3.02.030 Part-time members of the PFFA, PPCOA and PPA shall become eligible to participate in the Plan the first day of the month following 174 hours of eligible service.

3.02.040 Full time and part-time members of the Laborers' Local 483 Seasonal Maintenance Workers shall become eligible to participate if they worked as a Seasonal Maintenance Worker during the prior calendar year; satisfy the eligibility waiting period of eighty (80) paid hours in a month after re-employment from the prior year (excluding hours paid in a third pay period in a month) and have been paid at least 80 hours in the next month (excluding hours paid in a third pay period in a month).

3.03 Commencement of Participation

For Employees who meet the requirements of Section 3.02 on July 1 of a Plan Year, an Employee's eligibility to participate in the Plan will commence on that date.

3.03.010 For Employees who become Eligible Employees subsequent to the commencement of a Plan Year, participation will commence as of the first day of the month following the month in which the employee satisfies the eligibility requirements of Section

3.03.020 Eligible Employees must elect or purchase some or all of the Plan. If an Eligible Employee fails to file a Benefit Election Form within the time frame specified by the Administrator the Employee shall automatically be deemed to have purchased the applicable default plans described in Chapter 4.

3.04 On-Going Eligibility

3.04.010 City paid benefits will continue for non-represented, BOEC, COPPEA, DCTU, and Recreation employees each month in which they are actively employed in an eligible job class and status and working their regularly scheduled hours unless otherwise provided by a labor agreement or be in a qualified leave status for the City of Portland. Employees must make the required premium contribution. .

3.04.020 To maintain eligibility, PFFA, PPA and PPCOA Employees must receive pay for a minimum of 80 hours each calendar month or as other wise provided by an applicable labor agreement or be in a qualified leave status. Employees must make the required premium contribution. Pay includes compensation for hours worked, vacation leave, sick leave and comp time or otherwise provided under the applicable collective bargaining agreement. Pay does not include lump sum payouts of vacation and/or sick leave.

3.04.030 To maintain eligibility, seasonal maintenance workers must have received at least 80 hours of qualifying pay in the 1st and 2nd pay periods of the prior month and make the required premium contribution. Qualifying pay must consist of regular work hours, holiday pay, or comp time paid for absence from regular work hours. No other type of pay or benefit applies to make up the paid hours required.

3.04.040 Employees who are on non-paid Military Leave or personal leave without pay do not receive City paid benefits.

3.04.050 Participants must enroll their eligible dependents in the Plan at the same time the Participant becomes first eligible for the Plan or during the Annual Enrollment Period except as allowed below:

A. New Spouse/Eligible Stepchildren may be added within 60 days from the date of marriage. Coverage will become effective the

first of the month following the date the Participant adds the spouse/eligible stepchildren into the City's online enrollment system or files the required forms with the City's Wellness and Benefits Office. The Participant is required to provide the Office a completed Affidavit of Benefit Eligible Dependent Status form, a copy of the marriage certificate, and/or a copy of a birth certificate for each child added (as applicable.) If the required documentation is not received within 30 days of the online election or filing of paper forms, coverage for the new spouse/eligible stepchildren will terminate retroactively back to the effective date of coverage and the Participant will be held financially responsible for any claims paid on their behalf.

B. Oregon State's Certificate of Registered Domestic Partnership. Coverage will become effective the first of the month following the date the Employee adds the spouse/eligible stepchildren into the City's online enrollment system or files the required forms with the City's Wellness and Benefits Office. A completed and notarized Affidavit of Benefit Eligible Dependent Status form for the Employee and partner (or a copy of the Oregon state Certificate of Registered Domestic Partnership) and a copy of a birth certificate for each child added (as applicable) must be filed with the City's Wellness and Benefits Office. If the Office does not receive the required documentation within 30 days of the election, coverage for the new partner/eligible stepchildren will terminate retroactively back to the effective date of coverage and the Employee will be held financially responsible for any claims paid on their behalf.

C. Newborn Children will be covered from birth and claims will be paid for the newborn for the first 30 days. The Employee must add the newborn into the City's online enrollment system or file the required forms with the City's Wellness and Benefits Office within 60 days of the birth for continued eligibility. The Employee is required to provide the Benefits & Wellness Office a copy of the hospital or state issued birth certificate. If the Office does not receive the required documentation within 30 days of the online election, coverage for the dependent may terminate retroactively back to the 31st day and the Employee will be held financially responsible for any claims paid on the child's behalf.

D. Adopted Children may be added within 60 days of being physically placed in the Employee's home. Coverage may begin the date the child was placed in the home if the employee is assuming and retaining a legal obligation for financial support of the child. The Employee must add the child into the City's online enrollment system or file the required forms with the City's

Wellness and Benefits Office and submit a copy of the adoption or placement papers to the Benefits & Wellness Office. If the Office does not receive the required documentation within 30 days of the online election, coverage for the dependent may terminate retroactively back to the 31st day and the Employee will be held financially responsible for any claims paid on the child's behalf.

E. Newborn child of an Eligible Dependent Child will be covered from birth and claims will be paid for the dependent's newborn for the first 30 days. The Employee must add the child into the City's online enrollment system or file the required forms with the City's Wellness and Benefits Office for continued eligibility. The Employee is required to provide the Benefits & Wellness Office a copy of the hospital or state issued birth certificate. If the Office does not receive the required documentation within 30 days of the election, coverage for the Employee's dependent's child may terminate retroactively back to the 31st day and the Employee will be held financially responsible for any claims paid on the child's behalf.

F. Grandchild or other child may be added within 60 days from the date custody and guardianship are granted so long as the child qualifies as a dependent under the Plan. The employee must add the child into the City's online enrollment system or file the required forms with the City's Wellness and Benefits Office for continued eligibility and provide the Benefits & Wellness Office a copy of the court order granting custody and appointing the guardian and a copy of the letters of guardianship. If the Office does not receive the required documentation within 30 days of the election, coverage for the dependent may terminate retroactively and the Employee will be held financially responsible for any claims paid on the child's behalf.

G. Qualified Medical Child Support Order: If a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody requires health coverage for an employee's child, then the employee may change his or her election to (a) add coverage if the order requires coverage for the child under the employee's plan or (b) drop coverage if the order requires another individual to provide coverage for the child and the coverage is actually provided. If an election is not made by the employee, the Benefits & Wellness Office will add the child to the employee's coverage and will change any required premium share contribution.

H. HIPAA Special enrollment Rights: Mid year changes are allowed if: 1) an individual who was eligible for coverage but who didn't enroll because of preexisting coverage under another health plan at the time of initial enrollment and subsequently lost the other coverage (and loss of coverage was due to reasons other than failing to pay premiums on a timely basis) and 2) an individual becomes a dependent through marriage, birth or adoption or placement for adoption after the initial enrollment period. A change in status form must be returned within 60 days.

I. Medicare or Medicaid: Mid year changes are allowed if a person becomes entitled to or loses entitlement to Medicare or Medicaid. A change in status form must be returned to the Wellness and Benefits Office within 60 days of entitlement or loss of entitlement. Documentation from Medicare or Medicaid must be provided.

3.05 Termination

3.05.010 Participation in the Plan shall terminate when an individual ceases to be an Employee or when it is determined by the Administrator that the Employee no longer meets the eligibility criteria of Section 3.04 and/or fails to make the required premium contribution by the due date established by the Plan Administrator.

3.05.020 City paid benefits for non-represented, BOEC, COPPEA, DCTU, and Recreation employees will end on the last day of the month in which an employee terminates employment, enters an unpaid status because of military leave or personal unpaid leave or is unable to meet the minimum work requirements within their job class and/or standard hours designation.

3.05.030 Coverage for a non-represented, BOEC, COPPEA, DCTU, and Recreation employee and his/her eligible family members may be reinstated retroactively to the first of the month in which the employee returns to his/her regular work schedule.

3.05.040 Coverage for, PFFA, PPA and PPCOA employees will end on the last day of the month in which an employee has been paid at least eighty (80) hours in the prior calendar month unless otherwise provided under an applicable labor agreement. The 80 hours of pay must consist of regular work hours, vacation, sick, holiday, jury duty pay or comp time paid for absence from regular work hours. No other type of pay or benefit applies to make up the hours required. Lump sum vacation or sick leave payments at retirement or termination, time loss payments for workers'

compensation paid by Risk Management, disability payments from the Fire and Police Disability, Retirement and Death Benefit Plan or payments made pursuant to a long term disability plan do not count towards the 80 hour requirement.

3.05.050 Any required catch-up premium contributions will be deducted from the first paycheck the employee receives upon returning to paid status unless other repayment arrangements have been made.

3.05.060 Notwithstanding any provision to the contrary in this Plan, to the extent required by COBRA, a Participant and his or her spouse and Dependents, whose coverage terminates under the Medical or Dental benefits because of a COBRA qualifying event, shall be given the opportunity to continue on a self-pay basis the same coverage that he or she had under the Plan the day before the qualifying event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA).

3.06 Qualifying Leave Under Family Leave Act (FMLA)

3.06.010 Notwithstanding any provision to the contrary in the Plan, if a Participant goes on a qualifying leave under the Family and Medical Leave Act of 1993 (FMLA), then to the extent required by the FMLA, the Employer will continue to maintain the Participant's group healthcare plan benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the premium. If a Participant's coverage ceases while on FMLA leave, the Participant will be permitted to re-enter the Plan upon return from such leave on the same basis the Participant was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

3.06.020 A Participant may elect to continue his or her coverage under the Plan during the FMLA leave. If the Participant falls into an unpaid status and elects to continue coverage while on leave, the Administrator may terminate medical, dental and vision benefits if the Participant fails to make the required contribution. The Administrator may fund coverage during the leave if the Participant agrees to payment of "catch-up" amounts either through withholdings or an acceptable repayment schedule upon the Participant's return. During a FMLA leave, a Participant is eligible to participate in the Annual Enrollment Period.

CHAPTER 4

4.0 BENEFITS

4.01 Required Benefits

All Benefits are optional Employee elections except as follows:

4.01.010 All Full-Time Participants, except Seasonal Maintenance Workers, must elect a medical and vision plan from the menu unless the Employee provides evidence of enrollment in another Employer's group medical coverage. The determination to allow the Employee to opt-out of the City's medical coverage is made at the discretion of the Administrator after review of documentation that the Employee has medical coverage through another employer group medical plan. It shall be the responsibility of the Participant to immediately notify the Administrator upon cessation of any such other group medical coverage as described in the initial or annual enrollment form or online enrollment system.

4.01.020 All Full-time Eligible Employees, except Seasonal Maintenance Workers, must elect a group term life benefit plan from the menu irrespective of other life insurance coverage or financial resources of the Employee.

4.01.030 Part-time Eligible Employees, except Seasonal Maintenance Workers, must elect and purchase a group term life benefit plan from the menu irrespective of other life insurance coverage or financial resources of the Employee.

4.01.040 All Full-time Eligible Employees, except PFFA, PPA and Seasonal Maintenance Workers, must elect a group Long Term Disability benefit plan from the menu irrespective of other Long Term Disability benefit coverage or financial resources of the Employee.

4.01.050 Part-time Eligible Employees, except PFFA, PPA and Seasonal Maintenance Workers, must elect and purchase a group Long Term Disability benefit plan from the menu irrespective of other Long Term Disability benefit coverage or financial resources of the Employee.

4.01.060 All eligible full-time and part-time seasonal maintenance worker employees are deemed to have elected single party seasonal maintenance worker medical plan coverage as provided in

their collective bargaining agreement unless the Employee provides evidence of enrollment in another medical plan. The determination to allow the Employee to opt-out of the City's medical coverage is made at the discretion of the Administrator after review of documentation that the Employee has medical coverage through another plan. It shall be the responsibility of the Participant to immediately notify the Administrator upon cessation of any such other group medical coverage as described in the initial or annual enrollment form.

4.01.070 Notwithstanding any other language in this Chapter, Participants who elect the long term disability insurance plan shall, for all purposes under the Code, be treated as having received cash equal to the amount required to purchase such plan(s) and then purchasing such plan(s) with after-tax dollars.

4.01.080 Notwithstanding any other language in this Chapter, Participants who purchase any medical, dental, vision or life insurance plan and elect coverage for someone other than a spouse or Dependent of the Participant, as permitted by the medical, dental, vision or life insurance plan purchased, shall, for all purposes under the Code, be treated as having received cash equal to the amount required to purchase such coverage and then purchasing such coverage with after-tax dollars.

4.02 Default Benefits

With respect to the Plan Year commencing on July 1, 2010 and for any subsequent Plan Year, any participant who fails to make a proper election for such Plan Year, on or before the specified due date, in conformance with the procedures prescribed by the Administrator, shall be deemed automatically to have elected the default benefits outlined below:

4.02.010 For any Plan Year in which any one or all of the medical, dental, vision, life and long term disability benefit options have not been substantially changed as determined by the Administrator, any Eligible Employee who fails to make a proper election for such Plan Year, on or before the specified due date, in conformance with the procedures prescribed by the Administrator, shall be deemed automatically to have elected:

A The same benefit coverages, if any, as were in effect for the Participant just prior to the end of the preceding Plan Year, and

B. An agreement to a reduction in the Participant's compensation for such Plan Year equal to the Participant's share of the cost during such Plan Year of such benefit coverage.

4.02.020 For any Plan Year in which any one or all of the medical, dental, vision, life and long term disability benefit options have been substantially changed as determined by the Administrator or for which no prior election was made by a Participant, any Eligible Employee who fails to make a proper election for such Plan Year, on or before the specified due date, in conformance with the procedures prescribed by the Administrator, shall be deemed automatically to have elected:

A. For Initial Enrollment, for the Eligible non-represented, BOEC, COPPEA, DCTU, PFFA, PPCOA and recreation employees, Employee only coverage with the self-insured CityCore medical plan option, the vision plan offered with the self-insured medical plan, the dental plan option with the lowest total premium cost other than Kaiser Dental, the Employer funded group term life insurance and the Employer funded group long term disability plan as applicable.

B. For Initial Enrollment, for the Eligible Seasonal Maintenance Worker Employee the self-insured SMW medical plan option for the employee only,

C. For Initial Enrollment, for the Eligible PPA Employee only the Insured CityNet medical plan option, the vision plan offered with the insured medical plan, the dental plan option with the lowest total premium cost other than Kaiser Dental and the Employer funded group term life insurance.

D. For Annual Enrollment, the non-represented, BOEC, COPPEA, DCTU, PFFA, PPCOA and recreation eligible employees will be enrolled in the self-insured medical plan option, the vision plan offered with the self-insured medical plan, the dental plan option with the lowest total premium cost other than Kaiser Dental, at the same tier (i.e. single, two-party or family) as elected the prior Plan Year; the Employer funded group term life insurance, the employer funded group long term disability plan, and if previously enrolled, the Employee funded group long term disability plan buy-up and the Employee funded term supplemental life insurance.

E. For Annual Enrollment, the Seasonal Maintenance Worker employee will be enrolled in the self-insured medical plan option.,

F. For Annual Enrollment, the PPA employees will be enrolled in the CityNet insured medical plan option, the vision plan offered with the CityNet medical plan, the dental plan option with the lowest total premium cost other than Kaiser Dental, at the same tier

(i.e. single, two-party or family) as elected the prior Plan Year and the Employer funded group term life insurance and if previously enrolled, the Employee funded term supplemental life insurance.

4.03 Claims Procedure

All claims shall be made directly to the Third Party Administrator or insurer providing claims payment or coverage.

CHAPTER 5

5.0 TERMS AND PROVISIONS OF THE PLAN

5.01 General

5.01.010 "CityCore", "Seasonal Maintenance Worker", and "Economy" are self-insured medical plans sponsored by the City of Portland as is any run out from the formerly self-insured "CityNet" plan. CityNet became insured as of September 2007. Self-insured means there is no insurance company responsible for paying the claims incurred by plan participants. The City contracts with vendors to provide claims payment, utilization review, large case management, disease management and access to provider and facility networks' fee schedules.

A. Benefit-eligible non-represented employees, BOEC, COPPEA, DCTU, PFFA, PPCOA and Recreation members are eligible to participate in the CityCore plan.
B. Benefit-Eligible Seasonal Maintenance Workers are eligible to participate in the Seasonal Maintenance Worker plan.
C. Benefit-eligible non-represented employees are eligible to participate in the Economy plan.

5.01.020 The City Self-Insured Plans utilize a Preferred Provider Organizations (PPO) benefit design. The PPO consists of networks of hospitals, physicians and other health care providers who work with the City to provide medical and associated services to plan participants. The City has fee schedule arrangements with the PPO networks and with network fee schedule savings passed on to plan participants and the City. The PPO networks for the CityCore, CityNet and Economy plans include Managed Healthcare Northwest (MHN), the ODS Plus Network, the ODS Alternative Care Network and the PHCS Network.. The Seasonal Maintenance Worker Plan includes the ODS Plus Network.

5.01.030 The City Self-Insured Plan Participants have the freedom to choose any provider at each point in time they need medical care. A participant may choose a PPO provider and receive the same services for a reduced cost or may see a provider who is not part of the PPO network. Participants make the choice each time they seek medical care whether or not they desire to use a PPO or non-PPO provider.

5.02 Coordination of Benefits (COB)

5.02.010 An employee and/or dependent may be covered under more than one health care plan. For example, a husband and wife/domestic partner both

work, and may be covered under a medical, dental and/or vision plan at his and her places of employment. If each spouse or domestic partner covers the other and/or their children, stepchildren or domestic partner's children, there might be questions as to which plan should pay what amount in the event of illness or injury.

5.02.020 Coordination of Benefits is a method of determining the amount that each plan should pay when there is coverage under two or more health care plans. This provision considers a "plan" to include group coverage, most government programs, any coverage specified by law, any labor-management trusteed plan, union welfare plan, employer organization plan or employee benefit organization plan, and any individual automobile no-fault insurance plan.

A. For purposes of COB, plan includes:

1. Group insurance contracts and group-type contracts;

2. HMO (Health Maintenance Organization) coverage;

3. Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;

4. Medical care components of group long-term care contracts, such as skilled nursing care;

5. Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law; or

6. Other arrangements of insured or self-insured group or group-type coverage.

B. For purposes of COB, plan does not include:

1. Hospital indemnity coverage or other fixed indemnity coverage;

2. Accident-only coverage;

3. Specified disease or specified accident coverage;

4. School accident coverage;

5. Benefits for non-medical components of group long-term care policies;

6. Medicare supplement policies;

7. Medicaid policies, or;

8. Coverage under other federal governmental plans, unless permitted by law.

C. Each contract or other arrangement for coverage described above is a separate plan. If a plan has two parts and COB rules apply to only one of the two, each of the parts is treated as a separate plan.

5.02.030 For purposes of Coordination of Benefits, the following definitions apply:

A. An Allowable Expense means a healthcare expense, including deductibles, coinsurance, and co-payments, which is covered at least in part by any plan covering the claimant. When a plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the claimant is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a claimant is not an allowable expense.

1. The following are examples of expenses that are **not** allowable expenses:

(a) The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the plans provides coverage for private hospital room expenses;

(b) The amount of the reduction by the primary plan because a claimant has failed to comply with the plan provisions concerning second surgical opinions or prior authorization of admissions or services, or because the claimant has a lower benefit because that claimant did not use an in-network provider;

(c)Any amount in excess of the highest reimbursement amount for a specific benefit, if a claimant is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology;

(d) Any amount in excess of the highest of the negotiated fees, if a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees;

(e) If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

(f) If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any healthcare expense incurred that may not be subject to the deductible as described in Section 223(c)(2)(C).

B. Complying Plan is a plan that complies with these COB rules.

C. Non-complying Plan is a plan that does not comply with these COB rules.

D. Claim means a request that benefits of a plan be provided or paid.

E. Claimant means the enrollee for whom the claim is made.

F. This Plan is the part of this group contract that provides benefits for healthcare expenses to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing healthcare benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

G. Closed Panel Plan is a plan that provides healthcare benefits to covered persons primarily in the form of services through a network of providers that has contracted with or is employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by an in-network provider.

H. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

5.03 Coordination of Benefit- Payment of Claims

If the claimant is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then the other plan(s) pay(s). The order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

5.03.010 The Primary Plan (the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

5.03.020 The Secondary Plan (the plan(s) that pay(s) benefits after the primary plan) will reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

5.03.030 If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall provide benefits as if it were the primary plan when an enrollee uses an out-of-network provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

5.03.040 This Plan will coordinate with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in OAR 836-020-0770 to 836-020-0805 (non-complying plan) on the following basis:

A. If this Plan is primary, it will provide its benefits first.

B. If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan's benefits. This Plan will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan.

C. If the non-complying plan reduces its benefits so that the enrollee receives less in benefits than s/he would have received had this Plan provided its benefits as the secondary plan and the non-complying plan provided its benefits as the primary plan, then this Plan shall advance additional benefits equal to the difference between the amount that was actually paid and the amount that should have been paid if the non-complying plan had not improperly reduced its benefits. Additional payment will be limited so that ODS will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the enrollee against the non-complying plan.

5.03.050 Order of Claim Payments for Eligible Participants:

The first of the following rules that applies will govern:

A. Non-dependent/Dependent. If a plan covers the claimant as other than a dependent, for example, an employee, member, subscriber, or retiree, then that plan will determine its benefits before a plan which covers the person as a dependent. However, if the claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber, or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

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

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

1. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual

knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.

2. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent has responsibility for the healthcare expenses of the child, the 'birthday rule' described above applies.

3. If there is not a court decree allocating responsibility for the dependent child's healthcare expenses, the order of benefits is outlined below. (This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.)
(a) The plan covering the custodial parent;
(b) The plan covering the spouse or Partner of the custodial parent;
(c) The plan covering the non-custodial parent; and then
(d)The plan covering the spouse or Partner of the non-custodial parent.

D. Dependent Child Covered by Individual Other than Parent. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the first applicable provision (#2 or #3) above shall determine the order of benefits as if those individuals were the parents of the child. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

E. Active/Retired or Laid Off Employee. The plan that covers a claimant as an active employee, that is, one who is neither laid off nor retired (or as that employee's dependent) determines its benefits before those of a plan that covers a claimant as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

F. COBRA or State Continuation Coverage. If a claimant whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering that claimant as an employee, member, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

G. Longer/Shorter Length of Coverage. The plan that covered an employee, member, subscriber, or retiree (non-dependent) longer is the primary plan and the plan that covered the claimant for the shorter period of time is the secondary plan. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

H. None of the Above. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

I. Where part of a plan coordinates benefits and a part does not, each part will be treated as a separate plan.

5.03.060 Effect of COB on City Plan Benefits

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other healthcare coverage.

If a claimant is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by an out-of-network provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

5.03.070 Third Party Administrator's (ODS) Right To Collect and Release Needed Information

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

5.03.080 Facility of Payment

If another plan makes payments we should have made under this coordination provision, we can reimburse the other plan directly. Any such reimbursement payments will count as benefits paid under this Plan and we will be released from liability to you regarding them. The term 'payments' includes providing benefits in the form of services, in which case 'payments' means the reasonable cash value of the benefits provided in the form of services.

5.03.090 Right of Recovery

If the amount of payments made by this Plan is more than it should have paid under this COB provision, this Plan may recover the excess payment from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may

be responsible for the benefits or services provided for the claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services. Where the Plan does not have to pay its full benefits because of Coordination of Benefits, the savings will be credited to the claimant for the Plan Year. These savings are then applied to any unpaid allowable expense during the Plan Year.

5.04 Family And Medical Leave Provision

The City's healthcare plans are subject to the provisions of the Family and Medical Leave Act (FMLA) of 1993 and the Oregon Family Leave Act (OFLA). When there are conflicting provisions the City of Portland will comply with the stricter standard, i.e., the most beneficial to the employee. All available leaves will run concurrently (at the same time). An employee granted a leave of absence under FMLA and/or OFLA may retain benefits as outlined in City Administrative Rule 6.05.

In all events, the employee's and/or his enrolled dependents' rights under this provision are determined by the Family and Medical Leave Act of 1993 and its regulations, as amended.

5.05 Continuation of Benefit Coverage

Under certain conditions, employees and/or their eligible dependents may continue medical and vision, dental and vision insurance when such coverage would otherwise terminate. The types of continuation coverage may include: Worker's Compensation/Industrial Accident Leave, Legally Separated, Divorced or Widowed Spouses Over 55 Years of Age, Disabled Employees, Retirees and COBRA enrollees and/or other temporary state and federal continuation programs. The continuation provisions associated with applicable ongoing continuation provisions are described below:

5.05.010 Continuation of coverage during Worker's Compensation or Industrial Accident Leave

Benefits may continue during a Worker's Compensation or Industrial Accident Leave, the applicable Labor Agreement and/or Administrative Rule 6.13. Employees must continue to pay any applicable employee premium share contributions in order to continue coverage, even while in an unpaid status.

5.05.020 Legally Separated, Divorced, or Widowed Spouses Over 55

A surviving spouse of a deceased employee or a legally separated or divorced spouse age 55 or over, and their eligible dependents, may continue coverage until 1) Medicare eligibility for the surviving, divorced or legally separated spouse and 2) until the dependents reach the maximum eligibility age limits under the Plan in the same manner

as provided under Oregon law. The surviving or legally separated/divorced spouse and any dependent children whose coverage under the policy otherwise would terminate because of the death of, or legal separation/divorce from the covered employee, may continue coverage if the spouse is 55 years of age or older at the time of the death, legal separation or divorce. Coverage will be subject to all other regulations governing COBRA administration but is not considered a second qualifying event.

5.05.030 Disabled Employee Continuation

City of Portland disabled employees and their eligible dependents may continue medical and vision and dental coverage by self-paying the monthly premium costs. Where collective bargaining agreement language deviates from this document, the collective bargaining agreement language will be the governing language.

A. Eligibility

In order to be eligible for disabled employee continuation of coverage, the employee must meet all of the following conditions:

1. Be eligible to receive disability benefits from the Oregon Public Employees Retirement System (PERS) system, the Oregon Public Employees Retirement System (OPSRP) or the Fire and Police Disability and Retirement Fund; and

2. Must have been covered under the active employee health plans on a City paid basis in the month preceding disability.

B. PERS Disabled Employee Continuing Eligibility

Disabled participants not eligible for Medicare and their non-Medicare eligible, covered dependents are able to continue on the City's healthcare plans for active employees by self-paying the monthly premium by the due date set by the Administrator. Once a disabled employee and/or dependent become eligible for Medicare and/or attains age 65, he or she is no longer eligible for the City active employee medical, vision, or dental plans. However, if the disabled employee has a covered spouse or domestic partner under age 65 at the time the disabled employee becomes entitled to Medicare and/or attains age 65, the disabled employee may move to a Medicare Supplement plan and the spouse or domestic partner may continue on the "under 65" medical plan until he or she become entitled to Medicare and/or attain age 65 or no longer meets the definition of a dependent as defined by the Plan. Disabled employees age 65 who have eligible dependents under age 65, are eligible for coverage under the City's or Kaiser Medicare Supplement plans. When both the disabled employee and the spouse or domestic partner become entitled to Medicare and/or attain age 65, eligibility for any City benefit plan ends.

C. Fire and Police Disability and Retirement Fund Disabled Continuing Eligibility

Disabled employees not eligible for Medicare and their non-Medicare eligible covered dependents are able to continue on the City's active employee medical plans by self-paying the monthly premium. Once a disabled employee and/or dependent become entitled to Medicare and/or attains age 65, he or she is only eligible for the City's or Kaiser's Medicare Supplement plan. However, if the disabled employee has a covered spouse or domestic partner under age 65 at the time the disabled employee becomes entitled to Medicare and/or attains age 65, the spouse or domestic partner may continue on the active employee medical plan until he or she becomes entitled to Medicare and/or attain age 65, or no longer meets the definition of a dependent as defined by the Plan. Dependent children covered at the time the disabled employee becomes entitled to Medicare and/or attains age 65 are eligible to continue on the active employee plan until they no longer meet the definition of a dependent as defined by the Plan.

1. Fire fighters and police officers who reach age 65 and establish through formal documentation that they are not entitled to Medicare through any means, are eligible to continue on the active employee plans by self-paying the monthly premiums. If a participant becomes entitled to Medicare at a later date based on his or her spouses' or ex-spouse's Social Security eligibility, he or she will no longer be able to continue medical coverage on the active employee plan.

2. Disabled employees age 65 or older and their eligible dependents that are age 65 or older are eligible for the City's or Kaiser's Medicare Supplement Plan. The Medicare Supplement Plans are the only plans available to disabled employees and dependents age 65 or older. However, if the disabled employee has a covered spouse or domestic partner under age 65, the spouse or domestic partner may continue on the "under 65" medical plan until Medicare eligibility and/or attain age 65 or no longer meets the definition of a dependent as defined by the plan.

D. Termination of Coverage

If disabled participants elect to terminate coverage under City plans prior to age 65, they can only return to the City's medical and dental plans in which they were previously enrolled, if they are not Medicare eligible and they maintain continuous medical and dental group (employer sponsored) coverage between the time they leave the City plans to the date they want to return. An independent election to dental coverage is not allowed if the participant continues to maintain other group medical coverage. Written verification from the other employer-sponsored plan will be required.

E. Coordination with other Continuation Rights

Retiree or disabled participant continuation rights run concurrently with COBRA and Workers Compensation continuation rights. In the case of disability, the Administrator can approve eligibility if the disabled has shown continued coverage on a self-pay basis. Where collective bargaining agreement language deviates from this document, the collective bargaining agreement language will be the governing language.

5.06 Retiree Eligibility

City of Portland retirees and their eligible dependents may continue medical and vision and dental coverage by self-paying the monthly premium costs. Where collective bargaining agreement language deviates from this document, the collective bargaining agreement language will be the governing language.

5.06.01 Eligibility

In order to be eligible for retiree continuation of coverage, the employee must meet the following conditions:

A. Be eligible to receive retirement income from the Oregon Public Employees Retirement System (PERS) system, the Oregon Public Employees Retirement System (OPSRP) or the Fire and Police Disability and Retirement Fund; and

B. Must have been covered under the active employee health plans on a City paid basis in the month preceding retirement.

C. PERS Retirees Continuing Eligibility

Retirees not eligible for Medicare at retirement and their non-Medicare eligible, covered dependents are able to continue on the City's healthcare plans for active employees by timely self-paying the monthly premium. Once a retiree and/or dependent becomes eligible for Medicare and/or attains age 65, they are no longer eligible for the City active employee medical, vision, or dental plans. However, if the retired employee has a covered spouse or domestic partner under age 65 at the time the retiree becomes entitled to Medicare and/or attains age 65, the retiree may move to a Medicare Supplement plan and the spouse (or domestic partner) may continue on the "under 65" medical plan until they become entitled to Medicare and/or attain age 65 or they no longer meet the definition of a dependent as defined by the Plan. Retirees 65 and older at retirement that have eligible dependents under age 65 are eligible for coverage under the City's or Kaiser Medicare Supplement plans. When both the retiree and the spouse (or domestic partner) become entitled to Medicare and/or attain age 65, they are no longer eligible for any City benefit plan.

D. Fire and Police Disability and Retirement Fund Retirees Continuing Eligibility

Retirees not eligible for Medicare at retirement and their non-Medicare eligible covered dependents are able to continue on the City's active employee medical plans by self-paying the monthly premium. Once a retiree and/or dependent becomes entitled to Medicare and/or attains age 65, the enrollee is only eligible for the City's or Kaiser's Medicare Supplement plan. However, if the retiree has a covered spouse or domestic partner under age 65 at the time the retiree becomes entitled to Medicare and/or attains age 65, the spouse or domestic partner may continue on the active employee medical plan until becoming entitled to Medicare

and/or attain age 65, or no longer meets the definition of a dependent as defined by the Plan. Dependent children covered at the time the retiree becomes entitled to Medicare and/or attains age 65 are eligible to continue on the active employee plan until no longer meeting the definition of a dependent as defined by the Plan.

1. Fire fighters and police officers who reach age 65 and establish through formal documentation that they are not entitled to Medicare through any means are eligible to continue on the active employee plans by self-paying the monthly premiums. If participants become entitled to Medicare at a later date based on their spouses' or ex-spouse's Social Security eligibility, they will no longer be able to continue medical coverage on the active employee plan.

2. Retirees age 65 or older at retirement and their eligible dependents that are age 65 or older are eligible for the City's or Kaiser's Medicare Supplement Plan. The Medicare Supplement Plans are the only plans available to retirees and dependents age 65 or older. However, if the retiree has a covered spouse (or domestic partner) under age 65, the spouse (or domestic partner) may continue on the "under 65" medical plan until becoming entitled to Medicare and/or attaining age 65 or no longer meeting the definition of a dependent as defined by the plan.

3. Termination of Coverage: If retirees elect to terminate coverage under City plans prior to age 65, they can only return to the City's medical and dental plans in which they were previously enrolled if they are not Medicare eligible and they maintain continuous medical and dental group (employer sponsored) coverage between the time they leave the City plans to the date they want to return. An independent election to dental coverage is not allowed if the participant continues to maintain other group medical coverage. Written verification from the other employer-sponsored plan will be required.

5.07 Continuation of Coverage "COBRA Provisions"

Federal law requires most employers sponsoring group health plans to offer employees and their eligible dependents ("qualified beneficiaries") the opportunity to elect a temporary extension of health coverage (called "continuation coverage" or "COBRA" coverage) in certain instances where coverage under the group health plan would otherwise end. The following outlines COBRA coverage, when it may become available and events/actions are necessary to qualify and enroll in COBRA coverage.

There are four group health components to the City's COBRA continuation coverage: 1. Medical/Vision, 2) Dental, 3) Employee Assistance Program (EAP) and 4) the Medical Expense Reimbursement Plan (MERP.) COBRA applies only to these components and not to any other benefits offered by the City of Portland. The City provides no greater COBRA rights than what the federal COBRA law requires.

A. Employee COBRA Qualifying Events

A City employee may have the right to elect continuation coverage if he or she loses coverage under the Plan because of any one of the following "qualifying events":

1. Termination of employment (for reasons other than gross misconduct) or reduction in hours of employment.
2. Appointment to a non-benefit eligible position.
3. Leave of Absence in excess of, or outside the parameters of the maximum leave covered under the Family and Medical Leave Act (FMLA).
4. For PPCOA and PFFA employees, reduction to less than 80 hours paid in a month.
5. Absence upon denial of a workers' compensation claim.

B. Spouse COBRA Qualifying Events

A spouse of an employee covered by the Plan has the right to elect continuation coverage if he or she loses coverage under the Plan because of any of the following "qualifying events":

1. The death of the employee.
2. The termination of the employee's employment (for reasons other than gross misconduct).
3. The reduction in the employee's hours of employment.
4. Divorce or legal separation from the employee.

If an employee eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.

C. Dependent COBRA Qualifying Events

A dependent child of an employee covered by the Plan has the right to elect COBRA continuation coverage if the dependent child's group health coverage under the Plan is lost for any of the following qualifying events:

1. The death of the employee-parent;
2. The termination of the employee-parent's employment (for reasons other than gross misconduct);
3. Reduction in the employee-parent's hours of employment;
4. The parents' divorce or legal separation;

5. The employee-parent becomes entitled to Medicare benefits under Title XVIII of the Social Security Act; or

6. The dependent ceases to be a "dependent child" under the Plan.

D. Newborn or Newly Adopted Child: If a child is born or adopted by the covered employee during the period of COBRA continuation coverage, and the covered employee has elected COBRA continuation coverage, then the employee (or other guardian) may elect COBRA continuation coverage for the child.

E. Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Plan during the leave. Contact the City Benefits & Wellness Office for more information about these special rules.

5.07.010 - COBRA Coverage under the Medical Expense Reimbursement Plan (MERP)

A. COBRA coverage under the MERP component is only available to qualified beneficiaries who have remaining MERP account balances at the time of COBRA eligibility. A qualified beneficiary has an under spent account if the annual limit elected by the covered employee, reduced by reimbursements up to the time of the qualifying event, is equal to or more than the amount of the premiums for MERP COBRA coverage that will be charged for the remainder of the plan year.

B. COBRA coverage will consist of the MERP coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event.) The "use it or lose it" rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year and COBRA coverage will terminate at the end of the plan year.

C. Unless otherwise elected, all qualified beneficiaries who were covered under the MERP will be covered together for MERP COBRA coverage. Alternatively, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate MERP annual limit and a separate premium.

D. Qualified beneficiaries may not enroll in the MERP at annual enrollment.

5.07.020 - Participant Obligations under COBRA

A. When the qualifying event is the end of employment, reduction of hours, or death of the employee, the City will offer COBRA coverage to qualified beneficiaries.

B. Under COBRA, the covered employee or a covered family member has the responsibility to inform the City's Benefits & Wellness Office of the employee's divorce or legal separation, or a child losing dependent status under the Plan. COBRA continuation will only be available to those qualified beneficiaries who notify the City Benefits & Wellness Office in writing, with the appropriate documentation within 60 days after the later of (1) the date of such an event, or (2) the date on which the

affected employee or family member would otherwise lose coverage because of such event.

C. Notice to the Office must be made either through the City's electronic online program (BenefitsOnline) or by completion and submission of a Family Status Change Form. If the notice is not provided to the Office within the required 60-day period, the affected employee or family member will not be entitled to elect COBRA continuation coverage.

D. When the Benefits & Wellness Office is notified that one of these qualifying events has occurred, it will notify the qualified beneficiaries that they have the right to elect COBRA continuation coverage.

E. To elect COBRA continuation coverage the qualified beneficiaries must complete and submit the Election Form provided within the COBRA notice packet within 60 days after the later of (1) the date that coverage under the Plan would otherwise terminate due to the qualifying event, or (2) the date that the qualified beneficiaries are provided with written notification of their right to elect COBRA continuation coverage.

F. If the Benefits and Wellness Office does not receive a completed election form by the due date, the Participant will lose the right to elect COBRA.

5.07.030 Independent COBRA Election Rights

A. While an election by a covered employee or covered spouse will be treated as an election of COBRA continuation coverage by the entire family, each family member may make a separate election as to COBRA continuation coverage. This allows a covered spouse or dependent child to elect COBRA continuation coverage even if the employee does not make that election.

B. If a child is born to, or placed for adoption with, a covered former employee during the COBRA continuation coverage period and the covered employee has elected COBRA continuation coverage, then the employee may elect COBRA continuation coverage for that child provided that the covered former employee notifies the plan administrator within the Plan's normal enrollment window for newborn children, adopted children, or children placed for adoption.

C. An employee, covered spouse or dependents may elect COBRA continuation coverage even if the Participant is covered under another group health plan or is entitled to Medicare prior to electing COBRA continuation coverage. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice loses the right to elect COBRA Coverage.

D. If the Participant is enrolled in a region-specific HMO that will not service the Participant's health needs in an area to which the Participant is relocating, the

Participant may elect alternative applicable coverage available to other City active employees.

E. The former Employee and covered dependents (if any) have the same opportunity as an active employee to change coverage at annual enrollment, add new family members or drop dependents.

F. A qualified beneficiary who has elected COBRA continuation coverage may elect to cover certain family members under special enrollment rights if certain requirements are satisfied.

1. There are special enrollment rights as described in these COBRA provisions for certain family members upon the loss of other group health plan coverage or upon the acquisition by the employee or participant of a new spouse or of a new dependent through birth, adoption, or placement for adoption.

2. A family member first enrolled during an open enrollment period or special enrollment period while the former Employee is receiving COBRA continuation coverage and who was not covered by the Plan on the day before the initial COBRA qualifying event occurred is not eligible to extend the initial COBRA continuation period unless that family member is a child born to the covered employee or placed with the covered employee for adoption during the initial 18-month period of COBRA continuation coverage and enrolled in the Plan while the covered employee was receiving COBRA continuation coverage.

5.07.040 - Special Participant Considerations in Deciding Whether to Elect COBRA

A Participant's failure to elect COBRA will affect his or her future rights under the COBRA federal law.

A. The participant can lose the right to avoid having preexisting condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage.

B. The Participant will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if he or she does not get COBRA coverage for the maximum time available.

C. The participant will waive the special enrollment rights under federal law to request special enrollment in another group health plan for which the Participant may be otherwise eligible (such as a plan sponsored by the spouse's employer) within 30 days after the Participant's group health coverage under the Plan ends because of one of the qualifying events listed above. The Participant will also have the same special enrollment right at the end of COBRA coverage if COBRA is elected for the maximum time available to the Participant.

5.07.050 - Length of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods.

A. COBRA coverage under the MERP component can last only until the end of the year in which the qualifying event occurred.

B. When coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's loss of eligibility as a dependent child, COBRA coverage under the Plan's Medical/Vision, Dental and EAP components may continue for up to a total of 36 months.

C. When coverage is lost due to the employee's termination of employment, appointment to a non-benefits eligible position, leave of absence or a reduction in hours and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan's Medical/Vision, Dental and EAP components for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can continue until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months.) This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

D. Otherwise, when coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's loss of eligibility as a dependent child, COBRA coverage under the Plan's Medical/Vision, Dental and EAP components may continue for up to a total of 18 months.

5.07.060 - Extension of Maximum Period of Coverage

A. Second Qualifying Event

In the event of a second qualifying event, the covered dependents of an employee may extend their COBRA continuation coverage for up to 36 months from the date the covered employee terminated employment or lost Plan coverage because his or her hours were reduced, leave of absence, or change to a non-benefit eligible position. The covered employee or a covered family member must notify the Benefits & Wellness Office of the employee's divorce or legal separation, or a child losing dependent status under the Plan within 60 days after the occurrence of such event. Failure to notify the Office of a second qualifying event within the 60 day timeframe will eliminate the right to extend the period of COBRA coverage. A family member whom the covered employee first enrolls during the annual enrollment period or special enrollment period while the covered employee is receiving COBRA continuation coverage is not eligible to extend the COBRA continuation period as

described in this paragraph, unless that family member is a child born to the covered employee or placed with the covered employee for adoption and enrolled in the Plan while the covered employee is receiving COBRA continuation coverage.

B. Disability-

1. If a qualified beneficiary is determined by the Security Administration to be disabled and the Benefits & Wellness Office is notified in a timely fashion, all of the qualified beneficiaries in the family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months.

2. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because a covered employee terminated employment or lost Plan coverage because his or her hours were reduced, leave of absence, or change to a non-benefit eligible position.

3. The disability must have started at some time before the 61st day after the qualifying event and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above.)

4. Each qualified beneficiary will be entitled to the disability extension if one of them qualifies. Notice to the Benefits & Wellness Office must be provided with a copy of the Social Security determination letter within 60 days after it is made and before the 18-month COBRA period expires. If notice to the Benefits & Wellness Office is not received within this timeframe, there will be no disability extension of COBRA coverage.

5. Each covered employee or covered family member who is determined to be disabled (under Title II or XVI of the Social Security Act) at any time during the first 60 days of COBRA continuation coverage has the responsibility to: (1) inform the Benefits & Wellness Office within 60 days after the date of that determination, and (2) if applicable, inform the Benefits & Wellness Office within thirty (30) days after the date of any final determination that the covered employee or covered family member is not disabled.

5.07.070 -Termination of COBRA Coverage Before the End of the Maximum Coverage Period

The law provides that COBRA continuation coverage will automatically terminate before the end of the maximum period for any of the following reasons:

A. The City no longer provides group health coverage to any of its employees;

B. The premium for the COBRA continuation coverage is not paid in full on time (the first premium payment is payable in a lump sum forty-five (45) days after electing COBRA continuation coverage; all subsequent premium payments are due on the first

day of the month for that month's coverage. There is a thirty (30) day grace period following the due date);

C. The qualified beneficiary first becomes, after the date of the COBRA continuation coverage election, covered under another group health plan (as an employee or otherwise (but only after any exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied.) In this case, the qualified beneficiary must notify the Benefits & Wellness Office within 30 days of eligibility for such other coverage.

D. The qualified beneficiary first becomes, after the date of the COBRA continuation coverage election, entitled to Medicare (under Part A, Part B, or both.) The qualified beneficiary must notify the Benefits & Wellness Office within 30 days of entitlement to Medicare.

E. During a disability extension period, the Social Security Administration makes a final determination that the disabled qualified beneficiary is no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate.) In this case, the qualified beneficiary must notify the Benefits & Wellness Office within 30 days after the date of the Social Security final determination.

F. Upon the occurrence of any event (such as submission of fraudulent claims) by a covered individual that permits termination of Plan coverage for cause with respect to similarly situated non-COBRA beneficiaries.

5.07.080 Cost of Coverage

A. The cost of COBRA continuation coverage will generally not exceed 102% of the total cost for coverage under the Plan. The cost of COBRA continuation coverage will increase in the middle of the 12-month determination period only in the following instances:

1. Where coverage extends beyond 18 months for a disabled individual, the cost of COBRA continuation coverage will be 150% of the applicable premium,

2. Where the qualified beneficiary changes to more expensive coverage, or

3. Where the Plan was previously requiring payment of less than the maximum permissible amount.

B. An individual seeking COBRA continuation coverage is liable for the cost of that coverage during the entire applicable 18-, 29-, or 36-month period (measured from the date that coverage would otherwise end due to the qualifying event). Due to the required 60 day COBRA election period, it is likely that a covered individual will be responsible for retroactive premiums. These premiums must be paid in a lump sum within forty-five (45) days after electing COBRA continuation coverage in order for the COBRA continuation coverage to be effective. After that payment, premiums are due on a monthly basis, on the first day of the month for that month's coverage.

Coverage will terminate if premiums are not paid within thirty (30) days after the date they are due.

C. An individual need not show proof of insurability to elect COBRA continuation coverage.

D. The amount of COBRA premiums may change from time to time during the period of COBRA coverage and will most likely increase over time. Participants will be notified of COBRA premium changes.

5.07.090 - Payment for COBRA Coverage

A. All COBRA premiums must be paid by check or money order or other available approved electronic method. The first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the individual at the payment address specified in the election notice provided at the time of the Participant's qualifying event. However, if the Benefits & Wellness Office notifies the Participant of a new address for payment, he or she must mail or hand deliver all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

B. If mailed, the payment is considered to have been made on the date that it is postmarked. If hand-delivered, the payment is considered to have been made when it is received by the individual at the address specified above. The Participant will not be considered to have made any payment by mailing or hand delivering a check if the check is returned due to insufficient funds or otherwise.

C. No payments are required to be sent with the Election Form. However, the Participant must make the first payment for COBRA coverage not later than 45 days after the date of the COBRA election. (This is the date the Election Form is postmarked, if mailed, or the date the Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.)

D. The first payment must cover the cost of COBRA coverage from the time the coverage under the Plan would have otherwise terminated up through the end of the month before the month in which the Participant makes the first payment. (For example, if employment terminates on September 26 and the Participant's coverage ends on September 30 and COBRA is elected on November 10, the initial premium payment for October and November is due on or before December 25 (the 45th day after the date of the COBRA election). The Participant is responsible for making sure that the amount of the payment is correct.

E. Claims for reimbursement will not be processed and paid until the Participant has elected COBRA and made the first payment.

F. If the Participant does not make the first payment for COBRA coverage in full within 45 days after the date of the election, all COBRA rights under the Plan are lost.

5.07.010 - Monthly Payments for COBRA Coverage

A. After the first COBRA payment is made, the Participant is required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided at the time of the qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's coverage. If a monthly payment is made on or before the first day of the month to which it applies, COBRA coverage will continue for that month without any break. The Benefits & Wellness Office will not send a bill for COBRA coverage

B. There is a grace period of 30 days after the first day of the month to make each monthly payment. Coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if a monthly payment is received later than the first day of the month to which it applies, but before the end of the grace period for the month, coverage may be suspended as of the first day of the month and then retroactively reinstated (back to the first day of the month) when payment is received. This means that any claim submitted for benefits, including requests for prescriptions, while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

C. If a Participant fails to make a monthly payment before the end of the grace period for that month, all rights to COBRA coverage under the Plan are lost.

5.07.011- COBRA Notice Procedures

B. If a Participant does not follow these notice procedures, he or she and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable.)

B. Any notice provided by the Participant concerning changes in family status must be made through the BenefitsOnline system or in writing to the Benefits Office on the City's Change in Family Status form. The change in Family Status form is available at http://www.portlandonline.com/shared/cfm/image.cfm?id=28504. Alternatively, the Participant may mail or hand deliver the notice to:

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

C. If mailed, the notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, the notice must be received by the COBRA Administrator at the address specified above no later that the last day of the applicable notice period.

D. Any notice provided by the Participant must include:

1. The name and address of the employee who is (or was) covered under the Plan;
2. The names and addresses of all qualified beneficiaries who lost coverage as a result of the qualifying event;

3. The qualifying event and the date it happened; and
4. The certification, signature, name, address and telephone number of the person providing the notice.

E. If the qualifying event is a divorce or legal separation, the notice must include a copy of the decree of divorce or legal separation. If the former Employee's coverage is reduced or eliminated and later a divorce or legal separation occurs, and if the former Employee is notifying the Benefits & Wellness Office that Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, the notice must include evidence satisfactory to the Benefits & Wellness Office that coverage was reduced or eliminated in anticipation of the divorce or legal separation.

F. If the qualifying event is due to disability, the notice of disability must include:

1. The name and address of the disabled qualified beneficiary;
2. The date the qualified beneficiary became disabled;
3. The names and addresses of all qualified beneficiaries who are still receiving COBRA coverage;
4. The date the Social Security Administration made its determination;
5. A copy of the Social Security Administration's determination; and
6. A statement whether the Social Security Administration has subsequently determined the disable qualified beneficiary is no longer disabled.

G. If the qualifying event is due to a second qualifying event, the notice must include:

1. The names and addresses of all qualified beneficiaries who are still receiving COBRA coverage;
2. The second qualifying event and the date it happened;
3. If the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

H. The covered employee (i.e., the employee or former employee who is or was covered under the Plan,) a qualified beneficiary who lost coverage due to the qualifying event described in the notice or a representative acting on behalf of either may provide the required notices. A properly submitted notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

5.08 Oregon Medical Insurance Pool (OMIP) Portability Coverage

A. The Oregon Medical Insurance Pool provides medical insurance to City COBRA Participants who are Oregon residents and who have exhausted their COBRA benefits. The purpose of the pool is to provide insurance to Oregon residents who are 1) unable to obtain medical insurance because of health conditions or 2) who qualify

for "portability" coverage as result of the loss of other group health insurance. OMIP has two "portability PPO medical plans with two different deductible levels.

B. Enrollees must pay the full premiums each month to maintain insurance coverage through OMIP. Information about OMIP plans and costs or the health care options may be obtained by calling 1-800-848-7280 or through the website at http://www.oregon.gov/DCBS/OMIP

5.09. Medical and Behavioral Health Management Services

5.09.010 To assist Participants with their health care needs and to assure that medical treatments are medically necessary, appropriate and reasonable, the City incorporated Medical and Behavioral Health Management Services into its medical plans. The programs include pre-certification for specialized services, medical review of complex or high cost cases, case management of complex or high cost cases, disease management of assistance for chronic conditions and wellness services.

5.09.020 In order to appropriately utilize plan benefits, Participants or the Participant's provider should contact the City's third party administrator (ODS) when any of the following occur:

A. When the Participant's physician recommends an inpatient hospitalization.

B. Within 48 hours of an emergency hospital admission or the first working day following a weekend or holiday admission.
C. If your physician recommends any of the health care services listed under Medical Review Services" requiring preauthorization .

D. When a mental health or chemical dependency admission has been recommended;

5.09.030 – Medical Review Services

A. Services Requiring Pre-Certification/Authorization

Review of recommended care for eligibility, benefits and medical necessity prior to the date services occur is required on all covered services listed below. Failure to follow the pre-certification procedure described below for the following services will result in an initial denial of reimbursement for the services. If a claim is denied, the Participant must request a retrospective service authorization. If the retrospective service authorization is approved, the claim will be adjusted. The Participant will still be responsible for any applicable in or out of network deductibles, co-payments and charges in excess of what would have been certified by the Plan

1. Behavioral Health Services, including:

2. Chemical dependency treatments, inpatient and residential services

3. Mental health services (inpatient and residential services)

4. Durable medical equipment rental and purchases. (Rental exceeds 30 days or cost is over $500)

5. Home health care

6. Hospice care

7. Hospital inpatient admissions and rehabilitation stays

8. Transportation in lieu of ambulance

9. Organ transplants

10. Skilled nursing facility care

11. Special duty nursing

12. Surgical procedures (inpatient and outpatient operative and cutting procedures requiring hospitalization or surgical center)

13. All elective surgery (operative and cutting procedures), inpatient or outpatient, excluding surgeries performed in a doctor's office

14. Colonoscopy for patients under age 50. In these cases, only those with medical or family history diagnosis will be eligible for plan benefits. No pre-certification is required for colonoscopy if age 50+.

15. Pet scans

16. Spect scans, unless being done for a cardiac diagnosis;

17. Genetic testing

18. Anesthesia/out patient hospital for dental procedures

19.. Speech therapy (after initial evaluation) rendered as a result of congenital abnormality, previous therapeutic process or injury or illness within one year of the onset of the injury/illness. Services rendered for the treatment of delays in speech development are not covered

20. Infusion services, dialysis, radiation and chemotherapy treatment

B. Pre-Certification Service Authorization Procedure

The following procedures will apply to all covered services that require a service authorization, unless otherwise noted. While the physician or hospital can complete the service authorization procedure on the participant's behalf, it is the responsibility of the participant to ensure that proper authorization is obtained.

1. Non-Emergency Service Authorization Procedure

In the event a participant requires a non-emergency service or treatment that has a service authorization requirement, the following procedure must be followed prior to receiving the service or treatment:

(a) The Participant's physician must call for a service authorization prior to admission (503-243-4496 (in the Portland Metropolitan Area) or 1-800-258-2037 (other areas inside and outside Oregon).

(b) Provide the covered member's name and identification number, covered patient's name, date and place of admission, physician's name and telephone number, diagnosis and surgery or procedure.

(c) The physician and/or hospital will be contacted for further information regarding diagnosis, proposed length of stay, reason for admission, surgical procedure, nature of prescribed service or treatment, etc. Once the service or treatment is determined to be a covered benefit and medically necessary, a service authorization approval is entered into the third party administrator's (ODS) claims payment system. An authorization letter is sent to the Participant, treating provider, and facility if applicable.

(d) If the Participant fails to follow the service authorization procedure, he or she will be responsible for charges in excess of what would have been reimbursed under the Plan.

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

2. Emergency Procedure Service Authorization

Authorization for emergency hospital admission must be obtained by calling the third party administrator (ODS at 503-243-4496 in the Portland Metropolitan Area or 1-800-258-2037 for other areas inside and outside Oregon) within 48 hours of the emergency hospital admission (or as soon as is reasonably possible).

5.09.040 - Additional Medical Service Review Services

A. During a hospitalization, a registered nurse, in collaboration with the Participant's physician and the facility discharge planners, may perform the following functions:

1. Concurrent Review - Review of the Participant's progress during a hospitalization and verification of the appropriate level of care for continued stay.

2. Discharge Planning- Coordination of discharge planning needs between all health care providers and the Participant's family to facilitate the Participant's return home or transfer to an appropriate facility.

3. Chemical Dependency and Mental Health Services Review- Review of future recommended treatment plans.

5.09.050 – Care Coordination Services (Case Management)

A. Care Coordination (case management) is performed by registered nurses. They work to create an individualized treatment programs for Participants with complex or high risk medical or mental health conditions or experiencing unusual and serious complications from a medical condition under treatment. The Participant has the option of using or not accepting the services. Examples of when case management may be offered include, but are not limited to:

1. Catastrophic illness/injury;

2. Organ transplant coordination, including medical therapies not available locally;

3. Chronic conditions which generate high use of outpatient services or frequent re-admissions to inpatient facility;

4. Referral coordination services;

5. Lengthy hospitalizations; and

6. High-risk pregnancies.

5.09.060 Disease Management/ Health Promotion

Disease Management and Health Promotion services are provided by registered nurses through the third party administrator (ODS) as a component of the City's medical service care coordination program. The program is intended to optimize health status for Participants through efforts such as educational mailings, individualized telephone consultations and targeted educational interventions.

A. Disease Management programs provide individualized education plans for those with a chronic disease such as asthma or other major conditions. Health Promotion activities focus on wellness, prevention of illness and early diagnosis including immunization reminders and maternity wellness. Participants can also request information on specific diseases, medical events (e.g., pregnancy) or medical concerns. The services are optional. Specifically, the program can:

1. Answer questions about pregnancy (Participants are encouraged to contact the third party administrator no later than the end of the first trimester.)

2. Answer questions medical concerns

3. Assist with the management of ongoing medical needs

4. Help you understand your medications

5. Clarify healthcare benefit options

6. Offer preventive wellness programs

7. Work with you to set personal health goals

8. Identify appropriate health-related community resources

9. Provide customized health or medical educational tools.

5.09. 070 Diabetes Disease Management Incentive Program

CityCore enrollees and their dependents will have the option of joining the City's diabetes management incentive program.

A. In order to enroll, individuals will be required to:

1. Complete a short, confidential questionnaire from the city's pharmaceutical manufacturer that assesses how compliant the people are with their diabetes management

2. Agree to an A1c check-up every six months – (Compliance would be based on the honor system.)

3. Understand that personal compliance data could be included in summary analysis of the program.

B. No review of personal medical records by the City will occur.

C. By joining the programs, participants would pay 5% rather than 10% when filling preferred generic prescriptions for specific classes of drugs that control blood sugar and insulin

D. Enrollees and their dependents will be charged a 10% co-pay (rather than 20%) when filling preferred brand name prescriptions for specific classes of drugs that control blood sugar and insulin

E. Enrollees and their dependents will be charged 15% co-pay for non-preferred drug costs (generic or brand)

F. Covered prescriptions will also include those used to treat complications of diabetes such as high blood pressure and other diseases.

5.09.080 - Hospital Bill Audit Program

If a Participant finds an incorrect charge on an itemized hospital bill after the applicable third party administrator has processed and paid the benefit, the Participant should notify the third party administrator of the billing error as soon as possible. The Participant will receive 50% of any savings realized by the third party administrator on the incorrect charges, with a minimum payment of $25 up to a maximum payment of $500 per inpatient hospital confinement.

5.10 Acts of Third Parties

A. Third-Party Liability - In situations in which a third party, including a participant's or another liability insurer, is responsible for the charges for health care services the Plan will seek reimbursement to the extent possible for expenses paid. For example, if a participant is injured in a store, the owner or the owner's insurance carrier

may be responsible for payment of the charges for the participant's health care services arising out of the injury. The following rules will apply in such situations. (For situations involving motor vehicle injuries, see the Motor Vehicle section.)

1. Assumption or Adjudication of Responsibility - If a third party has accepted financial responsibility or been adjudicated (determined) to be liable for all or a portion of the charges for the participant's health care services, the Plan shall not be responsible for the amount for which the third party has accepted responsibility or been adjudicated liable, and the provisions of the Plan shall not apply to the services for which responsibility has been accepted or liability has been adjudicated. The rules set forth in the following Subrogation section apply to any other services and charges.

2. Subrogation to Participant's Rights –

(a) For services and charges for which a third party may be responsible, other than those described above, the Plan will provide benefits for covered services but will be entitled to recover the charges for those services in the name of the participant or the Plan, or to be reimbursed from the third party or from participant's or another liability insurer. The Plan will not provide services unless the participant complies with the provisions of this paragraph. The Plan shall be entitled to recover or be reimbursed for the charges for all past and future health care services for which the Plan provides benefits, which are required on account of the condition from which recovery is sought. The Plan's recovery for health care charges is measured by the Plan's actual paid expenses. The Plan will provide the participant with information regarding the amount of these charges. If the participant continues to receive medical treatment for an illness or injury after obtaining a settlement or recovery from a Third Party, the Plan will continue to provide Benefits for the continuing treatment of that illness or injury only to the extent that the participant can establish that any sums that may have been recovered from the Third Party for the continuing medical treatment have been exhausted for that purpose.

(b) The participant agrees to cooperate in protecting the interest of the Plan under this provision. The Plan can require the participant to testify for the Plan and to sign and deliver all legal papers necessary to secure the participant's and the Plan's rights. If the Plan asks the participant to sign an agreement to reimburse the Plan and to hold the proceeds of any recovery in trust for the Plan, he or she must do so. Participant must agree to sign a subrogation agreement that allows the Plan to bring an action in the participant's name. The Plan has the right to deny coverage for claims related to the accident or incident pending receipt of the required legal papers and/or subrogation agreement. If a Plan participant fails to complete required paperwork after the payment of claims, the Plan will issue a retroactive denial of claims and the participant will be responsible for all claims associated with the accident or incident. The Plan will pay its share of the attorney fees and expenses of obtaining a recovery out of the proceeds of that recovery. The Plan will determine what share of attorney's fees and expenses are

appropriate to be paid by the Plan. If any action or proceeding against the participant is necessary to enforce the rights of the Plan under this paragraph, the prevailing party shall be entitled to such reasonable attorney fees and costs as the court shall find reasonable at trial or on appeal.

B. Motor Vehicle Coverage:

(a) Oregon law requires motor vehicle liability policies to provide personal injury protection benefits, which include benefits for health care expenses. This insurance is primary health care expense coverage of the insured and members of the insured's family who reside in the same household. To the extent coverage is available from the personal injury protection insurance, the Plan will be entitled to recover the cost of health care services that are required as a result of a motor vehicle injury for which the Plan provides benefits. A participant must give the Plan information about any personal injury protection insurance available to the participant or covered dependents.

(b) The Plan will provide benefits for the charges for health care services, which exceed the motor vehicle personal injury protection insurance. However, when the Plan provides benefits, it is entitled to recover the charges for health care services which exceed the motor vehicle personal injury protection insurance payment, and to recover the charges for health care services when it does not receive payment from personal injury protection insurance, from any recovery the participant makes from a claim or legal action related to the motor vehicle injury. This includes claims the participant makes against the participant's own uninsured or under-insured motorist coverage. The participant must promptly notify the Plan of any such claim or legal action. The Plan's recovery for health care charges is measured by the Plan's actual claims expenses. The Plan may recover the charges for health care services in one of the following ways:

(i) The Plan may use an inter-insurer reimbursement proceeding to obtain direct reimbursement from the motor vehicle liability insurer.

(ii) The Plan may elect to file a lien against the recovery of the claim or legal action. If it elects to file a lien, the Plan will notify the participant in writing within 30 days of when it receives notice of the claim or legal action. The Plan will also notify the person against whom the claim is made or the legal action instituted, within 30 days of receiving notice of the claim or legal action. The Plan shall give this written notice by U.S. Mail. If the participant has begun a legal action, the Plan will file with the clerk of the court a return showing service of such notice of election to file a lien. The lien is created by the Plan's notification of the parties. The Plan is entitled to recover the charges for health care services for which we have furnished benefits, less our portion of expenses, costs, and attorney fees incurred by the participant in connection with recovery of the amount of the lien. The participant must include as damages in the claim or legal action the charges for services for which the Plan furnished benefits.

(iii) If the Plan elects not to file a lien, it is entitled to the proceeds of any settlement or judgment the participant receives as the result of filing a claim or instituting a legal action, to the extent that the Plan has furnished benefits for health care costs resulting from the accident or incident. The Plan's recovery of health care charges will be less the Plan's share of expenses, costs, and attorney fees incurred by the participant in connection with the participant's recovery. The participant will hold all rights or recovery in a trust for the benefit of the Plan, up to the amount of the benefits provided by the Plan. The participant agrees to cooperate in protecting the Plan's interest under this provision.

C. If the Plan requests in writing that the Participant take such action necessary or appropriate to recover benefits provided for the Participant, the Participant must agree to do so. The Plan can require the Participant to testify for the Plan and to sign and deliver all legal papers necessary to secure the Participant's and the Plan's rights. For example the Plan can require a Participant to sign a subrogation agreement that allows the Plan to bring an action in the Participant's name. The Plan will also be reimbursed out of the recovery made from this action for the Participant's share of expenses, costs and attorney fees incurred in connection with the recovery. The Plan has the right to deny coverage for claims related to the accident or incident pending receipt of the required legal papers and/or subrogation agreement.

D. The City's and/or the Plan's first lien rights will not be reduced because of the Participant's own negligence, the Participant not being made whole, or due to attorney fees or costs.

E. The subrogation and right of recovery provisions apply to any funds recovered from a third party on behalf of and Employee's minor covered dependent, the estate of any Participant or on behalf of any incapacitated person.

5.11 Extension of Hospitalization Benefits

The City of Portland's self-insured plans (CityCore, Seasonal Maintenance Worker Medical Plan and Economy –High Deductible Plan) cover the hospitalization for a terminated enrollee when such enrollee is hospitalized at the time of termination. The coverage extends for the duration of the confinement, but not for any subsequent related hospitalizations.

5.12 Plan Claims and Payment Procedures

A. All claims submitted for payment are paid based upon the terms of the Plan in existence at the time that the expense was incurred. An expense is considered incurred on the date an eligible member of the plan receives medical treatment or services or when medical supplies or medications are prescribed.

B. All Claims must be received by the City's claim processing agent within 365 days of the date an expense has been incurred. The Plan will not pay claims received more than 365 days after the charge has been incurred.

C. It is the responsibility of the eligible plan Participant to file claims in a timely manner.

D. All claims must be submitted with the City's third party processing agent, which is currently:

ODS
Medical Claims – PO Box 40384
Portland, OR 97240-0384
Telephone: 503-243-3974 or 1-877-337-0649

E. If the Participant sees an in-network provider, the provider will directly bill ODS, the City's claim payer.

F. If the Participant receives services from a non-network services, most providers use a uniform billing system that provides ODS information on the diagnosis and nature of treatment. The Participant must send a copy of billings from non-network providers directly to ODS, the Medical Claims Administrator and include the employee's name, health plan ID number and to note "City of Portland" on the billing form.

G. When the City of Portland claim form is used, it should be accompanied by the itemized bill from the provider. This form allows the participant to indicate whether payments are to be made directly to the provider of service or to the participant.

5.13 Appealing a Claim or Pre-certification Decision

A. If a Participant disagrees with the decision to deny a claim or pre-certification decision, the Participant may appeal. The Plan has a two level formal appeal process. The Participant must file the appeal within 60 days of the date of the Plan's action. The Participant may also call the Plan's Medical Customer Service at (503) 243-3974 or toll-free at (877) 337-0649 to discuss the issue, as it may be possible to resolve it without filing a formal appeal.

1) First Level Appeal - If the Participant requests a First Level Appeal, the appeal must be submitted in writing along with any additional relevant information. The Plan will acknowledge receipt of a written appeal, in writing, within seven (7) days. The Plan will conduct an investigation by persons who were not involved in the claim denial. The Plan will keep the Participant informed of the progress, including if additional time or investigation is required for a full and complete review. Within 30 days of receipt of the appeal, the Participant will receive a written notice of the disposition of the appeal, including the basis for the decision, along with information on the rights to a Second Level of Appeal.

2) Second Level Appeal - If the Participant remains dissatisfied after the First Level Appeal, a Second Level Appeal through the Plan by persons who were not involved in the review of the First Level Appeal may be requested. The second appeal must be made within 60 days of the date of action on the First Level Appeal. The Plan will acknowledge receipt of a written appeal, in writing, within

seven (7) days and conduct an investigation. The Plan will keep the Participant informed of the progress, including if additional time or investigation is required for a full and complete review. Within thirty (30) days of receipt of the appeal, the Plan will notify the Participant in writing of the action taken.

3) The Participant has the right to appear before the panel in person or by conference call or other appropriate technology. The Plan will allow a representative to act on the Participant's behalf in the appeal process if the Participant so chooses. The appeal will be reviewed within twenty-five (25) working days of its receipt and a written decision will be sent within five (5) working days after the decision is made. This decision shall be final and binding.

4) If the Participant remains dissatisfied with the outcome, a review of the second appeal determination may be requested by the City's Wellness and Benefits Office. A response will be provided within 25 days.

5.14 Family Medical Leave

The City's health plans comply with the health continuation provisions of the federal Family Medical Leave Act (FMLA). The following rules apply to FMLA leaves:

A. The employee and his/her enrolled dependents will remain eligible to be covered under the plan up to twelve weeks during an approved FMLA leave.

B. If the employee does not return to work after the approved FMLA period of leave, reimbursement of all the City benefit payments will be requested unless there is a continuation, recurrence or onset of a serious health condition.

3. If the employee and/or his/her enrolled dependents elect not to remain covered during FMLA leave, the employee and/or enrolled dependents will be eligible to be reinstated in the plan on the date the employee returns from FMLA leave.

4. In all events, the employee's and/or his/her enrolled dependents' rights under this provision are determined by the Family and Medical Leave Act of 1993 and its regulations, as amended.

C. Payment of Premium While on An Approved FMLA Leave

1. While on an approved FMLA leave, an Employee may elect to continue his or her group health coverage, provided the Employee continues to pay the required portion of the cost, if any, of the elected plans. The employee also may pay the unpaid portion of the premium share upon the return to work.

5.15 Uniformed Services Employment and Reemployment Rights Act (USERRA)

A. If an Employee leaves his or her job to perform military service, he or she has the right to elect to continue his or her existing health plan coverage and for enrolled dependents for up to 24 months while in the military.

B If the employee doesn't elect to continue coverage during military service, the Employee has the right to be reinstated in the City's health plan upon reemployment

generally without any waiting periods or exclusions except for service-connected illnesses or injuries. 183725

C. The following rules apply to military leaves:

1. Employees on unpaid military leave 31 days or more shall have the right but are not required to elect and purchase continuation of medical, dental and vision benefits under COBRA for themselves if they are already enrolled in City medical/vision and/or dental coverage. COBRA coverage would be in addition to military coverage. Upon reemployment, the City will reinstate the employee's coverage without imposing any exclusion or waiting periods that would not have been imposed had the coverage not been terminated. The City will pay the cost of continuing to provide health insurance coverage under COBRA for up to 24 months and will waive the 2% administrative fee for the dependents of City employees who are called to active duty for a minimum of 31 days (training periods do not qualify) at the same level and cost provided while the employee was at work. The dependents of employees who have dual coverage through the City or a spouse/domestic partner's employer are not eligible for this benefit.

2. For employees on military leave less than 31 days, their City paid coverage will continue.

5.16 Termination of Coverage

A. In general, City paid benefits end on the last day of the month in which an employee terminates employment, enters an unpaid status because of military leave or personal unpaid leave or is unable to meet the minimum work requirements within their job class and/or standard hours designation. In addition, coverage will end automatically on the earliest of the following:

1. The last day of the last period for which the Employee makes a premium contribution

2. The date the group policy terminates;

3. The date the Employee or a dependent cease to qualify for coverage;

4. For PFFA and PPCOA employees, the first day of the calendar month following a calendar month in which the Employee is not paid by the City for at least 80 hours.

5. For Non-represented, BOEC, COPPEA, DCTU and Recreation employees, the last day of the month in which:

(a) Unpaid military leave begins;

(b) Unpaid, approved FMLA leave ends and the Employee has not returned to work for the City;

(c) Worker's compensation or service connected illness or injury leave ends and the Employee has not returned to work for the City;

(d) Any other unpaid leave ends and the Employee has not returned to work for the City;

(e) The employee's employment with the City ends.

5.17 Certificate of Creditable Coverage

A. When a Participant's coverage ends, the Employee and/or dependents will receive a certificate of creditable coverage that provides proof of prior medical coverage. The Participant may need to have this certificate to obtain medical coverage in the future. A written certificate will be provided when:

1. The Participant ceases to be covered under the Plan;
2. The Participant becomes eligible to elect COBRA coverage;
3. The Participant ceases to be covered under COBRA continuation coverage;
4. The Participant requests a Certificate of Creditable Coverage within 24 months of your termination of coverage.

5.18 The Federal Newborns' and Mothers' Health Protection Act of 1996

The Federal Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) relates to the amount of time a mother and newborn child can spend in the hospital in connection with the birth of a child. Under NMHPA, if a group health plan provides health coverage for hospital stays in connection with the birth of a child, this coverage must be provided for a minimum period of time. For example, NMHPA provides that coverage for a hospital stay following a normal vaginal delivery may generally not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection with childbirth following a cesarean section may generally not be limited to less than 96 hours for both the mother and newborn child. The City of Portland's health plans are in compliance with NMHPA.

5.19 Federal Women's Health and Cancer Rights Act of 1998

The Plan, as required by the Federal Women's Health and Cancer Rights Act of 1998 (Women's Health Act) provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema.)

1. Under the Women's Health Act, group health plans offering mastectomy coverage must provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and patient. Coverage includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

2. Deductibles and coinsurance charged for these services must be consistent with those established for other benefits under the Plan.

5.20 Plan Definitions:

A. Aggregate Benefit - Combined total benefits available to a Participant.

B. Alternative Health Care - Health care services provided by licensed acupuncturists, chiropractors and naturopaths.

C. Annual Enrollment - The period of time each year (May/June) when eligible enrolled employees or self-pay participants such as retirees or COBRA enrollees may make changes in their benefit plan coverage, effective July 1, from among those offered by the City. This is also the time for eligible persons to enroll themselves or eligible dependents, if they are not currently enrolled.

D. Concurrent Review - The process used to review hospital admissions and appropriateness in advance or within 48 hours after admission, and to verify medical necessity and appropriate level of care for continued stays. The participant and provider will be informed by the Utilization Review Organization (URO) whether or not the proposed services or treatment meet the URO's guidelines or standards for treatment. Agreement of the URO that the treatment meets established standards or guidelines does not guarantee plan payment. All benefits will be determined by the provisions of the plan.

E. Co-payment - That portion of covered charges which is the responsibility of the patient or participant. The co-payment is not part of the annual deductible.

F. Covered Charges - Medically necessary medical expenses eligible for reimbursement in accordance with the Plan document.

G. Deductible - The portion of eligible charges the participant must pay before benefits are payable under the plan.

H. Discharge Planning - A centralized, coordinated program developed by a hospital to ensure that each participant has a planned program for needed continued or follow-up care.

I. Domestic Partner - To be considered a domestic partner under this plan, the domestic partner and the employee must:

- Submit a copy of their State of Oregon's Certificate of Registered Domestic Partnership or
- Meet the criteria of the City's Domestic Partner Affidavit outlined below:
- Share the same regular and permanent residence;
- Have a close personal relationship, and are each other's sole domestic partner;
- Not be married to anyone;
- Each be eighteen (18) years of age or older;
- Not be related by blood, closer than would bar marriage in the state of residence;
- Be mentally competent to consent to contract when domestic partnership begins; and

- Be responsible for each other's common welfare, including the provision and/or payment of basic living expenses such as food, shelter and other necessities of life.

In taxable cases, the domestic partner and the employee must jointly be responsible for "basic living expenses". "Basic living expenses" are the cost of basic food, shelter and any other expenses. The individuals need not contribute equally or jointly to the cost of these expenses, as long as they agree that both are responsible for the cost.

In non-taxable cases, the employee must provide more than one half (1/2) of his/her domestic partner's financial support and be able to claim his/her domestic partner as a dependent on his/her individual tax form.

J. FDA Approved: Medications - Approved by the Federal Drug Administration.

K. Formulary - The process where prescription medications are reviewed by the Plan's Pharmaceutical Benefits Management service provider and determined to be most appropriate for medical conditions. This process occurs on a regular basis to ensure those medications in the formulary are best suited to treat specific medical conditions based on effectiveness, safety, and cost.

L. Home Health Care - Medical treatment administered to a patient confined at home who would otherwise require hospitalization. Such treatment must be administered by a state licensed home health agency and may include: professional nursing services; physical or occupational therapy; speech pathology and audiology; nutritional services; medical social services; medical supplies, equipment and appliances.

M. Hospice Care - Medically necessary and/or symptom controlling treatment administered to a patient who is terminally ill. Treatment must be rendered by a state licensed agency and may be on an inpatient or outpatient basis.

N. Hospital - An institution that provides diagnostic and treatment facilities for inpatient surgical and medical care for the injured and ill. It must be licensed as a general hospital, function under the supervision of a staff of physicians and include 24-hour nursing services by registered nurses. Rest, retirement or convalescent facilities, drug and alcohol treatment centers or facilities operated by an agency of the federal government are not considered hospitals.

O. Incurred Expenses - Those medical expenses that occur during a period of time while covered or enrolled in a plan.

P. Industry Recognized - Health care services and products that are accepted as appropriate by the health care community.

Q. Case Management - Review of specific high cost and/or complex case types for identification of cost effective alternatives which may be implemented, and intervention

which promotes care that is medically necessary, appropriate, high quality, and cost effective.

R. Magnetic Resonance Imaging (MRI) - A diagnostic radiological modality, using nuclear magnetic resonance technology. This test relies on magnetic fields, radio waves and a computer to produce three-dimensional pictures of thin slices of the internal area under examination.

S. Maximum Plan Allowance (MPA) - The maximum amount which the claims administrator will allow to base its reimbursement to physicians and providers. For in-network participating providers, the MPA is the contracted fee. For out-of-network providers, the maximum amount is determined by fees commonly charged for a given procedure in a given area, based on the Ingenix MDR System, a national database. If this database does not contain a fee for a particular procedure in a particular area, the claims administrator will refer the claim to their medical consultant who will determine a comparable code. The claims administrator will use the MPA for the comparable code to price the claim.

T. Medical Emergency - A medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

U. Medically Necessary - Those services and supplies that are required for diagnosis or treatment of illness or injury and which are consistent with the symptoms or diagnosis and treatment of the condition, and with standards of good medical practice. The fact that a provider may prescribe, order, recommend or approve a service does not, of itself, make the service or supply Medically Necessary.

V. Outpatient Surgery- Surgical procedures not requiring hospital confinement, which may be performed at a doctor's office, ambulatory surgical center or hospital.

W. Palliative Care- Medical services rendered to temporarily reduce or moderate the intensity of an otherwise stable medical condition as compared to those medical services rendered to diagnosis, heal or permanently alleviate or eliminate an undesirable medical condition.

X. PPO Provider - A health care service provider that is contracted with and credentialed by a managed care organization to provide quality and cost effective services.

Y... Pre-certification - Review of specific service types for medical necessity and appropriateness.

Z. Prescription Drugs - Those drugs and medicines, including insulin, that are medically necessary, and which must be prescribed by a licensed physician and dispensed by a licensed pharmacist.

AA. Respite Care - Care of a hospice patient for a period of time to relieve persons residing with and caring for the patient from their duties.

BB. Skilled Nursing Care Facility - Institutions that provide room and board, and skilled nursing services following an inpatient hospital stay. A facility must have one or more licensed nurses on duty at all times, who must be supervised by a Registered Nurse or a doctor. These facilities are also known as Extended Care Facilities (ECF) or Convalescent Facilities.

CC. Special Medical Situations:

1. Specialist or type of treatment is not provided in Participant's network service area and Participant lives in the network service area:

(a) *Out-of-network providers*: After the in-network deductible is met, the plan pays 80% for medically necessary covered services. Eligible charges are subject to the maximum plan allowance (MPA) limits. You are responsible for 20% co-insurance, and any amounts over the MPA limits. All determinations of when in-network benefits will apply to an out-of-network provider are made by the City's healthcare utilization and pre-certification program

2. Eligible dependent child, residing outside the elected network service area, needs health care and uses out of network providers and Participant lives in the network service area:

(a) *Out-of-network providers*: After the in-network deductible is met The plan pays 80% for medically necessary covered services. Eligible charges are subject to the maximum plan allowance (MPA) limits. You are responsible for 20% co-insurance, and any amounts over the MPA limits Your 20% co-insurance amounts will accrue towards your in-network maximums.

3. Emergency care (Urgent care is not paid the same as emergency care. Regular plan benefits apply to urgent care).

(a) Network providers: In-network benefit level applies after $100 emergency room co-pay for an emergency. (Co-pay is waived if admitted; not subject to deductible.) Co-pay amounts do not accrue towards out-of-pocket maximums

(b) Out-of-network providers: : In-network benefit level, up to MPA limits, after $100 emergency room co-pay for an emergency. (Co-pay waived if admitted; not subject to deductible.) Your 20% co-insurance amounts will accrue towards your in-network maximum. Co-pay amounts do not accrue towards out-of-pocket maximums.

4. Out of Network provider services ordered by in-network participating provider at an in-network hospital and/or urgent care center

(a) After the in-network deductible is met, out- of- network services by an anesthesiologist, assistant surgeon, radiologist or pathologist, or supplies provided

while a patient at an in-network hospital and/or urgent care center, when ordered by a participating provider, will be covered at the in-network benefit level (subject to MPA) when the covered member has no control over the choice of provider for these services. The out of pocket expenses (except for those charges in excess of MPA) will apply to the in-network out of pocket maximum.

5. Benefit level for employees residing outside their elected network service area

(a) Some Participants may live outside the service area of the network they elected. If these participants choose to travel to see a network provider, they will receive in-network benefits. However, if they do not wish to travel to access a network provider for non-emergent services, the out-of-network benefit level will apply. Under the CityCore plan, the out-of-network benefit for most covered expenses is 60% of the MPA after the annual deductible.

DD. Utilization Review - Case reviews done prospectively, concurrently and/or retrospectively to ensure medical necessity and appropriateness of care.

6.0 CityCore PPO Medical Plan

All medical services must be medially necessary to be covered under CityCore and are subject to the terms, conditions and limitations of the Plan. Services not listed herein are not covered. CityCore reimbursement levels for covered charges are as indicated in the following Schedule of Covered Services:

Medical Plan Feature	CityCore	
	In-Network	Out-of-Network
Network Required	Plan offers two networks: the MHN **or** the ODS/PHCS Network. Each plan year, you elect a network. During the year you can go in-network or out-of-network as you choose. When you go in-network, however, you must use the network you have elected. All family members must use the same network.	
Maximum Plan Allowance (MPA)	After the deductible, plan pays benefits based on negotiated rates.	After the deductible, plan pays benefits based on MPA limits.
Plan Year Deductible CityCore in-network deductible applies to services as indicated throughout this chart. Out of network excludes in-network expenses. Charges over MPA not applied to deductible.	CityCore: $200/person; $600/family maximum	CityCore: $500/person; $1,500/family maximum
Plan Year Out-of-Pocket Maximum (CityCore prescription drug co-insurance, office visit and all other co-pays and charges over MPA do not apply to annual maximum)	CityCore: $1,800/person; $5,400/family maximum	CityCore: $5,400/person; $16,200/family maximum
Lifetime Maximum Benefits	$2,000,000/person, including benefits previously paid under CityCore, Economy, CityBasic, CitySelect and CityPremium Plans	
Pre-certification	Required for hospitalization. Other services requiring pre-certification are listed beginning on page **54**	

Medical Plan Feature	CityCore	
	In-Network	Out-of-Network
Wellness Routine Physical Exams & Immunizations (except for travel-related immunizations) Non-routine lab work and/or tests and other medically necessary exams are *not* covered at 100%, but will be covered at regular benefit levels.	100% No deductible Your Responsibilities: o When making an appt., double check when your last routine exam occurred to ensure you are eligible for the service at the 100% benefit level. o Seek services through an in-network provider. o Ensure your provider uses an in-network lab. Read your ODS explanation of benefits to confirm billing & payment to your provider. If there is an error contact ODS & your provider to ensure the correct payment.	60% of MPA after deductible
	Routine physical exam maximum: Newborn — 2 hospital exams Under age 2 — 7 exams in 24 months Ages 2+ — 1 exam per 12 months ***Cancer Screenings:*** ***Breast Cancer-Mammogram maximum:*** Ages 35-39 — 1 Ages 40+ — 1 per 12 months (365 days) At any age when high risk and deemed necessary by physician ***Cervical Cancer-Pap Smear maximum:*** *1 per 12 months or at any time when high risk and deemed necessary by physician.* ***NOTE****: Women should begin screenings within 3 years of sexual activity or age 21 whichever is earlier.* ***Prostate Cancer-PSA maximum:*** 1 per 12 months (365 days) ***Colorectal cancer screening maximums(procedure only, no ancillary expenses—pre or post op office visits are covered at regular co-pays):*** Age 50 + — 1 sigmoidoscopy every 5 years or 1 colonoscopy every 10 years More frequent sigmoidoscopy or colonoscopy procedures will be covered when deemed necessary by a physician because of high risk or family history. Age 50 + — 1 fecult occult blood test per 12 mos.	
Office Care Office visits;, lab work, allergy shots; and other medically necessary exams.	$15.00 co-pay	60% of MPA after deductible
Pregnancy – Prenatal visits and physician delivery charges	$250 co-pay for physician services	60% of MPA after deductible

Medical Plan Feature	CityCore	
	In-Network	Out-of-Network
Diagnostic x-rays, MRIs, CT scans, ultrasound and other radiology services.	$25.00 co-pay per service	60% of MPA after deductible
Inpatient Care Semi-private room and board, diagnostic x-rays and lab work, surgeries, anesthesia and miscellaneous services.	80% after deductible	60% of MPA after deductible
Emergency Room (co-pay waived if admitted as inpatient following emergency)	80% after $100 co-pay (not subject to deductibles)	80% of MPA after $100 co-pay (not subject to deductibles)
Urgent Care	$15.00 co-pay	60% of MPA , not subject to deductible
Ambulance	80% of MPA; no deductible	
Alternative Care Providers (chiropractic, acupuncture, and naturopathic providers) The ODS Plus network provides in-network alternative care services for the CityCore plan.	$15.00 co-pay	60% of MPA after deductible
	35-visit annual maximum for chiropractic. Services must be pre-certified by ODS for more than 20 visits.	
Gastric Restrictive Procedures (with or without gastric bypass or the revision of the same).	80% after deductible	60% of MPA after deductible
	$15,000 maximum lifetime benefit	
Nutritional Counseling & Hospital Based Weight Reduction Programs for those with BMI 26+	80%, not subject to deductible. $500 annual maximum.	
Physical Therapy	80% after deductible	60% of MPA after deductible
Skilled Nursing Facility	80% after deductible (30 day plan year maximum.)	60% of MPA after deductible (30 day plan year maximum.)
Durable Medical Equipment	80% after deductible	60% of MPA after deductible
	Precertification required if rental exceeds 30 days or cost exceeds $500	
Home Healthcare	80% after deductible	60% of MPA after deductible
	60-visit plan year maximum	
Hospice	80% after deductible	60% of MPA after deductible
	$25,000 lifetime maximum	
Refractive Eye Surgery	Not covered	Not covered

Medical Plan Feature	CityCore	
	In-Network	Out-of-Network
Hearing Aids	60% of MPA (no deductible), up to $1,200 per ear; new hearing aid covered once every 36 months if medically necessary.	
TMJ Treatment	Not covered	Not covered
Behavioral Health **Mental Health Treatment** **Pre-Certification is required for all in-patient and residential treatment programs.**	$15.00 co-pay for outpatient office visits. 80% after deductible for inpatient and residential treatment programs. Mental health residential treatment limited to 45 days per year	60% of MPA after deductible Mental health residential treatment limited to 45 days per year
Chemical Dependency Treatment **Pre-Certification is required for all in-patient and residential treatment programs**	$15.00 co-pay for outpatient office visits. 80% after deductible for inpatient and residential treatment programs. Mental health residential treatment limited to 45 days per year	60% of MPA after deductible
Sterilization, Contraceptive Implants (e.g., IUD and Norplant)	80% after deductible	60% of MPA after deductible $335 annual maximum contraceptive implant benefit
Sleep Apnea $5,000 maximum lifetime benefit effective for services on or after 7/1/2010.	80% after deductible	60% of MPA after deductible
Infertility Treatment	Not covered	Not covered
Prescription Drugs **Network retail pharmacy** (up to 30-day supply) **Out-of-network pharmacy** (up to 30-day supply) **Mail order pharmacy** (up to 90-day supply)	For the CityCore plan, deductible does not apply. In-Network Pharmacy : – 90% of preferred generic drug cost – 80% of preferred brand name drug cost – 70% of non-preferred drug cost (generic or brand name) $5 minimum – $50 maximum co-pay per prescription Out-of Network pharmacy: You pay pharmacy; then submit claims to ODS for 60% reimbursement after out of network deductible is met. Same as in-network retail pharmacy benefit levels shown above	

6.01 Accessing the Networks:

Within their chosen network, participants may choose any of the PPO providers and facilities to receive covered services. Plan participants are encouraged to select and utilize a primary care physician for routine medical services. Plan participants are not required to select a primary care physician and do not need referrals to specialists. Participants are provided on-line directories that list PPO service providers. A paper directory may be requested from the Medical Claims Administrator.

6.02 Identification Cards:

Plan participants are provided identification cards within six weeks after initial enrollment. ID cards provide health care service providers with plan benefit and payment information. ID cards may be required to be shown in order to access service.

6.03 Deductibles:

A. No individual or family plan year (July 1 through June 30) deductible is required for covered services related to most Office visits, Emergency Room treatment, Alternate Coverage or Hearing Aids. All Emergency Room treatment, Alternate Coverage or Hearing Aids are considered in-network.

B. The Plan provides for a deductible carry-over. Expenses incurred and applied to the deductible during the last three months of the plan year (April, May and June) may count towards meeting the following plan year's deductible.

6.04 Plan Year Maximum Out-of-Pocket Limits:

After the plan year maximum out of pocket is met, the plan will reimburse 100% of the allowable cost for services incurred during the remainder of the plan year. Services with specific maximums, charges in excess of Maximum Plan Allowance, emergency room and prescription drugs co-payments are not applied to the Plan Year Maximum Out-of-Pocket Limits. Co-payments and other costs for network services do not apply to the maximum out-of-pocket for non-network services. Non-network co-payments and costs for services do not apply to in-network plan year maximum out-of-pocket limits.

6.05 Notice of Declination:

The City of Portland reserves the right to disallow costs associated with any provider, facility, product or service outside the scope of this plan.

6.06 Covered Services

A. The following services, when medically necessary, are covered under this plan at the levels previously stated in 6.01.

B.Pre-certification is required for certain services as outlined in 5.07.030.

1. **Allergy shots** and office visits for allergy testing.

2. **Alternative Care**. Medically necessary services by Chiropractors, Naturopaths and Acupuncturists are covered subject to maximums outlined in the Medical Plan Features chart. For in-network chiropractic benefits, services must be pre-certified and provided by a ODS Alternative Network provider.

3. **Ambulance.** Up to 300 miles per year to or from the nearest hospital when medically necessary.

4. **Appliances.** Items used for performing or facilitating the performance of a particular bodily function, including orthopedic braces and compression stockings, are covered when medically necessary as determined by the Plan's third-party administrator. Appliances do not include dental appliances and braces, supporting devices such as corsets, eye glasses or contact lenses.

5. **Artificial Limbs.** The first extremity prosthesis after loss of a body part is covered, including artificial eyes and post-mastectomy bra and prosthetic. An additional prosthesis may be authorized if the attending physician provides documentation to the Plan that a new prosthetic device is medically necessary because of changing fit or poor function. Testicular prostheses are not covered.

6. **Chemical Dependency Treatment** (drug and/or alcohol). This benefit does not apply to addiction or dependency on tobacco, tobacco products or foods nor does it include volunteer mutual support groups or educational programs for drinking drivers referred by the judicial system. Inpatient and residential treatment must be pre-certified (except for emergency hospital admissions, which must be certified within 48 hours of emergency admission).

7. **Colorectal Screening** is covered in accordance with the schedule detailed in the Medical Plan Features chart.

8. **Contraceptive device** insertion and removal.

9. **Diabetes Self Management**. The plan will provide a benefit for diabetic education services for covered persons who are diagnosed to have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes when prescribed by a health care professional legally authorized to prescribe such programs. These services are not subject to a deductible and are covered as in-network up to a $1,000 maximum benefit every 24 months regardless of authorized program used. Services must be provided through an education program credentialed or accredited by a state or national entity accrediting such programs or provided by a physician, a registered nurse, a nurse practitioner, a certified diabetes educator or a licensed dietitian with demonstrated expertise in diabetes. The medical benefit will not cover diabetic supplies such as insulin, pumps, strips, etc., normally covered under the prescription drug benefit.

10. Durable medical equipment. When medically necessary, limited to either the total rental cost or the purchase price of such equipment, whichever is less. Dental appliances are not included.

11. Emergency medical conditions. Defined as a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

12. Gastric Restrictive Procedures (CityCore plan only). Subject to pre-certification--with or without gastric bypass or the revision of the same.

13. Hearing aids. Includes the cost of any maintenance or repairs, subject to benefit maximums.

14. Home Health Care. Services must be ordered by the attending physician.

15Hospice Care for medically necessary charges. When ordered by an attending physician for patients who are terminally ill with a life expectancy of six months or less and provided by a state licensed agency.

16. Hospital Services, Inpatient. Includes:

a. Intensive Care/Coronary Care when medically necessary;
b. Room & Board (medically necessary semi-private room and board). Personal comfort items are not covered;
c. Other miscellaneous medically necessary in-patient services and supplies furnished by the hospital which are not included in the room charge;
d. Special Duty Nursing when ordered by the attending physician.

17. Hospital Services, Outpatient. Includes:

(a) Emergency room service when medically necessary;

(b) Other medically necessary out-patient hospital charges;

(c)Outpatient hospital charges and general anesthesia for extensive dental treatment for children under 12 years of age, or a patient with mental incapacity, is covered.

18. Laboratory Services. Diagnostic laboratory expenses are covered when medically necessary and performed or ordered by a physician due to illness, accident or injury. To maximize benefits, it is the patient's responsibility to make sure that referral is made to an in-network PPO service provider.

19 Maternity Care. For the employee, spouse, domestic partner, and dependent children. Coverage for the newborn, beyond the initial nursery care, will be allowed if the child meets the City's definition of an eligible dependent.

20. Maxillofacial Prosthetic Services. For repair of head and facial structures damaged by trauma, disease, surgery or congenital deformity that cannot be managed

with living tissue are covered when medically necessary and unrelated to TMJ treatment or therapy.

21. Mental health inpatient and residential services which have been pre-certified.

22. Nonprescription Enteral Formula For Home Use and Inborn Errors of Metabolism. When medically necessary and ordered by the doctor for the treatment of severe intestinal malabsorption and must comprise the sole source, or an essential source, of nutrition.

23. Nutritional Counseling and/or hospital-based weight reduction programs **for BMI 26+** covered subject to an annual maximum of $500

24. Oral Surgery. Extraction of impacted teeth. Lifetime benefit maximum is $500.

25. Organ transplants. The Plan will pay benefits for medically necessary and appropriate transplant procedures as approved by the Medical Management Program, which conform to accepted medical practice and are not experimental or investigational.

(a) Definitions:

(i) Transplant means:

- A procedure or a series of procedures by which tissue (e.g., solid organ, marrow, stem cells) is removed from the body of one person (donor) and implanted in the body of another person (recipient); and/or
- A procedure or series of procedures by which tissue is removed from one's body and later re-introduced back into the body of the same person.

(ii) Transplant does not include:

- The collection of and/or transfusion of blood or blood products.
- Corneal transplants.

(iii) Transplant period means the time from the day of the admission for transplant conditioning through the day of discharge for a transplant.

(iv) Complications resulting from a transplant mean all medical and surgical treatments except the transplantation of hematopoietic cells or solid organ(s).

(b) Covered Transplant Benefits - Benefits for transplants are limited as follows:

(i) If the Recipient or Self-Donor is enrolled under this Plan, donor costs related to a covered transplant will be paid in accordance with the Plan's copays and maximums. "Donor costs" mean the covered expense of

removing the tissue from the donor's body and preserving or transporting it to the site where the transplant is performed as well as any other necessary charges directly related to locating and procuring the organ. If the donor is covered under this Plan and the recipient is not, no benefits toward donor costs will be paid. Expenses incurred by an enrolled donor which result from complications and unforeseen effects of the donation will be covered as any other sickness. Expenses incurred by a donor not enrolled in the Plan which result from complications and unforeseen effects of the donation will not be covered.

(c) Covered transplants are medically necessary and appropriate when they meet the Pre-Certification/ Utilization Management Program Criteria for the following organs or tissues:

(i) Heart;

(ii) Lung;

(iii) Heart and lung;

(iv) Liver;

(v) Kidney;

(vi) Kidney and pancreas when transplanted together in the same operative session;

(vii) Pancreas (this includes pancreas alone and pancreas after kidney transplantation);

(viii) Small bowel;

(viii) Autologous bone marrow or stem cell transplant for the treatment of:

- ✓ acute leukemia;
- ✓ chronic leukemias;
- ✓ lymphoproliferative disorders;
  - o germ cell tumors of the testes, ovaries, mediastinum and retroperitoneum;
  - o plasma cell disorders;
  - o solid tumors of childhood;
  - o neuroductal tumors;
  - o other malignancies.

(ix) Homogenic/allogenic bone marrow or stem cell transplant for the treatment of:

- ✓ acute leukemia
- ✓ chronic leukemia
- ✓ myelodysplastic syndromes;
- ✓ stem cell disorders
- ✓ myeloproliferative disorders;
- ✓ lymphoproliferative disorders;
- ✓ inherited metabolic disorders;
- ✓ inherited erythrocyte abnormalities;
- ✓ inherited immune system disorders;
- ✓ other inherited disorders;

- ✓ plasma cell disorders;
- ✓ other malignancies.

(d) Physician or professional provider transplant services according to the benefits for physicians and professional providers under the Plan will be paid;

(e) Anti-rejection drugs following the covered transplant will be paid according to the benefits for prescriptions drugs, if any, under the Plan.

(f) Transplant Service Authorization Requirement: The service authorization requirement relates only to the administration of benefits under the Plan. The outcome of a service authorization request does not constitute a treatment recommendation or requirement. It relates solely to whether the procedure will be covered under the Plan. The actual course of medical treatment the enrollee chooses remains strictly a matter between the enrollee and his or her physician.

(g) Transplant Service Authorization Procedures. To request service authorization, the enrollee's physician must contact the Medical Service Authorization Unit of ODS prior to the transplant admission. To be valid, service authorization approval must be in writing from ODS. Service authorization should be obtained as soon as possible after an enrollee has been identified as a possible transplant candidate.

Mail: Medical Service Authorization Unit
The ODS Companies
P.O. Box 40384
Portland, Oregon 97240
Telephone: (503) 243-4496 - Portland Area
Toll-free: 1-800-258-2037 - Nationwide

(h) Organ Transplant Exclusions - the Plan will not pay for the following transplant or transplant related services:

(i) Donation related services or supplies provided to a Donor who is an enrollee under this Plan if the Recipient is not enrolled under this Plan and eligible for transplant benefits;

(ii) Services or supplies for any transplant not specifically named as covered, including the transplant of animal organs or artificial organs; and

(iii) Chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not specifically named as covered above.

26. Preventive Care and Well Child Care. Coverage for preventive care and well child care according to the schedule listed in the Medical Plan Features chart.

27. Professional Services – Medically necessary services of a professional provider (see next page for a list of eligible professional providers) are covered subject to plan limits.

28. Reconstructive surgery after breast cancer. Includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

29. Short term rehabilitation. Services consist of physical therapy, occupational therapy and/or speech therapy furnished to a person who is not confined as an inpatient in a hospital or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins. Rehabilitation services include physical, occupational, speech or audiological therapy services necessary to restore or improve lost function caused by illness or injury. Services must begin within one year of the illness or injury being treated. Recreational or educational therapy, non-medical self-help or training, services rendered for the treatment of delays in speech development, or treatment of psychotic or psychoneurotic conditions are not included.

30. Skilled Nursing Facility Care. Medically necessary skilled nursing care is covered up to a maximum 30 days per plan year. Services must be ordered by the attending physician and require pre-certification.

31. Smoking Cessation. This benefit provides reimbursement to **certain providers** to assist enrollees to stop smoking. This coverage allows reimbursement for prescription drugs and for smoking cessation educational meetings and programs. These services are not subject to a deductible and are covered as in network up to a $500 annual maximum regardless of authorized program used.

32. Surgical Benefits. All inpatient procedures and some outpatient surgeries require pre-certification. Covered medically necessary surgical services include: Primary surgeon; assistant surgeon (as requested by the surgeon and only to the extent that hospital staff assistance is not available or appropriate); anesthesiologist (only as required by the surgeon); radio-active therapy; iodine therapy; super-voltage therapy; deep x-ray therapy; burn treatment, fractures and dislocations; surgeon consultation while an inpatient, as required in the diagnosis or treatment of an illness or injury; outpatient surgical and related services on the day of the surgery; second surgical opinions, and medically necessary inpatient lab and x-ray expenses.

33. X-ray Services. Medically necessary diagnostic x-ray expenses are covered when performed or ordered by a physician due to illness, accident or injury. To maximize benefits, it is the patient's responsibility to make sure referral is made to an in-network PPO service provider.

6.07 CityCore Plan Professional Providers

A. A professional provider means any of the following who provides medically necessary covered services within the scope of his/her license. In all cases, the services must be medically necessary and covered under this plan to be eligible for benefits. To be eligible for the in-network level of coverage, services must be rendered by a preferred provider within a Participant's elected network or through the alternative care services network. Only the alternative care network is considered in-network for chiropractic, acupuncture and naturopath services. When a Participant does not use a network provider, the plan benefits will be based on the maximum plan allowance (MPA) and subject to a higher deductible and co- payment.

1. A doctor of medicine (M.D.)

2. A doctor of osteopathy (D.O.)

3. A certified nurse practitioner

4. A podiatrist

5. A chiropractor (in-network benefit only provided through the ODS Alternative Care Network providers)

6. An acupuncturist (in-network benefit only provided through the ODS Alternative Care Network providers)

7. A Naturopath (in-network benefit only provided through the ODS Alternative Care Network providers)

8. A dentist (doctor of medical dentistry or doctor of dental surgery), but only for treatment of accidental injury to natural teeth provided within 12 months after the injury, or for surgery that does not involve repair, removal or replacement of teeth, gums, or supporting tissue

9. A registered psychologist

10. A State-licensed physician assistant

11. A State-licensed clinical social worker

12. A registered physical, occupational, speech or audiological therapist

13. A registered nurse or licensed practical nurse, but only for services provided upon the written referral of a doctor of medicine or osteopathy, or only for those services which nurses customarily bill patients

14. An optometrist

15. The term "professional provider" does not include any other class of provider not named above, and no Plan benefits will be paid for their services.

6.08 CityCore Prescription Drug Program

A. The prescription drug benefit for the CityCore PPO Plan is managed by a pharmaceutical benefits management (PBM) service provider (Caremark).

B. The CityCore plan's pharmacy coverage pays benefits based on whether or not the prescription drug is on the formulary (i.e., a broad list of prescription drugs). The PBM will pay prescription drug benefits on its formulary which is not a static list. The

PBM will continually review and update the formulary on recommendation by its panel of pharmacists and physicians.

C. Certain drugs require prior authorization to ensure appropriate utilization and cost effectiveness for the plans and members. If the Participant's provider prescribe a drug that requires prior authorization, the provider must call the PBM to ensure the most appropriate medication is prescribed. Drugs which require pre-certification include but are not limited to the following drug classes: anabolic steroids, growth hormones and GH related, Gaucher Disease, select interferons and ribavirins, erectile dysfunction, multiple sclerosis, ADHD/narcolepsy, anemia, arthritis and topical acne..

D. Participant's share of the costs is based on a percentage of the actual costs, not a flat dollar co-payment amount and depends on whether the drug is a preferred generic, preferred brand name or a non-preferred generic or brand name drug.

E. Mail Order Service

1. If a Participant uses the mail order service, the Participant will have a 90-day supply of the prescription mailed directly to his or her home. The co-pay is based on the total cost of the medication for the 90-day supply at the co-pay levels.

2. There may be times when there are short delays in filling a prescription if the PBM is temporarily out of stock. Generally the medication should be available within 72 hours. If the drug manufacturer has supply problems which have caused a medication to be unavailable nationwide, then a longer delay may occur. In such case, the PBM will contact the Participant and provide options including:

(a) Offering to transfer the prescription to a local retail pharmacy with in-stock medication, or

(b) Offering to contact the Participant's doctor to provide a therapeutic alternative.

(c) Because of the fluctuation in drug costs, the PBM may be unable to provide an exact cost of a prescription at the time of order. If the Participant pays by check, this may cause a balance due on a mail order account.

(d) If the Participant has a balance owing on his or her mail order account, the PBM cannot fill the next prescription until the balance is paid or it is told to charge the Participant's credit/debit card account on file.

6.09 CityCore Plan Lifetime Benefit Maximum

CityCore will pay a lifetime maximum of $2,000,000 in claims per participant. On July 1 of each year, the maximum benefit available with respect to any participant shall be increased by an amount equal to the amount paid under the Plan during the prior calendar year up to $25,000. Therefore, any yearly benefit of $25,000 or less will not be counted toward the lifetime maximum. Any yearly benefit of more than $25,000 will count toward the lifetime maximum. The maximum lifetime benefit will not be increased

above $2,000,000.00. As required under the the Health Care and Education Affordabilty Reconcilation Act of 2010 this provision will be removed upon the required effective date

6.10 CityCore Plan Exclusions and Limitations

A. CityCore will not cover any expenses incurred for which the participant is not legally liable or which are not medically necessary. Other expenses not covered are those in excess of the Maximum Plan Allowance (MPA), or in excess of what would have been charged in the absence of plan coverage. Charges specifically excluded from coverage or limited in any way are as follows:

- Services that are not provided.
- Services received before your effective date of coverage.
- Services that are not a covered service or relate to complications resulting from a non-covered service, even if such service was previously covered under the Plan.
- Services that are not furnished by a qualified practitioner acting within the scope of his/her license or qualified treatment service.
- Services for which no charge is made or you would not be required to pay if you did not have health plan coverage.
- Charges in excess of the Maximum Plan Allowance (**MPA**).
- Services related to injury, illness or condition to the extent a payment or any other benefit including the amount received as a settlement is provided under any workers compensation or City liability on the account of the injury, illness, or condition arising out of the course of gainful employment.
- Services provided by a dentist (doctor of medical dentistry or doctor of dental surgery) but only for treatment of an accidental injury to natural teeth provided within 12 months of the injury or for surgery that does not involve repair, removal or replacement of teeth, gums, or supporting tissue
- Intentional self-inflicted injury is limited to $10,000 per lifetime for such injuries.
- Bodily injury or illness arising out of duty as a member of the armed forces of any state or country, or a war or any act of war (declared or undeclared).
- Injury or illness resulting from the plan participant's commission or attempt to commit an assault or other illegal act, a civil revolution or riot.
- Services or supplies not listed as covered services or not considered medically necessary by the Plan.
- Expenses or services provided by a local, state or federal agency and emergency rescue services.
- Charges for telephone consultations with participants or other medical providers.

- Services, prescription drugs, and supplies you or your dependent may receive while in the custody of any state or federal law enforcement authorities or while in jail or prison.
- Experimental or Investigational Procedures: services, prescription drugs, and supplies that are deemed by the plan administrator to be:
    - those not rendered by an accepted institution, physician or provider within the United States or by one which has not demonstrated medical proficiency in the rendering of the service or supplies;
    - those not recognized by the medical community in the service area in which they are received;
    - those for which the approval of government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered;
    - those for which scientific or medical assessment has not been completed and the effectiveness of the treatment has not been generally established;
    - those rendered in the service area only as part of clinical trial or research program for the illness or condition being treated;
    - those unavailable in the service area for the illness or condition being treated and available for that illness or condition within the United States as part of a clinical trial or research program only; and
    - those expenses incidental to or incurred as a direct consequence of experimental or investigational procedures, if the expenses were incurred primarily as the result of obtaining experimental or investigational services, prescription drugs, and supplies.
- Services, Prescription Drugs, Supplies, and/or Treatment Not Medically Necessary; including:
- Services, prescription drugs, and supplies that are either inappropriate or inconsistent with the symptoms or diagnosis of your condition or that of your dependent;
- Services, prescription drugs, and supplies that are inappropriate with regard to standards of good medical practice in the service area;
- Services, prescription drugs, and supplies that are primarily rendered for the convenience of you or your dependents or a physician or provider of services or supplies; and/or
- Services that are not the least costly of the alternative supplies or levels of service, which can be safely provided to you or your dependent. For example, coverage would not be allowed for an inpatient hospital stay when the same level of treatment could be delivered in an outpatient setting such as an ambulatory surgery facility.

<u>Exclusions Related to Miscellaneous Services and Items:</u>

- Support Education including Level I educational programs related to Driving Under the Influence (DUI), voluntary mutual support groups, such as Alcoholics Anonymous, or family education or support groups.
- Behavior modification, psychological enrichment or self-help programs for mentally healthy individuals. These include assertiveness training, image therapy, sensory movement groups, marathon group therapy, and sensitivity training.
- Routine optometric eye examinations, including the fitting, provision, or replacement of eyeglasses or contact lenses, and any charges for orthoptics, vitamin therapy, vision therapy, eye exercises, or fundus photography. Vision benefits may be available through the City's vision plan and are subject to the terms of that Plan.
- Refractive surgery, laser vision correction, and any other procedure which alters the refractive character of the eye, the purpose of which is to cure or reduce myopia, hyperopia, or astigmatism. This exclusion includes, but is not limited to, radial keratotomy, corneal rings, LASIK, PRK, any procedure using the Excimer Laser or the Holmium: YAG laser, and other procedures of the refractive keratoplasty type. Reversals or revision of any procedures that alter the refractive character of the eye and any complications of these procedures are excluded.
- Treatment for sleep apnea services after July 1, 2010 in excess of the $5,000 maximum lifetime benefit.
- Reversal of sterilization procedures.
- Miscellaneous services, including (but not limited to):
    a. Custodial Care, including routine nursing care and hospitalization for environmental change;
    b. Private Nursing Services even if related to a condition which is otherwise covered by the Plan;
    c. Services provided by a member of your immediate family;
    d. Services provided by volunteer workers;
    e. Supplies intended for use outside hospital settings or considered personal in nature;
    f. Routine miniature chest x-ray films or full body scans;
    g. Other services and supplies not directly connected to the diagnosis or curative treatment of an illness or injury.
- Supportive environmental materials, or any service or product that is primarily promoted as a personal convenience item; is prescribed or recommended by a healthcare provider and does not meet industry treatment standards or protocols or is a product or service that may be purchased or obtained by the general public without a prescription. Examples include, but are not limited to, hand rails, ramps, bath benches, cervical pillows, humidifiers, air filters, air conditioners, heat lamps, tanning lights, whirlpools, saunas, whirlpools, hot tubs, fitness

equipment, telephones, home furnishings and costs associated with local or distant travel, even if related to a condition otherwise covered by the Plan.

- Normal necessities of living, including but not limited to food, clothing and household supplies.
- Separate charges for the completion of reports or claim forms and the cost of records.
- Ambulance services exceeding 300 miles per plan year.
- Biofeedback therapy services are limited to medically necessary treatment of tension or migraine headaches and the Plan will pay for no more than 10 visits during the participant's lifetime.
- Cosmetic/Reconstructive Surgery: Cosmetic procedures (any procedure that is requested for the purpose of improving appearance without restoring bodily function or correcting physical impairment) are exclusions under this plan. Complications of reconstructive surgeries will be covered if medically necessary, clinically distinct and not specifically excluded under this plan. Breast augmentation, lipectomy, liposuction, hair removal (including electrolysis and laser) and rhinoplasty are not covered procedures.
- Experimental or Investigational Procedures: Services, prescription drugs, and supplies that are deemed by the plan administrator to be:
  a. those not rendered by an accepted institution, physician or provider within the United States or by one which has not demonstrated medical proficiency in the rendering of the service or supplies;
  b. those not recognized by the medical community in the service area in which they are received;
  c. those for which the approval of government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered;
  d. those for which scientific or medical assessment has not been completed, and the effectiveness of the treatment has not been generally established;
  e. those rendered in the service area only, as part of clinical trial or research program for the illness or condition being treated; and
  f. those unavailable in the service area for the illness or condition being treated and available for that illness or condition within the United States as part of a clinical trial or research program only.
  g. those expenses incidental to or incurred as a direct consequence of experimental or investigational procedures, if the expenses were incurred primarily as the result of obtaining experimental or investigational services, prescription drugs, and supplies.
- In alternative healthcare environments, only traditional medical testing will be covered by the plan.
- Any services related to the treatment of infertility and/or the cause of infertility are excluded from coverage under the Plan. This includes artificial insemination

procedures, including, but not limited to, in-vitro fertilization (IVF), Gamete intrafallopian Transfer (GIFT), Zygote Intrafallopian Transplant (ZIFT), and Tubal Embryo Transplant (TET). Only the initial visit and initial diagnostics to determine infertility are covered.

- Replacement of lost hearing aids or batteries for hearing aids are not covered.
- Charges incurred for telephone consultations with or between medical providers.
- Non-surgical treatment of oral diseases or other medical conditions, extraction of erupted teeth, and dental repair are not covered under the Oral Surgery benefit.
- Over-the-counter medications, including nutritional supplements, herbal and homeopathic remedies, and contraceptive products are not covered.
- Treatments defined as holistic and/or are treatments outside of industry-recognized standards of care.
- Services of a massage therapist, even if related to a condition otherwise covered by the Plan.
- Immunizations for the sole purpose of travel or to prevent illness which may be caused by a work environment.
- Services/supplies requiring pre-certification are not covered under this plan unless certified as medically necessary through the City's contracted Service Authorization/Pre-Certification Program.
- Services to alter a participant's physical characteristics to that of the opposite sex, including Sexual Reassignment Surgery and related therapies.
- Chelation therapy is not covered under the Plan, except for acute arsenic, gold, mercury or lead poisoning.
- Donation related services or supplies provided to an insured Donor if the Recipient is not enrolled under this Plan and eligible for transplant benefits. This exclusion does not apply to complications or unforeseen infections resulting from the donation of tissue.
- Services or supplies for any transplant not specifically named as covered including the transplant of animal organs or artificial organs.
- Chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not specifically named as covered.
- Foot orthoses (orthotics) made of high impact plastics or other materials, designed to be inserted into shoes;
- Temporomandibular joint (TMJ) treatment and surgery.
- Orthognathic surgery and services or supplies to add to or reduce the upper or lower jaw.
- Genetic testing or counseling unless medically necessary and pre-certified through the City's contracted Utilization Review provider. Genetic testing for family members not covered under the Plan is excluded.

- Services and supplies for speech therapy, unless provided by a licensed speech therapist and rendered within one year of the onset of the illness/injury, congenital abnormality, or previous therapeutic process. Services rendered for the treatment of delays in speech development are not covered.
- Counseling related to family, marriage, sex and career, in the absence of medical necessity/illness;
- Vocational, pastoral or spiritual counseling;
- Dance, poetry, music or art therapy, except as part of a treatment program in an inpatient setting.
- Non-organic therapies including, but not limited to, bioenergetics therapy, confrontation therapy, crystal healing therapy, educational remediation, EMDR, guided imagery, marathon therapy, primal therapy, rolfing, sensitivity training, training psychoanalysis, transcendental meditation and Z therapy.
- Organic therapies including, but not limited to, aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, narcotherapy with LSD, and sedative action electrostimulation therapy.
- Routine foot care services that are not medically necessary.
- Routine physical exams for employment, licensing, insurance coverage or court order or required for parole or probation.
- Designated Blood Donations-collection, processing and storage of blood donated by donors designated by plan participants and procurement and storage of cord blood, unless medically necessary for the imminent use at the time of collection for a designated recipient.
- Hypnotherapy.

6.11 Prescription Drug Program Exclusions

(a) Drugs or medications purchased or obtained without a physician's written prescription.

(b) "Over-the-counter" products (with the exception of insulin, syringes and needles).

(c) Nose drops or nasal preparations that do not require a physician's written prescription.

(d) Immunization agent.

(e) Non-drug items, dietary supplements, vitamins (other than prescription pre-natal vitamins) or health and beauty aids.

(f) Drugs dispensed by a hospital, nursing care facility, health care center, urgent or immediate care center, ambulatory surgical center, doctor's office, or other institution.

(g) Drugs obtained after eligibility and/or coverage terminates.

(h) Any refill of a prescription that exceeds the number specified by the prescribing physician or that is dispensed after one year from the date of the prescription.

(i) Drugs prescribed or used for cosmetic purposes.

(j) Services and supplies subject to the "Plan Limitation and Exclusion" section of this plan (see above).

(k) Non-legend or over-the-counter (OTC) drugs.

(l) Prescriptions which are covered by workers' compensation laws, the Fire & Police Disability Retirement Fund, or other county, state or federal programs.

(m) Compounds unless the prescription includes at least one legend drug that is an essential ingredient.

(n) Naturopathic supplements, including when prescribed as a compound drug;

(o) Drugs that are determined by the Plan Administrator to be experimental or investigational or that are labeled: "Caution-Limited by federal law to investigational use"

7.0 Economy – High Deductible PPO Medical Plan

7.01 Medical Services

All medical services must be medially necessary to be covered under the Economy-High Deductible Plan and are subject to the terms, conditions and limitations of the Plan. Services not listed herein are not covered. The Economy High Deductible reimbursement levels for covered charges are as indicated in the following Schedule of Covered Services:

Medical Plan Feature	PPO Economy-High Deductible Medical Plan	
	In-Network	**Out-of-Network**
Network Required	Plan offers two networks: the MHN **or** the ODS/PHCS Network. Each plan year, Employee elects a network. During the year Participant can go in-network or out-of-network. When Participant goes in-network, however, the elected network must be used. All family members must be enrolled in same network.	
Maximum Plan Allowance (MPA)	After the deductible, plan pays benefits based on negotiated rates.	After the deductible, plan pays benefits based on MPA limits.
Plan Year Deductible Out of network excludes in-network expenses. Charges over MPA not applied to deductible.	Economy Plan $2,850/person; $5,700/family maximum	Economy Plan: $2,850 /person; $5,700/family maximum
Plan Year Out-of-Pocket Maximum (CityCore prescription drug, emergency room co-pays and charges over MPA do not apply to annual maximum)	Economy: Plan $5,250/person; $10,500/family maximum	Economy Plan : $5,250/person; $10,500/family maximum
Lifetime Maximum Benefits	$2,000,000/person, including benefits previously paid under CityCore, Economy, CityBasic, CitySelect and CityPremium Plans	
Pre-certification	Required for hospitalization and other services as listed in Plan Document .	

Medical Plan Feature	PPO Economy-High Deductible Medical Plan	
	In-Network	**Out-of-Network**
Wellness Routine Physical Exams & Immunizations (except for travel-related immunizations) Non-routine lab work and/or tests and other medically necessary exams are *not* covered at 100%, but will be covered at regular benefit levels.	100% No deductible Participant Responsibilities: o When making an appt., double check when last routine exam occurred to ensure eligibility for the service at the 100% benefit level. o Seek services through an in-network provider. o Ensure provider uses an in-network lab.	60% of MPA after deductible
	Routine physical exam maximum: Newborn — 2 hospital exams Under age 2 — 7 exams in 24 months Ages 2+ — 1 exam per 12 months ***Cancer Screenings:*** ***Breast Cancer-Mammogram maximum:*** Ages 35-39 — 1 Ages 40+ — 1 per 12 months (365 days) At any age when high risk and deemed necessary by physician ***Cervical Cancer-Pap Smear maximum:*** *1 per 12 months or at any time when high risk and deemed necessary by physician.* ***NOTE****: Women should begin screenings within 3 years of sexual activity or age 21 whichever is earlier.* ***Prostate Cancer-PSA maximum:*** 1 per 12 months (365 days) ***Colorectal cancer screening maximums:*** Age 50 + — 1 sigmoidoscopy every 5 years or 1 colonoscopy every 10 years More frequent sigmoidoscopy or colonoscopy procedures will be covered when deemed necessary by a physician because of high risk or family history. Age 50 + — 1 fecult occult blood test per 12 mos.	
Outpatient Care Office visits; diagnostic x-rays, lab work, and MRIs; prenatal visits; allergy shots; outpatient hospital procedures, etc.	80% after deductible	60% of MPA after deductible
Inpatient Care Semi-private room and board; diagnostic x-rays and lab work; surgeries; miscellaneous services.	80% after deductible	60% of MPA after deductible

Medical Plan Feature	PPO Economy-High Deductible Medical Plan	
	In-Network	Out-of-Network
Emergency Room (co-pay waived if admitted as inpatient following emergency)	Economy Plan: 80% after deductible and $100 co-pay	Economy Plan: 60% of MPA after deductible and $100 co-pay
Urgent Care	80% after deductible	60% of MPA after deductible
Ambulance	80% of MPA; no deductible	
Alternative Care Providers (chiropractic, acupuncture, and naturopathic providers) o . ODS Alternative Care network provides in-network alternative care services.	80% after deductible in ODS Alternative Care network 35-visit annual maximum for chiropractic. Services must be pre-certified by ODS for more than 20 visits.	60% of MPA after deductible
Physical Therapy	80% after deductible	60% of MPA after deductible
Skilled Nursing Facility	80% after deductible (30 day plan year maximum.)	60% of MPA after deductible (30 day plan year maximum.)
Durable Medical Equipment	80% after deductible Pre-certification required if rental exceeds 30 days or cost exceeds $500	60% of MPA after deductible
Home Healthcare	80% after deductible 60-visit plan year maximum	60% of MPA after deductible
Hospice	80% after deductible $7,500 lifetime maximum	60% of MPA after deductible
Refractive Eye Surgery	Not Covered	Not covered
Hearing Aids	60% of MPA after deductible up to $1,200 per ear. New hearing aid covered once every 36 months if medically necessary	60% of MPA after deductible up to $1,200 per ear. New hearing aid covered once every 36 months if medically necessary
TMJ Treatment	Not covered	Not covered
Behavioral Health **Mental Health Treatment** **Pre-Certification is required for all in-patient and residential treatment programs.**	80% after deductible Inpatient & outpatient treated as any other medical condition. Residential treatment limited to 45 days per year	80% after deductible Inpatient & outpatient treated as any other medical condition. Residential treatment limited to 45 days per year

Medical Plan Feature	PPO Economy-High Deductible Medical Plan	
	In-Network	Out-of-Network
Chemical Dependency Treatment **Pre-Certification is required for all in-patient and residential treatment programs**	80% after deductible	60% after deductible
Sterilization, Contraceptive Implants (e.g., IUDs, Norplant)	80% after deductible ($335 annual maximum contraceptive implant benefit)	60% after deductible ($335 annual maximum contraceptive implant benefit)
Infertility Treatment	Not covered	Not covered
Prescription Drugs **In- network retail pharmacy (up to 30 day supply)** **Out-of-network pharmacy (up to 30 day supply)** **Mail order pharmacy (up to 30 day supply)**	No payments until annual deductible is met In-Network Pharmacy: -90% of preferred generic drug cost -80% of preferred brand drug name cost -70% of non-preferred drug cost (generic or brand name) Same as in-network retail pharmacy benefit levels shown above	No payments until annual deductible is met Out-of-Network pharmacy: Participant pays pharmacy and submits claims to ODS for 60% reimbursement after out-of-network deductible is met.

7.02 Accessing the Networks:

Within their chosen network, participants may choose any of the PPO providers and facilities to receive covered services. Plan participants are encouraged to select and utilize a primary care physician for routine medical services. Plan participants are not required to select a primary care physician and do not need referrals to specialists. Participants are provided on-line directories that list PPO service providers. A paper directory may be requested from the Medical Claims Administrator.

7.03 Identification Cards:

Plan participants are provided identification cards within six weeks after initial enrollment. ID cards provide health care service providers with plan benefit and payment information. ID cards may be required to be shown in order to access service.

7.04 Deductibles:

A. No individual or family plan year (July 1 through June 30) deductible is required for covered services related to Emergency Room treatment, Alternate Coverage or Hearing Aids. All Emergency Room treatment, Alternate Coverage or Hearing Aids are considered in-network.

B. The Plan provides for a deductible carry-over. Expenses incurred and applied to the deductible during the last three months of the plan year (April, May and June) may count towards meeting the following plan year's deductible.

7.05 Plan Year Maximum Out-of-Pocket Limits:

After the plan year maximum out of pocket is met, the plan will reimburse 100% of the allowable cost for services incurred during the remainder of the plan year. Services with specific maximums, charges in excess of Maximum Plan Allowance, emergency room and prescription drugs co-payments are not applied to the Plan Year Maximum Out-of-Pocket Limits. Co-payments and other costs for network services do not apply to the maximum out-of-pocket for non-network services. Non-network co-payments and costs for services do not apply to in-network plan year maximum out-of-pocket limits.

7.06 Notice of Declination:

The City of Portland reserves the right to disallow costs associated with any provider, facility, product or service outside the scope of this plan.

7.07 Covered Services

A. The following services, when medically necessary, are covered under this plan at the levels previously stated in 6.01.

B.Pre-certification is required for certain services as outlined in 5.07.030.

1. **Allergy shots** and office visits for allergy testing.
2. **Alternative Care**. Medically necessary services by Chiropractors, Naturopaths and Acupuncturists are covered subject to maximums outlined in the Medical Plan Features chart. For in-network chiropractic benefits, services must be provided by an ODS Alternative Care network provider.
3. **Ambulance.** Up to 300 miles per year to or from the nearest hospital when medically necessary.
4. **Appliances.** Items used for performing or facilitating the performance of a particular bodily function, including orthopedic braces and compression stockings, are covered when medically necessary as determined by the Plan's third-party

administrator. Appliances do not include dental appliances and braces, supporting devices such as corsets, eye glasses or contact lenses.

5. Artificial Limbs. The first extremity prosthesis after loss of a body part is covered, including artificial eyes and post-mastectomy bra and prosthetic. An additional prosthesis may be authorized if the attending physician provides documentation to the Plan that a new prosthetic device is medically necessary because of changing fit or poor function. Testicular prostheses are not covered.

6. Chemical Dependency Treatment (drug and/or alcohol). This benefit does not apply to addiction or dependency on tobacco, tobacco products or foods nor does it include volunteer mutual support groups or educational programs for drinking drivers referred by the judicial system. Inpatient and residential treatment must be pre-certified (except for emergency hospital admissions, which must be certified within 48 hours of emergency admission).

7. Colorectal Screening is covered in accordance with the schedule detailed on the Medical Plan features chart.

8. Contraceptive device insertion and removal.

9. Durable medical equipment. When medically necessary, limited to either the total rental cost or the purchase price of such equipment, whichever is less. Dental appliances are not included.

10. Emergency medical conditions. Defined as a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

11. Hearing aids. Includes the cost of any maintenance or repairs, subject to benefit maximums.

12. Home Health Care. Services must be ordered by the attending physician.

13.Hospice Care for medically necessary charges. When ordered by an attending physician for patients who are terminally ill with a life expectancy of six months or less and provided by a state licensed agency.

14. Hospital Services, Inpatient. Includes:

a. Intensive Care/Coronary Care when medically necessary;
b. Room & Board (medically necessary semi-private room and board). Personal comfort items are not covered;
c. Other miscellaneous medically necessary in-patient services and supplies furnished by the hospital which are not included in the room charge;
d. Special Duty Nursing when ordered by the attending physician.

15. Hospital Services, Outpatient. Includes:

(a) Emergency room service when medically necessary;

(b) Other medically necessary out-patient hospital charges;

(c)Outpatient hospital charges and general anesthesia for extensive dental treatment for children under 12 years of age, or a patient with mental incapacity, is covered.

16. Laboratory Services. Diagnostic laboratory expenses are covered when medically necessary and performed or ordered by a physician due to illness, accident or injury. To maximize benefits, it is the patient's responsibility to make sure that referral is made to an in-network PPO service provider.

17. Maternity Care. For the employee, spouse, domestic partner, and dependent children. Coverage for the newborn, beyond the initial nursery care, will be allowed if the child meets the City's definition of an eligible dependent.

18. Maxillofacial Prosthetic Services. For repair of head and facial structures damaged by trauma, disease, surgery or congenital deformity that cannot be managed with living tissue are covered when medically necessary and unrelated to TMJ treatment or therapy.

19. Mental health inpatient and residential services which have been pre-certified.

20. Nonprescription Enteral Formula For Home Use and Inborn Errors of Metabolism. When medically necessary and ordered by the doctor for the treatment of severe intestinal malabsorption and must comprise the sole source, or an essential source, of nutrition.

21. Oral Surgery. Extraction of impacted teeth. Lifetime benefit maximum is $500.

22. Organ transplants. The Plan will pay benefits for medically necessary and appropriate transplant procedures as approved by the Medical Management Program, which conform to accepted medical practice and are not experimental or investigational.

(a) Definitions:

(i) Transplant means:

- A procedure or a series of procedures by which tissue (e.g., solid organ, marrow, stem cells) is removed from the body of one person (donor) and implanted in the body of another person (recipient); and/or
- A procedure or series of procedures by which tissue is removed from one's body and later re-introduced back into the body of the same person.

(ii) Transplant does not include:

- The collection of and/or transfusion of blood or blood products.
- Corneal transplants.

(iii) Transplant period means the time from the day of the admission for

transplant conditioning through the day of discharge for a transplant.

(iv) Complications resulting from a transplant means all medical and surgical treatments except the transplantation of hematopoietic cells or solid organ(s).

(b) Covered Transplant Benefits - Benefits for transplants are limited as follows:

(i) If the Recipient or Self-Donor is enrolled under this Plan, donor costs related to a covered transplant will be paid in accordance with the Plan's copays and maximums. "Donor costs" mean the covered expense of removing the tissue from the donor's body and preserving or transporting it to the site where the transplant is performed as well as any other necessary charges directly related to locating and procuring the organ. If the donor is covered under this Plan and the recipient is not, no benefits toward donor costs will be paid. Expenses incurred by an enrolled donor which result from complications and unforeseen effects of the donation will be covered as any other sickness. Expenses incurred by a donor not enrolled in the Plan which result from complications and unforeseen effects of the donation will not be covered.

(c) Covered transplants are medically necessary and appropriate when they meet the Pre-Certification/ Utilization Management Program Criteria for the following organs or tissues:

(i) Heart;

(ii) Lung;

(iii) Heart and lung;

(iv) Liver;

(v) Kidney;

(vi) Kidney and pancreas when transplanted together in the same operative session;

(vii) Pancreas (this includes pancreas alone and pancreas after kidney transplantation);

(viii) Small bowel;

(viii) Autologous bone marrow or stem cell transplant for the treatment of:

- ✓ acute leukemia;
- ✓ chronic leukemias;
- ✓ lymphoproliferative disorders;
  - o germ cell tumors of the testes, ovaries, mediastinum and retroperitoneum;
  - o plasma cell disorders;
  - o solid tumors of childhood;
  - o neuroductal tumors;

- o other malignancies.

(ix) Homogenic/allogenic bone marrow or stem cell transplant for the treatment of:

- ✓ acute leukemia
- ✓ chronic leukemia
- ✓ myelodysplastic syndromes;
- ✓ stem cell disorders
- ✓ myeloproliferative disorders;
- ✓ lymphoproliferative disorders;
- ✓ inherited metabolic disorders;
- ✓ inherited erythrocyte abnormalities;
- ✓ inherited immune system disorders;
- ✓ other inherited disorders;
- ✓ plasma cell disorders;
- ✓ other malignancies.

(d) Physician or professional provider transplant services according to the benefits for physicians and professional providers under the Plan will be paid;

(e) Anti-rejection drugs following the covered transplant will be paid according to the benefits for prescriptions drugs, if any, under the Plan.

(f) Transplant Service Authorization Requirement: The service authorization requirement relates only to the administration of benefits under the Plan. The outcome of a service authorization request does not constitute a treatment recommendation or requirement. It relates solely to whether the procedure will be covered under the Plan. The actual course of medical treatment the enrollee chooses remains strictly a matter between the enrollee and his or her physician.

(g) Transplant Service Authorization Procedures. To request service authorization, the enrollee's physician must contact the Medical Service Authorization Unit of ODS prior to the transplant admission. To be valid, service authorization approval must be in writing from ODS. Service authorization should be obtained as soon as possible after an enrollee has been identified as a possible transplant candidate.

Mail: Medical Service Authorization Unit
The ODS Companies
P.O. Box 40384
Portland, Oregon 97240
Telephone: (503) 243-4496 - Portland Area
Toll-free: 1-800-258-2037 - Nationwide

(h) Organ Transplant Exclusions - the Plan will not pay for the following transplant or transplant related services :

(i) Donation related services or supplies provided to a Donor who is an enrollee under this Plan if the Recipient is not enrolled under this Plan and eligible for transplant benefits;

(ii) Services or supplies for any transplant not specifically named as covered, including the transplant of animal organs or artificial organs; and

(iii) Chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not specifically named as covered above.

23. Preventive Care and Well Child Care. Coverage for preventive care and well child care according to the schedule listed in the Medical Plan Features Chart.

24. Professional Services – Medically necessary services of a professional provider (see next page for a list of eligible professional providers) are covered subject to plan limits.

25. Reconstructive surgery after breast cancer. Includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

26. Short term rehabilitation. Services consist of physical therapy, occupational therapy and/or speech therapy furnished to a person who is not confined as an inpatient in a hospital or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins. Rehabilitation services include physical, occupational, speech or audiological therapy services necessary to restore or improve lost function caused by illness or injury. Services must begin within one year of the illness or injury being treated. Recreational or educational therapy, non-medical self-help or training, services rendered for the treatment of delays in speech development, or treatment of psychotic or psychoneurotic conditions are not included.

27. Skilled Nursing Facility Care. Medically necessary skilled nursing care is covered up to a maximum 30 days per plan year. Services must be ordered by the attending physician and require pre-certification.

28. Surgical Benefits. All inpatient procedures and some outpatient surgeries require pre-certification. Covered medically necessary surgical services include: Primary surgeon; assistant surgeon (as requested by the surgeon and only to the extent that hospital staff assistance is not available or appropriate); anesthesiologist (only as required by the surgeon); radio-active therapy; iodine therapy; super-voltage therapy; deep x-ray therapy; burn treatment, fractures and dislocations; surgeon consultation while an inpatient, as required in the diagnosis or treatment of an illness or injury; outpatient surgical and related services on the day of the surgery; second surgical opinions, and medically necessary inpatient lab and x-ray expenses.

29. X-ray Services. Medically necessary diagnostic x-ray expenses are covered when performed or ordered by a physician due to illness, accident or injury. To maximize benefits, it is the patient's responsibility to make sure referral is made to an in-network PPO service provider.

7.08 Economy Plan Professional Providers

A. A professional provider means any of the following who provides medically necessary covered services within the scope of his/her license. In all cases, the services must be medically necessary and covered under this plan to be eligible for benefits. To be eligible for the in-network level of coverage, services must be rendered by a preferred provider within a Participant's elected network or through the alternative care services network. Only the alternative care network is considered in-network for chiropractic, acupuncture and naturopath services. When a Participant does not use a network provider, the plan benefits will be based on the maximum plan allowance (MPA) and subject to a higher deductible and co- payment.

1. A doctor of medicine (M.D.)
2. A doctor of osteopathy (D.O.)
3. A certified nurse practitioner
4. A podiatrist
5. A chiropractor (in-network benefit only provided through the ODS Alternative Care Network of providers)
6. An acupuncturist (in-network benefit only provided through the ODS Alternative Care Network of providers)
7. A Naturopath (in-network benefit only provided through the ODS Alternative Care Network of s providers)
8. A dentist (doctor of medical dentistry or doctor of dental surgery), but only for treatment of accidental injury to natural teeth provided within 12 months after the injury, or for surgery that does not involve repair, removal or replacement of teeth, gums, or supporting tissue
9. A registered psychologist
10. A State-licensed physician assistant
11. A State-licensed clinical social worker
12. A registered physical, occupational, speech or audiological therapist
13. A registered nurse or licensed practical nurse, but only for services provided upon the written referral of a doctor of medicine or osteopathy, or only for those services which nurses customarily bill patients
14. An optometrist
15. The term "professional provider" does not include any other class of provider not named above, and no Plan benefits will be paid for their services.

7.09 Economy Prescription Drug Program

A. The prescription drug benefit for the Economy PPO Plan is managed by a pharmaceutical benefits management (PBM) service provider (Caremark).

B. The Economy plan's pharmacy coverage pays benefits based on whether or not the prescription drug is on the formulary (i.e., a broad list of prescription drugs). The PBM will pay prescription drug benefits on its formulary which is not a static list. The PBM will continually review and update the formulary on recommendation by its panel of pharmacists and physicians.

C. Certain drugs require prior authorization to ensure appropriate utilization and cost effectiveness for the plans and members. If the Participant's provider prescribe a drug that requires prior authorization, the provider must call the PBM to ensure the most appropriate medication is prescribed. Drugs which require pre-certification include but are not limited to the following drug classes: anabolic steroids, growth hormones and GH related, Gaucher Disease, select interferons and ribavirins, erectile dysfunction, multiple sclerosis, ADHD/narcolepsy, anemia, arthritis and topical acne..

D. Participant's share of the costs is based on a percentage of the actual costs, not a flat dollar co-payment amount and depends on whether the drug is a preferred generic, preferred brand name or a non-preferred generic or brand name drug.

E. Mail Order Service

1. If a Participant uses the mail order service, the Participant will have a 90-day supply of the prescription mailed directly to his or her home. The co-pay is based on the total cost of the medication for the 90-day supply at the co-pay levels.

2. There may be times when there are short delays in filling a prescription if the PBM is temporarily out of stock. Generally the medication should be available within 72 hours. If the drug manufacturer has supply problems which have caused a medication to be unavailable nationwide, then a longer delay may occur. In such case, the PBM will contact the Participant and provide options including:

(a) Offering to transfer the prescription to a local retail pharmacy with in-stock medication, or

(b) Offering to contact the Participant's doctor to provide a therapeutic alternative.

(c) Because of the fluctuation in drug costs, the PBM may be unable to provide an exact cost of a prescription at the time of order. If the Participant pays by check, this may cause a balance due on a mail order account.

(d) If the Participant has a balance owing on his or her mail order account, the PBM cannot fill the next prescription until the balance is paid or it is told to charge the Participant's credit/debit card account on file.

7.10 Economy Plan Lifetime Benefit Maximum

The Economy plan will pay a lifetime maximum of $2,000,000 in claims per participant. On July 1 of each year, the maximum benefit available with respect to any participant shall be increased by an amount equal to the amount paid under the Plan during the prior calendar year up to $25,000. Therefore, any yearly benefit of $25,000 or less will not be counted toward the lifetime maximum. Any yearly benefit of more than $25,000 will count toward the lifetime maximum. The maximum lifetime benefit will not be increased above $2,000,000.00. As required under the the Health Care and Education Affordabilty Reconcilation Act of 2010 this provision will be removed upon the required effective date.

7.11 Economy Plan Exclusions and Limitations

A. Economy will not cover any expenses incurred for which the participant is not legally liable or which are not medically necessary. Other expenses not covered are those in excess of the Maximum Plan Allowance (MPA), or in excess of what would have been charged in the absence of plan coverage. Charges specifically excluded from coverage or limited in any way are as follows:

1. Services that are not provided.
2. Services received before your effective date of coverage.
3. Services that are not a covered service or relate to complications resulting from a non-covered service, even if such service was previously covered under the Plan.
4. Services that are not furnished by a qualified practitioner acting within the scope of his/her license or qualified treatment service.
5. Services for which no charge is made or you would not be required to pay if you did not have health plan coverage.
6. Charges in excess of the Maximum Plan Allowance (MPA).
7. Services related to injury, illness or condition to the extent a payment or any other benefit including the amount received as a settlement is provided under any workers compensation or City liability on the account of the injury, illness, or condition arising out of the course of gainful employment.
8. Services provided by a dentist (doctor of medical dentistry or doctor of dental surgery) but only for treatment of an accidental injury to natural teeth provided within 12 months of the injury or for surgery that does not involve repair, removal or replacement of teeth, gums, or supporting tissue
9. Intentional self-inflicted injury is limited to $10,000 per lifetime for such injuries.
10. Bodily injury or illness arising out of duty as a member of the armed forces of any state or country, or a war or any act of war (declared or undeclared).
11. Injury or illness resulting from the plan participant's commission or attempt to commit an assault or other illegal act, a civil revolution or riot.
12. Services or supplies not listed as covered services or not considered medically necessary by the Plan.

13 Expenses or services provided by a local, state or federal agency and emergency rescue services.

14. Charges for telephone consultations with participants or other medical providers.

15. Out- of- network services by an anesthesiologist, assistant surgeon, radiologist or pathologist, or supplies provided while a patient at an in-network hospital, when ordered by a participating provider, will be covered at the in-network benefit level (subject to MPA) when the covered member has no control over the choice of provider for these services. The out of pocket expenses (except for those charges in excess of MPA) will apply to the in-network out of pocket maximum.

16. Services, prescription drugs, and supplies you or your dependent may receive while in the custody of any state or federal law enforcement authorities or while in jail or prison.

17. Experimental or Investigational Procedures: services, prescription drugs, and supplies that are deemed by the plan administrator to be:

a. Those not rendered by an accepted institution, physician or provider within the United States or by one which has not demonstrated medical proficiency in the rendering of the service or supplies;

b. Those not recognized by the medical community in the service area in which they are received;

c. Those for which the approval of government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered;

d. Those for which scientific or medical assessment has not been completed and the effectiveness of the treatment has not been generally established;

e. Those rendered in the service area only as part of clinical trial or research program for the illness or condition being treated;

f. Those unavailable in the service area for the illness or condition being treated and available for that illness or condition within the United States as part of a clinical trial or research program only; and

g. Those expenses incidental to or incurred as a direct consequence of experimental or investigational procedures, if the expenses were incurred primarily as the result of obtaining experimental or investigational services, prescription drugs, and supplies.

18. Services, Prescription Drugs, Supplies, and/or Treatment Not Medically Necessary; including:

a. Services, prescription drugs, and supplies that are either inappropriate or inconsistent with the symptoms or diagnosis of your condition or that of your dependent;

b. Services, prescription drugs, and supplies that are inappropriate with regard to standards of good medical practice in the service area;

c. Services, prescription drugs, and supplies that are primarily rendered for the convenience of you or your dependents or a physician or provider of services or supplies; and/or

d. Services that are not the least costly of the alternative supplies or levels of service, which can be safely provided to you or your dependent. For example, coverage would not be allowed for an inpatient hospital stay when the same level of treatment could be delivered in an outpatient setting such as an ambulatory surgery facility.

B. Exclusions Related to Miscellaneous Services and Items:

1. Support Education including Level I educational programs related to Driving Under the Influence (DUI), voluntary mutual support groups, such as Alcoholics Anonymous, or family education or support groups.

2. Behavior modification, psychological enrichment or self-help programs for mentally healthy individuals. These include assertiveness training, image therapy, sensory movement groups, marathon group therapy, and sensitivity training.

3. Routine optometric eye examinations, including the fitting, provision, or replacement of eyeglasses or contact lenses, and any charges for orthoptics, vitamin therapy, vision therapy, eye exercises, or fundus photography. Vision benefits may be available through the City's vision plan and are subject to the terms of that Plan.

4. Refractive surgery, laser vision correction, and any other procedure which alters the refractive character of the eye, the purpose of which is to cure or reduce myopia, hyperopia, or astigmatism. This exclusion includes, but is not limited to, radial keratotomy, corneal rings, LASIK, PRK, any procedure using the Excimer Laser or the Holmium: YAG laser, and other procedures of the refractive keratoplasty type. Reversals or revision of any procedures that alter the refractive character of the eye and any complications of these procedures are excluded.

5. Reversal of sterilization procedures.

6. Miscellaneous services, including (but not limited to):

a. Custodial Care, including routine nursing care and hospitalization for environmental change;

b. Private Nursing Services even if related to a condition which is otherwise covered by the Plan;

c. Services provided by a member of the Participant's immediate family;

d. Services provided by volunteer workers;

e. Supplies intended for use outside hospital settings or considered personal in nature;

f. Routine miniature chest x-ray films or full body scans;

g. Other services and supplies not directly connected to the diagnosis or curative treatment of an illness or injury.

7. Supportive environmental materials, or any service or product that is primarily promoted as a personal convenience item; is prescribed or recommended by a healthcare provider and does not meet industry treatment standards or protocols or is a product or service that may be purchased or obtained by the general public without a prescription. Examples include, but are not limited to, hand rails, ramps, bath benches, cervical pillows, humidifiers, air filters, air conditioners, heat lamps, tanning lights, whirlpools,

saunas, whirlpools, hot tubs, fitness equipment, telephones, home furnishings and costs associated with local or distant travel, even if related to a condition otherwise covered by the Plan.

8. Normal necessities of living, including but not limited to food, clothing and household supplies.

9. Separate charges for the completion of reports or claim forms and the cost of records.

10. Ambulance services exceeding 300 miles per plan year.

11. Biofeedback therapy services are limited to medically necessary treatment of tension or migraine headaches and the Plan will pay for no more than 10 visits during the participant's lifetime.

12. Cosmetic/Reconstructive Surgery: Cosmetic procedures (any procedure that is requested for the purpose of improving appearance without restoring bodily function or correcting physical impairment) are exclusions under this plan. Complications of reconstructive surgeries will be covered if medically necessary, clinically distinct and not specifically excluded under this plan. Breast augmentation, lipectomy, liposuction, hair removal (including electrolysis and laser) and rhinoplasty are not covered procedures.

13. Experimental or Investigational Procedures: Services, prescription drugs, and supplies that are deemed by the plan administrator to be:

a. Those not rendered by an accepted institution, physician or provider within the United States or by one which has not demonstrated medical proficiency in the rendering of the service or supplies;

b. Those not recognized by the medical community in the service area in which they are received;

c. Those for which the approval of government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered;

d. Those for which scientific or medical assessment has not been completed, and the effectiveness of the treatment has not been generally established;

e. Those rendered in the service area only, as part of clinical trial or research program for the illness or condition being treated; and

f. Those unavailable in the service area for the illness or condition being treated and available for that illness or condition within the United States as part of a clinical trial or research program only.

g. Those expenses incidental to or incurred as a direct consequence of experimental or investigational procedures, if the expenses were incurred primarily as the result of obtaining experimental or investigational services, prescription drugs, and supplies.

14. In alternative health care environments, only traditional medical testing will be covered by the plan.

15. Any services related to the treatment of infertility and/or the cause of infertility are excluded from coverage under the Plan. This includes artificial insemination procedures, including, but not limited to, in-vitro fertilization (IVF), Gamete

intrafallopian Transfer (GIFT), Zygote Intrafallopian Transplant (ZIFT), and Tubal Embryo Transplant (TET). Only the initial visit and initial diagnostics to determine infertility are covered.

16. Replacement of lost hearing aids or batteries for hearing aids are not covered.

17. Charges incurred for telephone consultations with or between medical providers.

18. Non-surgical treatment of oral diseases or other medical conditions, extraction of erupted teeth, and dental repair are not covered under the Oral Surgery benefit.

19. Over-the-counter medications, including nutritional supplements, herbal and homeopathic remedies, and contraceptive products are not covered.

20. Treatments defined as holistic and/or are treatments outside of industry-recognized standards of care.

21. Services of a massage therapist, even if related to a condition otherwise covered by the Plan.

22. Immunizations for the sole purpose of travel or to prevent illness which may be caused by a work environment.

23. Services/supplies requiring pre-certification are not covered under this plan unless certified as medically necessary through the City's contracted Service Authorization/Pre-Certification Program.

24. Services and supplies provided for the treatment of obesity or weight reduction. The plan will cover services and supplies that are necessary for the treatment of established medical conditions that may be caused by or made worse by obesity, but the plan will not cover services and supplies that do so by treating the obesity directly, even if morbid obesity is present. Services specifically excluded from this plan include, but are not limited to:

a. Surgical: Gastric restrictive procedures with or without gastric bypass, or the revision of the same.

b. Weight Management: Weight loss programs, exercise programs, counseling, hypnosis, biofeedback, neurolinguistic programming, guided imagery, or any form of relaxation training as well as subliminal suggestion used to modify eating behaviors.

c. Pharmaceutical: Any drug or formula related to or resulting from the treatment of weight loss or obesity even if prescribed by your physician.

25. Services to alter a participant's physical characteristics to that of the opposite sex, including Sexual Reassignment Surgery and related therapies.

26. Chelation therapy is not covered under the Plan, except for acute arsenic, gold, mercury or lead poisoning.

27. Donation related services or supplies provided to an insured Donor if the Recipient is not enrolled under this Plan and eligible for transplant benefits. This exclusion does not apply to complications or unforeseen infections resulting from the donation of tissue.

28. Services or supplies for any transplant not specifically named as covered including the transplant of animal organs or artificial organs.

29. Chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not specifically named as covered.

30. Foot orthoses (orthotics) made of high impact plastics or other materials, designed to be inserted into shoes;

31. Temporomandibular joint (TMJ) treatment and surgery.

32. Orthognathic surgery and services or supplies to add to or reduce the upper or lower jaw.

33. Genetic testing or counseling unless medically necessary and pre-certified through the City's contracted Utilization Review provider. Genetic testing for family members not covered under the Plan is excluded.

34. Services and supplies for speech therapy, unless provided by a licensed speech therapist and rendered within one year of the onset of the illness/injury, congenital abnormality, or previous therapeutic process. Services rendered for the treatment of delays in speech development are not covered.

35. Counseling related to family, marriage, sex and career, in the absence of medical necessity/illness;

36. Vocational, pastoral or spiritual counseling;

37. Dance, poetry, music or art therapy, except as part of a treatment program in an inpatient setting.

38. Non-organic therapies including, but not limited to, bioenergetics therapy, confrontation therapy, crystal healing therapy, educational remediation, EMDR, guided imagery, marathon therapy, primal therapy, rolfing, sensitivity training, training psychoanalysis, transcendental meditation and Z therapy.

39. Organic therapies including, but not limited to, aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, narcotherapy with LSD, and sedative action electrostimulation therapy.

40. Routine foot care services that are not medically necessary.

41 .Routine physical exams for employment, licensing, insurance coverage or court order or required for parole or probation.

42. Designated Blood Donations-collection, processing and storage of blood donated by donors designated by plan participants and procurement and storage of cord blood, unless medically necessary for the imminent use at the time of collection for a designated recipient.

43. Hypnotherapy.

7.12 Prescription Drug Program Exclusions

(a) Drugs or medications purchased or obtained without a physician's written prescription.

(b) "Over-the-counter" products (with the exception of insulin, syringes and needles).

(c) Nose drops or nasal preparations that do not require a physician's written prescription.

(d) Immunization agent.

(e) Non-drug items, dietary supplements, vitamins (other than prescription pre-natal vitamins) or health and beauty aids.

(f) Drugs dispensed by a hospital, nursing care facility, health care center, urgent or immediate care center, ambulatory surgical center, doctor's office, or other institution.

(g) Drugs obtained after eligibility and/or coverage terminates.

(h) Any refill of a prescription that exceeds the number specified by the prescribing physician or that is dispensed after one year from the date of the prescription.

(i) Drugs prescribed or used for cosmetic purposes.

(j) Services and supplies subject to the "Plan Limitation and Exclusion" section of this plan (see above).

(k) Non-legend or over-the-counter (OTC) drugs.

(l) Prescriptions which are covered by workers' compensation laws, the Fire & Police Disability Retirement Fund, or other county, state or federal programs.

(m) Compounds unless the prescription includes at least one legend drug that is an essential ingredient.

(n) Naturopathic supplements, including when prescribed as a compound drug;

(o) Drugs that are determined by the Plan Administrator to be experimental or investigational or that are labeled: "Caution-Limited by federal law to investigational use"

8.0 Seasonal Maintenance Worker PPO Medical Plan

8.01 Medical Services

All medical services must be medially necessary to be covered under the Seasonal Maintenance Worker Plan and are subject to the terms, conditions and limitations of the Plan. Services not listed herein are not covered. Seasonal Maintenance Worker Plan reimbursement levels for covered charges are as indicated in the following Schedule of Covered Services:

Medical Plan Feature	PPO Seasonal Maintenance Worker (SMW) Medical Plan	
	In-Network Participant Pays	**Out-of-Network Participant Pays**
Network Required	ODS/ Plus Networkk. During the year Participant can go in-network or out-of-network. When Participant goes in-network, however, ODS Plus network must be used. All family members must be enrolled in same network.	
Maximum Plan Allowance (MPA)	After the deductible, plan pays benefits based on negotiated rates.	After the deductible, plan pays benefits based on MPA limits.
Plan Year Deductible Out of network excludes in-network expenses. Charges over MPA not applied to deductible.	SMW Plan: $500/person; $1,500/family maximum	SMW Plan : $500/person; $1,500/family maximum
Plan Year Out-of-Pocket Maximum (SMW prescription drug, emergency room co-pays or other co-pays and charges over MPA do not apply to annual maximum)	SMW Plan: $2,500/person; $7,500/family maximum (excludes deductible & in-network expenses)	SMW Plan : $3,000/person; $9,000/family maximum (excludes deductible & in-network expenses)
Lifetime Maximum Benefits	$1,000,000/person, including benefits previously paid under CityCore, Economy, CityBasic, CitySelect and CityPremium Plans	
Pre-certification	Required for hospitalization and other services as listed in Plan Document .	

Medical Plan Feature	PPO Seasonal Maintenance Worker (SMW) Medical Plan	
	In-Network Participant Pays	**Out-of-Network Participant Pays**
Wellness Routine Physical Exams & Immunizations (except for travel-related immunizations) Non-routine lab work and/or tests and other medically necessary exams are *not* covered at 100%, but will be covered at regular benefit levels.	100% No deductible Participant Responsibilities: o When making an appt., double check when last routine exam occurred to ensure eligibility for the service at the 100% benefit level. o Seek services through an in-network provider. o Ensure provider uses an in-network lab.	50% of MPA after deductible
	Routine physical exam maximum: Newborn — 2 hospital exams Under age 2 — 7 exams in 24 months Ages 2+ — 1 exam per 12 months ***Cancer Screenings:*** ***Breast Cancer-Mammogram maximum:*** Ages 35-39 — 1 Ages 40+ — 1 per 12 months (365 days) At any age when high risk and deemed necessary by physician ***Cervical Cancer-Pap Smear maximum:*** *1 per 12 months or at any time when high risk and deemed necessary by physician.* ***NOTE****: Women should begin screenings within 3 years of sexual activity or age 21 whichever is earlier.* ***Prostate Cancer-PSA maximum***: 1 per 12 months (365 days) ***Colorectal cancer screening maximums:*** Age 50 + — 1 sigmoidoscopy every 5 years or 1 colonoscopy every 10 years More frequent sigmoidoscopy or colonoscopy procedures will be covered when deemed necessary by a physician because of high risk or family history. Age 50 + — 1 fecult occult blood test per 12 mos.	
Office Visits • Primary Care including urgent care •Specialty care •Prenatal care •Allergy shots & other injections •Routine immunizations •Rehabilitative therapies (35 visits annual max) Outpatient surgery	$30 per visit 30% $30 $10 100% no deductible 30% 30%	50% of out-of-network maximum plan allowance after deductible for all listed services

Medical Plan Feature	PPO Seasonal Maintenance Worker (SMW) Medical Plan	
	In-Network Participant Pays	**Out-of-Network Participant Pays**
X-Rays, imaging, laboratory & specialty diagnostic procedures	30%	50% of out-of-network maximum plan allowance after deductible
Inpatient Care Semi-private room and board; diagnostic x-rays and lab work; surgeries; miscellaneous services.	30% after deductible	50% of MPA after deductible
Emergency Room (co-pay waived if admitted as inpatient following emergency)	30% after $50 co-pay	50% after $50 co-pay
Urgent Care	30% after deductible	50% of MPA after deductible
Ambulance	30% of MPA; no deductible	
o **Alternative Care Providers** (chiropractic, acupuncture, and naturopathic providers) ODS Alternative Care Network provides in-network alternative care services.	30% after deductible in ODS Alternative Care network 35-visit annual maximum for chiropractic. Services must be pre-certified by ODS for more than 20 visits.	50% of MPA after deductible
Physical Therapy	30% after deductible	50% of MPA after deductible
Skilled Nursing Facility	30% after deductible (30 day plan year maximum.)	50% of MPA after deductible (30 day plan year maximum.)
Durable Medical Equipment	30% after deductible Precertification required if rental exceeds 30 days or cost exceeds $500	50% of MPA after deductible
Home Healthcare	30% after deductible 60-visit plan year maximum	50% of MPA after deductible
Hospice	30% after deductible $7,500 lifetime maximum	50% of MPA after deductible
Refractive Eye Surgery	Not Covered	Not covered
Hearing Aids	30% of MPA (no deductible) up to $1,200 per ear. New hearing aid covered once every 36 months if medically necessary	50% of MPA (no deductible) up to $1,200 per ear. New hearing aid covered once every 36 months if medically necessary
TMJ Treatment	Not covered	Not covered

Medical Plan Feature	PPO Seasonal Maintenance Worker (SMW) Medical Plan	
	In-Network Participant Pays	**Out-of-Network Participant Pays**
Behavioral Health **Mental Health Treatment** **Pre-Certification is required for all in-patient and residential treatment programs.**	30% after deductible Inpatient –same as hospital inpatient Outpatient subject to primary care office co-pay Residential treatment limited to 45 days per year	50% after deductible Inpatient –Same as hospital inpatient Outpatient subject to primary care office co-pay Residential treatment limited to 45 days per year
Chemical Dependency Treatment **Pre-Certification is required for all in-patient and residential treatment programs**	30% after deductible (same as hospital inpatient) Out-Patient & Residential	50% after deductible (same as hospital inpatient)
Sterilization, Contraceptive Implants (e.g., IUDs, Norplant)	30% after deductible ($335 annual maximum contraceptive implant benefit)	50% after deductible ($335 annual maximum contraceptive implant benefit)
Infertility Treatment	Not covered	Not covered
Prescription Drugs **In- network retail pharmacy (up to 30 day supply)** **Out-of-network pharmacy (up to 30 day supply)** **Mail order pharmacy (up to 30 day supply)**	Deductible does not apply In-Network Pharmacy: -90% of preferred generic drug cost -80% of preferred brand drug name cost -70% of non-preferred drug cost (generic or brand name) Same as in-network retail pharmacy benefit levels shown above	Out-of-Network pharmacy: Participant pays pharmacy and submits claims to ODS for 60% reimbursement after out-of-network deductible is met.

8.02 Accessing the Networks:

Within the ODS Plus Network, participants may choose any of the PPO providers and facilities to receive covered services. Plan participants are encouraged to select and utilize a primary care physician for routine medical services. Plan participants are not required to select a primary care physician and do not need referrals to specialists. Participants are provided on-line directories that list PPO service providers. A paper directory may be requested from the Medical Claims Administrator.

8.03 Identification Cards:

Plan participants are provided identification cards within six weeks after initial enrollment. ID cards provide health care service providers with plan benefit and payment information. ID cards may be required to be shown in order to access service.

8.04 Deductibles:

A. No individual or family plan year (July 1 through June 30) deductible is required for covered services related to Emergency Room treatment, Alternate Coverage or Hearing Aids. All Emergency Room treatment, Alternate Coverage or Hearing Aids are considered in-network.

B. The Plan provides for a deductible carry-over. Expenses incurred and applied to the deductible during the last three months of the plan year (April, May and June) may count towards meeting the following plan year's deductible.

8.05 Plan Year Maximum Out-of-Pocket Limits:

After the plan year maximum out of pocket is met, the plan will reimburse 100% of the allowable cost for services incurred during the remainder of the plan year. Services with specific maximums, charges in excess of Maximum Plan Allowance, emergency room and prescription drugs co-payments are not applied to the Plan Year Maximum Out-of-Pocket Limits. Co-payments and other costs for network services do not apply to the maximum out-of-pocket for non-network services. Non-network co-payments and costs for services do not apply to in-network plan year maximum out-of-pocket limits.

8.06 Notice of Declination:

The City of Portland reserves the right to disallow costs associated with any provider, facility, product or service outside the scope of this plan.

8.07 Covered Services

A. The following services, when medically necessary, are covered under this plan at the levels previously stated in 6.01.

B.Pre-certification is required for certain services as outlined in 5.07.030.

1. **Allergy shots** and office visits for allergy testing.
2. **Alternative Care**. Medically necessary services by Chiropractors, Naturopaths and Acupuncturists are covered subject to maximums outlined in the Medical

Plan Features chart. For in-network chiropractic benefits, services must be provided by an ODS Alternative Care Network provider..

3. Ambulance. Up to 300 miles per year to or from the nearest hospital when medically necessary.

4. Appliances. Items used for performing or facilitating the performance of a particular bodily function, including orthopedic braces and compression stockings, are covered when medically necessary as determined by the Plan's third-party administrator. Appliances do not include dental appliances and braces, supporting devices such as corsets, eye glasses or contact lenses.

5. Artificial Limbs. The first extremity prosthesis after loss of a body part is covered, including artificial eyes and post-mastectomy bra and prosthetic. An additional prosthesis may be authorized if the attending physician provides documentation to the Plan that a new prosthetic device is medically necessary because of changing fit or poor function. Testicular prostheses are not covered.

6. Chemical Dependency Treatment (drug and/or alcohol). This benefit does not apply to addiction or dependency on tobacco, tobacco products or foods nor does it include volunteer mutual support groups or educational programs for drinking drivers referred by the judicial system. Inpatient and residential treatment must be pre-certified (except for emergency hospital admissions, which must be certified within 48 hours of emergency admission).

7. Colorectal Screening is covered in accordance with the schedule detailed on the Medical Plan Features chart.

8. Contraceptive device insertion and removal.

9. Durable medical equipment. When medically necessary, limited to either the total rental cost or the purchase price of such equipment, whichever is less. Dental appliances are not included.

10. Emergency medical conditions. Defined as a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

11. Hearing aids. Includes the cost of any maintenance or repairs, subject to benefit maximums.

12. Home Health Care. Services must be ordered by the attending physician.

13. Hospice Care for medically necessary charges. When ordered by an attending physician for patients who are terminally ill with a life expectancy of six months or less and provided by a state licensed agency.

14. Hospital Services, Inpatient. Includes:

a. Intensive Care/Coronary Care when medically necessary;

b. Room & Board (medically necessary semi-private room and board). Personal comfort items are not covered;

c. Other miscellaneous medically necessary in-patient services and supplies furnished by the hospital which are not included in the room charge;

d. Special Duty Nursing when ordered by the attending physician.

15. Hospital Services, Outpatient. Includes:

a. Emergency room service when medically necessary;

b. Other medically necessary out-patient hospital charges;

c. Outpatient hospital charges and general anesthesia for extensive dental treatment for children under 12 years of age, or a patient with mental incapacity, is covered.

16. Laboratory Services. Diagnostic laboratory expenses are covered when medically necessary and performed or ordered by a physician due to illness, accident or injury. To maximize benefits, it is the patient's responsibility to make sure that referral is made to an in-network PPO service provider.

17. Maternity Care. For the employee, spouse, domestic partner, and dependent children. Coverage for the newborn, beyond the initial nursery care, will be allowed if the child meets the City's definition of an eligible dependent.

18. Maxillofacial Prosthetic Services. For repair of head and facial structures damaged by trauma, disease, surgery or congenital deformity that cannot be managed with living tissue are covered when medically necessary and unrelated to TMJ treatment or therapy.

19. Mental health inpatient and residential services which have been pre-certified.

20. Nonprescription Enteral Formula For Home Use and Inborn Errors of Metabolism. When medically necessary and ordered by the doctor for the treatment of severe intestinal malabsorption and must comprise the sole source, or an essential source, of nutrition.

21. Oral Surgery. Extraction of impacted teeth. Lifetime benefit maximum is $500.

22. Organ transplants. The Plan will pay benefits for medically necessary and appropriate transplant procedures as approved by the Medical Management Program, which conform to accepted medical practice and are not experimental or investigational.

(a) Definitions:

(i) Transplant means:

- A procedure or a series of procedures by which tissue (e.g., solid organ, marrow, stem cells) is removed from the body of one person (donor) and implanted in the body of another person (recipient); and/or

- A procedure or series of procedures by which tissue is removed from one's body and later re-introduced back into the body of the same person.

(ii) Transplant does not include:

- The collection of and/or transfusion of blood or blood products.
- Corneal transplants.

(iii) Transplant period means the time from the day of the admission for transplant conditioning through the day of discharge for a transplant.

(iv) Complications resulting from a transplant means all medical and surgical treatments except the transplantation of hematopoietic cells or solid organ(s).

(b) Covered Transplant Benefits - Benefits for transplants are limited as follows:

(i) If the Recipient or Self-Donor is enrolled under this Plan, donor costs related to a covered transplant will be paid in accordance with the Plan's copays and maximums. "Donor costs" mean the covered expense of removing the tissue from the donor's body and preserving or transporting it to the site where the transplant is performed as well as any other necessary charges directly related to locating and procuring the organ. If the donor is covered under this Plan and the recipient is not, no benefits toward donor costs will be paid. Expenses incurred by an enrolled donor which result from complications and unforeseen effects of the donation will be covered as any other sickness. Expenses incurred by a donor not enrolled in the Plan which result from complications and unforeseen effects of the donation will not be covered.

(c) Covered transplants are medically necessary and appropriate when they meet the Pre-Certification/ Utilization Management Program Criteria for the following organs or tissues:

(i) Heart;

(ii) Lung;

(iii) Heart and lung;

(iv) Liver;

(v) Kidney;

(vi) Kidney and pancreas when transplanted together in the same operative session;

(vii) Pancreas (this includes pancreas alone and pancreas after kidney transplantation);

(viii) Small bowel;

(viii) Autologous bone marrow or stem cell transplant for the treatment of:

- ✓ acute leukemia;
- ✓ chronic leukemias;
- ✓ lymphoproliferative disorders;
  - o germ cell tumors of the testes, ovaries, mediastinum and retroperitoneum;
  - o plasma cell disorders;
  - o solid tumors of childhood;
  - o neuroductal tumors;
  - o other malignancies.

(ix) Homogenic/allogenic bone marrow or stem cell transplant for the treatment of:

- ✓ acute leukemia
- ✓ chronic leukemia
- ✓ myelodysplastic syndromes;
- ✓ stem cell disorders
- ✓ myeloproliferative disorders;
- ✓ lymphoproliferative disorders;
- ✓ inherited metabolic disorders;
- ✓ inherited erythrocyte abnormalities;
- ✓ inherited immune system disorders;
- ✓ other inherited disorders;
- ✓ plasma cell disorders;
- ✓ other malignancies.

(d) Physician or professional provider transplant services according to the benefits for physicians and professional providers under the Plan will be paid;

(e) Anti-rejection drugs following the covered transplant will be paid according to the benefits for prescriptions drugs, if any, under the Plan.

(f) Transplant Service Authorization Requirement: The service authorization requirement relates only to the administration of benefits under the Plan. The outcome of a service authorization request does not constitute a treatment recommendation or requirement. It relates solely to whether the procedure will be covered under the Plan. The actual course of medical treatment the enrollee chooses remains strictly a matter between the enrollee and his or her physician.

(g) Transplant Service Authorization Procedures. To request service authorization, the enrollee's physician must contact the Medical Service Authorization Unit of ODS prior to the transplant admission. To be valid, service authorization approval must be in writing from ODS. Service authorization should be obtained as soon as possible after an enrollee has been identified as a possible transplant candidate.

Mail: Medical Service Authorization Unit
The ODS Companies
P.O. Box 40384
Portland, Oregon 97240
Telephone: (503) 243-4496 - Portland Area
Toll-free: 1-800-258-2037 - Nationwide

(h) Organ Transplant Exclusions - the Plan will not pay for the following transplant or transplant related services :

(i) Donation related services or supplies provided to a Donor who is an enrollee under this Plan if the Recipient is not enrolled under this Plan and eligible for transplant benefits;

(ii) Services or supplies for any transplant not specifically named as covered, including the transplant of animal organs or artificial organs; and

(iii) Chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not specifically named as covered above.

23. Preventive Care and Well Child Care. Coverage for preventive care and well child care according to the schedule listed in the Medical Plan Features chart.

24. Professional Services – Medically necessary services of a professional provider (see next page for a list of eligible professional providers) are covered subject to plan limits.

25. Reconstructive surgery after breast cancer. Includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

26. Short term rehabilitation. Services consist of physical therapy, occupational therapy and/or speech therapy furnished to a person who is not confined as an inpatient in a hospital or other facility for medical care. This therapy shall be expected to result in significant improvement of the person's condition within 60 days from the date the therapy begins. Rehabilitation services include physical, occupational, speech or audiological therapy services necessary to restore or improve lost function caused by illness or injury. Services must begin within one year of the illness or injury being treated. Recreational or educational therapy, non-medical self-help or training, services rendered for the treatment of delays in speech development, or treatment of psychotic or psychoneurotic conditions are not included.

27. Skilled Nursing Facility Care. Medically necessary skilled nursing care is covered up to a maximum 30 days per plan year. Services must be ordered by the attending physician and require pre-certification.

28. Surgical Benefits. All inpatient procedures and some outpatient surgeries require pre-certification. Covered medically necessary surgical services include: Primary

surgeon; assistant surgeon (as requested by the surgeon and only to the extent that hospital staff assistance is not available or appropriate); anesthesiologist (only as required by the surgeon); radio-active therapy; iodine therapy; super-voltage therapy; deep x-ray therapy; burn treatment, fractures and dislocations; surgeon consultation while an inpatient, as required in the diagnosis or treatment of an illness or injury; outpatient surgical and related services on the day of the surgery; second surgical opinions, and medically necessary inpatient lab and x-ray expenses.

29. X-ray Services. Medically necessary diagnostic x-ray expenses are covered when performed or ordered by a physician due to illness, accident or injury. To maximize benefits, it is the patient's responsibility to make sure referral is made to an in-network PPO service provider.

8.08 SMW Medical Plan Professional Providers

A. A professional provider means any of the following who provides medically necessary covered services within the scope of his/her license. In all cases, the services must be medically necessary and covered under this plan to be eligible for benefits. To be eligible for the in-network level of coverage, services must be rendered by a preferred provider within a Participant's elected network or through the alternative care services network. Only the alternative care network is considered in-network for chiropractic, acupuncture and naturopath services. When a Participant does not use a network provider, the plan benefits will be based on the maximum plan allowance (MPA) and subject to a higher deductible and co- payment.

1. A doctor of medicine (M.D.)
2. A doctor of osteopathy (D.O.)
3. A certified nurse practitioner
4. A podiatrist
5. A chiropractor (in-network benefit only provided through the ODS Alternative Care network)
6. An acupuncturist (in-network benefit only provided through the ODS Alternative Care network)
7. A Naturopath (in-network benefit only provided through the ODS Alternative Care network)
8. A dentist (doctor of medical dentistry or doctor of dental surgery), but only for treatment of accidental injury to natural teeth provided within 12 months after the injury, or for surgery that does not involve repair, removal or replacement of teeth, gums, or supporting tissue
9. A registered psychologist
10. A State-licensed physician assistant
11. A State-licensed clinical social worker
12. A registered physical, occupational, speech or audiological therapist

13. A registered nurse or licensed practical nurse, but only for services provided upon the written referral of a doctor of medicine or osteopathy, or only for those services which nurses customarily bill patients

14. An optometrist

15. The term "professional provider" does not include any other class of provider not named above, and no Plan benefits will be paid for their services.

8.09 SMW Prescription Drug Program

A. The prescription drug benefit for the SMW Medical Plan is managed by a pharmaceutical benefits management (PBM) service provider (Caremark).

B. The SMW plan's pharmacy coverage pays benefits based on whether or not the prescription drug is on the formulary (i.e., a broad list of prescription drugs). The PBM will pay prescription drug benefits on its formulary which is not a static list. The PBM will continually review and update the formulary on recommendation by its panel of pharmacists and physicians.

C. Certain drugs require prior authorization to ensure appropriate utilization and cost effectiveness for the plans and members. If the Participant's provider prescribe a drug that requires prior authorization, the provider must call the PBM to ensure the most appropriate medication is prescribed. Drugs which require pre-certification include but are not limited to the following drug classes: anabolic steroids, growth hormones and GH related, Gaucher Disease, select interferons and ribavirins, erectile dysfunction, multiple sclerosis, ADHD/narcolepsy, anemia, arthritis and topical acne..

D. Participant's share of the costs is based on a percentage of the actual costs, not a flat dollar co-payment amount and depends on whether the drug is a preferred generic, preferred brand name or a non-preferred generic or brand name drug.

E. Mail Order Service

1. If a Participant uses the mail order service, the Participant will have a 90-day supply of the prescription mailed directly to his or her home. The co-pay is based on the total cost of the medication for the 90-day supply at the co-pay levels.

2. There may be times when there are short delays in filling a prescription if the PBM is temporarily out of stock. Generally the medication should be available within 72 hours. If the drug manufacturer has supply problems which have caused a medication to be unavailable nationwide, then a longer delay may occur. In such case, the PBM will contact the Participant and provide options including:

(a) Offering to transfer the prescription to a local retail pharmacy with in-stock medication, or

(b) Offering to contact the Participant's doctor to provide a therapeutic alternative.

(c) Because of the fluctuation in drug costs, the PBM may be unable to provide an exact cost of a prescription at the time of order. If the Participant pays by check, this may cause a balance due on a mail order account.

(d) If the Participant has a balance owing on his or her mail order account, the PBM cannot fill the next prescription until the balance is paid or it is told to charge the Participant's credit/debit card account on file.

8.10 SMW Medical Plan Lifetime Benefit Maximum

The SMW Medical Plan will pay a lifetime maximum of $1,000,000 in claims per participant. On July 1 of each year, the maximum benefit available with respect to any participant shall be increased by an amount equal to the amount paid under the Plan during the prior calendar year up to $25,000. Therefore, any yearly benefit of $25,000 or less will not be counted toward the lifetime maximum. Any yearly benefit of more than $25,000 will count toward the lifetime maximum. The maximum lifetime benefit will not be increased above $1,000,000.00. As required under the the Health Care and Education Affordabilty Reconcilation Act of 2010 this provision will be removed upon the required effective date

8.11 SMW Plan Exclusions and Limitations

A. SMW will not cover any expenses incurred for which the participant is not legally liable or which are not medically necessary. Other expenses not covered are those in excess of the Maximum Plan Allowance (MPA), or in excess of what would have been charged in the absence of plan coverage. Charges specifically excluded from coverage or limited in any way are as follows:

1. Services that are not provided.
2. Services received before your effective date of coverage.
3. Services that are not a covered service or relate to complications resulting from a non-covered service, even if such service was previously covered under the Plan.
4. Services that are not furnished by a qualified practitioner acting within the scope of his/her license or qualified treatment service.
5. Services for which no charge is made or you would not be required to pay if you did not have health plan coverage.
6. Charges in excess of the Maximum Plan Allowance (MPA).
7. Services related to injury, illness or condition to the extent a payment or any other benefit including the amount received as a settlement is provided under any workers compensation or City liability on the account of the injury, illness, or condition arising out of the course of gainful employment.
8. Services provided by a dentist (doctor of medical dentistry or doctor of dental surgery) but only for treatment of an accidental injury to natural teeth provided within 12 months of the injury or for surgery that does not involve repair, removal or replacement of teeth, gums, or supporting tissue

9. Intentional self-inflicted injury is limited to $10,000 per lifetime for such injuries.

10. Bodily injury or illness arising out of duty as a member of the armed forces of any state or country, or a war or any act of war (declared or undeclared).

11. Injury or illness resulting from the plan participant's commission or attempt to commit an assault or other illegal act, a civil revolution or riot.

12. Services or supplies not listed as covered services or not considered medically necessary by the Plan.

13 Expenses or services provided by a local, state or federal agency and emergency rescue services.

14. Charges for telephone consultations with participants or other medical providers.

15. Out- of- network services by an anesthesiologist, assistant surgeon, radiologist or pathologist, or supplies provided while a patient at an in-network hospital, when ordered by a participating provider, will be covered at the in-network benefit level (subject to MPA) when the covered member has no control over the choice of provider for these services. The out of pocket expenses (except for those charges in excess of MPA) will apply to the in-network out of pocket maximum.

16. Services, prescription drugs, and supplies you or your dependent may receive while in the custody of any state or federal law enforcement authorities or while in jail or prison.

17. Experimental or Investigational Procedures: services, prescription drugs, and supplies that are deemed by the plan administrator to be:

a. Those not rendered by an accepted institution, physician or provider within the United States or by one which has not demonstrated medical proficiency in the rendering of the service or supplies;

b. Those not recognized by the medical community in the service area in which they are received;

c. Those for which the approval of government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered;

d. Those for which scientific or medical assessment has not been completed and the effectiveness of the treatment has not been generally established;

e. Those rendered in the service area only as part of clinical trial or research program for the illness or condition being treated;

f. Those unavailable in the service area for the illness or condition being treated and available for that illness or condition within the United States as part of a clinical trial or research program only; and

g. Those expenses incidental to or incurred as a direct consequence of experimental or investigational procedures, if the expenses were incurred primarily as the result of obtaining experimental or investigational services, prescription drugs, and supplies.

18. Services, Prescription Drugs, Supplies, and/or Treatment Not Medically Necessary; including:

a. Services, prescription drugs, and supplies that are either inappropriate or inconsistent with the symptoms or diagnosis of your condition or that of your dependent;

b. Services, prescription drugs, and supplies that are inappropriate with regard to standards of good medical practice in the service area;

c. Services, prescription drugs, and supplies that are primarily rendered for the convenience of you or your dependents or a physician or provider of services or supplies; and/or

d. Services that are not the least costly of the alternative supplies or levels of service, which can be safely provided to you or your dependent. For example, coverage would not be allowed for an inpatient hospital stay when the same level of treatment could be delivered in an outpatient setting such as an ambulatory surgery facility.

B. Exclusions Related to Miscellaneous Services and Items:

1. Support Education including Level I educational programs related to Driving Under the Influence (DUI), voluntary mutual support groups, such as Alcoholics Anonymous, or family education or support groups.

2. Behavior modification, psychological enrichment or self-help programs for mentally healthy individuals. These include assertiveness training, image therapy, sensory movement groups, marathon group therapy, and sensitivity training.

3. Routine optometric eye examinations, including the fitting, provision, or replacement of eyeglasses or contact lenses, and any charges for orthoptics, vitamin therapy, vision therapy, eye exercises, or fundus photography. Vision benefits may be available through the City's vision plan and are subject to the terms of that Plan.

4. Refractive surgery, laser vision correction, and any other procedure which alters the refractive character of the eye, the purpose of which is to cure or reduce myopia, hyperopia, or astigmatism. This exclusion includes, but is not limited to, radial keratotomy, corneal rings, LASIK, PRK, any procedure using the Excimer Laser or the Holmium: YAG laser, and other procedures of the refractive keratoplasty type. Reversals or revision of any procedures that alter the refractive character of the eye and any complications of these procedures are excluded.

5. Reversal of sterilization procedures.

6. Miscellaneous services, including (but not limited to):

a. Custodial Care, including routine nursing care and hospitalization for environmental change;

b. Private Nursing Services even if related to a condition which is otherwise covered by the Plan;

c. Services provided by a member of the Participant's immediate family;

d. Services provided by volunteer workers;

e. Supplies intended for use outside hospital settings or considered personal in nature;

f. Routine miniature chest x-ray films or full body scans;

g. Other services and supplies not directly connected to the diagnosis or curative treatment of an illness or injury.

7. Supportive environmental materials, or any service or product that is primarily promoted as a personal convenience item; is prescribed or recommended by a healthcare provider and does not meet industry treatment standards or protocols or is a product or service that may be purchased or obtained by the general public without a prescription. Examples include, but are not limited to, hand rails, ramps, bath benches, cervical pillows, humidifiers, air filters, air conditioners, heat lamps, tanning lights, whirlpools, saunas, whirlpools, hot tubs, fitness equipment, telephones, home furnishings and costs associated with local or distant travel, even if related to a condition otherwise covered by the Plan.

8. Normal necessities of living, including but not limited to food, clothing and household supplies.

9. Separate charges for the completion of reports or claim forms and the cost of records.

10. Ambulance services exceeding 300 miles per plan year.

11. Biofeedback therapy services are limited to medically necessary treatment of tension or migraine headaches and the Plan will pay for no more than 10 visits during the participant's lifetime.

12. Cosmetic/Reconstructive Surgery: Cosmetic procedures (any procedure that is requested for the purpose of improving appearance without restoring bodily function or correcting physical impairment) are exclusions under this plan. Complications of reconstructive surgeries will be covered if medically necessary, clinically distinct and not specifically excluded under this plan. Breast augmentation, lipectomy, liposuction, hair removal (including electrolysis and laser) and rhinoplasty are not covered procedures.

13. Experimental or Investigational Procedures: Services, prescription drugs, and supplies that are deemed by the plan administrator to be:

a. Those not rendered by an accepted institution, physician or provider within the United States or by one which has not demonstrated medical proficiency in the rendering of the service or supplies;

b. Those not recognized by the medical community in the service area in which they are received;

c. Those for which the approval of government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered;

d. Those for which scientific or medical assessment has not been completed, and the effectiveness of the treatment has not been generally established;

e. Those rendered in the service area only, as part of clinical trial or research program for the illness or condition being treated; and

f. Those unavailable in the service area for the illness or condition being treated and available for that illness or condition within the United States as part of a clinical trial or research program only.

g. Those expenses incidental to or incurred as a direct consequence of experimental or investigational procedures, if the expenses were incurred primarily as the result of obtaining experimental or investigational services, prescription drugs, and supplies.

14. In alternative health care environments, only traditional medical testing will be covered by the plan.

15. Any services related to the treatment of infertility and/or the cause of infertility are excluded from coverage under the Plan. This includes artificial insemination procedures, including, but not limited to, in-vitro fertilization (IVF), Gamete intrafallopian Transfer (GIFT), Zygote Intrafallopian Transplant (ZIFT), and Tubal Embryo Transplant (TET). Only the initial visit and initial diagnostics to determine infertility are covered.

16. Replacement of lost hearing aids or batteries for hearing aids are not covered.

17. Charges incurred for telephone consultations with or between medical providers.

18. Non-surgical treatment of oral diseases or other medical conditions, extraction of erupted teeth, and dental repair are not covered under the Oral Surgery benefit.

19. Over-the-counter medications, including nutritional supplements, herbal and homeopathic remedies, and contraceptive products are not covered.

20. Treatments defined as holistic and/or are treatments outside of industry-recognized standards of care.

21. Services of a massage therapist, even if related to a condition otherwise covered by the Plan.

22. Immunizations for the sole purpose of travel or to prevent illness which may be caused by a work environment.

23. Services/supplies requiring pre-certification are not covered under this plan unless certified as medically necessary through the City's contracted Service Authorization/Pre-Certification Program.

24. Services and supplies provided for the treatment of obesity or weight reduction. The plan will cover services and supplies that are necessary for the treatment of established medical conditions that may be caused by or made worse by obesity, but the plan will not cover services and supplies that do so by treating the obesity directly, even if morbid obesity is present. Services specifically excluded from this plan include, but are not limited to:

a. Surgical: Gastric restrictive procedures with or without gastric bypass, or the revision of the same.

b. Weight Management: Weight loss programs, exercise programs, counseling, hypnosis, biofeedback, neurolinguistic programming, guided imagery, or any form of relaxation training as well as subliminal suggestion used to modify eating behaviors.

c. Pharmaceutical: Any drug or formula related to or resulting from the treatment of weight loss or obesity even if prescribed by your physician.

25. Services to alter a participant's physical characteristics to that of the opposite sex, including Sexual Reassignment Surgery and related therapies.

26. Chelation therapy is not covered under the Plan, except for acute arsenic, gold, mercury or lead poisoning.

27. Donation related services or supplies provided to an insured Donor if the Recipient is not enrolled under this Plan and eligible for transplant benefits. This exclusion does not apply to complications or unforeseen infections resulting from the donation of tissue.

28. Services or supplies for any transplant not specifically named as covered including the transplant of animal organs or artificial organs.

29. Chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not specifically named as covered.

30. Foot orthoses (orthotics) made of high impact plastics or other materials, designed to be inserted into shoes;

31. Temporomandibular joint (TMJ) treatment and surgery.

32. Orthognathic surgery and services or supplies to add to or reduce the upper or lower jaw.

33. Genetic testing or counseling unless medically necessary and pre-certified through the City's contracted Utilization Review provider. Genetic testing for family members not covered under the Plan is excluded.

34. Services and supplies for speech therapy, unless provided by a licensed speech therapist and rendered within one year of the onset of the illness/injury, congenital abnormality, or previous therapeutic process. Services rendered for the treatment of delays in speech development are not covered.

35. Counseling related to family, marriage, sex and career, in the absence of medical necessity/illness;

36. Vocational, pastoral or spiritual counseling;

37. Dance, poetry, music or art therapy, except as part of a treatment program in an inpatient setting.

38. Non-organic therapies including, but not limited to, bioenergetics therapy, confrontation therapy, crystal healing therapy, educational remediation, EMDR, guided imagery, marathon therapy, primal therapy, rolfing, sensitivity training, training psychoanalysis, transcendental meditation and Z therapy.

39. Organic therapies including, but not limited to, aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, narcotherapy with LSD, and sedative action electrostimulation therapy.

40. Routine foot care services that are not medically necessary.

41 .Routine physical exams for employment, licensing, insurance coverage or court order or required for parole or probation.

42. Designated Blood Donations-collection, processing and storage of blood donated by donors designated by plan participants and procurement and storage of cord blood, unless medically necessary for the imminent use at the time of collection for a designated recipient.

43. Hypnotherapy.

8.12 Prescription Drug Program Exclusions

(a) Drugs or medications purchased or obtained without a physician's written prescription.

(b) "Over-the-counter" products (with the exception of insulin, syringes and needles).

(c) Nose drops or nasal preparations that do not require a physician's written prescription.

(d) Immunization agent.

(e) Non-drug items, dietary supplements, vitamins (other than prescription pre-natal vitamins) or health and beauty aids.

(f) Drugs dispensed by a hospital, nursing care facility, health care center, urgent or immediate care center, ambulatory surgical center, doctor's office, or other institution.

(g) Drugs obtained after eligibility and/or coverage terminates.

(h) Any refill of a prescription that exceeds the number specified by the prescribing physician or that is dispensed after one year from the date of the prescription.

(i) Drugs prescribed or used for cosmetic purposes.

(j) Services and supplies subject to the "Plan Limitation and Exclusion" section of this plan (see above).

(k) Non-legend or over-the-counter (OTC) drugs.

(l) Prescriptions which are covered by workers' compensation laws, the Fire & Police Disability Retirement Fund, or other county, state or federal programs.

(m) Compounds unless the prescription includes at least one legend drug that is an essential ingredient.

(n) Naturopathic supplements, including when prescribed as a compound drug;

(o) Drugs that are determined by the Plan Administrator to be experimental or investigational or that are labeled: "Caution-Limited by federal law to investigational use"

9.0. Medicare Supplement Plan

The Medicare Supplement plan is designed to coordinate with coverage provided under Medicare Parts A and B, supplementing those benefits. The Supplement plan bases its benefits on Medicare allowable charges, which may be different from amounts billed by some providers. However, some providers recognize the Medicare allowable charge as their total fee.

9.01 Identification Cards:

Plan participants are provided identification cards within six weeks after initial enrollment. ID cards provide health care service providers with plan benefit and payment information. ID cards may be required to be shown in order to access service.

9.02 Eligibility:

The Employee must be eligible for retirement benefits from City employment and be covered at the time of retirement under one of the City's active employee medical plans; must have Part B Medicare benefits; cannot have end-stage kidney disease or be participating in a Medicare-certified hospice program.

Additionally once a retiree and/or dependent become entitled to Medicare and/or attains age 65, the enrollee is only eligible for the City's or Kaiser's Medicare Supplement plan. However, if the retiree has a covered spouse (or domestic partner) under age 65 at the time the retiree becomes entitled to Medicare and/or attains age 65, the spouse (or domestic partner) may continue on the active employee medical plan until becoming entitled to Medicare and/or attain age 65, or no longer meets the definition of a dependent as defined by the Plan. Dependent children covered at the time the retiree becomes entitled to Medicare and/or attains age 65 are eligible to continue on the active employee plan until no longer meeting the definition of a dependent as defined by the Plan.

9.03 Notice of Declination:

The City of Portland reserves the right to disallow costs associated with any provider, facility, product or service outside the scope of this plan.

9.04 Covered Services

A. The following services, when medically necessary, are covered under this plan as described below

CITY OF PORTLAND MEDICARE SUPPLEMENT PLAN SUMMARY
If the Part A deductible and co-payments under Medicare are changed, the City's Supplement plan benefits will be changed accordingly. The City Medicare Supplement Plan does not offer prescription drug

CITY OF PORTLAND MEDICARE SUPPLEMENT PLAN SUMMARY	
coverage. If you want to purchase prescription drug benefits, you must elect Medicare Part D coverage through an individual carrier. For more information regarding prescription drug coverage, please contact Medicare at 1-800-Medicare.	
Annual Benefit Maximum	$100,000
Lifetime Maximum	$1,000,000 *(Reinstatement toward lifetime maximum benefit permitted up to $5,000 per year)*
Choice of Provider	Any hospital facility and licensed provider, except as otherwise indicated
Service Area	USA and US territories, Canada and Mexico under special circumstances, as defined by Medicare
Inpatient Hospital Services	Plan covers full amount of the Part A hospital deductible; difference between charges and Medicare reimbursement for 61-90 days per spell of illness; difference between charges and Medicare reimbursement for 91-150 days (including the 60 lifetime reserve days); 80% of charges after the Medicare lifetime reserve days are exhausted, up to $5,000 per year and up to $25,000 per lifetime.
Skilled Nursing Facility Care	Plan covers the difference between charges and Medicare reimbursement for 21-100 days in a skilled nursing facility; no benefits provided beyond 100 days per spell of illness.
Hospice Care	Plan does not reimburse beyond Medicare provided benefits.
Psychiatric Hospitalization	Covered as an inpatient hospital benefit; lifetime maximum of 190 days.
Home Health Services	Intermittent or part-time skilled nursing care and other services in the home are covered; daily skilled nursing is provided for up to 21 consecutive days with no prior hospitalization required; Home Health Services are not covered beyond Medicare benefits; durable medical equipment is covered at 20% of Medicare allowable charges.
Medical Expenses	Physician Services, Outpatient Services,

CITY OF PORTLAND MEDICARE SUPPLEMENT PLAN SUMMARY	
	Medical Supplies other than Prescribed Drugs are covered; plan covers 20% of Medicare allowable charges, including 20% of the annual deductible, unless fully covered by Medicare.
Independent Physical and Occupational Therapy	Plan covers 20% of Medicare allowable charges, unless fully covered by Medicare, up to $500 per category per year.
Clinical Diagnostic Lab Tests	Plan covers 20% of Medicare allowable charges, unless fully covered by Medicare.
Emergency Services	Covered as any other condition within the service area; no coverage outside the service area.
Outpatient Mental Health Care	Plan does not reimburse beyond Medicare provided benefits.
Outpatient Prescription Drugs	Plan does not reimburse prescriptions beyond Medicare provided benefits.
Vision Care	Plan covers 20% of Medicare-approved, non-routine vision services, unless service is fully covered by Medicare.
Hearing Exams and Aids	Plan does not reimburse beyond Medicare provided benefits.

10.0 HIPAA Notice of Privacy Practices

10.01 Health Insurance Portability and Accountability Act (HIPAA)

The Plan is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of August 1996. Certification of creditable coverage will be provided to plan participants pursuant to this act and to relevant administrative rules.

10.02 HIPPA Notice

The Notice below is provided to all Enrollees as part of their Health Plan member handbooks as required under HIPAA.

HIPAA Notice of Privacy Practices

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

Effective May 1, 2005

INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) requires the City provide you with this notice. It describes how medical information about you may be obtained, used, and disclosed by the City of Portland (City), by the Administrator of the Health Plans (Administrator), and by the various providers, consultants, and agencies (Agents) hired by the City, and how you can get access to this information and your medical records. Please review it carefully.

The City will maintain a limited amount of protected health information (PHI), such as enrollment data, for the Plans, COBRA, and Cafeteria Plan components. All of the Administrators and Agents are required by HIPAA to obey its requirements. The City has entered into Business Associate Agreements with each of these entities that makes their compliance with HIPAA part of their contractual obligations with the City.

The City of Portland, its Administrators, and Agents respect the privacy and confidentiality of your protected health information. All are committed to ensuring the confidentiality of your information in a responsible and professional manner. All are required by law to maintain the privacy of your protected health information and abide by the terms of this notice.

The City offers a self-insured (CityCore) and insured (Kaiser) health plan. The City hires a third party administrator, currently ODS (Administrator), to administer the Plans and to process medical claims and appeals made by participants in the Plans. It also hires various other agencies to assist in administering the cafeteria plan components, utilization review, pharmaceutical benefits, Employee Assistance Program (EAP) and other benefit consulting needs. These Agents are currently Healthways, BenefitHelp Solutions, Aliquant, AON Consulting, Kaiser Permanente, United Behavioral Health (UBH), Managed Healthcare Northwest, ODS, Caremark Pharmacy, and Vision Service Plan.

Should any of the City, Administrator, or Agency privacy practices change, the City reserves the right to change the terms of this notice and to make the new notice effective for all protected health information. Once revised, the City will notify you that a change has been made and post

the notice on our Web site at www.portlandonline.com/omf/bhr. You may also request the new notice be mailed to you.
This notice explains how the City, Administrator, and Agents use information about you and when that information can be shared with others. It also informs you about your rights. Finally, this notice provides you with information about exercising these rights.

HOW THE CITY USES OR SHARES INFORMATION

The City acquires limited "Protected Health Information" (PHI) about you in order to enroll, maintain, change and terminate your participation in the Plans. Those in the City performing these functions include City payroll employees in your bureau, employees in the Bureau of Technology Services (BTS), and employees assigned to the Benefits & Wellness Office in the Bureau of Human Resources. They will obtain the following information from you to perform these functions: The names, dates of birth, addresses, phone numbers, social security numbers, employment data with the City, enrollment in other medical benefit plans if any, of your self and any dependents and/or domestic partners that participate in the Plans. Other authorized City employees may also use this information to conduct quality assessment and improvement activities, other activities relating to the creation, renewal or replacement of health benefits and budget creation and analysis.

The City may also acquire information from the Plans that has been de-identified – that is medical information that cannot be linked to any individual participant, for purposes of utilization review, cost studies, and review of appeals decisions made by the Administrator with respect to any Plan benefit.

HOW THE ADMINISTRATORS AND AGENTS USE AND SHARE INFORMATION

The City's Agents and Administrators use protected health information and may share it with others as part of your treatment, payment for treatment, and Plan operations. The following are ways the Agents and Administrators may use or share information about you:

- The Agents and Administrator will use the information to administer your plan benefits and help pay your medical bills that have been submitted to the Agents and Administrator by doctors and hospitals for payment.
- The Agents and Administrator may share your information with your doctors or hospitals to help them provide medical care to you. For example, if you are in the hospital, the Agents and Administrator may provide access to any medical records sent to the Agents and Administrator by your doctor.
- The Agents and Administrator may use or share your information with others to help manage your health care. For example, the Agents and Administrator might talk to your doctor to suggest a disease management or wellness program that could help improve your heath.
- The Agents and Administrator may share your information with individuals who perform business functions for the City. The City will only share your information if there is a business need to do so and if our business partner agrees to protect the information, in accordance with this privacy notice.
- The Agents and Administrator may give you information about treatments and programs or about health related products and services that may be to your benefit. For example, the Agents and Administrator sometimes send out letters to notify you about chronic conditions, smoking cessation or nutrition programs.

There are also state and federal laws that may require the City Agents and Administrator to release your health information to others. The Agents and Administrator may be required by law to provide information to others for the following reasons:

- The Agents and Administrator may have to give information to law enforcement agencies. For example, the Agents and Administrator are required to report when child abuse or neglect or domestic violence is reasonably believed to have occurred.
- The Agents and Administrator may be required by a court or administrative agency to provide information because of a search warrant or subpoena.
- The Agents and Administrator may report health information to public health agencies if the Agents and Administrator believe there is a serious health or safety threat.
- The Agents and Administrator may report health information on job-related injuries because of requirements of state or other workers' compensation laws.
- The Agents and Administrator may report information to the Food and Drug Administration. This agency is responsible for investigating or tracking prescription drug and medical device problems.
- The Agents and Administrator may have to report information to state and federal agencies that regulate the City, such as the U.S. Department of Heath and Human Services.

If the City Agents and Administrator use or disclose your information for any reasons **other than the above,** your written authorization will be obtained first. If you give the Agents or Administrator written permission and change your mind, you may revoke your written authorization at any time. The Agents and Administrator will honor the revocation except to the extent that the Agents or Administrator have already relied on your authorization.

NOTE: If the City Agents or Administrator disclose information as a result of your written authorization, it may be re-disclosed by the receiving party and may no longer be protected by state and federal privacy rules. However, federal or state law may restrict re-disclosure of additional information such as HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment, or referral information.

What Are Your Rights

You have certain rights with respect to your protected health information. These include:

- ***You have the right to ask the City Agents and Administrator to restrict*** how your information is used or disclosed for treatment, payment, or health care operations. You also have the right to ask the Agents and Administrator to restrict information provided to persons involved in your care. While the Agents and Administrator may honor your request for restrictions, *they are not required to agree* to these restrictions.

- ***You have the right to submit special instructions*** to the Agents and Administrator regarding how information is sent to you that contains protected health information. For example, you may request that your information be sent by a specific means (for example, U.S. mail only) or to a specific address. The Agents and Administrator will accommodate reasonable requests by you as explained above. The Agents and Administrator may require that you make your request in writing.

- ***You have the right to inspect and obtain a copy*** of information that the Agents and Administrator maintain about you in a designated record set. *However*, you may not be permitted to inspect or obtain a copy of information that is:
  - contained in psychotherapy notes;
  - compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and
  - subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a, to the extent the provisions of access to the individual would be prohibited by law or exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2).

Additionally, in certain situations the Agents and Administrator may deny your request to inspect or obtain a copy of your information. If the Agents and Administrator deny your request, the Agents and Administrator will notify you in writing. Any denial will explain your right to have the denial reviewed.

The Agents and Administrator may require that your request be made in writing. The Agents and Administrator will respond to your request no later than 30 days after it is received. If the information you request is not maintained or accessible to the Agents and Administrator on-site, the Agents and Administrator will respond to your request no later than 60 days after it is received. If additional time is needed, the Agents and Administrator will inform you of the reasons for the delay and the date that the Agents and Administrator' action on your request will be completed.

If you request a copy, a reasonable fee based on copying and postage costs will be required. You may request a copy of the portion of your enrollment and claim record related to an appeal free of charge.

- ***You have the right to ask the Agents and Administrator to amend*** information maintained about you in a designated record set. The Agents and Administrator will require that your request be in writing and that you provide a reason for your request. The Agents and Administrator will respond to your request no later than 60 days after it is received. If a response cannot be made within 60 days, the time may be extended by no more than an additional 30 days. If additional time is needed you will be notified of the delay and the date by which action on your request will be completed.

If an amendment is made you will be notified that it was made, and the Agents and Administrator will obtain your authorization to notify the relevant persons you have identified with whom the amendment needs to be shared. The Agents and Administrator will notify these persons, including their business associates, if any, of the amendment.

If your request to amend is denied, you will be notified in writing of the reasons for the denial. The denial will explain your right to file a written statement of disagreement. The Agents and Administrator have a right to rebut your statement. However, you have the right to request that your written request, the Agents and Administrator written denial, and your statement of disagreement be included with your information for any future disclosures.

- ***You have the right to receive an accounting*** of certain disclosures of your information made by the Agents and Administrator during the six years prior to

your request, but this does not include disclosures made prior to April 14, 2003. The accounting may not include disclosures:

- for treatment, payment, and health care operations purposes;
- made for you;
- made in connection with a use or disclosure otherwise permitted;
- made pursuant to your authorization;
- for a facility's directory or to persons involved in your care or other notification purposes;
- for national security or intelligence purposes;
- to correctional institutions, law enforcement officials; or
- made as part of a limited data set for research, public health, or health care operations purposes.

Additionally, if the City Agents and Administrator disclose your information for research purposes pursuant to an authorization, the Agents and Administrator may not account for each disclosure of your information. Instead, the Agents and Administrator will provide for you: (1) the name of the research protocol or activity; (2) a description of the research protocol or activity including the purpose for the research and the criteria for selecting particular records; (3) a description of the type of protected health information that was disclosed; (4) the date or period of time when such disclosure occurred; and (5) the name, address, and telephone number of the entity that sponsored the research and researcher to whom the information was disclosed.

The Agents and Administrator will act on your request for an accounting within 60 days. Additional time may be needed to act on your request, and may therefore take up to an additional 30 days. Your first accounting will be free, and you will be entitled to one free accounting upon request every 12 months. However, if you request an additional accounting within 12 months of receiving a free accounting, you will be charged a fee. You will be informed of the fee in advance and you will be provided with an opportunity to withdraw or modify your request.

Exercising Your Rights

You have a right to receive a paper copy of this notice upon request at any time. You can also view a copy of the notice on our Web site at www.portlandonline.com/omf/bhr

If you have any questions about this notice or privacy practices of the City, its Agents or Administrator, please contact the HIPAA Program Coordinator at 503.823.5219. Our office is open Monday through Friday from 8 a.m. to 5 p.m.

If you believe your privacy rights have been violated by an Agent or Administrator you may file a complaint with the City by writing the City at the address as follows:

Anna Kanwit
City of Portland Privacy Officer
Bureau of Human Resources
City of Portland, Oregon
1120 SW 5th Avenue, Room 404
Portland, Oregon 97204
Phone: (503) 823.5219
Fax: (503) 823.3522
E-Mail: akanwit@ci.portland.or.us

You may also notify the Office of Civil Rights, U.S. Department of Health and Human Services of your complaint. The City cannot and will not take any action against you for filing a complaint. You may contact the Office of Civil Rights at

Office for Civil Rights
U.S. Department of Heath and Human Services
Room 509F, HHH Building
200 Independence Avenue, S.W.
Washington, DC 20201
OCR Hotlines-Voice: 1-800-368-1019
Ocrmail@hhs.gov

Chapter 11

11.0 Technical Plan Information

Employer Tax ID No.:	93-6002236
Agent for Legal Process:	City Attorney 1220 SW 5th Avenue, Room 440 Portland, OR 97204
Funding Process:	Funded through a combination of employee payroll deductions and employer benefit dollar allocations.
Type of Administration:	The Plan is administered by the Human Resources/Benefits & Wellness Office of the City of Portland.
Plan Administrator:	Benefit Program Manager City of Portland Bureau of Human Resources 1120 SW 5th Avenue, Room 404 Portland, Oregon 97204

IMPORTANT NOTICE

Any falsification, misrepresentation, misleading statements or omission of the employee when enrolling in these plans may be cause for immediate termination from the City benefit plans and may subject the employee to discipline, including discharge, from City employment, regardless of when or how discovered. If an employee fails to report family status change events within 60 days of the date eligibility would cease, such as divorce or cessation of dependent eligibility requirements, it will be the employee's obligation to reimburse the City of Portland any monies that are paid by a City of Portland Health Plan for claims incurred. If an employee or the employee's dependent fraudulently obtains any healthcare benefits under the City of Portland Health Plan, the employee and/or dependent will be prosecuted to the full extent of the law.

Proposed Plan Design Options

Current Benefit	Change To
Preventive Care – Routine Physical Exam	
Age bands: 1 to 4 years between visits after age 2 depending upon the participants age	1 exam every 12 months – age 2>
No cost to participant	No cost to participant
Outpatient Care (e.g. office visits, allergy shots, not outpatient hospital procedures)	
$150.00 Deductible 20% co-insurance up to $1,800 maximum out of pocket	$15.00 co-pay at point of service *no copay for lab services Co-pays outside of $1,800 maximum out of pocket
Outpatient/Inpatient Hospital, surgery, chemical and/or mental health treatments, physical therapy and all other plan benefits under co-insurance	
$150.00 Deductible 20% co-insurance up to $1,800 maximum out of pocket	$200.00 Deductible 20% co-insurance up to $1,800 maximum out of pocket
Diagnostic x-ray/MRIs, CT, etc.	
$150.00 Deductible 20% co-insurance up to $1,800 maximum out of pocket	$25.00 co-pay at point of service Co-pays outside of $1,800 maximum out of pocket
Prenatal Care – Physician Services	
$150.00 Deductible 20% co-insurance up to $1,800 maximum out of pocket	$250.00 co-pay (includes prenatal visits and physician delivery charges). Co-pays outside of $1,800 maximum out of pocket All other hospital related charges subject to deductible and co-insurance up to $1,800 maximum out of pocket
Emergency Room	
20% after $50.00 co-pay (no deductible)	20% after $100.00 co-pay (no deductible)
Urgent Care	
$150.00 Deductible 20% co-insurance up to $1,800 maximum out of pocket	$15.00 co-pay at point of service Co-pays outside of $1,800 maximum out of pocket
Alternative Care	
$150.00 Deductible 20% co-insurance up to $1,800 maximum out of pocket	$15.00 co-pay at point of service Co-pays outside of $1,800 maximum out of pocket
Services related to treatment of obesity	
Excluded	Surgical Intervention: Subject to deductible and 20% co-insurance, lifetime maximum benefit is $15,000. Nutritional counseling/hospital based weight loss programs: $500.00 annual maximum
Sleep Apnea	
$150.00 deductible 20% co-insurance. Pre-authorization for 2nd sleep study	$5,000 lifetime maximum benefit. Subject to deductible and 20% co-insurance