185368

EXHIBIT A

CITY OF PORTLAND

HEALTH PLAN DOCUMENT

185368

CITY OF PORTLAND
HEALTH PLAN DOCUMENT

TABLE OF CONTENTS

185368

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, 2012 (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 Member the right to be retained in the service of the City or to interfere with the right of the City to discharge any Member at any time regardless of the effect which such discharge shall have upon such employee as a Member 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 the Plan, 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, Members 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 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 Member 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 Member 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 Member's taxable compensation. Accordingly, there could be a decrease in the Member's Social Security benefits.

1.11 Type of Plan

This is an employee welfare plan which provides medical benefits to eligible Members and their beneficiaries. The CityCore Medical Plan, the SMW Plan for Seasonal Maintenance Workers, the Medicare Supplement Plan and the ODS Dental plan for certain employee groups 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 "Adverse Benefit Determination" shall mean a written notice from ODS, in the form of a letter or an Explanation of Benefits (EOB), of any of the following: rescission of coverage, or a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including one based on a determination of a member's eligibility to participate in the Plan and one resulting from the application of any pre-existing condition exclusion or utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not necessary and customary by the standards of generally accepted practice for the prevention or treatment of disease or accidental injury. A Final Internal Adverse Benefit Determination is an adverse benefit determination that has been upheld by ODS at the completion of the internal appeal process or with respect to which the internal appeal process has been exhausted.

2.01.030 "Aggregate Benefit" shall mean the combined total benefits available to a Member.

2.01.040 "Alternative Health Care" shall mean health care services provided by licensed acupuncturists, chiropractors and naturopaths

2.01.050 "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.

2.01.060 "Appeal" shall mean a written request by a member or his or her representative for ODS to review an adverse benefit determination.

2.01.070 "Benefits" shall mean for Eligible Employees of BOEC, COPPEA, DCTU, LOCAL 189-H (HOUSING) PFFA, PPCOA,

Recreation employees, Local 189-H (Housing) and non-represented employees for the Plan Year commencing on July 1, 2012, 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. The CityCore Dental Plan, as amended from time to time.

2.01.080 "Benefits" shall mean for Eligible Employees of the PPA for the Plan Year commencing on July 1, 2012 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 Kaiser 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.

2.01.090 "Benefits" shall mean for Eligible Employees of the Laborer's Local 483 Seasonal Maintenance Workers for the Plan Year commencing on July 1, 2012 and subsequent plan years.

A. The City of Portland Seasonal Maintenance Worker medical plan as amended form time to time.
B. The SMW Dental Plan, as amended from time to time.

2.01.100 "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.

2.01.110 "Case Management" shall mean the 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.

2.01.120 "Change In Status" shall mean an event that allows a Member 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.

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

2.01.140 "Claim Involving Urgent Care" shall mean any claim for medical care or treatment in which the application of the regular time period to review a denial of a pre-service claim could seriously jeopardize a member's life or health or ability to regain maximum function, or, in the opinion of a physician with knowledge of a member's medical condition, would subject the member to severe pain that cannot be adequately managed without the requested care or treatment.

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

2.01.160 "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.

2.01.170 "Complaint" shall mean an expression of dissatisfaction about a specific problem a member has encountered or about a decision by ODS or an agent acting on behalf of ODS, and which includes a request for action to resolve the problem or change the decision. A complaint does not include a request for information or clarification about any subject related to the Plan.

2.01.180 "Concurrent Review" shall mean 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 Member 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.

2.01.190 "Co-insurance" shall mean the reference to money that a member is required to pay for services, after a deductible has been paid. Coinsurance is often specified by a percentage. For example, the employee pays 20 percent toward the charges for a service and the employer or insurance company pays 80 percent.

2.01.200 "Copayment" shall mean the predetermined (flat) fee that an individual pays for health care services, in addition to what the insurance covers. For example, Kaiser requires a $10 "copayment" for each office visit, regardless of the type or level of services provided during the visit. Copayments are not usually specified by percentages.

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

2.01.220 "Covered Charges" shall mean medically necessary medical expenses eligible for reimbursement in accordance with the Plan document.

2.01.230 "Dependent," shall mean for purposes of the CityCore Seasonal Maintenance Worker medical plans, the Medicare Supplement plan and the self-insured dental 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. Child under the age of 26 who is not in active military status, including the Member's:

- natural child,

- stepchild,
- child who is required to be covered by Member or Member's spouse as a result of divorce decree or court order to provide coverage,
- adopted child or child placed for adoption,
- other child for whom the employee is the court-appointed legal guardian,
- eligible child of an enrolled domestic partner (as declared on the Domestic Partner Affidavit).

D. A newborn child of an Enrolled Dependent for the first 31 days of the newborn's life, but only if the employee is financially responsible for both the newborn and the enrolled dependent. After 31 days, the child of your Enrolled Dependent may be covered only as long as the child's parent is the Employee's eligible and Enrolled Dependent and both grandchild and birth parent reside in the Employee's home.

E. Incapacitated and dependent children may be covered past the qualifying age of 26 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.

2.01.240 "Deductible" shall mean the amount a member must pay for health care expenses before insurance (or a self-insured plan) covers the costs. For the City plans, the deductible is an annual amount and must be met each year.

2.01.250 "Discharge Planning" shall mean a centralized, coordinated program developed by a hospital to ensure that each Member has a planned program for needed continued or follow-up care.

2.01.260 "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.

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

2.01.280 "Effective Date" of this amendment and restatement is July 1, 2012.

2.01.290 "Eligible Employee" shall mean a full-time permanent or temporary employee appointed from 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.

2.01.300 "Emergency Services" shall mean those healthcare items and services furnished in an emergency department of a hospital, all ancillary services routinely available to the emergency department to the extent they are required for the stabilization of a member, and within the capabilities of the staff and facilities

available at the hospital, such further medical examination and treatment as are required to stabilize a member.

2.01.310 "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.

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

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

2.01.340 "Exclusions" shall mean medical services that are not covered by the health plan.

2.01.350 "FDA Approved Medications" shall mean approved by the Federal Drug Administration.

2.01.360 "FMLA" shall mean the Family Medical Leave Act of 1993, as amended.

2.01.370 "Formulary" shall mean 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.

2.01.380 "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.

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

2.01.400 "Home Health Care" shall mean 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.

2.01.410 "Hospice Care" shall mean a 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.

2.01.420 "Hospital" shal mean 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.

2.01.430 "HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

2.01.440 "Incurred Expenses" shall mean those medical expenses that occur during a period of time while covered or enrolled in a plan.

2.01.450 "Industry Recognized" shall mean health care services and products that are accepted as appropriate by the health care community.

2.01.460 "Initial Enrollment" shall mean the period immediately preceding the date on which the Member commences participation in the Plan.

2.01.470 "In-Network" shall mean Providers (physicians and other healthcare professionals) or health care facilities which are part of the health plan's network with which it has negotiated a discount. Members usually pay less when using an in-network provider.

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

2.01.490 "Limitations" shall mean a limit on the amount of benefits paid for a particular covered expense.

2.01.500 "Magnetic Resonance Imaging (MRI)" shall mean 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.

2.01.510 "Maximum Plan Allowance (MPA)" shall mean the maximum amount that ODS will reimburse providers under the CityCore plan. For an in-network provider, the MPA is the amount the provider has agreed to accept for a particular service. MPA for an out-of-network provider is based on the lesser of the amount payable under any supplemental provider fee arrangements ODS may have in place and the 75th percentile of fees commonly charged for a given procedure in a given area, based on the Ingenix MDR System, a national database. If a dollar value is not available in the national database, ODS will consider 75% of the billed charge as the MPA. In certain instances, when a dollar value is not available in the database, the claim is reviewed by ODS' medical consultant, who determines a comparable code to the one billed. Once a comparable code is established, the claim is processed as described above. MPA for emergency services by an out-of-network facility will be processed as follows: the maximum amount allowed will be is the greatest of the median in-network rate, the maximum amount as calculated according to this definition for out-of-network facility and the Medicare allowable amount. When using an out-of-network provider, any amount above the MPA is the member's responsibility.

2.01.520 "Medical Emergency" shall mean 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.

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

2.01.540 "Medically Necessary" shall mean 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.

2.01.550 "Member" or "member" shall mean a subscriber, dependent of a subscriber or a person otherwise eligible for a group health benefit plan who has enrolled for coverage under the terms of the Plan and who currently meets the eligibility requirements of Chapter 3 of this document and enrolls in the Plan.

2.01.560 "Network" shall mean a group of doctors, hospitals and other health care providers contracted to provide services to plan members for less than their usual fees. For the CityCore plan, the network offered is the ODS Plus Network.

2.01.570 "Out-of-Network" shall mean a reference to physicians, hospitals or other health care providers who are not participants in the plan's networks. Expenses incurred by services provided by out-of-network health professionals may not be covered (Kaiser), or covered after a higher deductible and co-insurance (City plans). You pay more when you use out-of-network providers.

2.01.580 "Out-Of-Pocket Maximum" shall mean the amount of money that an individual must pay out of their own pocket before the plan will pay 100 percent for a member's health care expenses.

2.01.590 "Outpatient Surgery" shall mean a surgical procedures not requiring hospital confinement, which may be performed at a doctor's office, ambulatory surgical center or hospital.

2.01.600 "Palliative Care" shall mean 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.

2.01.610 "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.

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

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

2.01.640 "Post-service claim" shall mean any claim for a benefit under the Plan for care or services that have already been received by a member.

2.01.650 "PPO Provider" shall mean a health care service provider that is contracted with and credentialed by a managed care organization to provide quality and cost effective services.

2.01.660 "Pre-service claim" shall mean any claim for a benefit under the Plan for care or services that require prior authorization.

2.01.670 "Prior Authorization" or "Prior Authorized" shall mean service approval by ODS for a member in the CityCore plan to be admitted to a hospital, in-patient facility, partial hospitalization or residential program granted prior to the admittance and for other services rendered. The goal of pre-admission certification prior authorization is to ensure that individuals members do not receive services that are not covered by the plan, including services that are not medically necessary. A complete list of services that require prior authorization is available on myODS or by contacting ODS' Customer Service.

2.01.680 "Prescription Drugs" shall mean 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.

2.01.690 "Respite Care" shall mean care of a hospice patient for a period of time to relieve persons residing with and caring for the patient from their duties.

2.01.700 "Skilled Nursing Care Facility" shall mean 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.

2.01.710 "Special Medical Situations" shall mean:

1. Specialist or type of treatment is not provided in Member's network service area and Member 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 prior authorization program. Services provided through Shriner's hospital and discounted through ODS Supplemental contracts will be paid as in-network and accrue to in-network plan year maximums. All determinations of when in-network benefits will apply to an out-of-network provider are made by the City's healthcare utilization and prior authorization program.

2. Eligible dependent child, residing outside the elected network service area, needs health care and uses out of network providers and Member 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 copay for an emergency. (Copay is waived if admitted; not subject to deductible.) Copay 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 copay for an emergency. (Copay waived if admitted; not subject to deductible.) Your 20% co-insurance amounts will

accrue towards your in-network maximum. Copay 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 Members may live outside the service area of the network they elected. If these Members 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.

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

2.01.730 "Utilization Review" shall mean a system of reviewing the medical necessity, appropriateness, or quality of medical care services and supplies using specified guidelines, including preadmission certification, the application of practice guidelines, continued stay review, discharge planning, prior authorization of ambulatory procedures, and retrospective review. An adverse benefit determination that the item or service is not medically necessary or appropriate is investigational or experimental, or in which the decision as to whether a benefit is covered involved a medical judgment is a utilization review decision.

CHAPTER 3

3.0 ELIGIBILITY AND PARTICIPATION

3.01 General

All Eligible Employees will become Members 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.

3.02 Initial Eligibility

3.02.010 Full-time and part-time non-represented, BOEC, COPPEA, DCTU, LOCAL 189-H (HOUSING) 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 and 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) or as otherwise defined within the collective bargaining agreement currently in effect.

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, LOCAL 189-H (HOUSING) 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 Members must enroll their eligible dependents in the Plan at the same time the Member 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 Member 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 Member 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 Member 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

did not 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, LOCAL 189-H (HOUSING) 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, LOCAL 189-H (HOUSING) 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 Member 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 Member 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 Member's group healthcare plan benefits on the same terms and conditions as if the Member were still an active Employee. That is, if the Member elects to continue his or her coverage while on leave, the Employer will continue to pay its share of the premium. If a Member's coverage ceases while on FMLA leave, the Member will be permitted to re-enter the Plan upon return from such leave on the same basis the Member was participating in the Plan prior to the leave, or as otherwise required by the FMLA.

3.06.020 A Member may elect to continue his or her coverage under the Plan during the FMLA leave. If the Member falls into an unpaid status and elects to continue coverage while on leave, the Administrator may terminate medical, dental and vision benefits if the Member fails to make the required contribution. The Administrator may fund coverage during the leave if the Member agrees to payment of "catch-up" amounts either through withholdings or an acceptable repayment schedule upon the Member's return. During a FMLA leave, a Member 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 Members, 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. If the Member elects Medical/Vision coverage, then the Member must elect a Dental 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 employer group medical plan. It shall be the responsibility of the Member 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 Member 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, Members 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, Members who purchase any medical, dental, vision or life insurance plan and elect coverage for someone other than a spouse or Dependent of the Member, 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, 2012 and for any subsequent Plan Year, any Member 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 Member just prior to the end of the preceding Plan Year, and

B. An agreement to a reduction in the Member's compensation for such Plan Year equal to the Member'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 Member, 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, LOCAL 189-H (HOUSING) 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, the SMW employees will be enrolled in Eligible Employee only coverage under the SMW self-insured medical plan

C. For Initial Enrollment, the PPA employees will be enrolled in Eligible Employee only coverage under 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, and the Employer funded group term life insurance plan.

D. For Annual Enrollment, the non-represented, BOEC, COPPEA, DCTU, LOCAL 189-H (HOUSING) 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 and dental plans with the Vision Service 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"and "Seasonal Maintenance Worker" plans, are self-insured medical plans sponsored by the City of Portland as is any run out from the formerly self-insured "CityNet" or "Economy" plan. CityNet became insured as of September 2007 and the "Economy" plan is no longer offered as of June 30, 2011. Self-insured means there is no insurance company responsible for paying the claims incurred by plan Members. 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

1. Benefit-eligible non-represented employees, BOEC, COPPEA, DCTU, LOCAL 189-H (HOUSING) PFFA, PPCOA and Recreation members are eligible to participate in the CityCore plan.
2. Benefit-Eligible Seasonal Maintenance Workers are eligible to participate in the Seasonal Maintenance Worker plan.

5.01.020 The City Self-Insured Plans utilize a Preferred Provider Organization (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 Members. The City has fee schedule arrangements with the PPO networks and with network fee schedule savings passed on to plan Members and the City. The PPO networks for the CityCore plan are the ODS Plus Network, the ODS Alternative Care Network, the ODS travel network and the PHCS Network. The PPO networks for the CityNet 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 Members have the freedom to choose any provider at each point in time they need medical care. A Member 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. Members 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 copayments, which is covered at least in part by any plan covering the claimant. When a plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the claimant is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a claimant is not an allowable expense.

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 Members:

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 a dependent child whose parents are married, registered under the Oregon Family Fairness Act, or are living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, the 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. Other. 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 Leave Provisions.

The City's health plans comply with the health continuation provisions of the federal Family Medical Leave Act (FMLA), Oregon Family and Medical Leave Act (OFLA) and the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

The employee and his/her enrolled dependents will remain eligible to be covered under the plan during an approved FMLA leave as outlined in City Administrative Rule 6.05 or as otherwise determined by collective bargaining agreement.. 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 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. 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.

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.

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 as provided for under the Uniform Services Employment and Reemployment Rights Act (USERRA). 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.

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

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 Members 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 ***(but will no longer be eligible for the City's dental or vision plans)*** 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 *(but will no longer be eligible for the City's dental or vision 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 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 Member 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 *(but will no longer be eligible for the City's dental or vision plans)*. 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 Members 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 Member 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 Member 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 ***(but will no longer be eligible for the City's dental or vision plans)*** 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 *(but will no longer be eligible for the City's dental or vision plans)*. 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 Members 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 *(but will no longer be eligible for the City's dental or vision plans)*. 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 Member 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.

5.07.020 - Member 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 Member 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 Member 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 Member is enrolled in a region-specific HMO that will not service the Member's health needs in an area to which the Member is relocating, the Member 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 Member 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 Member Considerations in Deciding Whether to Elect COBRA

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

B. The Member 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.

C. The Member 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.

D. The Member will waive the special enrollment rights under federal law to request special enrollment in another group health plan for which the Member may be otherwise eligible (such as a plan sponsored by the spouse's employer) within 30 days after the Member's group health coverage under the Plan ends because of one of the qualifying events listed above. The Member 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 Member.

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 of the 125 Plan 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. Members 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 Member's qualifying event. However, if the Benefits & Wellness Office notifies the Member 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 Member 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 Member 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 Member makes the first payment. (For example, if employment terminates on September 26 and the Member'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 Member 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 Member has elected COBRA and made the first payment.

F. If the Member 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 Member 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 Member 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 Member 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 Member 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 Member 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 Member 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 Members 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/OHA/OPHP/OMIP/

5.09 Washington State Health Insurance Pool (WSHIP) Portability Coverage

The Washington state Health Insurance Pool (WSHIP), offers individual health insurance coverage to Washington residents who have exhausted COBRA benefits and have been rejected for individual coverage based on medical reasons. WSHIP offers four preferred provider plans and one standard plan for qualified individuals who are not eligible for Medicare. Medicare supplement plans are also available. For more information, contact WSHIP Customer Service at 1-800-877-5187 or go to https://www.wship.org/

5.10. Medical and Behavioral Health Management Services

5.10.010 To assist Members 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 prior authorization 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.

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

A. When the Member'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;

5.10.030 – Medical Review Services

A. Services Requiring Prior 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 prior authorization procedure described below for the following services

will result in an initial denial of reimbursement for the services. If a claim is denied, the Member must request a retrospective service authorization. If the retrospective service authorization is approved, the claim will be adjusted. The Member will still be responsible for any applicable in or out of network deductibles, copayments and charges in excess of what would have been certified by the Plan

1. Behavioral Health Services, including:
    a. Chemical dependency treatments, inpatient, partial hospitalization and residential services
    b. Mental health services (inpatient, partial hospitalization and residential services)
2. Durable medical equipment rental and purchases. (Rental exceeds 30 days or cost is over $500)
3. Home health care (includes palliative care)
4. Hospice care
5. Inpatient Services, Partial Hospitalization and Residential Programs
    a. All non-emergency hospital confinements that are scheduled in advance and admission to any residential treatment program, must be authorized in order for maximum plan benefits to be payable. If the hospitalization, partial hospitalization or residential stay is not medically necessary, claims will be denied. ODS will authorize medically necessary lengths of stay, based upon the medical condition. Additional hospital or residential days are covered only upon medical evidence of need.
6. Transportation in lieu of ambulance
7. Organ transplants
8. Skilled nursing facility care
9. Special duty nursing
10. Surgical procedures--all inpatient elective surgeries and procedures
11. Surgery/treatment (outpatient)—all outpatient surgeries/treatment on the following
12. list:
    a. Cartilage transplants of the knee
    b. Capsule Endoscopy
    c. Hyperbaric oxygen therapy
    d. Nucleoplasty/IDET
    e. Neck/back/spine surgeries
    f. Prophylactic surgery (e.g. mastectomy)
    g. Thoracic Sympathectomy (for hyperhidrosis)
    h. Kyphoplasty/vertebroplasty
    i. Cryoablation of breast lesions
    j. Stereotactic radiosurgery (ie Gamma Knife)
    k. Arthroscopies
    l. Hip, knee, shoulder surgeries
13. Pet scans
14. Spect scans, unless being done for a cardiac diagnosis;
15. Genetic testing
16. Anesthesia/out patient hospital for dental procedures
17. Speech therapy (after initial evaluation)
18. Infusion services, dialysis, radiation and chemotherapy treatment

19. TMJ for second surgical appliance
20. Orthognathic surgery
21. Sleep studies and treatment for sleep apnea

B. Prior 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 prior authorization procedure on the Member's behalf, it is the responsibility of the Member to ensure that proper authorization is obtained.

1. Non-Emergency Prior Authorization Procedure

In the event a Member 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 Member'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 Member, treating provider, and facility if applicable.

(d) If the Member 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 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).

5.10.040 - Additional Medical Service Review Services

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

1. Concurrent Review - Review of the Member'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 Member's family to facilitate the Member's return home or transfer to an appropriate facility.

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

5.10.050 – Care Coordination Services (Case Management)

A. Care Coordination (case management) is performed by registered nurses. They work to create an individualized treatment programs for Members with complex or high risk medical or mental health conditions or experiencing unusual and serious complications from a medical condition under treatment. The Member 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.

The City may, at times, implement intensive chronic care management, or enhanced care management, designed to work with members living with chronic illnesses and/or who have higher than usual utilization of healthcare services. The enhanced care management program will be offered to specific individuals who meet eligibility requirements as set by ODS. Certain incentives may apply to those individuals who are eligible and who agree to participate and remain in compliance with the provisions of the enhanced care management plan. The terms of compliance and the offered incentives will be provided upon acceptance into this program.

5.10.060 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

Members 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. Members 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 medical concerns
2. Assist with the management of ongoing medical needs
3. Help you understand your medications
4. Clarify healthcare benefit options
5. Offer preventive wellness programs
6. Work with you to set personal health goals
7. Identify appropriate health-related community resources
8. Provide customized health or medical educational tools.

5.10.070 Maternity Care Program

The CityCore plan includes free support throughout your pregnancy with the ODS Maternity Care Program. Members who enroll in this program will receive:

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

5.10. 080 Diabetes Coaching

CityCore enrollees and their dependents will have the option of enrolling in a diabetes coaching program. This program aims to help patients better manage their diabetes by identifying, preventing and detecting long-term related complications through education and support.. This program is offered at no out-of-pocket costs to the Member.

Program Features:

- Meet one-on-one every 1 to 3 months with a pharmacist specially trained in diabetes to help treat and manage this condition
- Learn about meal planning skills with a registered dietitian
- Participate in a grocery store tour with a diabetes care team member to learn how to make healthier food choices
- Personalized topics covered include:
    - Monitoring, medications, and goals
    - Prevention and treatment of acute and chronic complications

- Planning ahead for meals, dining out, carbohydrate counting, and physical activity
- Lab work every 6 to 12 months (shared with your provider) to help Members track their progress

5.10.090 - Hospital Bill Audit Program

If a Member finds an incorrect charge on an itemized hospital bill after the applicable third party administrator has processed and paid the benefit, the Member should notify the third party administrator of the billing error as soon as possible. The Member 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.

5.11 Acts of Third Parties

A. Third-Party Liability - In situations in which a third party, including a Member'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 Member is injured in a store, the owner or the owner's insurance carrier may be responsible for payment of the charges for the Member'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 Member'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 Member'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 Member or the Plan, or to be reimbursed from the third party or from Member's or another liability insurer. The Plan will not provide services unless the Member 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 Member with information regarding the amount of these charges. If the Member 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 Member 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 Member agrees to cooperate in protecting the interest of the Plan under this provision. The Plan can require the Member to testify for the Plan and to sign and deliver all legal papers necessary to secure the Member's and the Plan's rights. If the Plan asks the Member 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. Member must agree to sign a subrogation agreement that allows the Plan to bring an action in the Member'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 Member fails to complete required paperwork after the payment of claims, the Plan will issue a retroactive denial of claims and the Member 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 Member 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 Member must give the Plan information about any personal injury protection insurance available to the Member 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 Member makes from a claim or legal action related to the motor vehicle injury. This includes claims the Member makes against the Member's own uninsured or under-insured motorist coverage. The Member 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 Member 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 Member 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 Member in connection with recovery of the amount of the lien. The Member 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 Member 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 Member in connection with the Member's recovery. The Member 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 Member agrees to cooperate in protecting the Plan's interest under this provision.

C. If the Plan requests in writing that the Member take such action necessary or appropriate to recover benefits provided for the Member, the Member must agree to do so. The Plan can require the Member to testify for the Plan and to sign and deliver all legal papers necessary to secure the Member's and the Plan's rights. For example the Plan can require a Member to sign a subrogation agreement that allows the Plan to bring an action in the Member's name. The Plan will also be reimbursed out of the recovery made from this action for the Member'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 Member's own negligence, the Member 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 Member or on behalf of any incapacitated person.

5.12 Extension of Hospitalization Benefits

The City of Portland's self-insured plans (CityCore and the Seasonal Maintenance Worker Medical 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.

5.13 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 Member 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 Member sees an in-network provider, the provider will directly bill ODS, the City's claim payer.

F. If the Member 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 Member 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 Member to indicate whether payments are to be made directly to the provider of service or to the Member.

5.14 Appeals and External Review

If you disagree with the decision to deny a claim, you may appeal the decision. The Plan has a two level formal appeal process. You 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.

5.14.010 Time Limit for Submitting Appeals

A member has **180 days** from the date of an adverse benefit determination to submit an initial written appeal. If an appeal is not submitted within the timeframes outlined in this section, the rights to the appeals process will be lost. The timelines addressed in the sections below do not apply when the member does not reasonably cooperate; or circumstances beyond the control of either party prevents that party from complying with the standards set (but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise).

5.14.020 The Review Process

The Plan has a 2-level internal review process consisting of a first level appeal and a second level appeal. If a Member is not satisfied with the outcome of the second level appeal, and the dispute meets the specifications outlined in the External Review section, the member may request external review by an independent review organization. The first and second levels of appeal will need to be exhausted to proceed to external review, unless the Plan agrees otherwise.

5.14.030 First Level Appeal

Before filing an appeal, it may be possible to resolve a dispute with a phone call to ODS' Customer Service. Otherwise, an appeal must be submitted in writing to ODS. If necessary, ODS' Customer Service can provide assistance filing an appeal. The member may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on his or her behalf. ODS will acknowledge receipt of the written appeal within 7 days and conduct an investigation by persons who were not involved in the original determination.

An appeal related to an urgent care claim will be entitled to expedited review upon request. An expedited review will be completed no later than 72 hours after receipt of the appeal by ODS, unless the member fails to provide sufficient information for ODS to make a decision. In this case, ODS will notify the member within 24 hours of receipt of the appeal of the specific information necessary to make a decision. The member will have 48 hours to provide the specified information. The investigation of an urgent care claim will be completed no later than 48 hours following the earlier of (a) ODS' receipt of the specified information, or (b) the end of the period provided to submit the specified additional information.

Investigation of a pre-service appeal will be completed within 15 days. Investigation of a post-service appeal will be completed within 30 days.

When an investigation has been completed, ODS will notify the member in writing of the decision, the basis for the decision, and if applicable, information on the right to a second level appeal.

5.14.040 Second Level Appeal

A member who disagrees with the decision regarding the first level appeal may request a review of the decision. The second level appeal must be submitted in writing within 60 days of the date of ODS' action on the first level appeal.

Investigations and responses to a second level appeal will be by persons who were not involved in the initial determinations, and will follow the same timelines as those for a first level appeal. The member may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on his or her behalf. If new or additional evidence or rationale is used by ODS in connection with the claim, it will be provided to the member, in advance and free of charge, before any final internal adverse benefit determination. Members may respond to this information before ODS' determination is finalized. ODS will notify the member in writing of the decision, the basis for the decision, and if applicable, information on the right to request an external review.

5.14.050 External Review

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

Within 6 business days following receipt of a request, ODS will send a written notice to the member if the request is incomplete or ineligible for external review. Otherwise, the independent review organization will provide a written notice of the final external review decision within 45 days after its receipt of the request. For claims involving urgent care, the independent review organization will expedite the review and provide notice within 72 hours after its receipt of the request. The decision of the independent review organization is binding, except to the extent other remedies are available to the member under state or federal law. If ODS fails to comply with the decision, the member may initiate a suit against ODS.

5.14.060 Additional Member Rights

Members may contact the Employee Benefits Security Administration at 866-444-3272 or the Oregon Insurance Division for questions about their appeal rights or for assistance:

By mail:	Oregon Insurance Division P.O. Box 14480 Salem, Oregon 97309-0405
By phone:	503-947-7984

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

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

5.15 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.

5.16 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.

185368

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	The CityCore Plan's network is the ODS Plus Network. During the year you can go in-network or out-of-network as you choose. When you go in-network, you will have fewer out-of-pocket expenses.	
Maximum Plan Allowance (MPA)	After the deductible, 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 copays 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	No Lifetime Maximum Benefit Limit	
Prior authorization	Required for hospitalization. Other services requiring prior authorization are listed beginning on page **54**	
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. Services as required under the Affordable Care Act	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

Medical Plan Feature	CityCare	
	In-Network	Out-of-Network
	Routine physical exam maximum: Infant 6 exams in first 12 months Ages 1 to 4 7 exams Ages 5 and older 1 exam per 12 months Routine vision screening for age 3 to 5 Newborn hearing screening ***Cancer Screenings:*** ***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(including hospital, sedation and related tissue pathology charges—pre or post op office visits are covered at regular copays):*** 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 copay	60% of MPA after deductible
Pregnancy – Prenatal visits and physician delivery charges	$250 copay for physician services and lab work	60% of MPA after deductible
Diagnostic x-rays, MRIs, CT scans, ultrasound and other radiology services.	$25.00 copay per service, Ancillary services (eg. Injection of dye, etc) are subject to deductible, then paid at 80%	60% of MPA after deductible
Inpatient Care/Outpatient Hospital: Including semi-private room and board; in—hospital diagnostic x-rays and lab work; surgery, anesthesia and miscellaneous services	80% after deductible	60% of MPA after deductible

	In-Network	Out-of-Network
Emergency Room (copay waived if admitted as inpatient following emergency)	80% after $100 copay (not subject to deductibles)	80% of MPA after $100 copay (not subject to deductibles)
Urgent Care	$15.00 copay	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 copay	60% of MPA after deductible
	35-visit annual maximum for chiropractic. Services must be prior authorized 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. 4 visit 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
Hearing Aids For members under age 26	80% (no deductible) up to a maximum of $4,225 every 48 months for members under age 26 and when services are provided in-network.	60% of MPA (no deductible), up to a maximum of $4,225 every 48 months for members under age 26 and when services are provided out-of-network

Medical Plan Feature	Oregon	
	In-Network	Out-of-Network
Hearing Aids For adults age 26 and older	60% of MPA (no deductible), up to $1,200 per ear; new hearing aid covered once every 36 months if medically necessary for member over age 26.	
TMJ Treatment	Non-surgical benefit subject to deductible, then paid at 80%. 2nd surgical appliance subject to prior authorization. Maximum lifetime benefit of $3000.	Non-surgical benefit subject to deductible, then paid at 60%. 2nd surgical appliance subject to prior authorization. Maximum lifetime benefit of $3000.
Behavioral Health **Mental Health Treatment** **Prior authorization is required for all in-patient and residential treatment programs.**	$15.00 copay for outpatient office visits. 80% after deductible for inpatient and residential treatment programs.	60% of MPA after deductible
Chemical Dependency Treatment **Prior authorization is required for all in-patient and residential treatment programs**	$15.00 copay for outpatient office visits. 80% after deductible for inpatient and residential treatment programs.	60% of MPA after deductible
Sterilization, Contraceptive Implants (e.g., IUD and Norplant)	80% after deductible $335 annual maximum contraceptive implant benefit	60% of MPA after deductible
Sleep Apnea $5,000 maximum lifetime benefit effective for services on or after 7/1/2010.	80% after deductible, subject to prior authorization	60% of MPA after deductible; subject to prior authorization
Infertility Treatment	Not covered	Not covered

Medical Plan Feature	Choices	
	In-Network	Out-of-Network
Prescription Drugs	Deductible does not apply. In-Network Pharmacy :	
Network retail pharmacy (up to 30-day supply)) , or a 90-day supply of maintenance meds at a Kroger owned pharmacy such as Fred Meyer or QFC)	– 90% of generic drug cost; $5 minimum ($0 minimum at $4 pharmacies), $25.00 maximum copay – 80% of preferred brand name drug cost; $5 minimum, $50.00 maximum copay For statins and proton pump inhibitors (PPI) member to pay difference between cost of brand name & generic in addition to the generic copay maximum of $25) – 70% of non-preferred drug cost; $5 minimum, $75.00 maximum copay.	
Out-of-network pharmacy (up to 30-day supply)		Out-of Network pharmacy: You pay the pharmacy; then submit claims to ODS for 60% reimbursement after out of network deductible is met.
Mail order pharmacy (up to 90-day supply)	Same as in-network retail pharmacy benefit levels shown above	

6.01 Accessing the Networks:

Within the network, Members may choose any of the PPO providers and facilities to receive covered services. Plan Members are encouraged to select and utilize a primary care physician for routine medical services. Plan Members are not required to select a primary care physician and do not need referrals to specialists. Members are provided access to electronic directories that list PPO service providers.

6.02 Identification Cards:

Plan Members 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,or Hearing Aids. All Emergency Room treatment 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 copayments are not applied to the Plan Year Maximum Out-of-Pocket Limits. Copayments and other costs for network services do not apply to the maximum out-of-pocket for non-network services. Non-network copayments 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.Prior authorization 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 prior authorized 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. For non mental health or chemical dependency conditions. Benefits will be paid to the member and the provider or directly to the provider. Services provided by a stretcher car, wheelchair car or similar methods are considered custodial and are not covered benefits under the Plan
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. Autism. Treatment of autism is covered in accordance with the diagnostic guidelines as approved by the American Psychiatric Association, subject to prior authorization for medical necessity

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

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

9. Contraceptive device insertion and removal.

10. Diabetes Self Management. The plan covers a benefit for diabetic education services for covered persons who are diagnosed to have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes when prescribed by a health care professional legally authorized to prescribe such programs. These services are not subject to a deductible and are covered as in-network. 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 authorized 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.

11. 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.

12. 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.

13. Gastric Restrictive Procedures (CityCore plan only). Subject to prior authorization--with or without gastric bypass or the revision of the same.

14. **Hearing aids for Adults (age 26 and older)**. Includes the cost of any maintenance or repairs, subject to benefit maximums.

15, Hearing Aids for members under age 26. The Plan covers one hearing aid per hearing impaired ear for enrolled dependent children. This benefit is subject to a 48-month maximum which will be adjusted annually as required by Oregon statute. An enrolled dependent child must be examined by a physician before obtaining a hearing aid that is prescribed, fitted and dispensed by a licensed audiologist.

Covered benefits include the following up to the dollar maximum every 48 months:

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

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

17. 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.

18. 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.

19. 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.

(d)Infusion therapy benefits require pre-authorization and ***include:***

- aerosolized pentamidine;
- intravenous drug therapy;
- total parenteral nutrition;
- hydration therapy;
- intravenous/subcutaneous pain management;
- terbutaline infusion therapy;
- SynchroMed pump management;
- IV bolus/push drugs; and
- Blood product administration.

In addition, covered expenses include only the following medically necessary services and supplies:

- solutions, medications, and pharmaceutical additives;
- pharmacy compounding and dispensing services;
- durable medical equipment for the infusion therapy;
- ancillary medical supplies;
- nursing services associated with:
- patient and/or alternative care giver training;
- visits necessary to monitor intravenous therapy regimen;
- emergency services;
- administration of therapy; and
- collection, analysis, and reporting of the results of laboratory testing services required to monitor response to therapy.

20. 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.

21. 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.

22. 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.

23. Mental health inpatient and residential services which have been prior authorized.

24. 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.

25 Nutritional Counseling and/or hospital-based weight reduction programs **for BMI 26+** covered subject to a four (4) visit maximum.

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

27. 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. Transplant Description:

a. A transplant is 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.

b. A transplant does not include the collection of and/or transfusion of blood or blood products, corneal transplants.

c. The transplant period means the time from the day of admission for transplant conditioning through the day of discharge for a transplant.

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

B. Covered Benefits

All transplant procedures must be authorized and be medically necessary and appropriate according to criteria established by ODS. Benefits for transplants are limited as follows:

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

b. All transplants must meet the Prior Authorization/Utilization Management Program Criteria. Prior authorization requests for transplants will be reviewed to ensure medical appropriateness and medical necessity of the proposed treatment for the enrollee's medical condition or disease.

- Physician or professional provider transplant services according to the benefits for physicians and professional providers under the Plan will be paid;
- Anti-rejection drugs following the covered transplant will be paid according to the benefits for prescriptions drugs, if any, under the Plan.
- The Plan will not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage.

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

28. Orthognathic surgery – Prior authorization for medical necessity required. Orthognathic surgery is covered for the correction of skeletal deformities of the maxilla or mandible when it is documented that these skeletal deformities are contributing to significant dysfunction and where the severity of the deformities precludes adequate treatment through dental therapeutics and orthodontics alone.

29. 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.

30. 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.

31. Radium, Radioisotopic, X-ray Therapy, and Kidney Dialysis--Covered expenses require pre-authorization and include: Treatment planning and simulation; Professional services for administration and supervision; and Treatments, including therapist, facility and equipment charges.

32. Reconstructive surgery after breast cancer. Includes reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. All reconstructive procedures must be medically necessary and prior authorized.

33. Routine Costs in Qualified Clinical Trials. Routine costs for the care of a member who is enrolled in or participating in qualifying clinical trials are covered. Routine costs mean medically necessary conventional care, items or services covered by the Plan if typically provided absent a clinical trial. Routine costs will be subject to the applicable deductible and standard copayments/coinsurance if provided in the absence of a clinical trial. The City of Portland Health Plan and/or ODS are not liable for any adverse effects of the clinical trials.

Qualified clinical trials are limited to those:

a. Funded or supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs;

b. Conducted as an investigational new drug application, an investigational device exemption or a biologics license application to the United States Food and Drug Administration; or

c. Exempt by federal law from the requirement to submit an investigational new drug application to the United States Food and Drug Administration.

The Plan does not cover:

a. The drug, device or service being tested in the clinical trial unless it would be covered by the Plan if provided outside of a clinical trial;

b. Items or services required solely for the provision of the drug device or service being tested in the clinical trial;

c. Items or services required solely for the clinically appropriate monitoring of the drug, device or service being tested in the clinical trial;
d. Items or services required solely for the prevention, diagnosis or treatment of complications arising from the provision of the drug, device or service being tested in the clinical trial;
e. Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the member;
f. Items or services customarily provided by a clinical trial sponsor free or charge to any person participating in the clinical trial; or
g. Items or services that are not covered by the Plan if provided outside of the clinical trial.

34. Sexual Reassignment Surgery: Medically necessary services to alter a Member's physical characteristics to that of the opposite sex, to include single stage or multiple stage reconstruction of genitalia and reconstruction of breast tissue to achieve the appearance of the new gender. Services require prior authorization and have a lifetime benefit maximum of $50,000.

35. Short term rehabilitation. Services consist of physical therapy, occupational therapy and/or speech therapy furnished to a person who is not confined as an inpatient in a hospital or other facility for medical care. This therapy shall be expected to result in continued improvement of the person's condition. Rehabilitation services include physical, occupational, speech or audiological therapy services necessary to restore or improve lost function caused by illness or injury. Recreational or educational therapy, non-medical self-help or training, are not included. Prior authorization is required.

36. 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 prior authorization. Charges are not covered related to an admission that began before the person was enrolled in the plan.

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

38. Telemedical Health Services. Covered medical services, delivered through a 2-way video communication that allows a physician or professional provider to interact with a member who is at an originating site, are covered. Benefit will be subject to the applicable deductible and standard copayments for the covered medical services. An originating site includes the following:

- Hospital;
- Rural health clinic;
- Federally qualified health center;
- Physician's office;
- Community mental health center;
- Skilled nursing facility;
- Renal dialysis center; or
- Site where public health services are provided.

If telemedical services are in connection with covered treatment of diabetes, communication can also be delivered via audio, Voice over Internet Protocol, or transmission of telemetry. One of the participants must be a representative of an academic health center.

39. Temporomandibular Joint Disease (TMJ) – Non-surgical treatment covered up to a $3,000 lifetime maximum. Preauthorization required for a second appliance.

40. **Tobacco Cessation**. This benefit provides reimbursement to **certain providers** to assist enrollees to stop the use of tobacco. This coverage allows reimbursement for prescription drugs and for tobacco 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.

41. 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 state-licensed professionals when providing 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 Member'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 Member 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. An authorized 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 practicing mental health nurse practitioner
12. A State-licensed clinical social worker (LCSW)
13. A State-licensed marriage & family therapist (LMFT)
14. A State-licensed professional counselor (LPC)
15. A clinician providing services under the auspices of a program licensed, approved, established, maintained, contracted with or operated by the Oregon Office of Mental Health & Addiction Services
16. A registered physical, occupational, speech or audiological therapist
17. 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
18. A registered nurse first assistant
19. An audiologist
20. An optometrist

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 Kroger Prescription Plan (KPP).

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 Member'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 prior authorization 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. Member's share of the costs is based on a percentage of the actual costs, not a flat dollar copayment amount (unless the cost of the medications exceed the maximum) and depends on whether the drug is a preferred generic, preferred brand name or a non-preferred generic or brand name drug.

E. Plan coverage for statin drugs (cholesterol-lowering medications) is limited to the cost of generic simvastatin. If a member chooses a higher-cost statin drug, the member will pay the difference in cost between the higher-cost drug and generic simvastatin in addition to the generic copay (with some exceptions as determined by KPP), which will be paid in accordance with the normal benefit schedule.

F. Plan coverage for Nexium will be limited to the cost of generic omeprazole. If a member chooses to purchase Nexium, the member will pay the difference in cost between the highter cost Nexium and generic omeprazole in addition to the generic copay.

G. Mail Order Service

1. If a Member uses the mail order service, the Member will have a 90-day supply of the prescription mailed directly to his or her home. Alternatively, the Member can elect to get a 90-day supply of medications through the PBM's Options90 plan at the retail pharmacy. Options90 is only available at Fred Meyer and QFC Pharmacy's. The copay is based on the total cost of the medication for the 90-day supply at the copay 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 Member 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 Member'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 Member pays by check, this may cause a balance due on a mail order account.

(d) If the Member 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 Member's credit/debit card account on file.

6.09 CityCore Plan Lifetime Benefit Maximum

The CityCore plan has no lifetime maximum for claims per Member.

6.10 CityCore Plan Exclusions and Limitations

A. CityCore will not cover any expenses incurred for which the Member 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) except for treatment of an accidental injury to natural teeth provided within 12 months of the injury or for surgery that does not involve repair, removal or replacement of teeth, gums, or supporting tissue
- Bodily injury or illness arising out of duty as a member of the armed forces of any state or country, or a war or any act of war (declared or undeclared).
- Injury or illness resulting from the plan Member'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.
- Telemedical Health Services Charges including telephone visits or consultations and telephone psychotherapy except as provided for in the paragraph titled "Telemedical Health Services"
- Services, prescription drugs, and supplies a member or a member's dependent may receive while in the custody of any state or federal law enforcement authorities or while in jail or prison.
- Services provided by a relative –Relatives, for the purpose of this exclusion, include a member or a spouse or domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner

- Third party liability claims – services and supplies for treatment of illness or injury for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party. Includes benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to, or makes benefits available to, a member, whether or not such benefits are requested. More information can be found in the "Third Party Liability" section.
- 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; 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.

Exclusions Related to Miscellaneous Services and Items:

- Support Education including Level 0.5 educational programs related to Driving Under the Influence (DUI), voluntary mutual support groups, such as Alcoholics Anonymous, or family education or support groups except for support groups rated A & B by the United States Preventive Services taskforce.

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

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

- Refractive surgery, laser vision correction, and any other procedure which alters the refractive character of the eye, the purpose of which is to cure or reduce myopia, hyperopia, or astigmatism. Includes radial keratotomy, corneal rings, LASIK, PRK, any procedure using the 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.

- 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 volunteer workers;
    d. Supplies intended for use outside hospital settings or considered personal in nature;
    e. Routine miniature chest x-ray films or full body scans;
    f. 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. Including, 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 for non mental health and chemical dependency conditions..
- Biofeedback therapy services are limited to medically necessary treatment of tension or migraine headaches and the Plan will pay for no more than 10 visits during the Member's lifetime.
- Cosmetic Surgery: Any procedure requested for the purpose of improving appearance without restoring bodily function or correcting physical impaoirment including procedures related to sexual reassignment surgery, breast augmentation, lipectomy, liposuction and hair removal (including electrolysis and laser) and rhinoplasty. Exceptions are provided for reconstructive surgery following a mastectomy and complications of reconstructive surgeries. If medically necessary, clinically distinct and not specifically exluded.
- Exclusions relative to sexual reassignment include:
    - Treatment of acne as a complication of hormone therapy
    - Treatment of infertility as a complication of gender identity treatment
    - Reversal of gender identity treatments and surgery
    - Removal of unwanted body hair
    - Liposuction
    - Thyroid cartilage reduction
    - Abdominoplasty
    - Facial reconstruction not related to accident or injury
    - Make up evaluation
    - Botox treatment
    - Voice Training
    - Legal Expenses related to name change
    - Procedures and treatments that are not hormone therapy, psychotherapy or surgery for the reconstruction of genitalia

- 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.
- For members under age 26 the following hearing aide related charges:
    - Implantable hearing aides and surgical procedure to implant them
    - Replacement of a hearing aid, for any reason, in a 48-month period after the maximum is met;
    - Batteries or other supplementary equipment other than those obtained upon purchase of the hearing aid;
    - A hearing aid exceeding the specifications prescribed for correction of hearing loss; and
    - Expenses incurred after coverage ends, unless the hearing aid is ordered before coverage terminated and it is received within 90 days of the end date.
- 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 prior authorization are not covered under this plan unless authorized as medically necessary through the City's contracted Service Authorization/Prior authorization Program.
- Chelation therapy is not covered under the Plan, except for acute arsenic, gold, mercury or lead poisoning.
- Transplant donor related services or supplies provided to an insured Donor if the Recipient is not enrolled under this Plan and eligible for transplant benefits. This exclusion does not apply to complications or unforeseen infections resulting from the donation of tissue.
- Services or supplies for any transplant not covered by the plan including the transplant of animal organs or artificial organs.
- Chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not specifically named as covered.
- Foot orthoses (orthotics) made of high impact plastics or other materials, designed to be inserted into shoes;

- Genetic testing or counseling unless medically necessary and prior authorized through the City's contracted Utilization Review provider. Genetic testing for family members not covered under the Plan is excluded.
- Counseling related to family, marriage, sex and career, in the absence of medical necessity/illness;
- Vocational, pastoral or spiritual counseling;
- Dance, poetry, music or art therapy, except as part of a treatment program in an inpatient setting.
- Non-organic therapies including, but not limited to, bioenergetics therapy, confrontation therapy, crystal healing therapy, educational remediation, 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. Including the following services unless required by the member's medical condition (e.g. diabetes):
    - Paring or cutting of benign hyperkeratotic lesion (e.g. corn or callus);
    - Trimming of dystrophic and non-dystrophic nails; and
    - Debridement of nail by any method.
- 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 Members and procurement and storage of cord blood, unless medically necessary for the imminent use at the time of collection for a designated recipient.
- Hypnotherapy.
- Never Events: Services and supplies related to never events, which are events that should never happen while receiving services in a hospital or facility include but not limited to the wrong surgery, surgery on the wrong body part, or surgery on the wrong patient. These also apply to any hospital acquired condition, as that term is defined in the Centers for Medicare and Medicaid Services (CMS) guidelines, which includes buty is not limited to serious preventable events.

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 diabetes supplies).

(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) Non-sedating antihistamines

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

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

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

(p) 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"

Chapter 7

7.0 SEASONAL MAINTENANCE WORKER PPO MEDICAL PLAN

7.01 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 Member Pays	**Out-of-Network Member Pays**
Network Required	ODS/ Plus Network. During the year Member can go in-network or out-of-network. When Member 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: $200/person; $600/family maximum	SMW Plan : $500/person; $1,500/family maximum
Plan Year Out-of-Pocket Maximum (SMW prescription drug, emergency room copays or other copays and charges over MPA do not apply to annual maximum)	SMW Plan: $1,800/person; $5,400/family maximum (excludes deductible & in-network expenses)	SMW Plan : $3,000/person; $9,000/family maximum (excludes deductible & in-network expenses)
Lifetime Maximum Benefits	There is no benefit lifetime maximum	
Prior authorization	Required for hospitalization and other services as listed in Plan Document .	

Medical Plan Feature	PPO Seasonal Maintenance Worker (SMW) Medical Plan	
	In-Network Member Pays	**Out-of-Network Member 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. Services as required under the Affordable Care Act	100% No deductible Member 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: Infant 6 exams in first 12 months Ages 1 t0 4 7 exams Ages 5 and older 1 exam per 12 months Routine vision screening aor age 3 to 5 Newborn hearing screening ***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 (Including hospital sedation and related tissue pathology charges) pre or post-op visits are covered at regular copays:*** 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.	

Medical Plan Feature	PPO Seasonal Maintenance Worker (SMW) Medical Plan	
	In-Network Member Pays	**Out-of-Network Member Pays**
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	$15 copy per visit 30% $15 copy per visit $10 copy per visit 100% no deductible 30% 30%	50% of out-of-network maximum plan allowance after deductible for all listed services
X-Rays, imaging, laboratory & specialty diagnostic procedures	30%	50% of out-of-network maximum plan allowance after deductible
Inpatient Care/Outpatient Hospital: Including semi-private room and board; in—hospital diagnostic x-rays and lab work; surgery, anesthesia and miscellaneous services	30% after deductible	50% of MPA after deductible
Emergency Room (copay waived if admitted as inpatient following emergency)	30% after $50 copay	50% after $50 copay
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 prior authorized 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	50% of MPA after deductible

Medical Plan Feature	PPO Seasonal Maintenance Worker (SMW) Medical Plan	
	In-Network Member Pays	**Out-of-Network Member Pays**
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
Behavioral Health **Mental Health Treatment** **Prior authorization is required for all in-patient and residential treatment programs.**	30% after deductible Inpatient & residential treatment programs – same as hospital inpatient Outpatient subject to primary care office copay	50% after deductible Inpatient & residential treatment programs –Same as hospital inpatient Outpatient - 50% of MPA after deductible.
Chemical Dependency Treatment **Prior authorization is required for all in-patient and residential treatment programs**	30% after deductible for inpatient and residential treatment programs (same as hospital inpatient) Out-Patient subject to primary care office copay	50% after deductible (same as hospital inpatient) Outpatient: 50% of MPA after deductible.
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

Medical Plan Feature	PPO Seasonal Maintenance Worker (SMW) Medical Plan	
	In-Network Member Pays	**Out-of-Network Member Pays**
Prescription Drugs	Deductible does not apply	
In- network retail pharmacy (up to 30 day supply) , or a 90-day supply of maintenance meds at a Kroger owned pharmacy such as Fred Meyer or QFC)	In-Network Pharmacy: -90% of preferred generic drug cost ($5.00 min/$25.00 maximum copay. $0 minimum at $4 pharmacies. -80% of preferred brand drug name cost ($5.00 min/$50.00 maximum copay. For statins and proton pump inhibitors (PPI) member to apy difference between cost of brand name & generic in addition to the generic copay maximum of $25.00 -70% of non-preferred drug cost (generic or brand name) $5.00 min/$75.00 max	
Out-of-network pharmacy (up to 30 day supply)		Out-of-Network pharmacy: Member pays pharmacy and submits claims to ODS for 60% reimbursement after out-of-network deductible is met.
Mail order pharmacy (up to 30 day supply)	Same as in-network retail pharmacy benefit levels shown above	

7.02 Accessing the Networks:

Within the ODS Plus Network, Members may choose any of the PPO providers and facilities to receive covered services. Plan Members are encouraged to select and utilize a primary care physician for routine medical services. Plan Members are not required to select a primary care physician and do not need referrals to specialists.
Members 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 Members 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 copayments are not applied to the Plan Year Maximum Out-of-Pocket Limits. Copayments and other costs for network services do not apply to the maximum out-of-pocket for non-network services. Non-network copayments 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.Prior authorization 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 for non mental health or chemical dependency conditions. Benefits will be paid to the member and the provider or directly to the provider. Services provided by a stretcher car, wheelchair car or similar methods are considered custodial and are not covered benefits under the plan..

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 prior authorized (except for emergency hospital admissions, which must be authorized 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.

d. Infusion therapy benefits require pre-authorization and ***include:***

i. aerosolized pentamidine;
ii. intravenous drug therapy;
iii. total parenteral nutrition;
iv. hydration therapy;
v. intravenous/subcutaneous pain management;
vi. terbutaline infusion therapy;
vii. SynchroMed pump management;
viii. IV bolus/push drugs; and
ix. Blood product administration.

In addition, covered expenses include only the following medically necessary services and supplies:

x. solutions, medications, and pharmaceutical additives;
xi. pharmacy compounding and dispensing services;
xii. durable medical equipment for the infusion therapy;
xiii. ancillary medical supplies;
xiv. nursing services associated with:
xv. patient and/or alternative care giver training;
xvi. visits necessary to monitor intravenous therapy regimen;
xvii. emergency services;
xviii. administration of therapy; and
xix. collection, analysis, and reporting of the results of laboratory testing services required to monitor response to therapy.

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 prior authorized.

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. Transplant Description:

a. A transplant is 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.

b. A transplant does not include the collection of and/or transfusion of blood or blood products, corneal transplants.

c. The transplant period means the time from the day of admission for transplant conditioning through the day of discharge for a transplant.

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

B. Covered Benefits

All transplant procedures must be authorized and be medically necessary and appropriate according to criteria established by ODS. Benefits for transplants are limited as follows:

a. If the Recipient or Self-Donor is enrolled under this Plan, donor costs related to a covered transplant are covered in accordance with the Plan's copays and maximums. "Donor costs" mean the covered expense of removing the tissue from the donor's body and preserving or transporting it to the site where the transplant is performed as well as any other necessary charges directly related to locating and procuring the organ. If the donor is covered under this Plan and the recipient is not, no benefits

toward donor costs will be paid. Expenses incurred by an enrolled donor 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 are not covered.

b. All transplants must meet the Prior Authorization/Utilization Management Program Criteria. Prior authorization requests for transplants will be reviewed to ensure medical appropriateness and medical necessity of the proposed treatment for the enrollee's medical condition or disease.

- Physician or professional provider transplant services according to the benefits for physicians and professional providers under the Plan will be paid;
- Anti-rejection drugs following the covered transplant will be paid according to the benefits for prescriptions drugs, if any, under the Plan.
- The Plan will not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage.

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

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. Radium, Radioisotopic, X-ray Therapy, and Kidney Dialysis--Covered expenses require pre-authorization and include: Treatment planning and simulation; Professional services for administration and supervision; and Treatments, including therapist, facility and equipment charges.

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. All reconstructive procedures must be medically necessary and prior authorized.

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. Prior authorization is required

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 prior authorization. Charges are not covered related to an admission that began before the person was enrolled in the Plan.

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

A professional provider means any of the following state-licensed professionals when providing 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 Member'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 Member 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. An authorized 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 practicing mental health nurse practitioner
12. A State-licensed clinical social worker (LCSW)
13. A State-licensed marriage & family therapist (LMFT)
14. A State-licensed professional counselor (LPC)
15. A clinician providing services under the auspices of a program licensed, approved, established, maintained, contracted with or operated by the Oregon Office of Mental Health & Addiction Services
16. A registered physical, occupational, speech or audiological therapist
17. 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
18. A registered nurse first assistant
19. An audiologist
20. An optometrist

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 SMW Prescription Drug Program

A. The prescription drug benefit for the SMW Medical Plan is managed by a pharmaceutical benefits management (PBM) service provider Kroger Prescription Plan (KPP).

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 Member'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 prior authorization 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. Member's share of the costs is based on a percentage of the actual costs, not a flat dollar copayment amount and depends on whether the drug is a preferred generic, preferred brand name or a non-preferred generic or brand name drug.

E. Plan coverage for statin drugs (cholesterol-lowering medications) is limited to the cost of generic simvastatin. If a member chooses a higher-cost statin drug, member will pay the difference in cost between the higher-cost drug and generic simvastatin in addition to the generic copay (with some exceptions as determined by KPP), which will be paid in accordance with the normal benefit schedule.

F. Plan coverage for Nexium will be limited to the cost of generic omeprazole. If a member chooses to purchase Nexium, the member will pay the difference in cost between the highter cost Nexium and generic omeprazole in addition to the generic copay.

G. Mail Order Service

1. If a Member uses the mail order service, the Member will have a 90-day supply of the prescription mailed directly to his or her home. Alternatively, the Member can elect to get a 90-day supply of medications through the PBM's Options90 plan at the retail pharmacy. Options90 is only available at Fred Meyer and QFC Pharmacy's. The copay is based on the total cost of the medication for the 90-day supply at the copay 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 Member 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 Member'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 Member pays by check, this may cause a balance due on a mail order account.

(d) If the Member 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 Member's credit/debit card account on file.

7.10 SMW Medical Plan Lifetime Benefit Maximum

185368

The SMW Medical Plan has no lifetime maximum for claims per Member

7.11 SMW Plan Exclusions and Limitations

A. SMW will not cover any expenses incurred for which the Member 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) except for treatment of an accidental injury to natural teeth provided within 12 months of the injury or for surgery that does not involve repair, removal or replacement of teeth, gums, or supporting tissue
- Bodily injury or illness arising out of duty as a member of the armed forces of any state or country, or a war or any act of war (declared or undeclared).
- Injury or illness resulting from the plan Member'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.
- Telemedical Health Services
- Services, prescription drugs, and supplies a member or a member's dependent may receive while in the custody of any state or federal law enforcement authorities or while in jail or prison.

- Services provided by a relative –Relatives, for the purpose of this exclusion, include a member or a spouse or domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner
- Third party liability claims – services and supplies for treatment of illness or injury for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party. Includes benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to, or makes benefits available to, a member, whether or not such benefits are requested. More information can be found in the "Third Party Liability" section.
- 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; 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.

Exclusions Related to Miscellaneous Services and Items:

- Support Education including Level 0.5 educational programs related to Driving Under the Influence (DUI), voluntary mutual support groups, such as Alcoholics Anonymous, or family education or support groups except for support groups rated A & B by the United States Preventive Services taskforce.
- Behavior modification, psychological enrichment or self-help programs for mentally healthy individuals. These include assertiveness training, image therapy, sensory movement groups, marathon group therapy, and sensitivity training.
- Routine optometric eye examinations, including the fitting, provision, or replacement of eyeglasses or contact lenses, and any charges for orthoptics, vitamin therapy, vision therapy, eye exercises, or fundus photography. Vision benefits may be available through the City's vision plan and are subject to the terms of that Plan.
- Refractive surgery, laser vision correction, and any other procedure which alters the refractive character of the eye, the purpose of which is to cure or reduce myopia, hyperopia, or astigmatism. Includes radial keratotomy, corneal rings, LASIK, PRK, any procedure using the 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.
- 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 volunteer workers;
    d. Supplies intended for use outside hospital settings or considered personal in nature;
    e. Routine miniature chest x-ray films or full body scans;
    f. 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. Including, 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 for non mental health and chemical dependency conditions..
- Biofeedback therapy services are limited to medically necessary treatment of tension or migraine headaches and the Plan will pay for no more than 10 visits during the Member's lifetime.
- Cosmetic Surgery: Any procedure requested for the purpose of improving appearance without restoring bodily function or correcting physical impaoirment including procedures related to sexual reassignment surgery, breast augmentation, lipectomy, liposuction and hair removal (including electrolysis and laser) and rhinoplasty. Exceptions are provided for reconstructive surgery following a mastectomy and complications of reconstructive surgeries. If medically necessary, clinically distinct and not specifically exluded.
- 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 prior authorization are not covered under this plan unless authorized as medically necessary through the City's contracted Service Authorization/Prior authorization Program.
- Chelation therapy is not covered under the Plan, except for acute arsenic, gold, mercury or lead poisoning.
- Transplant donor related services or supplies provided to an insured Donor if the Recipient is not enrolled under this Plan and eligible for transplant benefits. This exclusion does not apply to complications or unforeseen infections resulting from the donation of tissue.
- Services or supplies for any transplant not covered by the plan including the transplant of animal organs or artificial organs.
- Chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not specifically named as covered.
- Foot orthoses (orthotics) made of high impact plastics or other materials, designed to be inserted into shoes;
- Genetic testing or counseling unless medically necessary and prior authorized through the City's contracted Utilization Review provider. Genetic testing for family members not covered under the Plan is excluded.
- Counseling related to family, marriage, sex and career, in the absence of medical necessity/illness;
- Vocational, pastoral or spiritual counseling;
- Dance, poetry, music or art therapy, except as part of a treatment program in an inpatient setting.
- Non-organic therapies including, but not limited to, bioenergetics therapy, confrontation therapy, crystal healing therapy, educational remediation, 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. Including the following services unless required by the member's medical condition (e.g. diabetes):
    - Paring or cutting of benign hyperkeratotic lesion (e.g. corn or callus);
    - Trimming of dystrophic and non-dystrophic nails; and
    - Debridement of nail by any method.
- 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 Members and procurement and storage of cord blood, unless medically necessary for the imminent use at the time of collection for a designated recipient.
- Hypnotherapy.

- Never Events: Services and supplies related to never events, which are events that should never happen while receiving services in a hospital or facility include but not limited to the wrong surgery, surgery on the wrong body part, or surgery on the wrong patient. These also apply to any hospital acquired condition, as that term is defined in the Centers for Medicare and Medicaid Services (CMS) guidelines, which includes buty is not limited to serious preventable events.

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 diabetes supplies).

(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) Non-sedating antihistamines

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

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

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

(p) 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 ODS DENTAL PLAN

8.01 Self Insured Dental Plan

"ODS Dental Plan" is a self-insured dental plan sponsored by the City of Portland effective July 1, 2012 and offered to non-represented employees, BOEC, COPPEA, DCTU, LOCAL 189-H (HOUSING) PFFA, PPCOA, and Recreation members.

Dental Plan

Dental Plan Feature	ODS Dental Plan
Network Required	No
Plan Year Deductible	$25/member; $75/family of three or more
Plan Year Maximum Benefit	$2,000/person
Maximum Plan Allowance (MPA)	Plan pays benefits based on MPA for expenses; you pay coinsurance amount plus anything over the MPA
Diagnostic and Preventive	ODS Class I – 100% (no deductible) for eligible services
Routine	ODS Class II - 80% after deductible
Major (includes inlays, onlays, crowns, and permanent prosthetics.) In addition, Kaiser includes periodontics & endodontics in this category.	ODS Class III – 50% after deductible
Orthodontics	Covers children and adults; 50%, up to $2,500 lifetime maximum

8.02 Dental Care Program

The dental care program covers services when performed by a dental provider (licensed dentist, authorized denturist or registered hygienist). These services are covered only when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury

(accidental injury coverage is secondary to medical). A panel of dentists shall determine these standards.

8.03 Covered Dental Services

Covered dental services are outlined in 3 "classes" that start with preventive care and advance into specialized dental procedures.

Limitations may apply to these services, please see below.

Deductible: $25.00 Per member (not to exceed $75.00 per family) per plan year or portion thereof

Deductible applies to covered Class II and Class III services

Maximum Payment limit: $2,000.00 Per member per plan year, or portion thereof
All covered services (Class I, II, III) apply to Maximum Payment Limit

8.03.01. Class I: 100% is provided toward covered Class I services

A. **Diagnostic**

Examination
Intra-oral x-rays to assist in determining required dental treatment.

Diagnostic Limitations:

1. Periodic (routine) or comprehensive examinations or consultations are covered once in any 6-month period*.
2. Complete series x-rays or a panoramic film is covered once in any 5-year period *.
3. Supplementary bitewing x-rays are covered once in any 12-month period*.
4. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
5. Only the following x-rays are covered by the Plan: complete series or panoramic, periapical, occlusal, and bitewing.
6. ViziLite Plus TBlue is covered once in any 6-month period*.

B. Preventive

Prophylaxis (Cleanings)
Periodontal maintenance
Topical application of fluoride
Space maintainers
Sealants

Preventive Limitations:

1. Prophylaxis (cleaning) or periodontal maintenance is covered once in any 6-month period*†.
   †Additional cleaning benefit is available for enrollees with diabetes and female enrollees in their third trimester of pregnancy. To be eligible for this additional benefit, enrollees must be enrolled in the Oral Health, Total Health program.

2. Topical application of fluoride is covered once in any 6-month period* for members age 18 and under. Members age 19 and older could have fluoride covered at the above frequency if there is a recent history or periodontal surgery, or high risk of decay due to medical disease, chemotherapy or similar type of treatment (not due to ppor diet or oral hygiene.
3. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent bicuspids and molars. Benefits will be limited to one sealant per tooth, during any 5-year period.
4. Space maintainers are a benefit once per space. Space maintainers for primary anterior teeth, missing permanent teeth or for enrollees age 14 or over are not covered.

**Please Note: These time periods are calculated from the previous date of service.*

8.03.02 Class II: 80% is provided toward covered Class II services

A. Restorative

Provides amalgam (silver) fillings on posterior (back) teeth and composite (tooth colored) fillings on anterior (front) teeth for the treatment of carious lesions (decay).

Restorative Limitations:

1. Composite, resin, or similar (tooth colored) restorations in posterior (back) teeth are considered optional services. Coverage shall be made for a corresponding amalgam (silver) restoration. If a tooth colored filling is used to restore posterior (back) teeth, benefits are limited to the amount paid for a silver filling. The member is responsible for paying the difference.
2. Inlays are considered an optional service; an alternate benefit of an amalgam will be provided.
3. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.
4. Refer to Class III Limitations for further limitations when teeth are restored with crowns or cast restorations.
5. A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered.

B. Oral Surgery

Extractions (including surgical), other minor surgical procedures, general anesthesia or IV sedation (when administered by a dentist in conjunction with a covered surgical procedure performed in a dental office).

Oral Surgery Limitations:

1. A separate, additional charge for alveoloplasty done in conjunction with surgical removal of teeth is not covered.
2. General anesthesia and/or IV sedation is only a benefit when administered by a dentist in conjunction with covered surgery.
3. Surgery on larger lesions or malignant lesions is not considered minor surgery.

4. Brush biopsy is covered once in any 6-month period. The benefit for brush biopsy is limited to the sample collection and does not include coverage for pathology (lab) services.

C. Endodontic

Procedures for treatment of teeth with diseased or damaged nerves (for example, pulpal therapy and root canal filling).

Endodontic Limitations:

1. A separate charge for cultures is not covered.
2. Pulp capping is covered only when there is exposure of the pulp.
3. Cost of retreatment of the same tooth by the same dentist within 24 months of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.

D. Periodontic

Treatment of diseases of the gums and supporting structures of the teeth and/or implants.

Periodontic Limitations:

1. Periodontal scaling and root planing is limited to once per quadrant in any 24-month period.
2. Coverage for periodontal maintenance procedure under Class I, Preventive.
3. A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
4. Full mouth debridement is limited to once in a 3-year period and only if there has been no cleaning (prophylaxis, periodontal maintenance) within 24 months.

8.03.03 Class III: 50% is provided toward covered Class III services

A. Restorative

Cast restorations, such as crowns, onlays or lab veneers, necessary to restore decayed or broken teeth to a state of functional acceptability.

Restorative Limitations:

1. Cast restorations (including pontics) are covered once in a 5-year period on any tooth. See Class II for limitations on buildups.
2. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and you are responsible for paying the difference.
3. If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the patient or dentist, covered expense will be limited to the cost of amalgam. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

B. Prosthodontic

Implants, bridges, partial dentures, and complete dentures. Includes denture relines and repair of an existing prosthetic device.

Prosthodontic Limitations:

1. A bridge or denture (full or partial denture) will be covered once in a 5-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past 5 years.
2. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
3. Partial dentures: A temporary (interim) partial denture is only a benefit when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of enrollees age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture abutment teeth unless the tooth requires a cast restoration due to decayed or broken teeth.
4. Denture adjustments, repairs, and relines: A separate, additional charge for denture adjustments, repairs, and relines done within 6 months after the initial placement is not covered. Subsequent relines will be covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.
5. Tissue conditioning is covered no more than twice per denture in a 36-month period.
6. Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. We will also benefit:
   - The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space in any 5-year period;
   - Provide an alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device. The frequency limitation for prosthetic devices will apply to this alternate benefit (only once in any 5-year period); or
   - The final implant-supported bridge abutment and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space in any 5-year period;
   - Implant-supported bridges are not covered if one or more of the abutments is supported by a natural tooth;
   - These benefits or alternate benefits are not provided if the tooth, implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 5 years.
7. Fixed bridges or removable cast partial dentures are not covered for enrollees under age 16.
8. Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second, or third molars. Coverage

is limited to a corresponding metallic prosthetic. You are responsible for paying the difference.

C. Athletic Mouthguards

Covered at 50% once per year for members ages 15 and under and once every 2 years for ages 16 and over.

8.04 General Limitation – Optional Services

If a more expensive treatment than is functionally adequate is performed, the City will pay the applicable percentage of the maximum plan allowance for the least costly treatment. The member will then be responsible for the remainder of the dental provider's fee.

8.05 Non-Participating Dental Providers

The program requires that amounts payable for services of a Non-participating Dentist are be limited to the applicable percentages specified in the Plan for corresponding services in the non-participating provider fee schedule. The allowable fee in states other than Oregon shall be that state's Delta Affiliate's Non-participating Dentist allowance.

8.06 Oral Health, Total Health Program

To be eligible for the additional benefits described in this section, enrollment in the Oral Health, Total Health program is required.

A. Diabetes

Diabetic enrollees covered under this Policy are eligible for a total of 4 prophylaxes (cleanings) or periodontal maintenance sessions per calendar year. Please note this benefit is for the cleaning or periodontal maintenance only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in this Policy.

B. Pregnancy

Enrolled program Members are eligible for a prophylaxis (cleaning) or periodontal maintenance in the third trimester of pregnancy regardless of normal plan frequency limits. Please note this benefit is for the cleaning or periodontal maintenance only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in this Policy.

8.07 Orthodontic Benefit

Orthodontic services are defined as the procedures of treatment for correcting malocclusioned teeth.. The City will pay **50%** of the participating orthodontist's allowed fee for orthodontic services, up to the maximum benefit. The amount payable to a non-participating orthodontist will be the lesser of 50% of the orthodontist's fees or 50% of the median fee of all participating orthodontists' filed fees with ODS.

The lifetime maximum amount the City will pay for orthodontic services for an enrollee is $2,500.00. This lifetime maximum is not included in the dental policy maximum.

If the dental Policy has a deductible, it does not apply to orthodontic services.

8.07.01 Limitations

1.. The Plan's obligation of the City to make payments for treatment will cease upon termination of treatment for any reason prior to completion, or upon termination of eligibility under the Plan is not covered.
2. Repair or replacement of an appliance furnished under this program.
3. If treatment began before the member was eligible under the Plan, the Plan will base its obligation on the balance of the dentist's normal payment pattern. The orthodontic maximum will apply to this amount.

8.08 Exclusions

1. Procedures, appliances, restorations or any services that are primarily for cosmetic purposes are excluded.
2. The Plan does not cover:
   - Services that are not established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under this Plan;
   - Services that are inappropriate with regard to standards of good dental practice;
   - Services with poor prognosis.
3. Services Otherwise Available, including:
   - Services for injuries or conditions which are compensable under workers' compensation or employer's liability laws;
   - Services which are provided by any city, county, state or federal law, except for Medicaid coverage;
   - Services which are provided, without cost to the enrollee, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under this Plan;
   - Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or would have been provided had the patient enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, as amended.
4. A separate charge for periodontal charting is not covered.
5. Services or supplies caused by or provided to correct congenital or developmental malformations; including, but not limited to treatment of cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, and fluorosis (discoloration of teeth), are excluded.
6. Services or supplies for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth are excluded. This includes services only to prevent wear or protect worn or cracked teeth. Such services include, but are not limited to, increasing vertical dimension, equilibration, periodontal splinting, and nightguards (occlusal guard).

7. Services or supplies for treatment of any disturbance of the temporomandibular joint (TMJ) are excluded.
8. Gnathologic recordings or similar procedures are excluded.
9. Dental services started prior to the date the member became eligible for such services under the Policy are excluded.
10. Hypnosis, premedications, analgesics (e.g. nitrous oxide), local anesthetics or any other prescribed drugs are excluded.
11. Hospital or facility charges for services or supplies, or additional fees charged by the dental provider for hospital, extended care facility or home care treatment are excluded.
12. Charges for missed or broken appointments are excluded.
13. Experimental procedures or supplies are excluded.
14. This plan does not cover services provided or supplies furnished after the date coverage ends, except for Class III services which were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after individual eligibility ends. This provision is not applicable if the Group transfers the plan to another carrier.
15. General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office or in conjunction with covered services when necessary due to concurrent medical conditions.
16. Plaque control and oral hygiene or dietary instruction are not covered.
17. Claims submitted more than 12 months after the date of service are not covered, except as stated in the Claim Submission section.
18. Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue is excluded.
19. Services performed on the tongue, lip or cheeks.
20. Precision attachments are not covered.
21. Taxes.
22. Exclusions include all other services or supplies not specifically included in this Policy as covered dental services.
23. Bodily injury or illness arising out of duty as a member of the armed forces of any state country, or a war or any act of war (declared or undeclared).
24. Injury or illness resulting from the plan members commission or attempt to commit an assault or other illegal act, a civil revolution or riot.
25. Services provided by a relative. Relatives, for the purpose of this exclusion, include a spouse, domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner.
26. Services and supplies related to never events, which are events that should never happen while receiving services in a dental office, including but not limited to removing a non-diseased tooth structure or performing a procedure on the wrong patient or wrong tooth.

8.09 ODS Dental Plan Coordination of Benefits

Coordination of Benefits (COB) occurs when you have dental coverage under more than one Plan.

8.09.01 DEFINITIONS

For purposes of this section on Coordination of Benefits, the following definitions apply:

Plan means any of the following that provides benefits or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

Plan includes:

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

Plan does not include:

- Fixed indemnity coverage;
- Accident-only coverage;
- Specified disease or specified accident coverage;
- School accident coverage;
- Medicare supplement policies;
- Medicaid policies, or;
- Coverage under other federal governmental plans, unless permitted by law.

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

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

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

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

Claimant means the insured person for whom the claim is made.

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

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

- The amount of the reduction by the primary Plan because a claimant has failed to comply with the Plan provisions concerning second opinions or prior

authorization of services, or because the claimant has a lower benefit because that claimant did not use an in-network provider;

- Any amount in excess of the highest reimbursement amount for a specific benefit, if a claimant is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology;
- Any amount in excess of the highest of the negotiated fees, if a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees;
- If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan's arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the secondary Plan to determine its benefits.

This Plan is the part of this group contract that provides benefits for dental 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 dental benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

8.09.02 How COB Works

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

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

The Secondary Plan (the Plan(s) that pay(s) benefits after the Primary Plan) will reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

If the primary Plan is a Closed Panel Plan and the secondary Plan is not a Closed Panel Plan, the secondary Plan shall provide benefits as if it were the primary Plan when a covered person uses an out-of-network provider, except for emergency services or authorized referrals that are paid or provided by the primary Plan.

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

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

8.09.03 Which plan pays Primary

The first of the following rules that applies will govern:

1. **Non-dependent/Dependent.** If a Plan covers the claimant as other than a dependent, for example, an employee, member, subscriber, or retiree, then that Plan will determine its benefits before a Plan which covers the person as a dependent.
2. **Dependent Child/Parents Married, Registered under the Oregon Family Fairness Act, or Living Together.** If the claimant is a dependent child whose parents are married, registered under the Oregon Family Fairness Act, or 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.
3. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the claimant is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or

registered under the Oregon Family Fairness Act, then the following rules apply:

4. 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.
5. 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.
6. If there is not a court decree allocating responsibility for the dependent child's healthcare expenses, the order of benefits is as follows:
    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.
    e. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
7. **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.

8. **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.

9. **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.

10. **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.

11. **None of the Above.** If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

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

8.09.04 Effect on the Benefits of the Plan

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other dental 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 dental 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.

8.09.05 ODS' Right to collect and release needed information

Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. 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.

8.09.06 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.

8.09.07 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.

9.0 SMW DENTAL PLAN

9.01 Self Insured Dental Plan

"SMW Dental Plan" is a self-insured dental plan sponsored by the City of Portland effective July 1, 2012 and offered to Seasonal Maintenance Worker (SMW) employees.

Dental Plan

Dental Plan Feature	SMW Dental Plan
Network Required	No
Plan Year Deductible	$25/member; $75/family of three or more
Plan Year Maximum Benefit	$1,000/person
Maximum Plan Allowance (MPA)	Plan pays benefits based on MPA for expenses; you pay coinsurance amount plus anything over the MPA
Diagnostic and Preventive	ODS Class I – 100% (no deductible) for eligible services
Routine	ODS Class II - 80% after deductible
Major (includes inlays, onlays, crowns, and permanent prosthetics.) In addition, Kaiser includes periodontics & endodontics in this category.	ODS Class III – 50% after deductible

9.02 Dental Care Program

The dental care program covers services when performed by a dental provider (licensed dentist, authorized denturist or registered hygienist). These services are covered only when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury (accidental injury coverage is secondary to medical). A panel of dentists shall determine these standards.

9.03 Covered Dental Services

Covered dental services are outlined in 3 "classes" that start with preventive care and advance into specialized dental procedures.

Limitations may apply to these services, please see below.

Deductible: $25.00 Per member (not to exceed $75.00 per family) per plan year or portion thereof

Deductible applies to covered Class II and Class III services

Maximum Payment limit: $1,000.00 Per member per plan year, or portion thereof
All covered services (Class I, II, III) apply to Maximum Payment Limit

9.03.01. Class I: 100% is provided toward covered Class I services

A. **Diagnostic**

Examination
Intra-oral x-rays to assist in determining required dental treatment.

Diagnostic Limitations:

7. Periodic (routine) or comprehensive examinations or consultations are covered once in any 6-month period*.
8. Complete series x-rays or a panoramic film is covered once in any 5-year period *.
9. Supplementary bitewing x-rays are covered once in any 12 month period*.
10. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
11. Only the following x-rays are covered by the Plan: complete series or panoramic, periapical, occlusal, and bitewing.
12. ViziLite Plus TBlue is covered once in any 6-month period*.

B. Preventive

Prophylaxis (Cleanings)
Periodontal maintenance
Topical application of fluoride
Space maintainers
Sealants

Preventive Limitations:

5. Prophylaxis (cleaning) or periodontal maintenance is covered once in any 6-month period*†.
   †Additional cleaning benefit is available for enrollees with diabetes and female enrollees in their third trimester of pregnancy. To be eligible for this additional benefit, enrollees must be enrolled in the Oral Health, Total Health program.
6. Topical application of fluoride is covered once in any 6-month period* for members age 18 and under. Members age 19 and older could have fluoride covered at the above frequency if there is a recent history or periodontal surgery, or high risk of decay due to medical disease, chemotherapy or similar type of treatment (not due to ppor diet or oral hygiene.

7. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent bicuspids and molars. Benefits will be limited to one sealant per tooth, during any 5-year period.
8. Space maintainers are a benefit once per space. Space maintainers for primary anterior teeth, missing permanent teeth or for enrollees age 14 or over are not covered.

**Please Note: These time periods are calculated from the previous date of service.*

9.03.02 Class II: 80% is provided toward covered Class II services

A. Restorative

Provides amalgam (silver) fillings on posterior (back) teeth and composite (tooth colored) fillings on anterior (front) teeth for the treatment of carious lesions (decay).

Restorative Limitations:

1. Composite, resin, or similar (tooth colored) restorations in posterior (back) teeth are considered optional services. Coverage shall be made for a corresponding amalgam (silver) restoration. If a tooth colored filling is used to restore posterior (back) teeth, benefits are limited to the amount paid for a silver filling. The member is responsible for paying the difference.

6. Inlays are considered an optional service; an alternate benefit of an amalgam will be provided.
7. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.
8. Refer to Class III Limitations for further limitations when teeth are restored with crowns or cast restorations.
9. A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered.

B. Oral Surgery

Extractions (including surgical), other minor surgical procedures, general anesthesia or IV sedation (when administered by a dentist in conjunction with a covered surgical procedure performed in a dental office).

Oral Surgery Limitations:

5. A separate, additional charge for alveoloplasty done in conjunction with surgical removal of teeth is not covered.
6. General anesthesia and/or IV sedation is only a benefit when administered by a dentist in conjunction with covered surgery.
7. Surgery on larger lesions or malignant lesions is not considered minor surgery.
8. Brush biopsy is covered once in any 6-month period. The benefit for brush biopsy is limited to the sample collection and does not include coverage for pathology (lab) services.

C. Endodontic

Procedures for treatment of teeth with diseased or damaged nerves (for example, pulpal therapy and root canal filling).

Endodontic Limitations:

4. A separate charge for cultures is not covered.
5. Pulp capping is covered only when there is exposure of the pulp.
6. Cost of retreatment of the same tooth by the same dentist within 24 months of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.

D. Periodontic

Treatment of diseases of the gums and supporting structures of the teeth and/or implants.

Periodontic Limitations:

5. Periodontal scaling and root planing is limited to once per quadrant in any 24-month period.
6. Coverage for periodontal maintenance procedure under Class I, Preventtive.
7. A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
8. Full mouth debridement is limited to once in a 3-year period and only if there has been no cleaning (prophylaxis, periodontal maintenance) within 24 months.

9.03.03 Class III: 50% is provided toward covered Class III services

A. Restorative

Cast restorations, such as crowns, onlays or lab veneers, necessary to restore decayed or broken teeth to a state of functional acceptability.

Restorative Limitations:

2. Cast restorations (including pontics) are covered once in a 5-year period on any tooth. See Class II for limitations on buildups.
2. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and you are responsible for paying the difference.
3. If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the patient or dentist, covered expense will be limited to the cost of amalgam. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

B. Prosthodontic

Implants, bridges, partial dentures, and complete dentures. Includes denture relines and repair of an existing prosthetic device.

Prosthodontic Limitations:

2. A bridge or denture (full or partial denture) will be covered once in a 5-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past 5 years.
2. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a

standard full denture. Temporary (interim or provisional) complete dentures are not covered.

3. Partial dentures: A temporary (interim) partial denture is only a benefit when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of enrollees age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture abutment teeth unless the tooth requires a cast restoration due to decayed or broken teeth.
4. Denture adjustments, repairs, and relines: A separate, additional charge for denture adjustments, repairs, and relines done within 6 months after the initial placement is not covered. Subsequent relines will be covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.
5. Tissue conditioning is covered no more than twice per denture in a 36-month period.
6. Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. We will also benefit:
   - The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space in any 5-year period;
   - Provide an alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device. The frequency limitation for prosthetic devices will apply to this alternate benefit (only once in any 5-year period); or
   - The final implant-supported bridge abutment and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space in any 5-year period;
   - Implant-supported bridges are not covered if one or more of the abutments is supported by a natural tooth;
   - These benefits or alternate benefits are not provided if the tooth, implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 5 years.
7. Fixed bridges or removable cast partial dentures are not covered for enrollees under age 16.
8. Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. You are responsible for paying the difference.

C. Athletic Mouthguards

Covered at 50% once per year for members ages 15 and under and once every 2 years for ages 16 and over.

9.04 General Limitation – Optional Services

If a more expensive treatment than is functionally adequate is performed, the City will pay the applicable percentage of the maximum plan allowance for the least costly treatment. The member will then be responsible for the remainder of the dental provider's fee.

9.05 Non-Participating Dental Providers

The program requires that amounts payable for services of a Non-participating Dentist are be limited to the applicable percentages specified in the Plan for corresponding services in the non-participating provider fee schedule. The allowable fee in states other than Oregon shall be that state's Delta Affiliate's Non-participating Dentist allowance.

9.06 Oral Health, Total Health Program

To be eligible for the additional benefits described in this section, enrollment in the Oral Health, Total Health program is required.

A. Diabetes
Diabetic enrollees covered under this Policy are eligible for a total of 4 prophylaxes (cleanings) or periodontal maintenance sessions per calendar year. Please note this benefit is for the cleaning or periodontal maintenance only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in this Policy.

B. Pregnancy
Enrolled program Members are eligible for a prophylaxis (cleaning) or periodontal maintenance in the third trimester of pregnancy regardless of normal plan frequency limits. Please note this benefit is for the cleaning or periodontal maintenance only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in this Policy.

9.07 Exclusions

1. Procedures, appliances, restorations or any services that are primarily for cosmetic purposes are excluded.
2. The Plan does not cover:
   - Services that are not established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under this Plan;
   - Services that are inappropriate with regard to standards of good dental practice;
   - Services with poor prognosis.
3. Services Otherwise Available, including:
   - Services for injuries or conditions which are compensable under workers' compensation or employer's liability laws;

- Services which are provided by any city, county, state or federal law, except for Medicaid coverage;
- Services which are provided, without cost to the enrollee, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under this Plan;
- Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or would have been provided had the patient enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, as amended.

4. A separate charge for periodontal charting is not covered.
5. Services or supplies caused by or provided to correct congenital or developmental malformations; including, but not limited to treatment of cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, and fluorosis (discoloration of teeth), are excluded.
6. Services or supplies for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth are excluded. This includes services only to prevent wear or protect worn or cracked teeth. Such services include, but are not limited to, increasing vertical dimension, equilibration, periodontal splinting, and nightguards (occlusal guard).
7. Services or supplies for treatment of any disturbance of the temporomandibular joint (TMJ) are excluded.
8. Gnathologic recordings or similar procedures are excluded.
9. Dental services started prior to the date the member became eligible for such services under the Policy are excluded.
10. Hypnosis, premedications, analgesics (e.g. nitrous oxide), local anesthetics or any other prescribed drugs are excluded.
11. Hospital or facility charges for services or supplies, or additional fees charged by the dental provider for hospital, extended care facility or home care treatment are excluded.
12. Charges for missed or broken appointments are excluded.
13. Experimental procedures or supplies are excluded.
14. This plan does not cover services provided or supplies furnished after the date coverage ends, except for Class III services which were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after individual eligibility ends. This provision is not applicable if the Group transfers the plan to another carrier.
15. General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office or in conjunction with covered services when necessary due to concurrent medical conditions.
16. Plaque control and oral hygiene or dietary instruction are not covered.
17. Claims submitted more than 12 months after the date of service are not covered, except as stated in the Claim Submission section.
18. Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue is excluded.
19. Services performed on the tongue, lip or cheeks.
20. Precision attachments are not covered.
21. Taxes.

22. Exclusions include all other services or supplies not specifically included in this Policy as covered dental services.
23. Bodily injury or illness arising out of duty as a member of the armed forces of any state country, or a war or any act of war (declared or undeclared).
24. Injury or illness resulting from the plan members commission or attempt to commit an assault or other illegal act, a civil revolution or riot.
25. Services provided by a relative. Relatives, for the purpose of this exclusion, include a spouse, domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner.
26. Services and supplies related to never events, which are events that should never happen while receiving services in a dental office, including but not limited to removing a non-diseased tooth structure or performing a procedure on the wrong patient or wrong tooth.

9.08 SMW Dental Plan Coordination of Benefits

Coordination of Benefits (COB) occurs when you have dental coverage under more than one Plan.

9.08.01 DEFINITIONS

For purposes of this section on Coordination of Benefits, the following definitions apply:

Plan means any of the following that provides benefits or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

Plan includes:

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

Plan does not include:

- Fixed indemnity coverage;
- Accident-only coverage;
- Specified disease or specified accident coverage;
- School accident coverage;
- Medicare supplement policies;
- Medicaid policies, or;
- Coverage under other federal governmental plans, unless permitted by law.

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

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

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

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

Claimant means the insured person for whom the claim is made.

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

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

- The amount of the reduction by the primary Plan because a claimant has failed to comply with the Plan provisions concerning second opinions or prior authorization of services, or because the claimant has a lower benefit because that claimant did not use an in-network provider;
- Any amount in excess of the highest reimbursement amount for a specific benefit, if a claimant is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology;
- Any amount in excess of the highest of the negotiated fees, if a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees;
- If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan's arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the secondary Plan to determine its benefits.

This Plan is the part of this group contract that provides benefits for dental 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 dental benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

9.08.02 How COB Works

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

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

The Secondary Plan (the Plan(s) that pay(s) benefits after the Primary Plan) will reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

If the primary Plan is a Closed Panel Plan and the secondary Plan is not a Closed Panel Plan, the secondary Plan shall provide benefits as if it were the primary Plan when a covered person uses an out-of-network provider, except for emergency services or authorized referrals that are paid or provided by the primary Plan.

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

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

9.08.03 Which plan pays Primary

The first of the following rules that applies will govern:

12. **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.

13. **Dependent Child/Parents Married, Registered under the Oregon Family Fairness Act, or Living Together.** If the claimant is a dependent child whose parents are married, registered under the Oregon Family Fairness Act, or 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.

14. **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:

15. 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.

16. 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.

17. If there is not a court decree allocating responsibility for the dependent child's healthcare expenses, the order of benefits is as follows:
    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.
    e. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

18. **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.

19. **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.

20. **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.

21. **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.

22. **None of the Above.** If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

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

9.08.04 Effect on the Benefits of the Plan

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other dental 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 dental 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.

9.08.05 ODS' Right to collect and release needed information

Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. 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.

9.08.06 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.

9.08.07 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.

10.0. 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.

10.01 Identification Cards:

Plan Members 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.

10.02 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-authorized 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.

10.03 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.

10.04 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 copayments under Medicare are changed, the City's Supplement plan benefits will be changed accordingly. The City Medicare Supplement Plan does not offer prescription drug 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	No Annual Benefit Maximum
Lifetime Maximum	No Lifetime Benefit Maximum
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.

11.0 HIPAA PROVISIONS FOR THE "MERP" AND PREMIUM PAYMENT PLAN

11.01 Health Insurance Portability and Accountability Act

The City of Portland (the "Plan Sponsor") sponsors the City of Portland Health Plan (the "Plan"). Employees of the Benefit Office have access to the individually identifiable health information of Plan Members for administrative functions of the Plan. When this health information is provided from the Plan to the Plan Sponsors, it is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the Plan and Plan Sponsor's ability to use and disclose PHI.

11.01.010 The following HIPAA definition of PHI applies to the Plan:

(1) Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of Member; the provisions of health care to a Member; or the past, present or future payment for the provision of health care to a Member; and that identifies the Member or for which there is a reasonable basis to believe the information can be used to identify the Member. Protected health information includes information of persons living or deceased.

(2) The Plan Sponsor shall have access to PHI from the Plan only as permitted under this Chapter or as otherwise required or permitted by HIPAA.

11.02 Permitted Disclosure of Enrollment/Disenrollment Information

The Plan shall disclose to the plan sponsor information on whether the individual is participating in the Plan.

11.03 Permitted Uses and Disclosure of Summary Health Information

11.03.010 Summary Health Information. Summary Health Information is information that (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a health plan. The summary will only identify the general geographical location of the Member, and will not include any information by which a particular Member can be identified.

11.03.020 The Plan may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending, or terminating the Plan.

11.04 Permitted and Required Uses and Disclosure of Protected Health Information

Unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph IV and obtaining written certification pursuant to paragraph VI, the Plan may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit of the Plan Sponsor and they do not include any employment-related functions. In no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

11.05 Conditions of Disclosure for Plan Administration Purposes

The Plan Sponsor agrees, that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan, the Plan Sponsor shall:

1. Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law.

2. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan, agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

4. Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524.

5. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526

6. Make available the information required to provide and accounting of disclosure in accordance with 45 CFR §164.528.

7. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.

8. Return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which

disclosure was made.

185368

9. Ensure that the adequate separation between Plan and Plan Sponsor (i.e., the "firewall"), required in 45 CFR §504(f)(2)(iii), is satisfied.

11.06 Adequate Separation Between Plan and Plan Sponsor

The City as Plan Sponsor shall allow the following City employees access to PHI: Benefit Office employees, Payroll employees, and the Bureau of Technical Services employees that provide technical support for the Plan Member database, the City Attorney's Office for the provision of legal advice and representation as to any matter or issue regarding the Plan or Plan Member, and City Council as may be required by law or administrative rule to administer, authorize and approve issues related to the Plan. No other persons shall have access to PHI. These specified classes of employees shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified classes of employees do not comply with the provisions of this Chapter, that employee shall be subject to disciplinary action up to and including discharge by the Plan Sponsor for non-compliance.

11.07 Certification of Plan Sponsor

The Plan shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in 9.05 of this Chapter.

Chapter 12

12.0 HIPAA NOTICE OF PRIVACY PRACTICES

12.01 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 Members pursuant to this act and to relevant administrative rules.

12.02 HIPAA 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 Members 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 BenefitHelp Solutions, Aliquant, AON Consulting, Kaiser Permanente, Managed

Healthcare Northwest, ODS, Vision Service Plan, Cascade Centers, Kroger Prescription Plan (KPP), and Standard Life Insurance Company.

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 Member, 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) 823.3506

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 13

13.0 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.

185368

EXHIBIT B

City of Portland

Cafeteria Plan Document

TABLE OF CONTENTS

CAFETERIA PLAN

CHAPTER 1

1.0 GENERAL PROVISIONS

1.01 Establishment of Plan

1.03.010 The City of Portland (the "City") hereby amends and restates the City of Portland Cafeteria Plan (the "125 Plan") which includes Component Plans of the 125 Plan, effective July 1, 2012 (the "Effective Date"). Capitalized terms used in this 125 Plan that are not otherwise defined shall have the meanings set forth in Chapter 2.

1.03.020 This 125 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 this 125 Plan for the applicable Component Plan.

1.03.030 This 125 Plan is intended to include a Cafeteria Plan that qualifies under the Internal Revenue Code of 1986, as amended (the "Code"), and regulations issued thereunder and shall be interpreted to accomplish that objective.

1.03.040 The Premium Payment component is intended to qualify as a salary reduction plan under Code Section §125 to permit employees to pay their share of the rates or premiums for their medical, dental and/or vision benefits.

1.03.050 The Medical Expense Reimbursement Plan (""MERP"") Component is intended to qualify as a "self-insured medical reimbursement plan" under the Code, and the expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employee's gross income under Code §105(b).

1.03.060 The Dependent Care Assistance Plan (""DCAP"") component is intended to qualify as a "dependent care assistance plan" under the Code, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from participating Employees' gross income under Code § 129(a).

1.03.070 Although reprinted within this document, the Premium Payment Component, the ""MERP"" Component and the ""DCAP"" Component are separate plans for purposes of administration and all reporting and

nondiscrimination requirements imposed by Code §§§ 105, 125 and 129. The "MERP" Component is also a separate plan for purposes of the provisions of Employee Retirement Income Security Act of 1974 (ERISA) and Comprehensive Omnibus Budget Reconciliation Act of 1985, as amended (COBRA) as applicable to Government Plans by the Public Health Services Act (PHSA).

1.02 Governing Law

Except to the extent that this 125 Plan or any of its Component Plans are governed by federal law, this 125 Plan and all of its Components 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 12 month period beginning July 1 and ending June 30 each year.

1.04 Plan Limitations

Nothing contained in this 125 Plan or any of its Components 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 125 Plan. 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 125 Plan was established with the bona fide intention that it will be continued indefinitely, but the City has no obligation to maintain the 125 Plan or any Component, and reserves the right to amend, change, terminate or cancel the 125 Plan described herein, or any of its Components 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 125 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 to Participants 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

The 125 Plan and its Components shall be administered by the Administrator described in Chapter 2.01. The Administrator shall have responsibility for the general operation of the 125 Plan and its Components and shall have the power and duty to decide all questions arising in connection with the administration, interpretation and application of the 125 Plan and its Component Plans 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:

1.07.01 Determining an employee's eligibility to participate in any Components authorized by the 125 Plan;

1.07.02 Promulgating rules of procedure and keeping records necessary for the proper and efficient administration of the 125 Plan;

1.07.03 Advising the insurers and third party administrators with respect to Participants and with respect to contributions made on behalf of Participants;

1.07.04 Furnishing the City Council, Participants and insurers with information they may require;

1.07.05 Engaging the services of such agents as the Administrator may deem advisable to assist or perform the Administrator's duties;

1.07.06 Consulting with the City Attorney with respect to the meaning or construction of the 125 Plan and its Component Plans and the Administrator's duties thereunder;

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

1.07.08 The Administrator will be deemed to have properly exercised such discretionary authority unless the 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 125 Plan and its Components shall be provided to all eligible Employees of the City by the Administrator.

1.09 Tax Effects

Neither the Employer nor the 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 Administrator or the Employer with respect to any increased taxes or other losses or damages suffered by the Employees as the result thereof. The 125 Plan and its applicable Components are designed and intended to be operated as a Cafeteria Plan under Code section 125.

1.10 Social Security Impact

Participation in the 125 Plan may reduce the amount of an Employee's taxable compensation. Accordingly, there could be a decrease in the Employee's Social Security benefits.

CHAPTER 2

2.0 DEFINITIONS

2.01 Definitions. As used in the City of Portland Section 125 Plan and any of its Component Plans:

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

2.01.02 "Annual Enrollment Period" or "Annual Enrollment" shall mean the period immediately preceding the period of benefit coverage, generally during a portion of May and June of each year, designated by the Administrator during which an Employee may file or amend his or her benefit election form.

2.01.03 "Benefit Election Forms" shall mean the forms, including electronic enrollment forms, promulgated by the Administrator by which an Eligible Employee elects the Components of his or her choice pursuant to this plan.

2.01.04 "Change In Status" means an event that allows a Participant to make changes in his or her benefit elections as defined in Chapter 4. Changes made to coverage and elections must be consistent with and on account of the specific family status changes.

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

2.01.06 "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.

2.01.07 "Component Plan" or "Component" means the Premium Payment Plan, the Medical Expense Reimbursement Plan ("MERP") and the Dependent Care Expense Reimbursement Plan ("DCAP").

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

2.01.09 "Dependent," shall mean for purposes of the premium payment plan and the MERP , 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. Child under the age of 26 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. Other child for whom the employee is the court-appointed legal guardian,
6. Eligible child of an enrolled domestic partner (as declared on the Domestic Partner Affidavit).

D. A newborn child of an Enrolled Dependent for the first 31 days of the newborn's life, but only if the employee is financially responsible for both the newborn and the enrolled dependent. After 31 days, the child of your Enrolled Dependent may be covered only as long as the the child's parent is the Employee's eligible and Enrolled Dependent and both grandchild and birth parent reside in the Employee's home.

E. Incapacitated and dependent children may be covered past the qualifying age of 26 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.

2.01.10 "Dependent," for purposes of the Dependent Care Assistance Plan, means any individual who is (a) a dependent of the Participant who is under the age of 13 and with respect to whom the Participant is entitled to an exemption under Code Section 151(c), or (b) a dependent or spouse of the Participant who is physically or mentally incapable of caring for himself or herself; provided, however, that in the case of a divorced Employee, Dependent shall be as defined in Code Section 21(e)(5) (e.g. dependent of the parent with custody). For purposes of the Premium Payment Plan and the "MERP", dependent shall mean a Participant's spouse, children and parents of the Participant of his or her spouse, who qualify as dependents under Code Section 152 (as modified by Section 105(b) and § 152(a)) or dependents of employees no longer qualified as dependent participants under City medical, dental, or vision plans but still qualified as an employee's federal tax dependent for health coverage purposes..

2.01.11 "Dependent Care Account" means the Dependent Care Account established pursuant to Chapter 7.

2.01.12 "Dependent Care Assistance Plan" means the Dependent Care Assistance Plan established pursuant to Chapter 7.

2.01.13 "Dependent Care Expenses" means a Participant's incurred expenses which (a) are incurred for the care of a Dependent, (b) are paid or payable to a Dependent Care Service Provider and (c) are incurred to enable the Participant to be gainfully employed for any period during which the Participant has one or more Dependents. "Dependent Care Expenses" shall not include (i) amounts paid for services at an overnight camp, or (ii) expenses incurred for services outside the Participant's household for the care of a Dependent unless such Dependent is described in (a) above (under the definition of Dependent) or regularly spends at least eight (8) hours each day in the Participant's household.

2.01.14 "Dependent Care Service Provider" means a person who provides care or other services described above, but shall not include (a) a dependent care center (as defined in Code Section 21(b)(2)(D)), unless the requirements of Code Section 21(b)(2)(C) are satisfied, or a related individual described in Codes Section 129(c).

2.01.15 "Effective Date" of this amendment and restatement is July 1, 2012.

2.01.16 "Eligible Employee" means a full-time permanent or temporary employee appointed from 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.

2.01.17 "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, those members of the bargaining unit represented by Local189-H (Housing) and those members represented by Laborers' Local 483 Seasonal Maintenance Workers. The term "Employee" does not include an independent contractor.

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

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

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

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

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

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

2.01.24 "Medical Expenses" means amounts paid for medical care as defined in Code Section 213(d) for the Participant, his or her spouse and/or Dependents.

2.01.25 "Medical Expense Reimbursement Plan" means the Medical Expense Reimbursement Plan established pursuant to Chapter 8.

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

2.01.27 "Part-time Employee" shall mean for purposes of the 125 Plan, an employee 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.

2.01.28 "Plan" shall mean City of Portland Cafeteria Plan and all of its Component Plans included in this City of Portland Plan document.

2.01.29 "Plan Year" means the l2 month period beginning July 1 and ending June 30 each year.

2.01.30 "Qualified Benefits" means for Eligible Employees of BOEC, COPPEA, DCTU, PFFA, PPCOA, Local189-H (Housing), Recreation Employees for the Plan Year commencing on July 1, 2012, 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.

E. Dependent Care Assistance Plan ("DCAP") in Chapter 7.

F. Medical Expense Reimbursement Plan ("MERP") in Chapter 8.

G. Group Term Life Insurance in the amount designated by the appropriate collective bargaining agreement.

H. Long-term disability insurance for BOEC, COPPEA, DCTU, PPCOA, Local189-H (Housing) and Recreation employees,.

2.01.31 "Qualified Benefits" mean for Eligible non-represented Employees for the Plan Year commencing on July 1, 2012 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.

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.

F. Dependent Care Assistance Plan ("DCAP") in Chapter 7.

G. Medical Expense Reimbursement Plan ("MERP") in Chapter 8.

H. Group Term Life Insurance at the option of one-time the employee's annual salary to a maximum of $50,000 or a flat $50,000.

I. Long-term Disability Insurance.

2.01.32 "Qualified Benefits" means for Eligible Employees of the PPA for the Plan Year commencing on July 1, 2012 and subsequent plan years.

A. The Kaiser 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 CityNet medical plan and Vision Service Plan, as amended from time to time.

C. Oregon Dental 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. Dependent Care Assistance Plan ("DCAP") in Chapter 7.

F. Medical Expense Reimbursement Plan ("MERP") in Chapter 8.

G. Group Term Life Insurance in the amount of $50,000.

2.01.33 "Qualified Benefits" means for Eligible Employees of the Laborers' Local 483 Seasonal Maintenance Workers for the Plan Year commencing on July 1, 2012 and subsequent plan years.

A. The City of Portland Seasonal Maintenance Worker medical plan and Vision Service Plan, as amended from time to time.

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

2.01.34 "Qualifying Individual" means a dependent of the Participant who is under the age of 13 and for whom the Participant is entitled to a deduction for a personal exemption under Code Section 151(c).

2.01.35 "Salary Reduction Agreement" means a written or electronic agreement or collective bargaining agreement provision by which a Participant elects to reduce his or her compensation or to forego increases in compensation and directs the City to contribute such amounts, on behalf of the Participant, toward the cost of electing, purchasing or funding one or more Component Plans. Such agreement relates to compensation that has not been actually or constructively received by the Participant as of the date of the agreement and, subsequently, does not become currently available.

2.01.36 "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 and the City's flexible spending account plans i.e. the Medical Reimbursement Plan ("MERP") and the Dependent Care Assistance Plan ("DCAP").

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 described in Chapter 6.02.

3.02 Initial Eligibility

3.02.01 Full-time and part-time non-represented, BOEC, COPPEA, DCTU, Local189-H (Housing) and Recreation employees shall become eligible to participate in the plan the first day of the month following the date of hire.

3.02.02 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.

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

3.02.04 Full time and part-time members of the Laborers' Local 483 Seasonal Maintenance Workers shall become eligible to participate in the Premium Payment component of the Plan if the employee worked as Seasonal Maintenance Worker during the prior calendar year; satisfies 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) or as otherwise defined within the collective bargaining agreement currently in effect.

3.03 Commencement of Participation

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

3.03.01 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 applicable eligibility requirements of Chapter 3.02.

3.03.02 Eligible Employees must elect or purchase some or all of the Component Plans. 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 Components described in Chapter 6.02.

3.04 On-Going Eligibility

3.04.01 City paid benefits will continue for non-represented, BOEC, COPPEA, DCTU, Local189-H (Housing) and Recreation employees each month in which they are actively employed in an eligible job class and status and working their regularly scheduled hours, or be in a qualified leave status for the City of Portland, unless otherwise provided by a labor agreement. Employees must make the required premium contribution.

3.04.02 To maintain eligibility, PFFA, PPA and PPCOA Employees must receive pay for a minimum of 80 hours each calendar month, or be in a qualified leave status, or as other wise provided by an applicable labor agreement. 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.

3.04.03 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.

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

3.04.05 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 did not 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

3.05.01 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.

3.05.02 City paid benefits for non-represented, BOEC, COPPEA, DCTU, Local189-H (Housing) 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.

3.05.03 Coverage for a non-represented, BOEC, COPPEA, DCTU, Local189-H (Housing) 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.

3.05.04 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.

3.05.05 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.

3.05.06 Notwithstanding any provision to the contrary in the 125 Plan, to the extent required by COBRA, a Participant and his or her spouse and Dependents, whose coverage terminates under the "MERP" 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)

3.06.01 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 health care 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 contribution 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.

3.06.02 A Participant may elect to continue his or her coverage under the Premium Pay Component of 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 premium 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.

3.06.03 Participant may elect to continue his or her coverage under the "MERP" Component of the 125 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 the benefits if the Participant fails to make the required contribution. The Administrator may fund coverage during the leave if the participant agrees to the payment of "catch-up" amounts either through withholdings or an acceptable repayment schedule upon the Participant's return.

CHAPTER 4

4.0 METHOD AND TIMING OF ELECTIONS

4.03.010 A Participant's election of nontaxable benefits shall be via electronic form or in writing and filed with the Administrator on the prescribed Benefit Election Form during the Annual Enrollment Period and prior to the effective date of the election. The Participant shall execute such payroll reduction authorization as the Administrator shall require. When a new benefit is first offered under the Plan, the Participant may file an electronic or written election with respect to that benefit within an initial enrollment period established by the Administrator. Once an election is made under Section 4.0, the Participant may change that election only during a regular Annual Enrollment Period, except on the occurrence of an applicable Change in Status event.

4.03.020 Employees who become Eligible Employees subsequent to the expiration of the Annual Enrollment Period must elect Component Plans prior to the commencement of the payroll period in which their Plan coverage commences. After making an election of one or more Component Plans, a Participant may not revoke that election until the next Annual Enrollment Period after the period of coverage has commenced except if both the revocation and the new election are made on account of and are consistent with a qualifying Change in Status.

4.03.030 A Participant's election to apply his or her salary reduction to the payment of Component Plans will be irrevocable for the balance of the Plan Year, except in certain situations described in this Section 4.01.030. Any of the following election and revocations shall be made pursuant to procedures adopted by the Administrator and shall be effective no sooner than the first day of the payroll period coincident with or immediately following the date the Participant files a new election with the Administrator. An election change can be funded through pre-tax salary reduction only on a prospective basis, except for the retroactive enrollment rights under Code Section 9801(f), which applies in the case of an election made within 30 days of birth, adoption, or placement for adoption. A Participant otherwise entitled to make a new election under this Chapter must do so within sixty (60) days of the event. The circumstances under which a Participant may make a mid-year change of election vary with the type of Component Plan at issue, as follows:

1. Change in Status. A Participant may change an election during the Plan Year for Qualified Benefits under the Plan if a Change in Status has occurred and the requested election change is consistent

with the Change in Status.

2. "Consistency" with the Change in Status requires that: (i) Change in Status affect coverage eligibility of a Participant, the Participant's spouse, the Participant's domestic partner or the Participant's Dependent under the 125 Plan or another plan offered by the employer of the Participant, spouse, or Dependent, and (ii) the election change be on account of and correspond with the Change in Status. The Administrator, in its sole discretion, shall determine whether an election change meets the consistency requirement based on prevailing IRS guidance.

(a) Loss of Eligibility due to Family Change. If the Change in Status is the Participant's divorce, annulment or legal separation from a spouse, then a Participant's election to cancel Qualified Benefits for any individual other than the spouse would not be consistent with the Change in Status unless they were the children of the former Spouse's or Domestic Partner's and not the children of the Participant. Similarly, if the Change in Status is the death of the Participant's spouse or Dependent, then a Participant's election to cancel Qualified Benefits for an individual other than that deceased spouse or deceased Dependent would not be consistent with the Change in Status. In addition, if one of the Participant's Dependents ceases to satisfy the eligibility requirements for Qualified Benefits coverage under the 125 Plan, the Participant's election to cancel Qualified Benefits for any other Dependent, for the Participant, or for the Participant's spouse would not be consistent with the Change in Status.

(b) Gain of Eligibility under Other Employer's Plan. If a Participant, a Participant's spouse, or a Participant's Dependent gains eligibility for coverage under a premium only plan offered by the employer of the Participant's spouse or Dependent as a result of a Change in Status that is a change in marital or employment status, then a Participant's election to cease or decrease coverage for the Participant, spouse or Dependent under the 125 Plan is consistent with the Change in Status only if coverage for that individual becomes applicable or is increased under the other employer's plan.

(c) COBRA or Continuation Coverage. If the Participant, or his or her spouse or Dependent becomes eligible for continuation coverage for Qualified Benefits, the Participant

may elect to increase salary reduction contributions hereunder in order to pay for the continuation coverage.

(d) Health Insurance Portability and Accountability Act of 1996 ("HIPAA") Enrollment Rights. A Participant may revoke an election with respect to Qualified Benefits coverage and make a new election that corresponds with the Participant's special enrollment rights granted the Participant under Section 9801(f), whether or not the change in election is otherwise permitted under the Plan.

(e)FMLA Leave. A Participant who takes FMLA leave may revoke an existing election of Qualified Benefits coverage and make such other election for the remaining portion of the Plan Year as may be provided for under the FMLA.

(f)Judgments, Decrees and Orders. If a judgment, decree or order (an "Order") resulting from the divorce, legal separation, annulment, or change in legal custody requires accident or health coverage for a Participant's child or for a foster child who is a Dependent of the Participant, a Participant may change his or her election of Qualified Benefits coverage to: (a) provide coverage for the child (provided that the Order requires the Participant to provide coverage for the child under the Participant's Plan), or (b) cancel coverage for the child if the Order requires the spouse, former spouse, or other individual to provide coverage for the child, and that coverage is, in fact, provided.

(g)Medicare and Medicaid. If a Participant, spouse or Dependent who is enrolled in Qualified Benefits becomes entitled to Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may make a prospective election change under the 125 Plan to cancel or reduce coverage for that Participant, spouse or Dependent under the 125 Plan. In addition, if a Participant, spouse, or Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may make a prospective election to increase coverage for that Participant, spouse, or Dependent under the 125 Plan.

3. Changes in Cost.

(a) Automatic Changes. If the cost of a Qualified Benefit increases (or decreases) during the Plan Year, and under the terms of the Component Plan, Participants are required to make a corresponding change in their payments, the Administrator will automatically make a prospective increase (or decrease) in affected Participants pre-tax salary reduction contributions to the 125 Plan.

(b) Significant Cost Changes. If the cost charged to a Participant for a Qualified Benefit significantly increases or significantly decreases during the Plan Year, the Participant may make a corresponding change in election. Changes that may be made include: (a) commencing participation hereunder for a Qualified Benefit with a decreased cost; or (b) revoking an election for the Qualified Benefit with an increased cost and, in lieu thereof, either receiving on a prospective basis coverage under another Qualified Benefit providing Similar Coverage or dropping coverage if no Similar Coverage is available. The Administrator, in its sole discretion, will decide whether an increase or decrease in cost is significant and whether Participants may change their election based on the cost change. "Similar Coverage" is defined in Section 5 (Definitions) below.

(c) If the amount charged to a Participant by a Dependent Care Provider significantly increases or decreases during the Plan Year, or if the Participant changes Dependent Care Providers resulting in a significant increase or decrease in costs, the Participant may revoke an election under the Dependent Care Assistance Plan and make a new election to reflect the increase or decrease in the Dependent Care Provider's cost. This subsection applies to the "DCAP" only if the cost change is imposed by a Dependent Care Provider who is not a relative of the Employee, as described in Code Section 152(a)(1) – (8).

4. Changes in Coverage

(a) Loss of Coverage. If a Participant, the Participant's spouse, Participant's domestic partner or the Participant's Dependent has a Loss of Coverage (as defined below) under a Qualified Benefit, the Participant may revoke his or her election under the 125 Plan for that Qualified Benefit, and, in lieu thereof, elect either to receive

coverage under another Qualified Benefit providing Similar Coverage or to drop coverage if no Similar Coverage is available.

If the Participant has a Loss of Coverage under the "DCAP", the Participant may revoke his or her election under the "DCAP" and, in lieu thereof, either make a new election under the "DCAP" to receive coverage through another Dependent Care Provider or drop coverage under the "DCAP".

(b) Significant Curtailment of Coverage. If a Participant, the Participant's spouse, the Participant's domestic partner or the Participant's Dependent has a Significant Curtailment of Coverage (as defined below) under a Qualified Benefit, which is not a Loss of Coverage then that Participant may revoke his or her election for that coverage and, in lieu thereof, receive coverage under another Qualified Benefit providing Similar Coverage.

If a Participant has a Significant Curtailment of Coverage (that is not a Loss of Coverage) under the "DCAP", then that Participant may revoke his or her election for that coverage and, in lieu thereof, make a new election under the "DCAP".

(c) Addition or Improvement of a Benefit Package Option. If, during the Plan Year, a new Qualified Benefit is offered, a new coverage option is added to a Qualified Benefit, or coverage under an existing Qualified Benefit is significantly improved, Eligible Employees and Participants may revoke their elections under the 125 Plan and, in lieu thereof, make new election on a prospective basis for coverage under the new or improved Qualified Benefit.

(d) No part of this Subsection (4) applies to the Medical Expense Reimbursement Plan.

5. Definitions. As used in this Subsection 4.01.030.

(a) "Loss of Coverage" means a complete loss of coverage under a Qualified Benefit or under the Dependent Care Assistance Plan (including elimination of a Qualified Benefit for purposes of the 125 Plan or loss of a Dependent Care Provider for purposes of the "DCAP"). In addition, the Administrator may, in its discretion, treat the following as a Loss of Coverage:

(i) A substantial decrease in the medical care providers available under the Qualified Benefit;

(ii) A reduction in the benefits for a specific type of medical condition or treatment with respect to which the Participant or the Participant's spouse or Dependent is currently in a course of treatment; or

(iii) Any similar fundamental loss of coverage.

(b) "Significant Curtailment of Coverage" means an overall reduction in coverage provided under the Qualified Benefits or by a Dependent Care Provider under the "DCAP" so as to constitute reduced coverage generally. The Administrator, in it sole discretion, will determine whether a Significant Curtailment of Coverage has occurred, base on prevailing IRS guidance.

(c)"Similar Coverage" means coverage for the same category of benefits for the same individuals (e.g. family to family or single to single). For example, two plans that provide coverage for major medical care are considered Similar Coverage. Similar Coverage may be offered by a qualified plan of the Participant's spouse, domestic partner or Dependent's employer. The Administrator, in its sole discretion, will determine whether coverage is "similar" based on all the facts and circumstances.

(d) No part of this Subsection (5) applies to the Medical Expense Reimbursement Plan

6. Change in Coverage under Another Employer Plan.

(a) A Participant may make a prospective election change that is on account of and corresponds with a change made under a plan of the Participant's spouse's, domestic partner's or Dependent's employer ("Other Employer Plan"), so long as: (a) the Other Employer Plan permits its participants to make an election change that would be permitted under Code Section 125 and regulations issued thereunder: or (b) the 125 Plan permits Participants to make elections based on a coverage period that is different from the period of coverage under the Other Employer Plan. The Administrator shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under the Other Employer Plan.

(b) No part of this Subsection (6) applies to the Medical Expense Reimbursement Plan.

7. Loss of Coverage Under Other Group Health Coverage.

(a) A Participant may elect on a prospective basis to add coverage under the Plan for the Participant or the Participant's spouse, domestic partner or Dependent if the Participant or the Participant's spouse or Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including the following: (1) a State's children's health insurance program (SCHIP) under Title XXI of the Social Security Act; (2) a medical care program of an Indian Tribal government (as defined in section 7701(a)(40)), the Indian Health Service, or a tribal organization; (3) a State health benefits risk pool; or (4) a foreign government group health plan.

(b) No part of this subsection (7) applies to the Medical Expense Reimbursement Plan.

8. Duration of Plan Elections

(a) A Participant may not elect a Component Plan benefit for any period of time less than a Plan Year unless the Participant becomes eligible to enroll in the Plan during the Plan Year or makes an election on account of and consistent with a qualifying Change in Status during the Plan Year. Application to revoke and change elections in these circumstances must be made no later than 60 days of the date of the actual event giving rise to the Change in Status. Elections made pursuant to this Chapter shall be effective for the balance of the Plan Year following the change of election unless a subsequent event allows for a further election change, or as provided in Section 4.01.030, 2b for HIPAA special enrollment rights in the event of a birth, adoption, or placement for adoption. All election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the calendar month following the date that the election change was filed.) A Participant may also change elections each year during the Annual Enrollment Period by filing a new Benefit Election Form with the Administrator within the Annual Enrollment Period.

CHAPTER 5

5.0 BENEFITS OFFERED AND FUNDING

5.01 Benefits Offered

When first eligible or during the Annual Enrollment Period as described in Chapter 3, Participants will be given the opportunity to elect one or more of the following Component Plans unless otherwise provided under a collective bargaining agreement:

(1) Premium Payment Benefits described in Chapter 6;

(2) Dependent Care Assistance Plan described in Chapter 7;

(3) Medical Expense Reimbursement Plan described in Chapter 8.

5.02 Funding

The Cafeteria Plan will be funded through Employer contributions by the City and/or salary reduction agreements between the Eligible Employee and the City.

5.02.010 Employer Contributions: The Employer may, but is not required to, make available contributions on behalf of Participants. The amount of the contributions shall be set forth in the annual enrollment materials. Contributions may either be limited to purchase of a particular Qualified Benefit, or they may be unrestricted, as described in the enrollment materials. The amount of the Contribution for each Participant shall be based on the Employee's standard hours designation as of May 1 of each year or as otherwise provided in the applicable collective bargaining agreement.

5.02.020 Employee Contributions: The Employer shall withhold from the Eligible Employees compensation on a pre-tax basis or with after-tax deductions an amount equal to the contributions required by the Eligible Employee for the Qualified Benefits elected less any applicable employer contribution allocable to such benefits. One twenty-fourth of the annual Employee required contribution to fund each Component Plan elected by the Employee shall be credited to the Employee's plan accounts the first and second pay period of each month. In the event of a shortage of reducible compensation, an amount deemed appropriate by the Administrator not to exceed the actual cost of the Employee election in a Plan Year shall be withheld from current and future compensation.

5.02.030 Opt-Out dollars. Opt-Out dollars are a residual benefit determined at initial election and enrollment and annually thereafter at the time of the Annual Enrollment Period and election. Opt-Out dollars are generated under the 125

Plan solely as a result of the Eligible Employees affirmative choice not to elect coverage for medical and vision plans under Chapter 6 for the Plan Year. Opt-Out dollars elected by an Employee shall be a fully taxable benefit unless used as contributions to the "MERP" or "DCAP".

CHAPTER 6

PREMIUM PAYMENT BENEFIT COMPONENT

6.0 BENEFITS

The medical, dental and vision benefits that are offered under the Premium Payment Component are the benefits under the Medical/Vision Plans (PPO and HMO options) and Dental Plans (PPO and HMO options) of the City of Portland Health Plan. Notwithstanding any other provision in the 125 Plan, the Medical and Dental Benefits are subject to the terms and conditions of those plans as provided in the City of Portland Health Plan and no changes can be made with respect to such Benefits (such as mid-year changes in elections) if such changes are not permitted under the City of Portland Health Plan.

Medical/Vision and Dental Benefits will be provided by the Medical/Vision and Dental Plans as provided in the City of Portland Health Plan, not this 125 Plan. The specific benefits, amounts of benefits, the participation requirements, and the other terms and conditions of coverage are set forth in the City of Portland Health Plan. All claims to receive benefits under the City of Portland Health Plan shall be subject to and governed by the terms and conditions of the City of Portland Health Plan and the rules, regulations, polices and procedures adopted in accordance therewith as may be amended from time to time.

6.01 FUNDING

The annual Contribution for a Participant's Premium Payment Benefits is equal to the amount as authorized by the City.

6.02 ELECTIONS

Eligible Employees can (a) elect benefits under the Premium Payment Component by electing to pay their share of the contributions to the applicable Medical/Vision and Dental Plans under the City of Portland Health Plan on a pre-tax Salary Reduction basis (Premium Payment Benefits) or (b) elect no benefits under the Premium Payment Component and to pay their share of the Contributions, if any for the Medical/Vision and Dental Benefits with after tax dollars outside of this 125 Plan. Unless an exception applies as described in Chapter 4, elections are irrevocable for the duration of the Period of Coverage to which it relates. All Qualified Benefits are optional Employee elections except as follows:

6.03.010 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. If the Participant elects Medical/Vision coverage, then the Participant must elect a Dental 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 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.

6.03.020 All Full-time and Part-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.

6.03.030 All Full-time and Part-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.

6.03.040 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.

6.03.050 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.

6.03.060 Notwithstanding any other language in this Chapter, Participants who purchase any medical, dental or vision or plan and elect coverage for someone other than a spouse or Dependent of the Participant, as permitted by the medical, dental or vision 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.

6.03 DEFAULT BENEFITS

6.03.070 With respect to the Plan Year commencing on July 1, 2012 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 following default benefits:

1. 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.

2. 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, the non-represented, BOEC, COPPEA, DCTU, PFFA, PPCOA, Local189-H (Housing) and Recreation eligible employees will be enrolled in Eligible Employee only coverage under the CityCore 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, the Employer funded group term life insurance and, excluding PFFA, the Employer funded group long term disability plan.

   (b) For Initial Enrollment, the PPA employees will be enrolled in Eligible Employee only coverage under 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, and the Employer funded group term life insurance plan.

(c) For Initial Enrollment, the SMW employees will be enrolled in Eligible Employee only coverage under the SMW self-insured medical plan.

(b) For Annual Enrollment, eligible employees will be enrolled in the medical, vision and dental options most similar to their prior plan year election, 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, if applicable, and if previously enrolled, the Employee funded group long term disability plan buy-up and the Employee funded term supplemental life insurance.

6.03 Claims Procedure

All claims for reimbursement for Dependent Care and Medical Expenses shall be made as provided in Chapters 7 and 8 respectively. All other claims shall be made directly to the Third Party Administrator or insurer providing claims payment or coverage.

CHAPTER 7

7.0 DEPENDENT CARE ASSISTANCE PLAN

7.01 Purpose

This Chapter is to be known as the City of Portland Dependent Care Assistance Plan (""DCAP""). The purpose of this Chapter is to reimburse City Employees for the costs associated with Dependent Care Expenses incurred by such Employees. This Chapter is intended to qualify as a plan providing dependent care assistance within the meaning of Section 129(d)(1) of the Code, as amended, and it is intended that the amounts reimbursed pursuant to this Chapter be eligible for exclusion from the income of a Participant under Section 129(a) of the Code.

7.02 Eligibility and Enrollment

7.02.010 Each Employee, except a seasonal maintenance worker, who is a Participant in the Plan described in Chapter 3 may become a Participant in this ""DCAP"" by completing and filing an electronic or paper Benefit Election Form with the Administrator indicating the Employee's application to participate in the ""DCAP"" or by funding the ""DCAP"" with salary reductions.

7.02.020 An election to participate in the Dependent Care Assistance Plan shall be irrevocable after the period of coverage has commenced unless the Participant experiences a qualifying Change in Status or as allowed in Chapter 4. A Participant may revoke his or her election to participate in the "DCAP" after the period of coverage has commenced and may make a new election with respect to the remainder of the period of coverage if both the revocation and the new election are made on account of and are consistent with a qualifying Change in Status.

7.02.030 Participation in the "DCAP" 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 Plan eligibility criteria in Chapter 3. Participation in the "DCAP" may thereafter be renewed upon the satisfaction of the eligibility requirements described in Chapter 3.

7.02.040 A Participant who terminates participation prior to the end of a Plan Year shall have the right to submit claims for reimbursement for Dependent Care Expenses incurred during the remainder of the Plan Year at any time until ninety (90) days following the end of the Plan Year. No reimbursement shall exceed the balance in the Participant's Dependent Care Account for the Plan Year in which the expenses were incurred.

7.03 Establishing an Account; Payment of Expenses

The Administrator will establish and maintain a Dependent Care Account for each Participant hereunder. From amounts credited to a Participant's Dependent Care Account during the Plan Year, there shall be paid from time to time reimbursement of Dependent Care Expenses incurred by the Participant during the Plan Year.

7.04 Benefits.

7.04.010 Upon becoming eligible, each Participant may elect in electronically or in writing on a Benefit Election Form to reduce his or her salary or wages the first two pay checks of each month and to have the amount of the reduction contributed to a Dependent Care Account on such Participant's behalf. The Benefit Election Form shall be filed with the Administrator prior to the date the Participant is enrolled in the Plan. Such election may not reduce the Participant's salary or wages by more than $5,000 per Plan Year or $2,500 in the case of married individuals filing separately. The maximum amount a Participant may receive for any Plan Year for reimbursement for expenses incurred for Dependent Care Expenses shall be the lesser of:

1. The amount credited to his or her Dependent Care Account during the Plan Year; or

2. In the case of a Participant who is not married at the close of such taxable year the earned income of such Participant for such taxable year; or

3. In the case of a Participant who is married at the close of such taxable year, the lesser of:

   (a) The earned income of such Participant for such taxable year, or

   (b) The earned income of the spouse of such Participant for such taxable year. In determining the earned income of a spouse who is actively seeking employment, a student or incapable of self care, it shall be deemed for each month during which such spouse is a student at an Educational Institution or is incapable of self care that such spouse has an earned income not less than:

      (i) $250 if there is one qualifying individual with respect to the Participant, or
      (ii) $500, if there are two or more qualifying individuals with respect to the Participant;

(iii) $5,000 (or $2,500 in the case of a separate return by a married Participant).

7.04.020 Reimbursement will not be paid to a Participant for Dependent Care Expenses provided by an individual for whom a deduction is allowable under Code Section 151(c) (relating to personal exemptions for dependents) to a Participant or the Participant's spouse.

7.04.030 Reimbursement will not be paid to a Participant for Dependent Care Expenses provided by a child of the Participant within the meaning of Code Section 151(c)(3) under the age of 19.

7.04.040 Notwithstanding the previous subsection, a Participant will not receive reimbursement for the cost of Dependent Care Expenses provided by a Dependent Care Services Provider, unless the Dependent Care Service Provider complies with all applicable laws and regulations of the state or unit of local government where such center is located, (e.g., requirements for licensing, if applicable, and building and fire code regulations).

7.05 Forfeiture

7.05.010 Participants are ineligible to receive any benefits under this Chapter except as reimbursement for eligible Dependent Care Expenses and shall not receive any funds which may remain in their accounts after reimbursement for all eligible expenses has been made. Any unused funds remaining in said accounts at the end of a Plan Year may not be carried over to a subsequent Plan Year, shall not be available to the Participant in any other form or manner and the Participant shall forfeit all rights with respect to the unused funds.

7.05.020 Reimbursement under this "DCAP" shall be made only in the event, and to the extent, that reimbursement for amounts expended or payment, for dependent care assistance is not provided for under any other dependent care assistance plan or under any federal or state law. If there is such a policy, plan or law in effect providing for such reimbursement or payment in whole or in part, then to the extent of the coverage under such policy, plan or law no reimbursement shall be made hereunder.

7.06 Funding

Funding for participation in the Dependent Care Assistance Plan is as described in Chapter 5.

7.07 Claims Procedure

7.07.010 In order to obtain reimbursement for Dependent Care Expenses, a Participant shall submit an application in electronic form or in writing to the

Administrator or designated third party administrator , in such form as the Administrator or designated third party administrator may prescribe, setting forth:

1. The amount, date and nature of the expense with respect to which payment is requested;

2. The name of the person, organization or entity to which the expense was or is to be paid, and taxpayer identification number (Social Security Number if an individual);

3. Such other information as the Administrator or designated third party administrator may from time to time require.

4. The relationship, if any, of the person performing the services to the Participant;

5. If the dependent care services are being performed by a child of the Participant, the age of the child;

6. A statement as to where the dependent care services will be performed;

7. If any of the dependent care services are to be performed outside the Participant's household, a statement as to whether the Dependent for whom such services are being performed spends at least 8 hours a day in the Participant's household, and

8. If the services are being performed in a dependent care center, a statement that:

   (a). The dependent care center complies with all applicable laws, regulations and ordinances of the state, county and city where it is located;

   (b). The dependent care center provides care for more than six individuals (other than individuals residing at the center), and

   (c) The amount of the fee paid to the dependent care center;

7.07.020 Such applications shall be accompanied by bills, invoices, receipts, canceled checks or other statements showing the amounts of such expenses. The Participant must provide a written statement from an independent third party verifying the Dependent Care Expenses incurred and the amount of such expenses, and must verify in writing that the expenses have not been reimbursed under any other dependent care assistance plan.

7.07.030 Requests for reimbursement should normally be processed within 30 days of the receipt of the claim. Where additional information is required to process the claim or where no benefit is payable, a written notice/explanation shall be sent to the claimant within 30 days of claim filing. The eligibility of all claims shall be determined within 60 days of the receipt of proper documentation. The decision of the Administrator or designated third party administrator regarding claim eligibility shall be final.

7.07.040 If approved Dependent Care Expenses exceed the amount credited to a Participant's Dependent Care Account, the Administrator or designated third party administrator shall reimburse claims up to the account balance and hold the remainder of the claims until sufficient funds are credited to the account in the year in which the claims were incurred.

7.07.050 On or before January 31 of each year, the Administrator or designee shall furnish to Participants in the Dependent Care Assistance Plan, a written statement showing the amounts paid by the City in providing dependent care assistance to such Participants during the preceding calendar year.

CHAPTER 8

8.0 MEDICAL EXPENSE REIMBURSEMENT PLAN

8.01 Purpose

This Chapter is to be known as the City of Portland Medical Expense Reimbursement Plan (""MERP""). The purpose of this Chapter is to reimburse Participants for the cost of certain Medical Expenses enumerated herein. It is the intention of the City that this Chapter qualify as an accident and health plan within the meaning of Section 105 and Section 106 of the Code, and that the benefits payable under this Chapter be eligible for exclusion from the Participant's income.

8.02 Eligibility and Enrollment

8.02.010 Each Employee who is a Participant in the Cafeteria Plan described in Chapter 3 of the 125 Plan document may become a Participant in this "MERP" by completing and filing a Benefit Election Form with the Administrator indicating the Employee's desire to participate in the "MERP".

8.02.020 An election to receive reimbursement under the "MERP" shall be irrevocable after the period of coverage has commenced unless the Participant experiences a qualifying Change in Status. A Participant may revoke his or her election to participate in the Plan after the period of coverage has commenced and may make a new election with respect to the remainder of the period of coverage if both the revocation and the new election are made on account of and consistent with a qualifying Change in Status. Examples of Changes in Status for which a benefit election change may be permitted are described in Chapter 4, Section 4.01.030.

8.02.030 Participation in the "MERP" 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 for the Cafeteria Plan described in Chapter 3. Participation in the "MERP" may thereafter be renewed upon the satisfaction of the requirements of Chapter 3 and this Chapter.

8.02.040 To the extent required by law (COBRA) (see e.g., Internal Revenue Code Section 4980B, and regulations promulgated thereunder), a Participant, and the Participant's spouse and Dependents, whose coverage terminates under the "MERP" on account of a COBRA qualifying event, shall be given the opportunity to continue coverage under this "MERP" on an after-tax basis for the period prescribed by COBRA (subject to all conditions and limitations under COBRA). However, if the following two conditions are satisfied, a

special COBRA rule will apply, as discussed below, that limits the extent to which COBRA must be offered under the medical expense reimbursement plan. The two conditions which must be satisfied are:

1. "MERP" is Exempt From HIPAA. The "MERP" is exempt from HIPAA (i.e., a major medical plan is available to all Employees who are eligible for the "MERP" and the same eligibility and same entry rules apply to both, and the "MERP" benefit does not exceed two times the salary reduction or, if greater, the salary reduction plus $500); and

2. The COBRA Premium Equals or Exceeds the "MERP" benefit. If for the Plan Year in which the COBRA qualifying event occurs, the maximum amount the qualified beneficiary could be required to pay for a full year of "MERP" coverage equals or exceeds the maximum benefit available to the qualified beneficiary for the Plan Year.

8.02.050 Individuals will be eligible for COBRA continuation coverage only if they have a positive "MERP" balance at the time of a COBRA qualifying event (taking into account all claims submitted before the date of the qualifying event). Such individuals will be notified if eligible for COBRA continuation coverage. If COBRA is elected, it will be available only for the year in which the qualifying event occurs; such COBRA coverage for the medical expense reimbursement plan will cease at the end of the Plan Year and cannot be continued for the next Plan Year.

8.03 Establishing an Account - Payment of Expenses

The Administrator will establish and maintain a Health Care Spending Account for each Participant hereunder. From amounts credited to a Participant's Health Care Spending Account during a Plan Year, there shall be paid from time to time reimbursement of Medical Expenses incurred by the Participant, his or her spouse, and/or Dependents during the Plan Year.

8.04 Participation

Upon becoming eligible, a Participant may elect via an electronic enrollment form or in writing on a Benefit Election Form to reduce his or her salary or wages each pay day and to have the amount of the reduction contributed to a Health Care Spending Account on such Participant's behalf. The Benefit Election Form shall be filed with the Administrator prior to the date the Participant is enrolled in the Plan. Such election may not reduce the Participant's salary or wages by more than $3,999.84 during a Plan Year. If a Participant elects not to establish a Health Care Spending Account, he or she may later elect to establish such an account during the Annual Enrollment Period, effective as of the following July 1 or on account of a qualifying change in family status.

8.05 Benefits.

8.05.010 Payments shall be made to the Participant in cash as reimbursement for eligible Medical Expenses (as defined in Code Section 213(d) and Revenue Ruling 2003-102 and as modified by the 2010 Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010) incurred by the Participant or his or her Dependents while he or she is an Eligible Employee, during the Plan Year for which the Participant's election is effective. A Participant may receive payments or reimbursements for Medical Expenses as defined in Code Section 213 (d), but only to the extent that the Participant is not reimbursed (or entitled to reimbursement) for the expense through any insurance or otherwise. Reimbursement or payment for such Medical Expenses incurred in any Plan Year may be received up to the annual dollar amount specified by the Participant in his or her enrollment application, but not exceeding $3,999.84.

If, as of the end of the Plan Year, it is determined that a Participant has received payments under this "MERP" that exceed the amount of eligible reimbursement expenses that have been substantiated by the Participant during the Plan Year, the Administrator shall give the Participant prompt written notice of any such excess amount, and the Participant shall repay the amount of such excess to the employer within sixty (60) days of receipt of such notification.

8.05.020 A Participant shall be entitled to benefits under this "MERP" for expenses incurred in a prior Plan Year, but no reimbursement shall be made with respect to a request for reimbursement submitted more than 90 days following the end of the Plan Year in which expenses are incurred. Participants in this "MERP" are ineligible to receive any benefits under this Chapter except as reimbursement for eligible Medical Expenses and shall not receive any funds which may be designated for healthcare expenses after reimbursement for all eligible healthcare expenses has been made. Any unused benefits which may have been designated for Medical Expenses may not be carried over to a subsequent Plan Year, shall not be available to the Participant in any other form or manner and the Participant shall forfeit all rights with respect to the unused funds.

8.06 Claims Procedure

8.06.010 In order to obtain reimbursement for Medical Expenses, a Participant shall submit an application in writing or as otherwise allowed by the Administrator or designated third party administrator in such form and in such detail as the Administrator or designated third party administrator may prescribe with the following information:

1. The amount, date and nature of the expense.

2. The name of the person, organization or entity to which the expense was or is to be paid.

3. Such other information as the Administrator or designated third party administrator may from time to time require.

4. The name of the person for whom Medical Expenses were incurred and, if such person is not the Participant requesting reimbursement, the relationship of such person to the Participant and that such person is a Dependent of such Participant.

8.06.020 Such applications shall be accompanied by bills, invoices, receipts, cancelled checks or other statements showing the amount of such expenses. The Participant must provide a written statement from an independent third party verifying the Medical Expense incurred and the amount of such expenses, and must verify in writing that the expenses have not been reimbursed and are not reimbursable under any other health plan.

8.06.030 The Participant shall be reimbursed from the Participant's Health Care Spending Account for Medical Expenses incurred during the Plan Year for which the Participant submits documentation in accordance with this Chapter. Medical Expenses will be treated as having been incurred when the care is provided, and not when the Participant is formally billed, charged for, or pays for the expenses. Expenses that were incurred before the Effective Date or before the date the Participant was enrolled in the Plan will not be reimbursed. The Administrator, or third party administrator may, at its option, pay an Medical Expense directly to the medical care provider in lieu of reimbursing the Participant.

8.06.040 Requests for reimbursement should normally be processed within 30 days of receipt of the claim. Where additional information is required to process the claim or where no benefit is payable, a written notice/explanation shall be sent to the claimant within 30 days of claim filing. The eligibility of all claims shall be determined within 60 days of the receipt of proper documentation. The decision of the Administrator or third party administrator regarding claim eligibility shall be final.

8.06.050 On or before January 31 of each year, the Administrator or designated third party administrator shall furnish to Participants in the Medical Expense Reimbursement Plan, a written statement showing the amounts paid by the City in medical expense reimbursement to such Participants during the preceding calendar year.

8.07 Funding

The total amount which may be set aside by any Participant in a health care spending account shall not exceed $2,500.00 per Plan Year. It is intended that the health care spending accounts authorized under this Chapter be funded by funds made available pursuant to a salary reduction agreement affirmed by the Participant. However, if, at the time reimbursement is payable to a Participant, the eligible expenses exceed the amount of funds available in the Participant's account from such sources, the City of Portland will fund the account in an amount necessary to make up the difference between such available funds and the amount required to reimburse the Participant for his or her eligible expenses. The maximum funding to be provided by the City of Portland under this subsection in any Plan Year shall be $2,500.00 minus the sum of any funds available in the account and the amount of any reimbursement previously received by the Participant for expenses incurred during the Plan Year.

8.08 Termination of Participation

8.08.010 A Participant's participation in the "MERP" will end on the day on which he or she terminates employment, ceases to be an Eligible Employee, or ceases to make required contributions, whichever occurs first. Such Participant shall be entitled to reimbursement of Medical Expenses from his or her Health Care Spending Account for expenses incurred through the day on which the Participant terminates employment or ceases to be an Eligible Employee. A Participant has until September 30 following the end of the Plan Year to obtain reimbursement for Medical Expenses incurred during the eligibility period of the preceding Plan Year. Any amounts still credited to the Participant's account after September 30 shall be forfeited and applied to the costs of maintaining the "MERP". In the event that a Participant ceases to make required contributions, the Participant will not be permitted to again contribute to the Health Care Spending Account for the remaining portion of the coverage period during which the cessation of contributions occurred.

CHAPTER 9

9.0 HIPAA PROVISIONS FOR THE "MERP" AND PREMIUM PAYMENT PLAN

9.01 Health Insurance Portability and Accountability Act

The City of Portland (the "Plan Sponsor") sponsors this 125 Plan with the Medical Expense Reimbursement Plan and the Premium Payment Component Plans as well as the City of Portland Health Plan (the "Plans"). Employees of the Benefit Office have access to the individually identifiable health information of Plan Participants for administrative functions of the Plans. When this health information is provided from the Plans to the Plan Sponsor, it is Protected Health Information (PHI). The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the Plans and Plan Sponsor's ability to use and disclose PHI.

9.01.010 The following HIPAA definition of PHI applies to the 125 plan:

(1) Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of participant; the provisions of health care to a Participant; or the past, present or future payment for the provision of health care to a Participant; and that identifies the Participant or for which there is a reasonable basis to believe the information can be used to identify the Participant. Protected health information includes information of persons living or deceased.

(2) The Plan Sponsor shall have access to PHI from the Plans only as permitted under this Chapter or as otherwise required or permitted by HIPAA.

9.02 Permitted Disclosure of Enrollment/Disenrollment Information

The Plans shall disclose to the plan sponsor information on whether the individual is participating in the Plan.

9.03 Permitted Uses and Disclosure of Summary Health Information

9.03.010 Summary Health Information. Summary Health Information is information that (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a health plan. The summary will only identify the general geographical location of the Participant, and will not include any information by which a particular Participant can be identified.

9.03.020 The Plans may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health

insurance coverage under the Plan; or (b) modifying, amending, or terminating the Plan.

9.04 Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administrative Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph IV and obtaining written certification pursuant to paragraph VI, the Plan may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Plan Sponsor on behalf of the Plans, such as quality assurance, claims processing, auditing and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit of the Plan Sponsor and they do not include any employment-related functions. In no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

9.05 Conditions of Disclosure for Plan Administration Purposes

The Plan Sponsor agrees, that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plans, the Plan Sponsor shall:

1. Not use or further disclose the PHI other than as permitted or required by the Plans or as required by law.

2. Ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plans, agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

3. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

4. Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524.

5. Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526

6. Make available the information required to provide and accounting of disclosure in accordance with 45 CFR §164.528.

7. Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plans available to the Secretary of

Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements.

8. Return or destroy all PHI received from the Plans that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made.

9. Ensure that the adequate separation between Plans and Plan Sponsor (i.e., the "firewall"), required in 45 CFR §504(f)(2)(iii), is satisfied.

9.06 Adequate Separation Between Plans and Plan Sponsor

The City as Plan Sponsor shall allow the following City employees access to PHI: Benefit Office employees, Payroll employees, and the Bureau of Technical Services employees that provide technical support for the Plan Participant database, the City Attorney's Office for the provision of legal advice and representation as to any matter or issue regarding the Plan or Plan Participant, and City Council as may be required by law or administrative rule to administer, authorize and approve issues related to the Plan. No other persons shall have access to PHI. These specified classes of employees shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified classes of employees do not comply with the provisions of this Chapter, that employee shall be subject to disciplinary action up to and including discharge by the Plan Sponsor for non-compliance.

9.07 Certification of Plan Sponsor

The Plans shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the Plan has been amended to incorporate the provisions of 45 CFR § 164.504(f)(2)(ii), and that the Plan Sponsor agrees to the conditions of disclosure set forth in 9.05 of this Chapter.