EXHIBIT A

CITY OF PORTLAND
HEALTH PLAN DOCUMENT

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CHAPTER 1

1.0 GENERAL PROVISIONS

1.01 Establishment of Plan

1.01.010 The City of Portland, Oregon (the “City”) hereby amends and restates the City of Portland Health Plan (the “Plan”), which includes Benefits of the Plan, effective July 1, 2013 (the "Effective Date"). Capitalized terms used in the Plan that are not otherwise defined shall have the meanings set forth in Chapter 2.

1.01.020 The Plan is designed to permit an Eligible Employee to elect various Benefits, and to pay for those Benefits with a combination of Employer Contributions and Employee Contributions. Employee Contributions may be paid on a pre-tax salary reduction basis or with after-tax deductions, as permitted under the Code and the City of Portland Cafeteria Plan.

1.01.030 The Plan is intended to satisfy the requirements of Code Sections 105 and 106. The Plan shall be interpreted and construed in accordance with such Code Sections, the regulations issued thereunder, and all other applicable requirements of the law, including ERISA, COBRA, and HIPAA.

1.01.040 The Plan is a single consolidated health benefit plan, which includes all of the Benefits as described in this document. This document sets forth the specific terms on which various Benefits may be available to Eligible Employees and their Dependents.

1.02 Governing Law

Except to the extent that the Plan is governed by federal law, the 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 Limitations

1.03.010 Nothing contained in the Plan shall be deemed to give any Employee the right to be retained in the service of the City or to interfere with the right of the City to discharge any Employee at any time, regardless of the effect which such discharge shall have upon such Employee as a Member under the Plan.

1.03.020 The City 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.

1.04 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 Benefit, 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.

1.05 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.

1.06 Administrator

The Plan and its Benefits 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:

1.06.010 Determining an Employee's eligibility to participate in any Benefits authorized by the Plan;

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

1.06.030 Advising the Insurers and Third Party Administrators with respect to Members and with respect to contributions made on behalf of Members;

1.06.040 Furnishing the Council, Members, and Insurers with information they may require;

1.06.050 Engaging the service of such agents as the Administrator may deem advisable to assist with or perform the Administrator's duties;

1.06.060 Consulting with the City attorney with respect to the meaning or

construction of the Plan and its Benefits and the Administrator's duties thereunder; and

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

The 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.

1.07 Plan Notification

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

1.08 Tax Effects

Neither the City nor the 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 the Member's gross income for local, state, orfederal income tax purposes, then under no circumstances shall the Member have any recourse against the Administrator or the City with respect to any increased taxes or other losses or damages suffered by the Member as the result thereof.

1.09 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.

1.10 Type of Plan

This is an employee welfare plan which provides medical benefits to Members and their beneficiaries. The CityCore Medical Plan, the SMW Plan for Seasonal Maintenance Workers, the Medicare Supplement Plan, and the Moda Health 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 Member, subject to the City’s obligations under the Public Employees Collective Bargaining Act. Any amounts paid by the City on behalf of the Plan shall be paid out of the City Health Funds, unless otherwise required.

1.11 Misrepresentation

Any falsification, misrepresentation, misleading statements, or omission of an Employee when enrolling in the Plan may be cause for immediate termination of coverage under the Plan and may subject the Employee to discipline, including discharge, from City

employment, regardless of when or how discovered. If a Member 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 Member's obligation to reimburse the City any monies that are paid by the Plan for claims incurred. If an Employee or the Employee's Dependent fraudulently obtains any Benefits under the Plan, the Employee and/or Dependent will be prosecuted to the full extent of the law.

1.12 No Examination or Accounting

Neither the Plan nor any action taken hereunder shall be construed as giving any person the right to an accounting or to examine the books or affairs of the City.

1.13 Information to Be Furnished

1.13.010 Any Member or Dependent eligible to receive Benefits hereunder shall furnish to the Administrator, or to an Insurer or a Third Party Administrator, as applicable, any information or proof requested by the Administrator, the Insurer, or the TPA and reasonably required for the proper administration of the Plan. Failure on the part of any Member or Dependent to comply with any such request within a reasonable period of time shall be sufficient grounds for delay in the payment of any Benefit that may be due under the Plan until such information or proof is received by the Administrator, the Insurer, or the TPA.

1.13.020 The Administrator also may require documentation or certification to substantiate any Member or Dependent's eligibility for Benefits under the Plan. In addition to any action set forth above, if the Administrator, in its sole discretion, determines that any person is enrolled in the Plan, but is not an eligible Member or Dependent, the Administrator shall terminate his or her enrollment in the Plan and take any other action the Administrator deems appropriate.

1.14 Right to Use Data

On behalf of the City, the Administrator reserves the right to derive data for purposes of statistical analysis from the claims files held in connection with the Plan.

1.15 Severability

If any provision of the Plan is held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining parts of the Plan, and the Plan shall be construed and enforced as if the illegal or invalid provision had not been included in the Plan.

CHAPTER 2

2.0 DEFINITIONS

2.01 Definitions

As used in the Plan and any documents for the Benefits, the following terms have the following definitions.

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 the Third Party Administrator, 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 claimant's eligibility to participate in the Plan and one resulting from the application of any pre-existing condition exclusion (for anyone over the age of 18) 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 the TPA 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 and his or her beneficiaries.

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 Eligible Employee may file or amend his or her Benefit Election Form.

2.01.060 "Appeal" shall mean a written request by a claimant or his or her representative for the Third Party Administrator to review an Adverse Benefit Determination.

2.01.070 "Benefits" shall mean the following 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, 2013 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; and

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

D. The CityCore Dental Plan, as amended from time to time.

2.01.080 "Benefits" shall mean the following for Eligible Employees of the PPA for the Plan Year commencing on July 1, 2013 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; and

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

2.01.090 "Benefits" shall mean the following for Eligible Employees of the Laborer's Local 483 Seasonal Maintenance Workers for the Plan Year commencing on July 1, 2013 and subsequent Plan Years:

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

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 Benefits of his or her choice pursuant to the 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 an Eligible Employee or 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 claimant's life or health or ability to regain maximum function, or, in the opinion of a physician with knowledge of a claimant's medical condition, would subject the claimant 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 "COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (Code Section 4980B).

2.01.170 "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.

2.01.180 "Complaint" shall mean an expression of dissatisfaction about a specific problem a claimant has encountered or about a decision by the Third Party Administrator or an agent acting on its behalf, 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.

2.01.190 "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 the 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.

2.01.200 "Coinsurance" 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 Member

pays 20 percent toward the charges for a service, and the City or Insurer pays 80 percent.

2.01.210 "Copayment" shall mean the predetermined (flat) fee that a Member pays for health care services, in addition to what the Insurer 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.

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

2.01.230 "Covered Charges" shall mean Medically Necessary medical expenses eligible for reimbursement in accordance with the Plan.

2.01.240 "Dependent" 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. 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. A domestic partner as defined and declared in the City's Domestic Partner Affidavit, or who is a registered domestic partner pursuant to the Oregon Family Fairness Act of 2007 or any other state, or who is a same-sex spouse under the laws of any other state.

C. A child under the age of 26, including the Member's:

- Natural child;
- Stepchild;
- Child who is required to be covered by the 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; or
- 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. After 31 days, the child of the enrolled Dependent may be covered only as long as the child's parent is the Employee's eligible and enrolled Dependent, the Employee is

financially responsible for both the newborn and the 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 and continues to reside with and be primarily supported by the Employee.

2.01.250 "Deductible" shall mean the amount a Member must pay for health care expenses before the Plan covers the costs. For the Plan, the Deductible is an annual amount and must be met each Plan Year.

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

2.01.270 "Domestic Partner" shall mean an individual with whom the Employee must:

A. Submit a copy of their State of Oregon's Certificate of Registered Domestic Partnership, a certificate or registration form from any other state, or a marriage certificate for a same-sex marriage; or

B. 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 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.

C. 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 or her domestic partner's financial support and be able to claim his or her domestic partner as a dependent on his or her individual tax form.

2.01.280 "Earned Income" shall mean the same as the provisions in Code Section 32(c)(2).

2.01.290 "Effective Date" shall mean, for this Plan amendment and restatement, July 1, 2013.

2.01.300 "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 Eligible Employee does not include an independent contractor.

2.01.310 "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 patient, 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 patient.

2.01.320 **"**Employee**"** shall mean an elected official of the City, a non-represented employee of the City, 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"), a member of the Bureau of Fire, Rescue and Emergency Services in the bargaining unit represented by the Portland Fire Fighters Association ("PFFA"), a member of the Bureau of Police in the bargaining unit represented by the Portland Police Association ("PPA"), a member of the Bureau of Emergency Communications in the bargaining unit represented by AFSCME Council 75 Local 189, a member in the bargaining unit represented by the District Council of Trade Unions, a member in the bargaining unit represented by Laborers' Local 483

Recreation Employees, a member in the bargaining unit represented by Local 189-H (Housing), and a member in the bargaining unit represented by Laborers' Local 483 Seasonal Maintenance Workers. The term "Employee" does not include an independent contractor.

2.01.330 "Employee Contribution" shall mean the portion of the Plan costs paid by the Employee or another eligible Member.

2.01.340 "Employer Contribution" shall mean the portion of the Plan costs paid by the City.

2.01.350 "ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

2.01.360 "Exclusions" shall mean medical services that are not covered by the Plan.

2.01.370 "FDA Approved Medications" shall mean medications approved by the U.S. Federal Drug Administration.

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

2.01.390 "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.

2.01.400 "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 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.

2.01.410 "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; and medical supplies, equipment, and appliances.

2.01.420 "Health Reimbursement Account shall mean Internal Revenue Services (IRS) sanctioned employer funded health benefit plan that reimburses employees for out of pocket and individual health insurance

premiums in accordance with employer established parameters. An HRA is not portable nor contributed to by the employee.

2.01.430 "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.

2.01.440 "Hospital" shall 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.

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

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

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

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

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

2.01.500 "Insurer" shall mean an insurance company duly licensed to do business in the State of Oregon.

2.01.510 "Limitations" shall mean a limit on the amount of Benefits paid for a particular Incurred Expense.

2.01.520 "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.

2.01.530 "Maximum Plan Allowance (MPA)" shall mean the maximum amount that the Plan will reimburse providers under the CityCore medical Benefit. 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 the Third Party Administrator 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, the TPA 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 the TPA' 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.

2.01.540 "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.

2.01.550 "Medical Expenses" shall mean the amounts paid for medical care as defined in Code Section 213(d) for the Member, his or her spouse or domestic partner, and/or Dependents.

2.01.560 "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.

2.01.570 "Member" shall mean an Employee who currently meets the eligibility requirements of Chapter 3 and enrolls for Benefits under the terms of the Plan.

2.01.580 "Network" shall mean a group of doctors, Hospitals, and other health care providers contracted to provide services to Members for less

than their usual fees. For the CityCore Benefit, the Network offered is the ODS Plus Network.

2.01.590 "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 Coinsurance (City plans). Members pay more when they use Out-of-Network providers.

2.01.600 "Out-of-Pocket Maximum" shall mean the amount of money that Members must pay out of their own pocket before the Plan will pay 100 percent for a Member's health care expenses.

2.01.610 "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.

2.01.620 "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.

2.01.630 "Part-time Employee" shall mean, for purposes of this Plan, an Employee in a Benefit eligible 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.

2.01.640 "Plan" shall mean this City of Portland Health Plan.

2.01.650 "Plan Year" shall mean the 12-month period beginning July 1 and ending June 30 each year.

2.01.660 "Post-service Claim" shall mean any claim for a Benefit under the Plan for care or services that have already been received by a claimant.

2.01.670 "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.

2.01.680 "Pre-service Claim" shall mean any claim for a Benefit under the Plan for care or services that require Prior Authorization.

2.01.690 "Prior Authorization" or "Prior Authorized" shall mean service approval by the Third Party Administrator for a Member in the CityCore

Benefit 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 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 by contacting the Third Party Administratof.

2.01.700 "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.

2.01.710 "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.

2.01.720 "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.

2.01.730 "Special Medical Situations" shall mean:

A. Specialist or type of treatment is not provided in the Member's Network service area, and the Member lives in the Network service area:
   - 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. Members are responsible for a 20% Coinsurance, 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 Plan's healthcare utilization and Prior Authorization program. Services provided through Shriner's Hospital and discounted through the Third Party Administrator's 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 Plan's healthcare utilization and Prior Authorization program.

B. Eligible Dependent child, residing outside the elected Network service area, needs health care and uses Out-of-Network providers, and the Member lives in the Network service area:

- 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 MPA limits. Members are responsible for a 20% Coinsurance and any amounts over the MPA limits A Member's 20% Coinsurance will accrue towards the In-Network maximums.

C. Emergency care (urgent care is not paid the same as emergency care. Regular Plan Benefits apply to urgent care):
   - In-Network providers: An In-Network Benefit level applies after a $200 emergency room Copayment for an emergency. (The Copayment is waived if the patient is admitted and is not subject to the Deductible.) Copayments do not accrue towards Out-of-Pocket Maximums
   - Out-of-Network providers: An In-Network Benefit level applies, up to the MPA limits, after $200 emergency room Copayment for an emergency. (The Copayment is waived if the patient is admitted and is not subject to the Deductible.) The 20% Coinsurance will accrue towards In-Network maximums. Copayments do not accrue towards Out-of-Pocket Maximums.

D. Out of Network provider services ordered by In-Network providers at an In-Network Hospital and/or urgent care center:
   - After the In-Network Deductible is met, the 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 an In-Network provider, will be covered at the In-Network Benefit level (subject to the MPA) when the patient has no control over the choice of provider for these services. The Out of Pocket Maximums (except for those charges in excess of the MPA) will apply to the In-Network Out of Pocket Maximum.

E. Benefit level for Members residing outside their elected Network service area:
   - 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 Benefit, the Out-of-Network Benefit for most covered expenses is 60% of the MPA after the annual Deductible.

2.01.740 “Third Party Administrator” or “TPA” shall mean a company with which the City contracts to provide customer service and claims payment or reimbursement for the Plan's self-insured medical and dental Benefits.

2.01.750 “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, is investigational or experimental, or in which the decision as to whether a Benefit 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 during Initial Enrollment upon initially becoming eligible. If an Eligible Employee does not enroll within 31 days of first becoming eligible, the Eligible 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 Employees 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 Employees 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 Employees of the Laborers' Local 483 Seasonal Maintenance Workers shall become eligible to participate if they worked as a Seasonal Maintenance Worker during the prior calendar year, satisfy the eligibility waiting period of 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

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

3.03.020 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 3.02.

3.03.030 Eligible Employees must elect or purchase some or all of the Benefits. 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 Benefits 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 are in a qualified leave status for the City. Eligible Employees must make the required Employee Contributions.

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 otherwise provided by an applicable labor agreement, or be in a qualified leave status. Eligible Employees must make the required Employee Contributions. 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 Employee Contributions. 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, except as required by the Uniformed Services Employment and Reemployment Rights Act of 1994.

3.04.050 Members must enroll their eligible Dependents in the Plan at the same time the Member becomes first eligible for the Plan either during Initial Enrollment or during the Annual Enrollment Period, except as allowed below:

A. 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 completes the Benefit Election Forms. The Member is required to provide the Administrator with 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 60 days of the date of marriage, 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. For a domestic partnership, coverage will become effective the first of the month following the date the Member completes the Benefit Election Forms. A completed and notarized Affidavit of Benefit Eligible Dependent Status form for the Member 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 Administrator. If the Administrator does not receive the required documentation within 60 days of the date the domestic partnership commenced (or was registered), coverage for the new partner/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.

C. Newborn children will be covered from birth, and claims will be paid for the newborn for the first 31 days. The Member must add the newborn child by filing the Benefit Election Forms within 60 days of the birth for continued eligibility. The Member is required to provide the Administrator with a copy of the Hospital or state issued birth certificate. If the Administrator does not receive the required documentation within 60 days of the date of birth, coverage for the Dependent may terminate retroactively back to the 31st day, and the Member 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 Member's home. Coverage may begin the date the child was placed in the home if the Member is assuming and retaining a legal obligation for financial support of the child. The Member must complete the Benefit Election Forms and submit a copy of the adoption or placement papers to the Administrator. If the Administrator does not receive the required documentation within 60 days of being placed in the home, coverage for the Dependent may terminate retroactively back to the 31st day, and the Member will be held financially responsible for any claims paid on the child's behalf.

E. A 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 Member must complete the Benefit Election Forms for continued eligibility. The Member is required

to provide the Administrator with a copy of the Hospital or state issued birth certificate. If the Administrator does not receive the required documentation within 60 days of the date of birth, coverage for the Member's Dependent's child may terminate retroactively back to the 31st day, and the Member will be held financially responsible for any claims paid on the child's behalf.

F. A grandchild or other child may be added within 31 days from the date custody and guardianship are granted, so long as the child qualifies as a Dependent under the Plan. The Member must complete the Benefit Election Forms for continued eligibility and provide the Administrator with a copy of the court order granting custody and appointing the guardian and a copy of the letters of guardianship. If the Administrator does not receive the required documentation within 60 days of the date of custody or legal guardianship, coverage for the Dependent may terminate retroactively, and the Member 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 Eligible 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 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 Administrator will add the child to the Eligible Employee's coverage and will change any required Employee Contributions.

H. HIPAA Special enrollment Rights: Mid-year election 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 who 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 to the Administrator within 60 days.

I. Medicare or Medicaid: Mid-year election 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 Administrator 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 Employee Contributions by the due date established by the 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 (except as required by the Uniformed Services Employment and Reemployment Rights Act of 1994) or personal unpaid leave, or is unable to meet the minimum work requirements within his or her 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 Dependents 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 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, or 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 Employee Contributions will be deducted from the first paycheck the Member 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 other Dependents, whose coverage terminates under the health 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 FMLA

3.06.010 Notwithstanding any provision to the contrary in the Plan, if a Member goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the City will continue to maintain the Member's group healthcare 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 FMLA leave, the City will continue to pay the Employer Contributions. 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 FMLA leave, the Administrator may terminate medical, dental, and vision Benefits if the Member fails to make the required Employee Contributions. The Administrator may fund coverage during the FMLA 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 an 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 Employees, except Seasonal Maintenance Workers, must elect a medical and vision Benefit from the menu, unless the Eligible Employee provides evidence of enrollment in another employer's group medical coverage. If the Eligible Employee elects medical/vision Benefits, then the Member must elect a dental Benefits. The determination to allow the Eligible Employee to opt-out of the Plan's medical coverage is made at the discretion of the Administrator after review of documentation that the Eligible Employee has medical coverage through another employer group medical plan. It shall be the responsibility of the Eligible Employee to immediately notify the Administrator upon cessation of any such other group medical coverage as described in the Benefit Election Forms.

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

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

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

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

4.01.060 All eligible full-time and part-time Seasonal Maintenance Workers are deemed to have elected single party Seasonal Maintenance Worker medical Benefits as provided in their collective bargaining agreement, unless the Eligible Employee provides evidence of enrollment in another medical plan. The determination to allow the Eligible Employee to opt-

out of the Plan's medical coverage is made at the discretion of the Administrator after review of documentation that the Eligible Employee has medical coverage through another plan. It shall be the responsibility of the Eligible Employee to immediately notify the Administrator upon cessation of any such other group medical coverage as described in the Benefit Election Form.

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

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

4.02 Default Benefits

With respect to the Plan Year commencing on July 1, 2013 and for any subsequent Plan Year, 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 the following default benefits:

4.02.010 For any Plan Year in which any one or all of the medical, dental, vision, life, and long term disability Benefits 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 Employee Contributions for such Plan Year for 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 Benefits have been substantially changed as determined by the Administrator or for which no prior election was made by an Eligible Employee, 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, LOCAL 189-H (HOUSING), PFFA, PPCOA, and Recreation Eligible Employees will be enrolled in Eligible Employee only coverage with the self-insured CityCore medical Benefit, the vision Benefit offered with the self-insured medical Benefit, the dental Benefit with the lowest total premium cost other than Kaiser Dental, the City funded group term life insurance Benefit, and the City funded group long term disability Benefit, as applicable.

B. For Initial Enrollment, the Seasonal Maintenance Workers will be enrolled in Eligible Employee only coverage under the Seasonal Maintenance Worker self-insured medical Benefit, the vision Benefit offered with the self-insured medical Benefit and the Seasonal Maintenance Worker self-insured dental plan.

C. For Initial Enrollment, the PPA Eligible Employees will be enrolled in Eligible Employee only coverage under the CityNet insured medical Benefit, the vision Benefit offered with the CityNet medical Benefit, the dental Benefit with the lowest total premium cost other than Kaiser Dental, and the City funded group term life insurance Benefit.

D. For the Annual Enrollment Period, the non-represented, BOEC, COPPEA, DCTU, LOCAL 189-H (HOUSING), PFFA, PPCOA, and Recreation Eligible Employees will be enrolled in the plans they were enrolled in as of June 30th (except the flexible spending account plans MERP and DCAP) at the same tier (i.e. Employee only, two-party, or family) as elected the prior Plan Year; the City funded group term life insurance Benefit, the City funded group long term disability Benefit; and, if previously enrolled, the Employee funded group long term disability Benefit buy-up, the Employee funded vision buy-up and the Employee funded term supplemental life insurance Benefit.

E. For the Annual Enrollment Period, the Seasonal Maintenance Worker will be enrolled in the plans they were enrolled in as of June 30th..

F. For the Annual Enrollment Period, the PPA Eligible Employees will be enrolled in the plans they were enrolled in as of June 30th (except the flexible spending account plans MERP and DCAP), at

the same tier (i.e. Employee only, two-party, or family) as elected the prior Plan Year; the Employer funded group term life insurance Benefit; and, if previously enrolled, the Employee funded vision buy-up and term supplemental life insurance.

CHAPTER 5

5.0 TERMS AND PROVISIONS OF THE PLAN

5.01 General

5.01.010 "CityCore"and "Seasonal Maintenance Worker" Benefits are self-insured medical Benefits sponsored by the City, as is any run out from the formerly self-insured "CityNet". "CityNet" became insured as of September 2007. Self-insured means there is no Insurer responsible for paying the claims incurred by 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.

A. Benefit-eligible non-represented Employees, BOEC, COPPEA, DCTU, LOCAL 189-H (HOUSING), PFFA, PPCOA, and Recreation Employees are eligible to participate in the CityCore Benefit.

B. Benefit-eligible Seasonal Maintenance Workers are eligible to participate in the Seasonal Maintenance Worker Benefit.

5.01.020 The City self-insured Benefits 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 Members. The City has fee schedule arrangements with the PPO Networks and with Network fee schedule savings passed on to Members and the City. The PPO Networks for the CityCore Benefits are the ODS Plus Network, the ODS Alternative Care Network, the ODS travel Network, and the PHCS Network. The PPO Networks for the CityNet Benefits include the ODS Plus Network, the ODS Alternative Care Network, the ODS travel Network, and the PHCS Network. The Seasonal Maintenance Worker Benefit includes the ODS Plus Network.

5.01.030 The City self-insured Benefit 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:

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

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

- Hospital indemnity coverage or other fixed indemnity coverage;
- Accident-only coverage;
- Specified disease or specified accident coverage;
- School accident coverage;
- Benefits for non-medical components of group long-term care policies;
- Medicare supplement policies;
- Medicaid policies; or
- 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 COB, the following definitions apply:

A. An "Allowable Expense" shall mean 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.

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

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

- 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 Code Section 223, 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 Code Section 223(c)(2)(C).

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

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

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

F. "Claimant" means the enrollee for whom the claim is made.

G. 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.

H. "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.

I. "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 he or she 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 the Third Party Administrator 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. <u>Non-dependent/Dependent.</u> 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:

- 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.
- 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.
- 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.)
    - The plan covering the Custodial Parent;
    - The plan covering the spouse or partner of the Custodial Parent;

- The plan covering the non-Custodial Parent; and then
- 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 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. The TPA 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. The TPA need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give the TPA any facts it needs to apply those rules and determine benefits payable.

5.03.080 Facility of Payment: If another plan makes payments this Plan should have made under this COB provision, the Plan can reimburse the other plan directly. Any such reimbursement payments will count as benefits paid under this Plan, and the Plan will be released from liability to the Claimant 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 COB, 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

5.04.010 The Plan complies with the health continuation provisions of the FMLA, Oregon Family and Medical Leave Act ("OFLA"), and the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

5.04.020 The Member 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 Member continues to pay the required Employee Contributions, if any, of the elected Benefits. The Member also may pay the unpaid portion of the Employee Contributions upon the return to work. If the Member does not return to work after the approved FMLA 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 Member and/or his/her enrolled Dependents elect not to remain covered during an FMLA leave, the Member and/or enrolled Dependents will be eligible to be reinstated in the Plan on the date the Member returns from the FMLA leave.

5.04.030 In all events, the Member's and/or his enrolled Dependents' rights under this provision are determined by the FMLA and its regulations, as amended.

5.04.040 If a Member leaves his or her job to perform military service, he or she has the right to elect to continue his or her existing health Benefits coverage and coverage for enrolled Dependents for up to 24 months while in the military, as provided for under USERRA. If the Member does not elect to continue coverage during military service, the Member has the right to be reinstated in the City's health Benefits upon reemployment, generally without any waiting periods or exclusions, except for service-connected illnesses or injuries.

5.04.050 The City will pay the cost of continuing to provide health Benefit coverage under USERRA for up to 24 months and will waive the 2% administrative fee for the Dependents of City Members 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 Member was at work. The Dependents of Members who have dual coverage through the City or a spouse/domestic partner's employer are not eligible for this benefit. For Members on military leave less than 31 days, their City paid coverage will continue.

5.05 Continuation of Benefit Coverage

Under certain conditions, Members and/or their eligible Dependents may continue medical, dental, and vision Benefits 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. Members must continue to pay any applicable Employee 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 Member or a legally separated or divorced spouse age 55 or over, and his or her 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, legally separated, or divorced spouse and any Dependents whose coverage under the Plan otherwise would terminate because of the death of, or legal separation/divorce from, the Member, 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 Member Continuation: City disabled Members and their eligible Dependents may continue medical, vision, and dental Benefits by self-paying the monthly cost of the Benefits. Where collective bargaining agreement language deviates from this Plan, the collective bargaining agreement language will be the governing language.

A. Eligibility: In order to be eligible for disabled Member continuation of coverage, the Member must meet the following conditions:

- 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

- Must have been covered under the active Plan on a City paid basis in the month preceding disability.

B. PERS Disabled Member Continuing Eligibility: Disabled Members not eligible for Medicare and their non-Medicare eligible, covered Dependents are able to continue coverage under the Plan by self-paying the monthly cost of the Benefits by the due date set by the Administrator. Once a disabled Member and/or Dependent becomes eligible for Medicare, he or she is no longer eligible for the non-Medicare Plans including vision and dental.

C. Fire and Police Disability and Retirement Fund Disabled Continuing Eligibility: Disabled Members not eligible for Medicare and their non-Medicare eligible Dependents are able to continue coverage under the Plan by self-paying the monthly cost of the Benefits by the due date set by the Administrator. Once a disabled Member and/or Dependent becomes eligible for Medicare, he or she is no longer eligible for the non-Medicare Plans, including vision and dental.

- 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 coverage under the Plan by self-paying the monthly cost of the Benefits. 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 eligible for the non-Medicare Plans including vision and dental.

D. Termination of Coverage: If disabled Members elect to terminate coverage under the Plan prior to age 65, they can only re-enroll in the Benefits 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 Plan to the date they want to re-enroll. An independent election for dental Benefits 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 Member has shown continued coverage on a self-pay basis. Where

collective bargaining agreement language deviates from this Plan, the collective bargaining agreement language will be the governing language.

5.06 Retiree Eligibility

City retirees and their eligible Dependents may continue medical, vision, and dental Benefits by self-paying the monthly cost of the Benefits. Where collective bargaining agreement language deviates from this Plan, 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 Member 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 Plan on a City paid basis in the month preceding retirement.

C. Retirees Continuing Eligibility: Retired Members not eligible for Medicare and their non-Medicare eligible Dependents are able to continue coverage under the Plan by self-paying the monthly cost of the Benefits by the due date set by the Administrator. Once a Retired Member and/or Dependent becomes eligible for Medicare, he or she is no longer eligible for the non-Medicare Plans, including vision and dental.

- 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 coverage under the Plan by self-paying the monthly cost of the Benefits. 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 eligible for the non-Medicare Plans including vision and dental.
- Termination of Coverage: If retirees elect to terminate coverage under the Plan prior to age 65, they can only re-enroll in the Benefits 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 Plan to the date they want to re-enroll. An independent election for dental coverage is not allowed if the retiree 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"

COBRA requires that the Plan offer Members and their eligible Dependents ("qualified beneficiaries") the opportunity to elect a temporary extension of health coverage in certain instances where coverage under the Plan would otherwise end ("qualifying events").

Each Benefit made available under this Plan that is considered to be a "group health plan" under Code Section 5000(b)(1) due to Members and their Dependents being provided with health care benefits within the meaning of Code Section 213(d)(1) shall provide continuation coverage to qualified beneficiaries in the manner and to the extent required by Code Section 4980B(f) and Sections 601-608 of ERISA.

There are five group health components to the Plan's COBRA continuation coverage: (1) medical/vision, (2) dental, (3) Employee Assistance Program (EAP), and (4) the Medical Expense Reimbursement Plan ("MERP"), and the Health Reimbursement Account ("HRA"). COBRA applies only to these components and not to any other Benefits offered by the Plan. The Plan provides no greater COBRA rights than what COBRA requires.

5.08 Oregon Medical Insurance Pool ("OMIP") Portability Coverage

5.08.01 The Oregon Medical Insurance Pool (or other similar state-provided coverage, e.g. state health exchange) provides medical insurance to the Plan COBRA qualified beneficiaries 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.

5.08.02 Enrollees must pay the full premiums each month to maintain insurance coverage through OMIP. The Administrator will provide information about OMIP plans and costs or the health care options to eligible individuals.

5.09 Washington State Health Insurance Pool ("WSHIP") Portability Coverage

The Washington State Health Insurance Pool 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. The Administrator will provide information about WSHIP to eligible individuals.

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 Plan contains Medical and Behavioral Health Management Services in its medical Benefit options. 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 Plan's Third Party Administrator 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 a physician recommends any of the health care services listed under "Medical Review Services" requiring Prior Authorization.

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.

- Behavioral Health Services, including:
  a. Chemical dependency treatments, inpatient, partial hospitalization, and residential services.
  b. Mental health services (inpatient, partial hospitalization, and residential services),
- Durable medical equipment rental and purchases. (Rental exceeds 30 days or cost is over $500.)

- Home health care (includes palliative care).
- Hospice care.
- 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. The TPA 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.
- Transportation in lieu of ambulance.
- Organ transplants.
- Skilled nursing facility care.
- Special duty nursing.
- Surgical procedures--all inpatient elective surgeries and procedures.
- Surgery/treatment (outpatient)—all outpatient surgeries/treatment on the following 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
- Pet scans.
- Spect scans, unless being done for a cardiac diagnosis.
- Genetic testing.
- Anesthesia/out patient hospital for dental procedures.
- Speech therapy (after initial evaluation).
- Infusion services, dialysis, radiation and chemotherapy treatment.
- TMJ for second surgical appliance.
- Orthognathic surgery.
- Sleep studies and treatment for sleep apnea.

B. Prior Authorization Procedure: The procedures established by the Third Party Administrator 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.

- Non-Emergency Prior Authorization Procedure: In the event a Member requires a non-emergency service or treatment that has a service authorization requirement, the Member and/or provider must follow the Prior Authorization procedure established by the Third Party Administrator prior to receiving the service or treatment. 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.

5.10.040 Additional Medical Service Review Services: During a hospitalization, a registered nurse, in collaboration with the Member's physician and the facility discharge planners, may perform the following functions:

A. Concurrent Review: Review of the Member's progress during a hospitalization and verification of the appropriate level of care for continued stay.

B. 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.

C. Chemical Dependency and Mental Health Services Review: Review of future recommended treatment plans.

5.10.050 Care Coordination Services (Case Management): 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:

A. Catastrophic illness/injury;

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

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

D. Referral coordination services;

E. Lengthy hospitalizations; and

F. High-risk pregnancies.

The Plan may 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 the Third Party Administrator. 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 as a component of the Plan'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:

- Answer questions about medical concerns.
- Assist with the management of ongoing medical needs.
- Help Members understand medications.
- Clarify healthcare benefit options.
- Offer preventive wellness programs.
- Work with Members to set personal health goals.
- Identify appropriate health-related community resources.
- Provide customized health or medical educational tools.

5.10.070 Maternity Care Program: The CityCore Benefit includes free support throughout a Member's pregnancy with the Mode Health Maternity Care Program. Members who enroll in this program will receive:

A. Monthly one-on-one coaching by phone or e-mail.

B. Personal support throughout the pregnancy.

C. Educational materials about prenatal care.

D. Extra support for high-risk pregnancies.

E A baby monitor for active participation.

5.10.080 Diabetes Coaching: Members and their Dependents in the CityCore Benefit 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 include:

A. One-on-one meetings every 1 to 3 months with a pharmacist specially trained in diabetes to help treat and manage this condition.

B. Education about meal planning skills with a registered dietitian.

C. Participation in a grocery store tour with a diabetes care team member to learn how to make healthier food choices.

D. Personalized topics, which include:

- Monitoring, medications, and goals.
- Prevention and treatment of acute and chronic complications.
- Planning ahead for meals, dining out, carbohydrate counting, and physical activity.

E. Lab work every 6 to 12 months for the Member and his or her 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

5.11.010 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.)

A. Assumption or Adjudication of Responsibility: If a third party has accepted financial responsibility or been adjudicated 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.

B. Subrogation to Member's Rights

- 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.
- 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.

5.11.020 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:

- The Plan may use an inter-insurer reimbursement proceeding to obtain direct reimbursement from the motor vehicle liability insurer.
- 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 the Plan has furnished benefits, less its 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.
- 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.

5.11.030 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.

5.11.040 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.

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

5.12 Extension of Hospitalization Benefits

The Plan's self-insured plan options (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

The Administrator shall establish and communicate the Benefit claims procedures and payment procedures to all Members and Dependents. All claims shall be made directly to the Third Party Administrator or Insurer providing claims payment or coverage.

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 Moda Health's Customer Service. Otherwise, an appeal must be submitted in writing to Moda Health. If necessary, Moda Health's 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. Moda Health 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 Moda Health, unless the member fails to provide sufficient information for Moda Health to make a decision. In this case, Moda Health 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) Moda Health's 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, Moda Health 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 Moda Health's 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 Moda Health 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 Moda Health's determination is finalized. Moda Health 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 Moda Health 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, Moda Health 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 Moda Health fails to comply with the decision, the member may initiate a suit against Moda Health.

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: Moda Health Plan
P.O. Box 14480
Salem, Oregon 97309-0405
By phone: 503-947-7984
By internet: www.cbs.state.or.us//ins/index.html
By-email: cp.ins@state.or.us

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

5.15 Federal Newborns' and Mothers' Health Protection Act of 1996

The Plan is administered in accordance with the Newborns' and Mothers' Health Protection Act of 1996 and provides that 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 and a hospital stay following a cesarean section may generally not be limited to less than 96 hours for both the mother and newborn child.

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

The Plan is administered in accordance with the Federal Women's Health and Cancer Rights Act of 1998 and 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).

5.17 Genetic Information and Nondiscrimination Act of 2008

The Plan shall comply with the provisions of GINA and, accordingly, shall not, unless expressly permitted by GINA or corresponding regulations, restrict enrollment or adjust premiums based on genetic information or require or request genetic information or genetic testing prior to, or in connection with, enrollment.

5.18 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

The Plan is administered in accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

5.19 HIPAA Provisions

The Plan shall administer the provisions of the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), dealing with certificates of creditable coverage and special enrollment rights in the manner and to the extent required by the applicable provisions of ERISA Section 701.

5.20 Qualified Medical Child Support Orders

The Plan shall provide Benefits in accordance with the applicable requirements of any qualified medical child support order, within the meaning of ERISA Section 609, received by the Plan, in accordance with such written procedures as shall be established by the Administrator. Except to the extent permitted by ERISA Section 609(a)(4), no qualified medical child support order shall require the Plan to provide any type or form of benefit or option not otherwise provided by the Plan.

5.21 Health Care Outcomes

The adoption, establishment, and operation of the Plan, including, without limitation, any determination made by the Administrator and the payment for Benefits by the City, shall not constitute any express or implied representation, warranty, or covenant by or on behalf of the Plan, the Administrator, or the City, either jointly or severally, with respect to the outcome of any Benefit provided or rendered to any Member or Dependent.

5.22 Responsibility for Health Care

The provisions of the Plan shall not be construed to limit a Member or Dependent with regard to the choice of health care, such choices including, but not limited to, the kind,

type, duration, amount, or results thereof. Obtaining health care and determining which health care to utilize shall be at the sole discretion of the Member or Dependent and shall not be construed, interpreted, or deemed as resulting from the Plan.

Each Member or Dependent shall be solely responsible for deciding the health care that he or she receives and shall make such a decision as to his or her health care independent of any determinations to whether reimbursement will or will not be made under the Plan for a health care expense. The determination of whether or not a health care expense is Medically Necessary is made solely for purposes of determining whether payments will be made under the Plan and is not intended to be advice to a Member or Dependent concerning his or her health care. Each Member or Dependent shall be solely responsible for selecting the health care professionals, Hospitals, and other providers who will provide health care to him or her.

CHAPTER 6

6.0 CITYCORE PPO MEDICAL PLAN

All medical services must be medically 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: $250/person; $750family maximum	CityCore: $650/person; $1,950 family maximum
Plan Year Out-of-Pocket Maximum (CityCore prescription drug co-insurance, deductibles, office visit and all other copays, and charges over MPA do not apply to annual maximum)	CityCore: $2,250/person; $6,750family maximum	CityCore: $6,750/person; $20,250/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 **60**	

Medical Plan Feature	CityCore	
	In-Network	Out-of-Network
Wellness Routine Physical Exams & Immunizations (except for travel-related immunizations) Non-routine lab work and/or tests and other medically necessary exams are *not* covered at 100%, but will be covered at regular benefit levels. Services as required under the Affordable Care Act	100% no deductible Your Responsibilities: ▪ 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. ▪ Seek services through an in-network provider. ▪ Ensure your provider uses an in-network lab. Read your Moda Health explanation of benefits to confirm billing and payment to your provider. If there is an error contact Moda Health and your provider to ensure the correct payment	60% of MPA after deductible

Medical Plan Feature	CityCore	
	In-Network	Out-of-Network
	Routine physical exam maximum**:* Newborn 2 hospital exams 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 copay):** 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 fecal occult blood test per 12 mos.	
Office Care Office visits for non-specialty providers;, lab work, allergy shots; and other medically necessary exams.	$20.00 copay	60% of MPA after deductible
Pregnancy – Prenatal visits and physician delivery charges	$250 copay for physician services	60% of MPA after deductible
Specialist visits (cardiologists, orthopedics, ENT, urgent care, etc)	$35 copay	60% of MPA after deductible

Medical Plan Feature	CityCore	
	In-Network	Out-of-Network
Diagnostic x-rays, , 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
Advanced Imaging such as MRIs, CT scans, PET Scans	$75.00 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
Emergency Room (copay waived if admitted as inpatient following emergency)	: 80% after $200 copay (not subject to deductibles)	80% of MPA after $200 copay (not subject to deductibles)
Urgent Care	$35.00 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.	$20.00 copay 35-visit annual maximum for chiropractic. Services must be prior authorized by Moda Health for more than 20 visits.	60% of MPA after deductible
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.)

Medical Plan Feature	CityCore	
	In-Network	Out-of-Network
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
Refractive Eye Surgery	Not covered	Not covered
Hearing Aids For members under age 26	80% (no deductible) up to a maximum of $4,410 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 $4,410 every 48 months for members under age 26 and when services are provided 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.**	$20.00 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**	$20.00 copay for outpatient office visits. 80% after deductible for inpatient and residential treatment programs.	60% of MPA after deductible
Sterilization, Contraceptive Implants	100%	60% of MPA after deductible

Medical Plan Feature	CityCore	
	In-Network	Out-of-Network
(e.g., IUD and Norplant)		
Sleep Apnea	80% after deductible, subject to prior authorization	60% of MPA after deductible; subject to prior authorization
Infertility Treatment	Not covered	Not covered
Prescription Drugs **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) **Out-of-network pharmacy** (up to 30-day supply) **Mail order pharmacy** (up to 90-day supply)	Deductible does not apply. In-Network Pharmacy : – 90% of generic drug cost; $5 minimum ($0 minimum at $4 pharmacies), $25.00 maximum copay – 80% of preferred brand name drug cost; $10 minimum, $50.00 maximum copay. For statins, ARB's 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; $25 minimum, $75.00 maximum copay. Out-of Network pharmacy: You pay the pharmacy; then submit claims to Moda Health for 60% reimbursement after out of network deductible is met. Same as in-network retail pharmacy benefit levels shown above	

6.01 Accessing the Networks:

Within 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, Nutritional Counseling, Tobacco Cessation, certain contraception's, In-Network Preventive Care, Emergency Room treatment, Out-of-Network Urgent Care, Ambulance, In-Network Sterilization, In-Network Prescription Drugs 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, deductibles 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. Breastfeeding Support: Comprehensive lactation support and counseling is covered during pregnancy and/or the post partum period. The Plan will cover the purchase or rental charge (not to exceed the purchase price) for a breast pump and equipment. Charges for supplies such as milk storage bags and extra ice packs, bottles or coolers are not covered.

8. 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).

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

10. Contraceptive device insertion and removal.

11. 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.

12. 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.

13. 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.

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

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

16. 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.

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

18. 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.

19. 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.

20. 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.

21. 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.

22. 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.

23. 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.

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

25. 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.

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

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

28. 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 Moda Health. 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 Moda Health 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 Moda Health.

29. 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.

30. 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.

31. 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.

32. 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.

33. 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.

34. 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 Moda Health 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.

35. 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**.**

36. 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.

37. 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.

38. 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.

39. 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.

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

41. 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.

42. 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. Plan coverage for Angiotension Receptor Blockers (ARBs) will be limited to the cost of the generic ARB. If If a member chooses to purchase a Brand ARB, the member will pay the difference in cost between the highter cost Brand medication and generic in addition to the generic copay.

H. Erectile Dysfunction (ED) medications are limited to 8 doses per month.

I. 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.

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

- 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 impairment 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; or if medically necessary to restore function due to a congential craniofacial anomaly.

- 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 medically 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

Medical Plan Feature	PPO Seasonal Maintenance Worker (SMW) Medical Plan	
	In-Network Member Pays	**Out-of-Network Member Pays**
	Routine physical exam maximum**:* Newborn 2 hospital exams 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 ***<u>Cancer Screenings</u>: ***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.	
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 copay per visit 30% $15 copay per visit $10 copay 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

Medical Plan Feature	PPO Seasonal Maintenance Worker (SMW) Medical Plan	
	In-Network Member Pays	**Out-of-Network Member Pays**
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	
○ **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 Moda Health 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
Refractive Eye Surgery	Not Covered	Not covered
Hearing Aids	30% of MPA (no deductible) up to $1,200 per ear. New hearing aid covered once every 36 months if medically necessary	50% of MPA (no deductible) up to $1,200 per ear. New hearing aid covered once every 36 months if medically necessary
TMJ Treatment	Not covered	Not covered

Medical Plan Feature	PPO Seasonal Maintenance Worker (SMW) Medical Plan	
	In-Network Member Pays	**Out-of-Network Member Pays**
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)	100%	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 ($10.00 min/$50.00 maximum copay. For statins, ARBs, and proton pump inhibitors (PPI) member to pay 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) $25.00 min/$75.00 max	
Out-of-network pharmacy (up to 30 day supply)		Out-of-Network pharmacy: Member pays pharmacy and submits claims to Moda Health 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. Breastfeeding Support: Comprehensive lactation support and counseling is covered during pregnancy and/or the post partum period. The Plan will cover the purchase or rental charge (not to exceed the purchase price) for a breast pump and equipment. Charges for supplies such as milk storage bags and extra ice packs, bottles or coolers are not covered.

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 on the Medical Plan Features chart.

9. Contraceptive device insertion and removal.

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

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

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

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

14. 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.

15. 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.

16. 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.

17. 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.

18. 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.

19. 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.

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

21. 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.

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

23. 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).

<u>B. Covered Benefits</u>

All transplant procedures must be authorized and be medically necessary and appropriate according to criteria established by Moda Health. 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 Moda Health 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 Moda Health.

24. 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.

25. 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.

26. 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.

27. 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.

28. 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

29. 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.

30. 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.

31. 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. Plan coverage for Angiotension Receptor Blockers (ARBs) will be limited to the cost of the generic ARB. If If a member chooses to purchase a Brand ARB, the member will pay the difference in cost between the highter cost Brand medication and generic in addition to the generic copay.

H. Erectile Dysfunction (ED) medications are limited to 8 doses per month.G.

I. 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

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. or if medically necessary to restore function due to a congential craniofacial anomaly.
- 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"

CHAPTER 8

8.0 MODA HEALTH DENTAL PLAN

8.01 Self Insured Dental Plan

"Moda Health Dental Plan" is a self-insured dental plan sponsored by the City effective July 1, 2013 and offered to non-represented employees, BOEC, COPPEA, DCTU, LOCAL 189-H (HOUSING), PFFA, PPCOA, and Recreation Employees.

Dental Plan

Dental Plan Feature	Moda Health 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	Moda Health Class I – 100% (no deductible) for eligible services
Routine	Moda Health Class II - 80% after deductible
Major (includes inlays, onlays, crowns, and permanent prosthetics.) In addition, Kaiser includes periodontics & endodontics in this category.	Moda Health 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, Preventtive.
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 Moda Health.

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 Moda Health 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 Moda Health 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 Moda Health's 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. Moda Health 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. Moda Health need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Moda Health 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.

CHAPTER 9

9.0 SMW DENTAL PLAN

9.01 Self Insured Dental Plan

"SMW Dental Plan" is a self-insured dental plan sponsored by the City effective July 1, 2013 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	Moda Health Class I – 100% (no deductible) for eligible services
Routine	Moda Health Class II - 80% after deductible
Major (includes inlays, onlays, crowns, and permanent prosthetics.) In addition, Kaiser includes periodontics & endodontics in this category.	Moda Health 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:

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*†.
    i. †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.*

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.
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, Preventtive.
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.

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:

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.

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 Moda Health 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:

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.

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 Moda Health's 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. Moda Health 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. Moda Health need not tell, or get the consent of, any person to do this. Each person claiming benefits under

this Plan must give Moda Health 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.

CHAPTER 10

10.0 HIPAA PROVISIONS FOR THE PLAN

10.01 Health Insurance Portability and Accountability Act

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

10.01.020 The Benefits of the Plan that are not subject to HIPAA shall not be subject to this Chapter.

10.01.030 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.

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

A. "Protected Health Information" shall mean information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of the individual; the provisions of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

10.02 Permitted Disclosure of Enrollment/Disenrollment Information

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

10.03 Permitted Uses and Disclosure of Summary Health Information

10.03.010 "Summary Health Information" shall mean information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided

health Benefits under the Plan. The summary will only identify the general geographical location of the individual and will not include any information by which a particular individual can be identified.

10.03.020 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 the Plan for providing health insurance coverage, or (b) modifying, amending, or terminating the Plan.

10.04 Permitted and Required Uses and Disclosure of PHI

10.04.010 Unless otherwise permitted by law, and subject to the conditions of disclosure described in Subsection 11.05 and obtaining written certification pursuant to Subsection 11.07, 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" shall mean 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).

10.04.020 The Plan may use or disclose an individual's PHI without the consent or authorization of the individual for purposes of payment, health care operations, and any other purpose for which use or disclosure is permitted or required under the HIPAA Privacy Rule.

10.04.030 Notwithstanding anything herein to the contrary, the Plan may disclose PHI to the Plan Sponsor in accordance with an individual's authorization or as otherwise permitted or required by the HIPAA Privacy Rule.

10.04.040 The Plan Sponsor shall report to the Plan any uses and disclosures of PHI of which it becomes aware that are inconsistent with uses and disclosures provided for under this Chapter.

10.05 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:

10.05.010 Not use or further disclose the PHI other than as permitted or

required by the Plan or as required by law.

10.05.020 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.

10.05.030 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.

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

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

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

10.05.070 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.

10.05.080 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.

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

10.06 Adequate Separation Between Plan and Plan Sponsor

The Plan Sponsor shall allow the following City Employees access to PHI: Benefit Office Employees, Payroll Employees, the Bureau of Technical Services Employees that provide technical support for the 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 Members, and the 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.

10.07 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 Section 11.05 above.

10.08 HIPAA Security Rule

This Section is included in the Plan pursuant to the Standards for the Security of Electronic PHI as set forth in 45 CFR Parts 160 and 162 and Part 164, Subpart C (the "Security Standards"). The Plan shall comply with the following provisions.

10.08.010 The City shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan, consistent with the requirements of the Security Standards.

10.08.020 The City shall ensure that the adequate separation requirement set forth in 45 CFR §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures, consistent with the requirements of the Security Standards.

10.08.030 The City shall take reasonable steps to ensure that any agent, including a subcontractor, to whom it provides the Electronic PHI agrees to implement reasonable and appropriate security measures to protect such information.

10.08.040 The City shall report to the Plan any security incident, as defined in the HIPAA Security Standards, of which it becomes aware.

10.09 Health Information Technology Act

The City shall comply with the breach notification provisions as set forth in the Health Information Technology Act of the American Recovery and Reinvestment Act of 2009 and the regulations thereunder.

10.10 HIPAA NOTICE OF PRIVACY PRACTICES

10.1.01 Health Insurance Portability and Accountability Act (HIPAA)

The Plan is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of August 1996. Certification of creditable coverage will be provided to plan participants pursuant to this act and to relevant administrative rules.

10.1.02 HIPAA Notice

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 to 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 MODA Health (Administrator), to administer the Plans and to process medical claims and appeals made by participants in the Plans. It also hires various other agencies to assist in administering the cafeteria plan components, utilization review, pharmaceutical benefits, Employee Assistance Program (EAP) and other benefit consulting needs. These Agents are currently BenefitHelp Solutions, Aliquant, AON Consulting, Kaiser Permanente, Cascade Centers, Managed Health care Northwest, MODA Health, Kroger Pharmacy, and Vision Service Plan.

Should any of the City, Administrator, or Agency privacy practices change, the City reserves the right to change the terms of this notice and to make the new notice effective for all protected health information. Once revised, the City will notify you that a change has been made and post the notice on our Web site at www.portlandonline.com/omf/bhr. You may also request the new notice be mailed to you.

This notice explains how the City, Administrator, and Agents use information about you and when that information can be shared with others. It also informs you about your rights. Finally, this notice provides you with information about exercising these rights.

HOW THE CITY USES OR SHARES INFORMATION

The City acquires limited "Protected Health Information" (PHI) about you in order to enroll, maintain, change and terminate your participation in the Plans. Those in the City performing these functions include City payroll employees in your bureau, employees in the Bureau of Technology Services (BTS), and employees assigned to the Benefits and Wellness Office in the Bureau of Human Resources. They will obtain the following information from you to perform these functions: The names, dates of birth, addresses, phone numbers, social security numbers, employment data with the City, enrollment in other medical benefit plans if any, of your self and any dependents and/or domestic partners that participate in the Plans. Other authorized City employees may also use this information to conduct quality assessment and improvement activities, other activities relating to the creation, renewal or replacement of health benefits and budget creation and analysis.

The City may also acquire information from the Plans that has been de-identified – that is medical information that cannot be linked to any individual participant, for purposes of utilization review, cost studies, and review of appeals decisions made by the Administrator with respect to any Plan benefit.

HOW THE ADMINISTRATORS AND AGENTS USE AND SHARE INFORMATION

The City's Agents and Administrators use protected health information and may share it with others as part of your treatment, payment for treatment, and Plan operations. The following are ways the Agents and Administrators may use or share information about you:

- The Agents and Administrator will use the information to administer your plan benefits and help pay your medical bills that have been submitted to the Agents and Administrator by doctors and hospitals for payment.
- The Agents and Administrator may share your information with your doctors or hospitals to help them provide medical care to you. For example, if you are in the hospital, the Agents and Administrator may provide access to any medical records sent to the Agents and Administrator by your doctor.
- The Agents and Administrator may use or share your information with others to help manage your health care. For example, the Agents and Administrator might talk to your doctor to suggest a disease management or wellness program that could help improve your heath.
- The Agents and Administrator may share your information with individuals who perform business functions for the City. The City will only share your information if there is a business need to do so and if our business partner agrees to protect the information, in accordance with this privacy notice.
- The Agents and Administrator may give you information about treatments and programs or about health related products and services that may be to your benefit. For example, the Agents and Administrator sometimes send out letters to notify you about chronic conditions, tobacco 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's 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
Email: Anna.Kanwit@portlandoregon.gov

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 Health 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