Health Benefit Handbook

School District No. 1 | Health and Welfare Trust

For PAT Early Retirees

Rev. August 2016

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Welcome

The School District No. 1 Health and Welfare Trust (Trust) provides benefits to:

- Early retirees covered by collective bargaining agreements with the Portland Association of Teachers (PAT) who meet Trust eligibility requirements
- Dependent children, spouses and domestic partners of early retirees.

The Trust offers medical and prescription drug options depending on the collective bargaining group under which you retire. Benefits provided through Kaiser and the Providence Personal Option Plan are described in separate booklets available from the Trust Office or the health plan. Voluntary dental and vision coverage is offered to most retirees and dependents. (See “Coverage Options for Early Retirees and Dependents” on page 2 for the specific plans for which you are eligible.)

This handbook is updated on a regular basis. Please refer to the Trust web site at www.sdtrust.com for the most recent version of this handbook.

You can also find up-to-date information about all Trust benefit plans at the Trust’s web site, www.sdtrust.com. From the web site, you can download and print plan booklets and forms. If you have questions about the Trust, the benefits it provides or how Trust eligibility or procedural requirements apply to you, contact the Trust Office at (844) 203-0239.

Benefits are provided according to the written terms of the Trust’s plans or, where applicable, insurance policies. The Trustees have the discretionary authority to determine eligibility for benefits and to construe the terms of the Trust’s plans. Statements made by persons other than the Board of Trustees or the Board’s authorized representatives are not authorized by, and will not be binding on, the Trust.

The terms of the Trust’s plans may be amended periodically by the Board of Trustees to change eligibility or benefits, subject to the terms and conditions of collective bargaining agreements providing for participation in the Trust and any applicable laws or regulations. Any benefit option may also be modified, suspended or terminated at any time by the Trustees. The Trust or its benefit options are not a guarantee of future employment. It is complementary to, and does not affect, any requirement for coverage by workers’ compensation insurance.

Coverage Options for Early Retirees and Dependents

The benefit options available to you depend on the collective bargaining agreement under which you retire. The following options are available to the different groups of retirees participating in the Trust and their dependents.

The actual benefits provided under each option are described in *Medical*, *Prescription Drug*, *Dental* and *Vision*.

Medical and Prescription Drug Coverage Options

The medical options that are available to you depend on the collective bargaining agreement under which you retire.

PAT Early Retirees

If you have retired under a Portland Association of Teachers (PAT) bargaining agreement, you are eligible to elect to participate in:

- Early Retiree Trust Plan 1 (includes prescription drugs) – Closed – not open to new enrollment
- Early Retiree Trust Plan 2 (includes prescription drugs) – Open
- Early Retiree Providence Personal Option Plan and Trust Prescription Drug Plan
- Kaiser Permanente HMO Option (includes prescription drugs).

Voluntary Dental and Vision Options

If you have retired under the PAT bargaining agreement and otherwise meet the eligibility requirements for the Trust Early Retiree Voluntary Dental/Vision Plans, you may choose either:

- Basic Dental/Vision
- Buy-up Dental/Vision

Dental and vision coverage must be purchased together; however, you may elect only dental coverage if you are enrolled in the Kaiser Permanente early retiree option. (See *Participating in the Plans — Eligibility* for details.)

Participating in the Plans

This section describes the eligibility and enrollment procedures for the Trust's Early Retiree Plan medical and prescription drug options and voluntary dental and vision coverages. It also describes the Trust's continuation of coverage provisions. Eligibility, enrollment and benefit information that applies to active employees is described in a separate handbook.

Eligibility

This section describes what is required for you as a retiree and your dependents to be eligible for Trust benefits.

Active Employees

The eligibility requirements for active employees are described in a separate booklet. If you have other questions about retiree benefit options, please contact the Trust Office.

Medical and Prescription Drug Coverage

This section describes the eligibility requirements for the Trust's Early Retiree Plan medical and prescription drug options. Different requirements exist and different retiree options are available depending on the bargaining unit from which you retired.

The Trust has two retiree eligibility categories. The first is for retirees who are eligible for a contribution from the District toward the cost of the retiree coverage. The second is for retirees who are eligible to participate in an early retiree option but who do not qualify for a contribution from the District toward the cost of the retiree coverage.

Early Retirees — Eligible for District Contribution for Retiree Coverage

In defined situations, collective bargaining agreements that provide for participation in the Trust for eligible retirees and require that the District make contributions to the Trust for early retiree medical coverage.

The current eligibility rules governing when a retiree is eligible for a District contribution under collective bargaining agreements with the Portland Association of Teachers (PAT) remain in effect until the below sunset dates are met and require that the individual:

- Elects early retirement and is eligible to retire under the Public Employees Retirement System (PERS)
- Has completed at least 15 years of service with the District

- Retires from the District and from an employee classification that participates in the Trust and that is eligible to participate in the Trust Early Retiree Plan
- Is eligible under a retiree plan option then offered by the Trust.

Below are the Sunsets for the different PAT bargaining groups:

- June 30, 2016 – End of deferring of retirement benefits, except those that retired that date or earlier and have chosen to defer
- September 30, 2016 – Members who have 15 years of service with the District, regardless of age, will be eligible for retiree insurance benefits and Early Retiree Insurance stipend
- Those who retire without 15 years of service on September 30, 2016 or retire after that date will only have the self-pay option between the ages of 55 and 65.

Early Retirees — Not Eligible for District Contribution

Individuals not eligible for a District contribution may still be eligible to participate in a Trust Early Retiree Plan if they meet the following requirements:

- Retire from the District and are in an employee classification that participates in the Trust and that is eligible to participate in a Trust Early Retiree Plan
- Are eligible to receive a retirement benefit under the PERS
- Apply within 60 days of their effective date of retirement from the District.

Voluntary Dental and Vision Coverage

The following eligibility requirements apply to the Trust early retiree voluntary dental and vision coverages.

Retirees

You, as an early retiree under the PAT collective bargaining agreement, and your dependents are eligible to elect to participate in the Trust Early Retiree Voluntary Dental and Vision Plan. To be eligible, you must:

- Be participating in a Trust early retiree medical plan option
- Be receiving a retirement benefit under the Public Employees Retirement System (PERS)
- Apply within 60 days of your initial election of Trust early retiree medical coverage.

DEPENDENTS

If you enroll yourself in a Trust early retiree medical plan option, you may enroll your eligible dependents in the same option. Eligible dependents are:

- Your legal spouse or eligible domestic partner
- Your and your legal spouse's or domestic partner's children under age 26, including:
  - Biological and adopted children (or children placed with you for adoption)
  - Stepchildren
  - Eligible foster children who are defined as children placed with you by an authorized placement agency or by a judgment or other order of a court of competent jurisdiction
  - Children related to you by blood or marriage for whom you are legal guardian (you will need to provide a court order showing legal guardianship)
  - Children for whom there is a court order that meets applicable legal requirements, requiring you to maintain coverage, such as for a child in the custody of a former spouse. You may submit a medical child support order to the Trust Office to determine whether it is qualified. Upon request, the Trust Office will provide you with a copy of the procedures for determining the qualified status of a medical child support order.
- Your, your legal spouse's or domestic partner's children 26 or older who are incapable of self-support due to a physical or mental disability. The child's disability must have started *and* been reported to the Trust Office before the child reached age 26. To maintain eligibility under this provision, the child must be unmarried, financially dependent on you and incapable of supporting himself or herself.

ENROLLING DOMESTIC PARTNERS

To enroll a domestic partner or a domestic partner's dependent children, you must submit a completed *Affidavit of Domestic Partnership* to the District HR/Benefits Department. The affidavit defines a domestic partnership as two people of the same or opposite sex who:

- Have shared the same residence for at least six months immediately preceding the date of the Affidavit and intend to continue doing so indefinitely
- Have a close personal relationship with each other
- Are not legally married to anyone else
- Are each at least 18 years of age
- Are not related by blood to a degree of kinship that would bar marriage in the state where you live

Affidavit of Domestic Partnership

The Affidavit of Domestic Partnership is available from the Trust Office at (844) 203-0239, District HR/Benefits at (503) 916-3544, or on the Trust web site at www.sdtrust.com.

- Were mentally competent to contract when the domestic partnership began
- Are each other's sole domestic partner
- Are jointly responsible for each other's welfare, including basic living expenses such as food and shelter. (Partners are not required to contribute equally to these expenses.)

When you submit an *Affidavit of Domestic Partnership*, you may enroll your domestic partner and/or the partner's eligible children who reside in your home for coverage under your Trust-provided medical plan.

Enrollment

Benefits Enrollment Forms Are Available…

- At www.sdtrust.com.
- From the Trust Office at (844) 203-0239.

Submit the form to the Trust Office.

You may enroll in a Trust early retiree medical and prescription drug option and/or Trust early retiree voluntary dental/vision coverage during these times:

- **Initial enrollment —** when you and/or a dependent first becomes eligible or first enrolls for coverage
- **Annual open enrollment —** during a subsequent annual open enrollment only if you have not previously enrolled for coverage because you have suspended or deferred Trust early retiree medical coverage or have dental/vision coverage through another group health plan
- **Midyear enrollment —** following a qualifying change in family status, when you may make midyear benefit changes related to the status change.

See "Enrolling for Medical and Prescription Drug Coverage" on page 6 and "Enrolling for Voluntary Dental and Vision Coverage" on page 9 for more detailed information.

Enrolling for Medical and Prescription Drug Coverage

You may enroll in an early retiree medical and prescription drug plan option when you are first eligible, during open enrollment or if you have a qualifying change in family status.

Initial Enrollment

To participate in an early retiree plan, you must complete and return a *Benefits Enrollment Form* to the Trust Office. Benefit Enrollment Forms are available from the Trust Office or from the Trust web site at www.sdtrust.com.

Even if you plan to defer enrolling in a Trust early retiree medical plan option, you should notify the Trust Office of your decision to defer enrollment before your active employee coverage through the Trust ends.

If You are Eligible for a District Contribution

If you are eligible for a District contribution for retiree medical coverage and do not elect a medical plan option within 60 days of the effective date of your retirement, your enrollment will automatically be deferred (subject to retiree sunset rules) until the first of the month after you have returned a completed enrollment form to the Trust Office.

If You are Not Eligible for a District Contribution

If you are not eligible for a District contribution for retiree medical coverage, you must submit your *Benefits Enrollment Form* within 60 days of the effective date of your retirement; otherwise, you will forfeit your right to self-pay for retiree coverage through the Trust.

If You Defer Enrollment

If you defer enrollment and decline enrollment for yourself and/or your eligible dependents because you have other health insurance coverage, you may enroll yourself and/or your dependents if your or your dependents' other coverage ends. To enroll, you must complete and submit a *Benefits Enrollment Form* to the Trust Office. To activate coverage more than 60 days after the effective date of your retirement, you must show that you and any dependents had creditable coverage from another health plan from the date of your retirement.

Annual Open Enrollment

The Trust holds an open enrollment period each fall. During this period, you have the opportunity to change your benefit elections for medical and prescription drug coverage and add or drop dependent coverage. The elections you make during the annual open enrollment period take effect February 1, 2016 and continue through December 31, 2016. Thereafter, elections will take effect January 1 and continue through December 31.

Under the Trust early retiree voluntary dental and vision coverages, you cannot change your coverage once it has been elected. See "Enrolling for Voluntary Dental and Vision Coverage" on page 9 for more information.

Midyear Enrollment

Certain changes in your family or employment status qualify you to make midyear benefit changes. A "qualifying status change" occurs when you:

- Get married
- Establish a domestic partnership that meets the Trust's requirements
- Divorce, legally separate or end a domestic partnership
- Lose a spouse or domestic partner through his or her death

- Acquire a new dependent child through:
  - Your marriage or domestic partnership
  - Birth, adoption or placement for adoption
  - Assumption of legal guardianship (certain requirements apply)
- Lose a dependent child when:
  - You divorce or dissolve a domestic partnership and a stepchild or domestic partner's child moves out of your home
  - The child passes the age limit for eligibility
  - The child marries or otherwise ceases to be a dependent
  - The child dies
- Lose other health care coverage (for example, through your spouse's employer).

When you experience any of these qualifying status changes, you may make related enrollment changes. To make changes, submit a *Benefits Enrollment Form* to the Trust Office.

Cost of Your Coverage

If you are not eligible for a District contribution, you are responsible for paying the full cost of Trust early retiree medical coverage. The amount is set annually by the Trust.

If you are eligible for a District contribution**,** the District will contribute toward the cost of your medical coverage and toward the cost of medical coverage for your spouse or domestic partner, if he or she is not eligible for Medicare. The amount contributed will be based on the requirements in the collective bargaining agreement covering the unit from which you retired. Provided you meet eligibility requirements, you may choose to receive District contributions during any 60-month period subject to the events listed below which can end coverage before the maximum period. (See "When District Contributions Begin" on page 11 for details.)

You are responsible for paying the full cost of Trust early retiree voluntary dental/vision coverage.

The Trust Office will bill you on a monthly basis for the payment amount that applies given your specific circumstances. For details on contribution rates, contact the Trust Office or visit the Trust web site at www.sdtrust.com. Your payments are due by the fifth of each month.

If you choose to remit payment by Electronic Funds Transfer (EFT), you will not receive a monthly bill. The amount will be automatically deducted from your account on the fifth of each month.

Contribution rates may change from year to year. During open enrollment, you will be notified of the rates for the upcoming plan year (January 1 through December 31).

Enrolling for Voluntary Dental and Vision Coverage

Generally, the Trust early retiree voluntary dental and vision coverages must be elected as a package — either Basic Dental/Vision or Buy-up Dental/Vision — at the time you or your dependents are eligible to make your initial election for Trust early retiree medical coverage. The following are exceptions to this rule:

- You can elect dental/vision coverage separately from medical coverage if you defer or suspend early retiree medical coverage because you have other group medical coverage.
- You may elect dental only coverage if you are enrolled in the Kaiser Permanente HMO.

Except for early retirees who defer or suspend early retiree medical coverage, ***once you have enrolled in Trust early retiree voluntary dental/vision coverage, it must be continuous***. (See "If You Defer Enrollment" on page 7 for details.) That means, if you terminate Trust early retiree voluntary dental/vision coverage for any reason other than suspending or deferring Trust early retiree medical coverage, you cannot reinstate coverage. Coverage under the Trust Early Retiree Voluntary Dental/Vision Plans requires you to make monthly self-payments.

Also, once you elect a Trust Early Retiree Voluntary Dental/Vision Plan, you will not be able to change to another dental/vision coverage option in the future. For example, if you enroll in the Basic Dental/Vision, you may not enroll in Buy-up Dental/Vision or vice versa at a later time.

INITIAL ENROLLMENT

To participate in a Trust Early Retiree Voluntary Dental/Vision Plan, you must complete and return a *Benefits Enrollment Form* to the Trust Office. Even if you plan to defer enrollment to a later date, you must notify the Trust Office of your enrollment decision before your active District employee coverage ends.

You must submit your *Benefits Enrollment Form* within 60 days of the effective date of your retirement; otherwise, you will forfeit your right to self-pay for early retiree voluntary dental/vision coverage through the Trust, except as explained in "If You Defer Enrollment" on page 7.

Annual Open Enrollment

The Trust holds an open enrollment period each fall. You may enroll in a Trust Early Retiree Voluntary Dental/Vision Plan during open enrollment only if you have not previously enrolled for this coverage because you have suspended Trust early retiree medical coverage or you have dental/vision coverage through another group health plan.

If you have terminated dental/vision coverage for any reason other than suspending or deferring early retiree medical coverage, you may not re-enroll for dental/vision coverage during open enrollment. If you have previously elected a Trust Early Retiree Voluntary Dental/Vision Plan, you will not be able to change to another dental/vision plan option during open enrollment. For example, if you enroll in the Basic Dental/Vision, you may not enroll in Buy-up Dental/Vision or vice versa during open enrollment or at a later date.

Midyear Enrollment

Certain changes in your family or employment status qualify you to make midyear benefit changes. These changes are the same that apply to medical coverage and are discussed in “Midyear Enrollment” on page 7.

When Coverage Begins

When Your Medical and Prescription Drug Coverage Begins

If you submit a completed *Benefits Enrollment Form* to the Trust Office before the first month of retirement, your coverage will be effective on the first day you begin early retirement. Coverage for enrolled family members begins when your coverage begins.

If you defer enrollment when you are initially eligible at retirement, you may enroll at a later date by submitting a completed *Benefits Enrollment Form* to the Trust Office. Under this scenario, coverage for you and your enrolled family members begins the first of the month after enrollment.

If you are eligible for a District contribution for retiree coverage and do not elect early retiree medical coverage within 60 days of the effective date of your retirement, your coverage will be deferred until you have submitted a completed enrollment form to the Trust Office.

When District Contributions Begin

If you retire before age 60 and do not elect to begin the District contribution immediately, you must maintain continuous heath coverage from the date your Trust coverage ends to be eligible for District contributions to begin at age 60. If you retire before age 60, however, you may elect to have the District contribution begin upon retirement, but the District's contribution will end after 60 months of contributions subject to the occurrence of an event that ends coverage before the 60-month maximum period.

Alternatively, you may defer participation in a Trust Early Retiree Medical Plan to a date after your retirement. To do this, you must notify the Trust Office of your election to defer coverage and you must maintain other health coverage from the time your active employee coverage ends until the District contribution begins. This is because coverage under the Trust Early Retiree Medical Plan and your other health coverage must be continuous. This other health coverage can be from outside the Trust or result from making self-payments to one of the Trust early retiree medical plan options or by making self-payments under the *Continuation of Coverage* provisions of the plan you had through the Trust while employed.

If you are eligible for a District contribution, the District will contribute toward early retiree medical coverage based on the requirements in the collective bargaining agreement covering the unit from which you retired.

You may suspend your District contribution once it starts if you have other group health coverage. To suspend payment of the District contribution, you must notify the Trust Office in writing when other coverage begins. You must then notify the Trust Office within 30 days of the other coverage ending for the contribution to resume.

Eligibility for a District contribution toward the cost of your coverage will end as provided for in the applicable collective bargaining agreement. Currently under the PAT collective bargaining agreements, this is after 60 months of contributions or, if earlier, when you or a covered dependent reaches age 65 or otherwise becomes eligible for Medicare.

When Your Voluntary Dental and Vision Coverage Begins

If you submit a completed *Benefits Enrollment Form* to the Trust Office before the first month of retirement, your coverage will be effective on the first day you begin early retirement. Coverage for eligible dependents begins when your coverage begins.

If you or your dependents defer or suspend Trust early retiree medical coverage because you have other health coverage, you may defer dental or vision coverage. You may enroll at a later date by submitting a completed *Benefits Enrollment Form* to the Trust Office. Coverage for you and your enrolled family members will begin the first of the month after you enroll.

When Coverage Ends

When Your Medical and Prescription Drug Coverage Ends

RETIREE

Coverage under a Trust Early Retiree Medical Plan automatically ends for you and your covered dependents on the last day of the month (except where noted) when:

- You lose eligibility for coverage
- You reach age 65 or otherwise become eligible for Medicare
- You fail to make any required payments for the following month's coverage
- You die while covered (see "Dependents" on page 12 for benefits available to surviving eligible dependents); if you die, coverage ends on the date of death
- The Trust Early Retiree Medical Plan or the option in which you participate is terminated
- The active employee classification from which you retired no longer participates in the Trust or no longer provides for an early retiree medical plan option for which you are eligible as contained in this handbook.

Your dependents may continue coverage on a self-pay basis if the Trust's requirements for continuing coverage on a self-pay basis are met. (See "Continuing Coverage on a Self-Pay Basis" on page 14 for more information.)

DEPENDENTS

Important!

Please be aware that if an individual who has been reported as your dependent receives benefits after Trust eligibility has or should have ended, the Trust may recover the improperly paid benefits from you.

Coverage for dependents ends when the coverage for the early retiree ends (except for the provision allowing coverage to continue after the retiree's death) and in the following additional situations:

- **Spouse**
  - Coverage ends on the last day of the month before your spouse becomes eligible for Medicare.
  - Coverage for your spouse ends the last day of the month in which a divorce or annulment becomes final. Your ex-spouse may continue coverage on a self-pay basis if the Trust's requirements for continuing coverage on a self-pay basis are met. (See "Continuing Coverage on a Self-Pay Basis" on page 14 for more information.)
  - Failure to make payment for the following month's coverage.
- **Domestic partner**
  - Coverage ends for your domestic partner on the last day of the month before your domestic partner becomes eligible for Medicare.
  - Coverage for a domestic partner and his or her covered children ends on the last day of the month in which the domestic partnership ends. The domestic partner and/or his or her eligible children may continue coverage on a self-pay basis if the requirements for continuing coverage on a self-pay basis are met. (See "Continuing Coverage on a Self-Pay Basis" on page 14 for more information.)
  - Failure to make payment for the following month's coverage.
- **Dependent children**
  - Coverage automatically ends on the last day of the month in which an otherwise eligible dependent child reaches age 26 or the last day of the month in which the child otherwise no longer meets the Trust's requirements for dependent eligibility.
  - Coverage can be continued past age 26 if a dependent child is unmarried, financially dependent on you and incapable of self-support due to a physical or mental disability.
  - A dependent child whose coverage ends may continue coverage on a self-pay basis if the requirements for continuing coverage on a self-pay basis are met. (See "Continuing Coverage on a Self-Pay Basis" on page 14 for more information.)

You should inform the Trust if a dependent spouse, domestic partner or child is no longer eligible to receive benefits from the Trust.

When Your Voluntary Dental and Vision Coverage Ends

Coverage ends when any of the events listed under “When Coverage Ends” on page 12 occurs.

Continuing Coverage on a Self-Pay Basis

Your covered dependents may continue coverage if they lose coverage due to:

- Divorce, legal separation or termination of a domestic partnership
- A child’s loss of dependent status under the plan
- Your becoming entitled to Medicare
- Your death.

Continuation of coverage will end when a covered dependents becomes Medicare eligible.

Notification Responsibility

Your covered dependents are responsible for notifying the Trust Office of a divorce, legal separation, termination of domestic partnership or a child’s loss of dependent status within 60 days after the date coverage would end as a result of the event. If notice is not given, coverage will end as it normally would end under the terms of the plan.

After Notification

When the Trust Office is timely notified that one of the events listed under “When Coverage Ends” on page 12 occurs, it will notify your covered dependent that he or she may elect continuation coverage within 60 days after the later of:

- The date your covered dependent’s coverage would otherwise end
- The date notification is furnished by the Trust Office.

Elections of continuation coverage must be in writing. If a covered dependent does not elect continuation coverage within this 60-day period, coverage will end as it normally would under the plan. If a covered dependent elects continuation coverage within the 60-day period, coverage will be retroactive to the first day after the date coverage otherwise would have ended. Your covered dependents will need to pay the cost for any retroactive coverage.

Available Coverage

The benefits available during continuation of coverage will be the same as those provided to other plan participants.

Cost of Continuation Coverage

Your dependents are responsible for the full cost of continuation coverage plus a 2% administrative fee. The Trust requires that payments be received by the fifth of the month. However, you have a 30-day grace period to make payment. Failure to pay by that date could result in Trust records not showing current eligibility or other inconveniences. If payment is not sent by the last day of the month for the month for which coverage is sought, the right to continue coverage through self-payments will terminate. The only exception is that your dependents have up to 45 days from the date they initially elect continuation coverage to make their first payment to cover the period preceding their election.

How Long Coverage May Continue

If your eligible dependents lose coverage as a result of one of the events described below, they have the following continuation rights:

- ***If you divorce, legally separate, end a domestic partnership or die,*** your eligible dependents may elect to continue coverage for up to 36 months. If your spouse or domestic partner is age 55 or older at the time of the qualifying event, the 36-month limit does not apply — your spouse or domestic partner may continue self-paid coverage until reaching age 65 or otherwise becoming eligible for Medicare.
- ***If your dependent child ceases to qualify as a dependent under the Trust Early Retiree Medical Plan,*** he or she may continue coverage for up to 36 months.
- ***If you become entitled to Medicare while covered under the Trust Early Retiree Medical Plan,*** your eligible dependent children may continue coverage for up to 36 months from the date of your Medicare entitlement. See “When Coverage Ends” on page 12 for information on when spouse/domestic partner coverage ends.

In all situations, continuation coverage ends on the last day of the payment period during which any of the following occurs:

- Payment for continuation coverage for the next monthly coverage period is not made to the Trust Office on a timely basis
- A covered person obtains coverage under any other group health plan after electing continuation coverage. However, continuation coverage will not end if the other plan excludes or limits coverage for a pre-existing condition of a qualified beneficiary, taking into account creditable coverage under the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

- A covered person becomes entitled to Medicare after electing continuation coverage
- The maximum period of continuation coverage ends.

In addition, continuation coverage will end if this plan is terminated or if the District begins contributing to another group health plan on behalf of the active employee classification in which you worked while employed by the District. However, coverage may still be available under a succeeding plan.

Medical

If you are a member of the PAT bargaining unit covered by the Trust, your medical coverage options vary depending on your employment status with the District, as shown below.

The Trust's self-funded medical options for retirees are administered by Regence BlueCross Blue Shield of Oregon.

The provisions of your medical plan are set forth in the plan booklets available through Kaiser, Providence and The Trust Plan – Regence. Contact the plan's customer service for more information. See *Contacts* for details.

PAT Early Retirees

- Early Retiree Trust Plan 1 (includes prescription drug coverage)
- Early Retiree Trust Plan 2 (includes prescription drug coverage)
- Early Retiree Providence Personal Option Plan (includes Trust Prescription Drug Plan coverage)
- Kaiser Permanente HMO Option (includes prescription drug and vision coverage)

Highlights of the Plans

A benefit comparison chart can be found on the sdtrust.com website.

Prescription Drug

You are covered under the Trust Prescription Drug Plan if you are a retired member of the Portland Association of Teachers (PAT) bargaining unit covered by the Trust and enrolled in the one of the following Trust-provided medical plans:

- Trust Early Retiree Providence Personal Option Plan

If you are enrolled in the Trust Early Retiree Plan 1 (*closed*), the Trust Early Retiree Plan 2 or the Kaiser Permanente HMO, prescription drug benefits are provided through the respective medical plan. Contact the plan's customer service department for more information. See *Contacts* for details. (See *Participating in the Plans — Eligibility* for details on who is eligible for coverage.)

Highlights of the Trust Prescription Drug Plan

The following chart provides highlights of the Trust Prescription Drug Plan.

Features	
Who is eligible	• **PAT** Early Retirees enrolled in the Providence Personal Option Plan
What the plan covers	• **Retail prescriptions** purchased at participating pharmacies or any other retail pharmacy • **Mail order prescriptions** purchased through the designated mail order service
What you pay	• **Participating retail pharmacies** — For each 30-day supply, you pay 50% of cost of drug, up to $50 for generic or brand* • **Mail order service** — For each 90-day supply, you pay 50% of cost of drug, up to $150 for generic or brand*
**You also pay the difference in cost for brand-name drugs if a generic drug is available*	

How the Trust Prescription Drug Plan Works

The Trust Prescription Drug Plan is designed to provide a convenient and economical way for you to buy prescription drugs. The plan pays benefits for outpatient drugs or medicines prescribed by a professional provider. Benefits for inpatient (hospital) prescription drugs are covered by your medical plan. No benefits are payable for services for which the patient is not liable.

Under the Trust Prescription Drug Plan, you may fill prescriptions through the CVS Caremark retail pharmacy network or the mail order service.

Retail Prescription Drugs

Retail prescription drug benefits under the Trust Prescription Drug Plan are administered by CVS Caremark networks. When you need a prescription filled for immediate treatment of an illness or injury, you may use a participating pharmacy *or* any other pharmacy.

IF YOU USE PARTICIPATING RETAIL PHARMACIES

When you go to a participating or CVS Caremark network pharmacy, simply show your prescription drug ID card, which identifies you as a CVS Caremark member. For each 30-day supply, you pay 50% of the cost of the drug, up to $50.

Automatic Generic Substitution

A CVS Caremark network pharmacist will automatically substitute an approved generic drug for a brand-name drug when available and legally permissible. If you or your doctor request the brand-name drug in this event, you'll pay the brand name coinsurance *plus* the difference in cost between the brand-name drug and its generic equivalent. Compounded prescriptions are covered as a brand-name drug.

If the pharmacy bills you for a retail charge that's higher than the CVS Caremark discounted in-network charge, you will *not* be reimbursed for the portion of the charge that is above the in-network amount.

Important!

If a CVS Caremark network pharmacy charges you the full retail cost of a prescription (for example, if you don't have your ID card with you at the time of purchase), or if you agree to be billed instead of paying the coinsurance, you'll need to file a claim form to receive a benefit. Your benefit will be the in-network charge minus your payment amount.

CVS Caremark Pharmacies

Many regional and national pharmacy chains, including Costco, Safeway, Rite Aid, Fred Meyer, Target, Walmart and Walgreens, as well as many independent pharmacies, participate in the CVS Caremark network.

For information on participating pharmacies in your area, call CVS Caremark at (800) 552-8159 or visit their web site at https://www.caremark.com/wps/portal.

If You Use a Nonparticipating Retail Pharmacy

The Trust Prescription Drug Plan is designed to help you save money on your prescription drugs when you use participating retail pharmacies. However, there may be times when you need to use a pharmacy that is not part of the CVS Caremark retail network.

If you use a nonparticipating pharmacy, you must pay the full cost of the prescription at the time of purchase. You may then file a claim for reimbursement with CVS Caremark.

Claim forms are available from the Trust Office or District HR/Benefits. Submit claim forms to:

CVS Caremark
P.O. Box 52116
Phoenix, AZ 85072

Mail Order Prescription Drugs

You may use the CVS Caremark mail order service whenever you or a covered dependent needs a maintenance prescription for an ongoing condition such as asthma, diabetes, high blood pressure or heart disease. For each 90-day supply, you pay 50% of the cost of the drug, up to $150.

The Trust Prescription Drug Plan does not cover prescription drugs purchased through any other mail order service.

Generic Substitution

CVS Caremark will automatically substitute an approved generic drug for a brand-name drug when available and legally permissible. If you request the brand-name drug in this event, you'll pay the brand name coinsurance *plus* the difference in cost between the brand-name drug and its generic equivalent.

Call CVS Caremark at (800) 552-8159 for…

- Answers to questions about the mail order service
- Refills for maintenance prescriptions (or order at https://www.caremark.com/wps/portal)

How to Order Initial Prescriptions

Follow these steps to start a maintenance prescription:

1. **Ask your doctor for two written prescriptions** — one for a month's supply that you can fill right away at a retail pharmacy to get you started, and one for a 90–day supply with refills that you can order from CVS Caremark.
2. **Complete a CVS Caremark order form.** You can request the order form by calling the Trust Office at **(844) 203-0239** or visit the CVS Caremark web site at **https://www.caremark.com/wps/portal**. From the CVS Caremark web site home page, select ***Print Plan Forms,*** then select ***Mail Service Order Form.*** Print and complete the form. Be sure to provide all requested information and attach the original prescription for each medication you are ordering.
3. **Enclose your payment for each prescription.** You may pay by check or money order or by providing your Visa, MasterCard, Discover or American Express card number and expiration date.

Your order will be delivered to your home via U.S. first-class mail, UPS or Federal Express.

How to Order Refills

Follow these steps to order refills from CVS Caremark:

- Order refills at least *two* weeks (for telephone, fax or online orders) or *three* weeks (for orders by U.S. mail) before you expect to run out of a medication. This will allow ample time for your order to be processed and delivered to you.
- Order in any of the following ways:
  - Order online at **https://www.caremark.com/wps/portal**. From the CVS Caremark web site home page, select ***Refill Prescriptions & Check Order Status***. Follow the instructions to refill a prescription.
  - Call CVS Caremark at (800) 552-8159.
  - Mail CVS Caremark a completed order form.

If you order by phone or the Internet, your payment must be charged to a credit card.

TRUST PILL-SPLITTING PROGRAM

The Trust Pill-Splitting Program gives you the option to buy a higher dose of medication, then split it into two equivalent strength doses. For example, if you currently take a 25 mg strength medication, talk to your doctor about prescribing the 50 mg strength medication before you purchase your next prescription. If your doctor agrees that pill splitting is appropriate for you, you can split the 50 mg pill in half, and take one half when you are scheduled to take the 25 mg dose. Pill splitting appropriate prescription drugs can save you and the Trust money.

Not all medications can be safely split. Only your doctor can decide if pill splitting is right for you, and if your prescription medication is still effective when the pills are split in half. When your doctor writes the prescription appropriately, you could get up to a 180-day supply of the drug for the same coinsurance that would apply for a 90-day supply.

The Trust Pill-Splitting Program is voluntary and available only through the CVS Caremark mail order service. Drugs which are included in the pill-splitting program are:

- Celexa (Citalopram), 20 mg
- Lexapro (Escitalopram), 10 mg
- Paxil (Paroxetine), 20 mg
- Zoloft (Sertraline), 50 mg
- Lipitor (Atorvastatin) 10, 20, 40 mg.

Please note: This list is subject to change without notice. For an updated list, please contact CVS Caremark at (800) 552-8159.

SpecialtyRx Program

If you or a family member takes specialty injection medications for a chronic illness, the CVS Caremark SpecialtyRx Program provides a convenient way to get your medications. The SpecialtyRx Program is designed for early retirees and their eligible, covered dependents who take medications with special handling requirements for such chronic conditions as multiple sclerosis, rheumatoid arthritis, hemophilia, Gaucher disease, cystic fibrosis, hepatitis C, growth hormone deficiency, Crohn's disease, respiratory syncytial virus, infertility, pulmonary hypertension or immunologic disorders.

Through this service, you can order your medication and have your order delivered to the location of your choice (your home, doctor's office, vacation spot, etc.) within 24–72 hours. In addition, the SpecialtyRx Program provides you and your dependents with expert care services such as counseling, disease-related educational materials and access to health experts 24 hours a day, seven days a week. For details about this program, please contact CVS Caremark at (800) 237-2767.

When Preauthorization Is Required

Certain prescription drugs require preauthorization from CVS Caremark before a prescription can be filled. Your pharmacist will advise you when preauthorization is needed and will call the doctor. The doctor will call CVS Caremark on your behalf.

If preauthorization is needed for a specific drug or supply amount being filled by the mail order service, CVS Caremark will request preauthorization by fax from the prescribing physician. If preauthorization is needed for a vacation supply, contact CVS Caremark at (800) 552-8159.

What's Not Covered

The Trust Prescription Drug Plan has a number of limitations and exclusions (See "Limitations" on page 24 and "Exclusions" on page 25 for details):

Limitations

The Trust Prescription Drug Plan has a number of limitations:

- **Drugs for cosmetic use** — not covered unless authorized as medically necessary by a professional provider
- **Drugs for family planning** — oral contraceptives and contraceptive patch covered; Depo-Provera (injectable contraceptive) covered after a three-month copayment. Drugs for infertility treatment are not covered
- **Drugs for sexual dysfunction** — covered if due to illness, injury or other organic cause. Limited to six tablets/applications per month
- **Drugs requiring preauthorization** — certain drugs require preauthorization by the prescribing physician before a prescription can be filled. The pharmacist will advise you when preauthorization is necessary and will contact CVS Caremark on your behalf or ask you to contact CVS Caremark to obtain the required preauthorization. If preauthorization is not obtained, the drugs are not covered
- **Herbal and naturopathic medications** — covered only if FDA-approved, NDC code available and purchased at a licensed pharmacy
- **Medications purchased outside the United States** — generally not covered, but may be reimbursed if urgent medical need exists while outside the U.S.
- **New drugs on the market** — covered after review by CVS Caremark and if in a covered class on the Trust Prescription Drug Plan
- **Over-the-counter medications** — not covered even if prescribed, if the same strength is available without a prescription
- **Smoking cessation products** — prescription medication covered; over-the-counter patches not covered.

Exclusions

The following are also excluded from coverage:

- Benefits not specifically listed as provided
- Charges above usual and customary or reasonable (UCR) charges. Cash purchases at CVS Caremark pharmacies will be reimbursed at plan rates
- Drugs administered in a physician's office. However, services may be covered by your medical plan (See *Medical* for details.)
- Drugs for male or female baldness
- Drugs for obesity and weight control
- Experimental or investigational drugs, or drugs dispensed for studies or trials
- FDA-approved drugs dispensed or administered for non-FDA approved uses
- Fees for writing prescriptions or filling out claim forms
- Immunization agents, blood, blood plasma or biological sera
- Oxygen
- Professional provider charges for administering drugs
- Services or supplies for which no charge is made
- Services or supplies for which you could have received payment (in whole or part) under any government program or law if you had applied
- Services or supplies for which your employer is required to provide benefits under workers' compensation, liability or other law, even if you waive your right to those benefits
- Services or supplies you receive before your coverage begins or after it ends
- Take-home drugs dispensed when a member is a patient in a facility such as a hospital — not covered by the Prescription Drug Plan though often covered by a medical plan. (See *Medical* for details.)
- Vitamins — not covered, even if prescribed.

Dental

If you have retired under the PAT bargaining agreement and otherwise meet the eligibility requirements for the Trust Early Retiree Voluntary Dental/Vision Plans, you may choose either Basic Dental/Vision or Buy-up Dental/Vision. This coverage is generally provided as a package; however, you may elect dental only coverage if you are enrolled in the Kaiser Permanente early retiree medical plan option. (See *Participating in the Plans — Eligibility* for details on who is eligible for coverage and *Medical* for additional vision-related information.)

This section describes the Basic Dental and Buy-up Dental benefits. For information about Basic Vision and Buy-up Vision benefits, see *Vision*.

Highlights of the Plans

Features	
Who is eligible	PAT early retirees and eligible dependents enrolled in the Trust Early Retiree Plan1 (Closed), Trust Early Retiree Plan2 (Open), Kaiser Permanente HMO, Providence Personal Option Plan or have medical coverage through a spouse/domestic partner's plan
Enrollment	You must enroll and make monthly self-payments to participate in the Trust Early Retiree Voluntary Dental/Vision Plans
Basic Dental/Vision	Combined dental/vision package that provides: • **Dental** — benefits for diagnostic and preventive care, basic, restorative and prosthodontic services up to a maximum annual benefit of $1,200 per person per calendar year • **Vision** — benefits for routine eye exams, lenses, frames and additional discounts through VSP doctors. Copayments and maximum benefit allowances apply. You may purchase eye services and materials not covered by the plan at discounted prices from VSP preferred providers

Features	
Buy-up Dental/Vision	Combined dental/vision package that provides a higher level of coverage: • **Dental** — benefits for diagnostic and preventive care, basic, restorative and prosthodontic services up to a maximum annual benefit of $1,750 per person per calendar year. Orthodontic services paid up to $1,250 lifetime benefit maximum per person • **Vision** — benefits for routine eye exams, lenses, frames and additional discounts through VSP preferred providers. Many services covered in full up to the benefit maximum. You may purchase eye services and materials not covered by the plan at discounted prices from VSP preferred providers

How the Plans Work

For both the Basic and Buy-up Dental Plans, you may go to any licensed dentist for dental care. During your initial appointment, tell your dentist that you have dental benefits through the Trust Early Retiree Voluntary Dental Plan. Give your member ID number and group number to the dentist. Your ID and group number are printed on your ID card. The group number is 10013296.

How the Plans Pay Benefits

The Trust Early Retiree Voluntary Dental Plans pay a percentage of covered expenses, based on usual and customary or reasonable rates (UCR), up to a maximum benefit amount per calendar year. There is no maximum for children under 19. UCR rates represent the fees and prices regularly charged by your dentist and other dentists in your area for the dental services and supplies generally furnished for cases like yours. You are responsible for paying coinsurance for covered services, costs exceeding the UCR, and all expenses over the annual benefit maximum and lifetime orthodontic maximum.

If you select a more expensive plan of treatment than is UCR, the Trust Early Retiree Voluntary Dental Plans will pay the applicable percentage of the UCR fee for the less expensive treatment. You will be responsible for the remainder of the dentist's fee.

The Basic and Buy-up Dental Plans cover many of the same services. The plans differ in the amount of benefits they pay — you will pay an annual deductible and higher coinsurance for some services under the Basic Dental Plan, but you will also pay a lower monthly premium rate for this coverage. The Basic Dental Plan also does not cover orthodontia services, while the Buy-up Dental coverage does.

Annual Deductible

The Basic Dental Plan annual deductible is $50 per person per calendar year. You pay the deductible each year before the plan begins to pay benefits.

There is no annual deductible under the Buy-up Dental Plan.

Maximum Benefits

The Basic Dental Plan pays a percentage of covered expenses based on UCR, up to $1,200 per person per calendar year.

The Buy-up Dental Plan pays a percentage of covered expenses based on UCR, up to $1,750 per person per calendar year. This plan also pays orthodontic benefits up to a lifetime maximum of $1,250 per person.

The dollar amount that the Trust pays toward covered dental services for you or a covered dependent during a calendar year is applied toward this annual maximum.

If you wish to see how much has been paid toward the annual maximum as of a given date, you may call Regence. You should remember that the amount you will be given will only reflect the bills for service that Regence has received and processed as of the date your inquiry is made.

Predetermination of Benefits

Predetermination of benefits is a procedure by which your dentist submits a description of your treatment plan ***before*** work starts. When you or a covered dependent requires dental care, you may ask your dentist to file for predetermination of benefits.

The Trust will review the recommended treatment and notify your dentist of the dollar amounts payable under the plan for the procedures in question. Remember that a predetermination is not a guarantee of payment. To receive benefits for the predetermined services, you or a covered dependent must be eligible when the services are rendered. Predetermined benefits are subject to all plan provisions, including the annual benefit maximum for the specific dental plan.

What the Plans Cover

The Trust Early Retiree Voluntary Dental Plans cover the following services when performed by a licensed dentist and 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, including masticatory function. No benefits are payable for services or supplies for which the patient is not liable.

The following services may also be provided by a dental mechanic or denturist to the extent that he or she is operating within the scope of his or her license as required under law in the state of Oregon.

Covered Services	Basic Dental	Buy-up Dental
Class I Services *Preventive services*, including: • Cleaning (prophylaxis) two times per calendar year, two additional cleanings per year with periodontic issues • Fluoride application for dependents age 14 and under, two times per calendar year • Sealants for dependents through age 18, once every five calendar years • Space maintainers *Diagnostic services*, including: • Routine examination, two times per calendar year • Bitewing X-rays, two times per calendar year • Full mouth X-rays or panoramic film, once every five calendar years	Plan pays 80% of UCR after deductible	Plan pays 100% of UCR
Class II Services • *Oral surgery:* Surgical extractions and certain other minor surgical procedures, including general anesthesia when administered by a dentist in connection with a covered oral surgery and when given in a dental office • *Restorative:* Treatment of tooth decay with amalgam, synthetic porcelain, and plastic materials (Refer to Class III Services for other restorations.) • *Endodontic:* Procedures for pulpal therapy and root canal filling • *Periodontic:* Treatment of tissues supporting the teeth, including scaling once every three years	Plan pays 80% of UCR after deductible	Plan pays 80% of UCR
Class III Services • *Restorative*: Treatment of tooth decay with crowns, jackets and gold or cast restorations, including onlays and implants. Covered only when teeth cannot be restored with other materials (See “Limitations” on page 32.)	Plan pays 50% of UCR after deductible	Plan pays 80% of UCR
Class IV Services • *Prosthodontic:* Procedures for construction or repair of fixed bridges, partials and complete dentures (See “Limitations” on page 32.)	Plan pays 50% of UCR after deductible	Plan pays 50% of UCR
Class V Services • *Orthodontic***:** Benefits will be provided to eligible early retirees and their covered dependents	Not covered	Plan pays 50% of UCR up to a lifetime maximum benefit of $1,250 per person

What's Not Covered

The Trust Early Retiree Voluntary Dental Plans have the following exclusions and limitations. (See "Exclusions" on page 31 and "Limitations" on page 32 for details.)

Exclusions

The Trust Early Retiree Voluntary Dental Plans do not cover:

- All other services or supplies not specifically covered (See "What the Plans Cover" on page 29 for details.)
- Charges for canceled appointments
- Claims submitted more than 12 months after the date of rendition of the service
- Experimental procedures
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized
- Orthodontia services (excluded under the Basic Dental Plan only)
- Periodontal splinting, including crowns or bridgework for splinting
- Prescribed drugs, pre-medications or analgesia (nitrous oxide)
- Separate charges for anesthesia, other than general anesthesia administered by a licensed dentist in connection with covered oral surgical services performed in a dental office. Separate charges for anesthesia when used for restorative procedures are not covered
- Services covered under workers' compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency
- Services for cosmetic reasons
- Services for plaque control, oral hygiene or dietary instructions
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Such services include, but are not limited to, increasing vertical dimension, equilibration and periodontal splinting
- Services for repair or replacement of an orthodontic appliance furnished under the plan
- Services for the application of fluoride for children over the age of 14 or adults
- Services for the application of sealants for children over the age of 18 or adults
- Services started prior to the date the individual became eligible for services under the plan

- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis and disturbance of the temporomandibular joint
- Temporary devices.

Limitations

The Trust Early Retiree Voluntary Dental Plans have a number of limitations:

- A separate charge for anesthesia is not covered when used for restorative procedures
- Benefits will be limited to one sealant, per tooth, during any five-year period
- If a tooth can be restored with a material such as amalgam, silicate or plastic, but another type of restoration is selected, covered expense will be limited to the cost of amalgam, silicate or plastic
- Oral surgery benefits are limited to minor surgical procedures and do not allow payment for services such as vestibuloplasty
- Replacement of an existing prosthetic device is covered only if it cannot be made satisfactory. Replacement is never covered if the existing device is less than seven years old. Specialized or personalized prosthetics are limited to the cost of standard devices
- Replacement of necessary crowns, jackets, and gold or cast restorations, including onlays, is covered only if seven years have elapsed since the last prior crown, jacket, and gold or cast restoration was furnished on the tooth. Inlays are not covered. Alternative benefits may apply
- Sealant benefits for the occlusal surfaces of unrestored permanent bicuspids and first and second molars are limited to children under age 19
- The obligation under the Buy-up Dental Plan to make payments for orthodontic treatment will cease upon termination of treatment for any reason prior to completion of the case
- The obligation under the Buy-up Dental Plan to make payments for orthodontic treatment begun prior to the patient's eligibility date will be calculated on the balance of a dentist's normal payment pattern remaining at the patient's initial eligibility date. The maximum orthodontic benefit amount will apply fully to this amount
- The obligation under the Buy-up Dental Plan to make monthly or other periodic payments for orthodontics will cease on termination of eligibility.

How to File a Dental Claim

You do not need to fill out claim forms. Your dentist will submit an electronic claim for you. However, you will need to provide the required patient identification information. If your dependents receive services through the Trust Early Retiree Voluntary Dental Plan, make sure that ***your*** member ID number and group number are listed on the claim.

Once the claim is processed, the plan pays benefits directly to your dentist. You are notified when the claim has been processed.

Vision

If you have retired under a PAT bargaining agreement and otherwise meet the eligibility requirements for the Trust Early Retiree Voluntary Dental/Vision Plan, you may choose either Basic Dental/Vision or Buy-up Dental/Vision. This coverage is generally provided as a package; however, you may elect dental only coverage if you are enrolled in the Kaiser Permanente early retiree medical plan option. (See *Participating in the Plans — Eligibility* for details on who is eligible for coverage and *Medical* for additional vision-related information.)

This section describes the Basic Vision and Buy-up Vision benefits. For information about Basic Dental and Buy-up Dental benefits, see *Dental*.

Highlights of the Plans

Features	
Who is eligible	PAT early retirees and eligible dependents enrolled in the Trust Early Retiree Plan 1 (Closed), Trust Early Retiree Plan 2 (Open), Kaiser Permanente HMO, Providence Personal Option Plan
Enrollment	You must enroll and make monthly self-payments to participate in the Trust Early Retiree Voluntary Dental/Vision Plans
Basic Dental/Vision	Combined dental/vision package that provides: • **Dental** — benefits for diagnostic and preventive care, basic, restorative and prosthodontic services up to a maximum annual benefit of $1,200 per person per calendar year • **Vision** — benefits for routine eye exams, lenses, frames and additional discounts through VSP preferred providers. Copayments and maximum benefit allowances apply. You may purchase eye services and materials not covered by the plan at discounted prices from VSP preferred providers

Features	
Buy-up Dental/Vision	Combined dental/vision package that provides a higher level of coverage: • **Dental** — benefits for diagnostic and preventive care, basic, restorative and prosthodontic services up to a maximum annual benefit of $1,750 per person per calendar year. Orthodontic services paid up to $1,250 lifetime benefit maximum per person • **Vision** — benefits for routine eye exams, lenses, frames and additional discounts through VSP doctors. Many services covered in full up to the benefit maximum. You may purchase eye services and materials not covered by the plan at discounted prices from VSP preferred providers

How the Plans Work

For both the Basic and Buy-up Vision Plans, you have the choice of receiving care from any qualified vision provider. However, the plans pay higher benefits if you receive care from one of the VSP preferred providers who participate in the Trust Early Retiree Voluntary Vision Plans network. No matter which provider you choose, there is no annual deductible to satisfy.

The Basic and Buy-up Vision Plans cover many of the same services. The plans differ in the amount of benefits they pay — you will generally pay a higher copayment for some services under the Basic Vision Plan, but you will also pay a lower monthly premium rate for this coverage.

Qualified Vision Providers

Qualified vision providers include any licensed optometrist or ophthalmologist.

VSP Preferred Providers

VSP preferred providers include VSP optometrists and ophthalmologists. These doctors have contracted with VSP to provide vision care services and eyewear at discounted prices.

When you receive care from a VSP preferred provider, routine eye exams and standard spectacle lenses are paid in full. Frames and contact lenses are paid up to a maximum benefit amount. (See “How the Plans Pay Benefits” on page 37 for more information.) VSP preferred providers will bill VSP directly for your services. You have no claim forms or paperwork to complete for services received from VSP network doctors. You will, however, be responsible for any charges above the maximum benefit amount.

For a List of Participating VSP Preferred Providers

Visit the VSP web site at www.vsp.com. From the homepage, click *Members & Consumers* and sign on. Then select *Find a VSP Doctor* and follow the instructions.

If You Use a Non-VSP Provider

You can always see a covered provider outside the VSP network and still receive plan benefits. However, the plan will pay a reduced benefit, up to a maximum benefit amount. At the time of service, you are required to pay for the vision services or eyewear in full. You may submit a claim for reimbursement of covered services to:

VSP
Attn: Claims Department
P.O. Box 385018
Birmingham, AL 35238-5018
Phone: (800) 877-7195

VSP pays benefits directly to you. Claims must be submitted within 365 days from the date of service.

The itemized receipt must include the following information:

- Retiree's name, last 4 digits of Social Security number and date of birth
- Patient's name, date of birth and relationship to the retiree
- Retiree's address and phone number.

How the Plans Pay Benefits

All covered services are provided according to the schedule of benefits shown below.

	Basic Vision		Buy-up Vision	
Benefits	**VSP Preferred Provider**	**Non-VSP Provider Reimbursement**	**VSP Preferred Provider**	**Non-VSP Provider Reimbursement**
Exam	Covered in full after a $25 copayment	Covered up to $45 after a $25 copayment	Covered in full	Covered up to $70
Lenses				
Single vision	Standard lenses paid in full after $25 copayment	Covered up to $45 after $25 copayment	Standard lenses covered in full	Covered up to $50
Lined bifocal	Standard lenses paid in full after $25 copayment	Covered up to $65 after $25 copayment	Standard lenses covered in full	Covered up to $75
Lined trifocal	Standard lenses paid in full after $25 copayment	Covered up to $85 after $25 copayment	Standard lenses covered in full	Covered up to $100
Polycarbonate lenses (for dependent children)	Covered in full	Not covered	Covered in full	Not covered

	Basic Vision		Buy-up Vision	
Benefits	**VSP Preferred Provider**	**Non-VSP Provider Reimbursement**	**VSP Preferred Provider**	**Non-VSP Provider Reimbursement**
Progressive	35% – 40% discount off usual and customary charges	Covered up to $85 after $25 copayment	35% – 40% discount off usual and customary charges	Covered up to $100
Frame	Covered up to $120, 20% off remaining balance	Covered up to $47	Covered up to $100, 20% off remaining costs	Covered up to $75
Contacts in lieu of lenses and a frame	Covered up to $105	Covered up to $105 for contact lens exam and contacts	Covered up to $137	Covered up to $137 for contact lens exam and contacts
Contact Lens Exam (fitting and evaluation)	Covered in full after a not-to-exceed copay of $60		Covered in full after a not-to-exceed copay of $60	
Benefit Frequency				
Exam	Once every 24 months for children and adults		Once every 12 months for children up to age 17; every 24 months for adults	
Lenses	Once every 24 months for children and adults		Once every 12 months for children up to age 17; every 24 months for adults	
Frames	Once every 24 months for children and adults		Once every 24 months for children and adults	

You are responsible for paying any expenses in excess of the plan's benefits. No benefits are payable for services or supplies for which the patient is not eligible.

What the Plans Cover

The Trust Early Retiree Voluntary Vision Plans pay the benefits listed under "How the Plans Pay Benefits" on page 37. In addition, a low vision benefit is provided for adults and children who have severe visual problems that are not correctable with regular lenses. Benefits are available as needed and are subject to approval by VSP. The low vision benefit maximum is $1,000 per person every two years. Low vision benefits include:

- **Supplementary testing.** Complete low vision analysis and diagnosis, including a comprehensive examination of visual functions, as well as the prescription of corrective eyewear or vision aids where indicated.
  - ***VSP preferred providers*** — The plan covers supplementary testing in full.

- ***Non-VSP providers*** — The plan covers supplementary testing up to the benefit maximum of $125.

- **Supplemental care aids.** Subsequent low vision aids as deemed visually necessary or appropriate by VSP.
  - ***VSP preferred providers*** — The plan covers supplemental care aids at 75% of usual and customary charges.
  - ***Non-VSP providers*** — The plan covers supplemental care aids at 75% of the usual and customary charges that would be paid to a VSP preferred provider.

Additional Discounts Through VSP Preferred Providers

The Trust Early Retiree Voluntary Vision Plans allow you to purchase additional frames, eyeglass lenses and other eye services and materials not covered by the plan at discounted prices from VSP preferred providers. Discounts apply to all covered family members. At the time of service, you pay the full cost, which is discounted as follows:

Additional Service/Eyewear Not Covered by the Plan	Discount
Lasik eye surgery	Average of 15% off the regular price or 5% off the promotional price. Discounts are available from participating Lasik surgery providers. For more information, contact VSP at (800) 877-7195
Additional pairs of prescription glasses and sunglasses	30% off additional glasses and sunglasses, including lens options, on the same day as your exam. Or get 20% off an additional pair of complete glasses from any doctor if it is purchased within 12 months of your eye exam
Contact lens exam (evaluation and fitting)	15% discount off the cost of a contact lens exam (evaluation and fitting)

What's Not Covered

Expenses not covered by the Trust Early Retiree Voluntary Vision Plans include:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.50 diopter power); or two pair of glasses in lieu of bifocals
- Benefits not specifically listed as covered
- Charges for complications from services not covered by the plan
- Charges that exceed usual, customary or reasonable charges
- Corrective vision treatment that is considered experimental
- Eye exams performed by anyone other than a licensed optometrist or ophthalmologist

- Eye exams required by an employer or the government
- Oversized, tinted, high index or special computer lenses
- Replacement or duplication of lost, stolen or broken lenses and frames if you are not ordinarily eligible for new lenses or frames
- Services and supplies covered under the Trust Early Retiree Plan 1 (Closed), Trust Early Retiree Plan 2 (Open) or Providence Personal Option Plan
- Services or eyewear covered under workers' compensation or similar laws
- Services or eyewear for which no charge is made
- Services or eyewear the covered person received before the effective date of this plan, before the covered person's effective date of coverage or after coverage ends
- Shipping costs for supplies
- Sunglasses or other special-purpose vision aids (Lenses with tints other than tints #1 or #2 are considered sunglasses.)
- Treatment of eyes or special procedures such as orthoptics and vision training.

VSP may, at its discretion, waive any plan limitation if, in the opinion of VSP's optometric consultants, it is necessary for the welfare of the covered person.

Administrative Information

This section includes additional information about how the Trust Plans and other benefit arrangements are administered, claims information and a statement of your rights as a participant.

Important Information About Appeals

The following appeal procedures apply to any appeal involving eligibility or benefits not provided by Kaiser or Providence. These are medical and prescription drug benefits under the Trust Early Retiree Indemnity Medical Plan for PAT participants, the Trust Early Retiree Prescription Drug Plan and the Trust Early Retiree Voluntary Dental and Vision Plan. For the appeal procedures for benefits provided by Kaiser and Providence, refer to the procedures described in the booklets they provide. See *Contacts* for details.

How to Appeal an Administrative Decision

ELIGIBILITY/ENROLLMENT

If an enrollment or eligibility request submitted to the Trust Office is denied in whole or in part, the Trust Office will provide you with a notice identifying the reason(s) for the denial, any other information needed to consider your request and your right to obtain additional information about the Trust's eligibility and enrollment rules. You may appeal an adverse eligibility or enrollment decision by filing a written appeal with the Trust Office within 180 days of the denial. Appeals should be sent to the following address:

School District No. 1 Health and Welfare Trust Appeals
P.O. Box 12267
Seattle, WA 98102

The appeal shall identify the eligibility or enrollment determination involved, set forth the reasons for the appeal and provide any additional information you believe is relevant. Your appeal will not be considered and the denial by the Trust Office will be final if no appeal is received within 180 days.

Appeals Procedures for the Trust Vision Plan

Appeal of Denied Claims: Under the Plan, if a claim is denied in whole or in part, you or your authorized representative may request a full review of the denial. You may designate any person, including your provider, as your authorized representative.

Initial Appeal: The request must be made within 180 days following denial of a claim and should contain sufficient information to identify the Trust participant for whom the claim was denied, including the VSP enrollee's name, the VSP enrollee's member identification number, the Trust participant's name and date of birth, the provider's name, and the claim number. You may review during normal working hours any documents held by VSP pertinent to the denial. You may also submit written comments or supporting documentation concerning the claim to assist in VSP's review. VSP's response to the initial appeal, including specific reasons for the decision, will be provided and communicated to you as follows:

- Prior authorization for visually necessary or appropriate services: within 30 calendar days after receipt of your request for an appeal; and
- Denied claims for services rendered: within 30 calendar days after receipt of your or your authorized representative's request for an appeal.

Second Level Appeal: If you or your authorized representative disagrees with the response to the initial appeal of the claim, you or your authorized representative has the right to a second level appeal. Within 60 days after receipt of VSP's response to the initial appeal, you or your authorized representative may submit a second appeal to VSP along with any pertinent documentation. VSP will communicate its final determination to you or your authorized representative in compliance with applicable state and federal laws and regulations and will include the specific reasons for the determination.

Other Remedies: If you remain dissatisfied after completing the VSP appeals process, you may request that the Trust review your appeal. Details about how to access the Trust Claim Appeal Procedures are set forth below.

Determination on Submitted Claims

The Claim Administration Agent (Regence; Kaiser Permanente; Providence HealthPlan; VSP and CVS/Caremark) will process a properly filed claim within 30 days of its receipt. This 30-day period can be extended for 15 days if the circumstances require. If additional information is needed to process your claim, you will be notified of the additional necessary information and be given up to 45 days to produce it.

If your claim is denied in whole or in part, the Claim Administration Agent will provide you with a notice identifying the reasons for the denial, any additional information necessary to consider your claim, your right to obtain additional information and the Trust's claims appeal procedures. Please note that these procedures are partially modified (as discussed below) if your claim involves an urgent care claim.

Internal (Initial) Grievance or Appeal

You may appeal a benefit claim denial by filing with the Claim Administration Agent a written appeal within 180 days of the denial. The appeal shall identify the benefit determination involved, set forth the reasons for the appeal and provide any additional information you believe is relevant. Your appeal will not be considered and the denial by the Claim Administration Agent will be final if no appeal is received within 180 days.

Your Rights on Appeal

If you appeal, you or your authorized representative may, upon request and free of charge, have reasonable access to all documents relevant to your claim appeal. Relevant documents include documents relied on, submitted, considered or generated in making the benefit determination, including any internal guidelines or policies considered in processing your appeal. If the denial is based on a medical determination, an explanation of that determination, and its application to your medical situation, is also available upon request.

If you are not satisfied with the decision of the Internal Grievance or Appeal and your Appeal involves an Adverse Benefit Determination, you may request a voluntary second level internal appeal. If your case is eligible, it will be reviewed by the claims appeal panel.

Administrative Review of Appeal

The initial review of any appeal will be an administrative review done by the Trust Office in conjunction with the assistance of the Trust's medical review organization or other appropriate provider. The Trust Office will notify you of its decision within 30 days of receipt of your appeal. The administrative review decision shall:

- State the specific reason for the denial;
- Reference the plan provision(s) relied on;
- Describe any additional information necessary to perfect your claim and the reason it is necessary;
- Explain the Trust's claims procedures; and
- Describe what information is available to you.

The Trust Office's administrative review will be final and binding unless you submit a written request for review within 60 days of the denial. Upon receipt of a request for review the Trust Office may refer the matter to the Administrative Committee at its next meeting for informal consultation and comment. If this consultation does not resolve the appeal, the matter will be referred to the Claims Appeal Panel for formal review.

Trust Appeal Panel

The Trust's Administrative Committee serves as the Appeal Panel. The Appeal Panel will consider properly filed appeal requests at the next regularly scheduled Administrative Committee meeting following receipt of the appeal and the completion of any informal consultation process. If your request for Appeal Panel review is received within 20 days of the next regularly scheduled Administrative Committee meeting, your appeal will be heard at the second regularly scheduled Administrative Committee meeting.

The Appeal Panel will review all documents relevant to the appeal. The review will be de novo (i.e., without any deference to the original decision).

You or your authorized representative will be allowed to appear before the Appeal Panel and present evidence or witnesses. The Appeal Panel may in its discretion set conditions related to the conduct of an appeal, the testimony or attendance of any individual or other procedural and evidentiary matters.

The Claim Appeal Panel will notify the claimant of its decision within 10 days of the hearing. If any part of the appeal is denied, the written decision will set out the specific reason for the adverse decision, reference the plan provision involved, identify any internal rules or guidelines considered in making its decision, and a statement identifying what information is available to you upon request.

A vote by three of the four members of the Appeal Panel is required to constitute a decision. A decision of the Claims Appeal Panel will be final and binding unless the Appeal Panel refers the matter to the Board of Trustees or cannot reach a decision.

Referral to Board of Trustees

If a matter is referred to the Board of Trustees from the Appeal Panel, a decision will be made at the next regularly scheduled Board of Trustees meeting. You or your authorized representative may appear before the Board of Trustees if you appeared before the Appeal Panel. If the Board of Trustees is unable to make a decision at its next regularly scheduled meeting, you will be notified and the matter will be heard at its next subsequent meeting. The decision issued by the Board of Trustees will contain the same information as decisions issued by the Claim Appeal Panel. The Board of Trustees' decision will be final and binding.

Exhaustion of Claim(s) Appeal Procedures and Standard of Review

You must exhaust these claim(s) appeal procedures prior to undertaking any legal action with respect to a claim. In any action challenging a denial of benefits the standard of review shall be whether the Trustees were in error upon an issue of law, acted arbitrarily or capriciously or entered findings of fact that were unsupported by substantial evidence.

Special Rules for Urgent Care Claims

The Trust will modify its procedures in situations involving urgent care claims. Urgent care claims are claims for services where the application of the normal time frames for appeals could seriously jeopardize the life or health of the claimant or expose the claimant to severe pain. Urgent care claims may be filed, orally or in writing, by you or a health care provider with knowledge of your medical condition. Urgent care claims only involve services that have not been provided as a result of the Trust's denial.

The Trust Office will make an initial decision on an urgent care claim within 72 hours of receipt. If additional information is needed to process the claim, you or your health care provider will be notified and given 48 hours to provide additional information.

If you appeal an urgent care claim, a decision will be made within five (5) working days of the appeal. The Claims Appeal Panel may meet via teleconferencing to consider an urgent care claim. Given the shorter time frame there will be no right to a personal appearance.

Coordination of Benefits

Coordination of benefits applies when you or covered dependents have health care coverage under more than one plan. The following rules determine whether the benefits of the Trust's plan are paid before or after the benefits of another plan. The benefits of the Trust's plan will ***not*** be reduced when, under these rules, the Trust's plan pays benefits first. The benefits of the Trust's plan may be reduced when another plan pays benefits first.

When there is a basis for a claim under the Trust's plan and another plan, the Trust's plan is the secondary plan (which pays benefits after the other plan) unless:

- The other plan has rules coordinating its benefits with those of the Trust's plan
- The rules of both plans require that the Trust's plan's benefits be paid before those of the other plan, as follows:

The Trust's plan determines its order of benefits by the first of the following rules that applies:

- The benefits of the plan that cover a person as an employee are determined before the benefits of the plan that cover a person as a dependent.
- When the Trust's plan and another plan cover the same child as a dependent of both parents:
  - The benefits of the plan of the parent whose birthday falls earlier in the calendar year are determined before those of the plan of the parent whose birthday falls later in the year

  - If both parents have the same birthday, the benefits of the plan that has covered a parent for the longer time are determined before the benefits of the plan that has covered a parent for the shorter time
  - If the other plan has a rule based on gender of the parents instead of birthdays, the other plan's rule will determine the order of benefits.
- If two or more plans cover a dependent child of divorced or separated parents, benefits for the child are determined in this order:
  - First, the plan of the parent with custody of the child
  - Second, the plan of the spouse of the parent with the custody of the child
  - Third, the plan of the parent without custody of the child.
- However, if a court decree states that one of the parents is responsible for the health care expenses of the child, the benefits of that plan are determined first.
- The benefits of a plan that covers a person as an active employee or dependent of an active employee will be determined before the benefits of a plan that covers a person as an early retiree, continuation coverage, self-pay or laid off employee or the dependent of such a person. This rule is ignored if the other plan does not have the same rule and if, as a result, the plans do not agree on the order of payment.
- If none of the previous rules determine the order of benefits, the plan that has covered the early retiree or dependent for a longer time determines benefits before the plan that has covered the person for a shorter time.

Effect on Plan Benefits

If you have other health care coverage, the benefits payable under the Trust Early Retiree Preferred Provider and Indemnity Medical Plans, and the Trust Early Retiree Voluntary Dental/Vision Plan may be reduced.

THE TRUST EARLY RETIREE MEDICAL PLANS

If you have other health care coverage, the benefits payable under the Trust Early Retiree Plan 1 (Closed) and the Trust Early Retiree Plan 2 (Open) may be reduced, as follows:

- ***If the other plan providing health care coverage does not have a coordination of benefit provision:*** The Trust Early Retiree Medical Plans (Plan 1 and Plan 2) will reduce the amount they pay so that the amount paid under both plans does not exceed 100% of covered expenses. The benefits payable under each plan will be reduced proportionally to assure that benefits do not exceed the amount of the covered expenses.

- ***If the other plan providing health care coverage has a coordination of benefits provision:*** The coordination of benefits provision will be followed to determine which plan pays secondary. If the Trust Early Retiree Medical Plans (Plan 1 and Plan 2) pay secondary, they will not pay more than the amount of benefits they would have paid for the covered service or supply had they been the primary plan. The Trust, however, will keep a record of the difference between what was paid and what would have been paid if the Trust Early Retiree Medical Plans (Plan 1 and Plan 2) were the primary payer. These savings will be applied to other covered expenses you incur during the same calendar year. These savings cannot be used for expenses other than covered expenses under the Trust Early Retiree Medical Plans (Plan 1 and Plan 2) and cannot be carried forward beyond the calendar year in which the savings were recognized.

The Trust Early Retiree Voluntary Dental/Vision Plan

If you have other health care coverage, the benefits payable under the Trust Early Retiree Voluntary Dental/Vision Plan may be reduced, as follows:

- ***If the other plan providing dental/and or vision coverage does not have a coordination of benefit provision:*** The Trust Early Retiree Voluntary Dental/Vision Plan will reduce the amount it pays so that the amount paid under both plans does not exceed 100% of covered expenses. The benefits payable under each plan will be reduced proportionally to assure that benefits do not exceed the amount of the covered expenses.
- ***If the other plan providing dental and/or vision coverage has a coordination of benefits provision:*** The coordination of benefits provision will be followed to determine which plan pays secondary. If the Trust Early Retiree Voluntary Dental/Vision Plan pays secondary, it will not pay more than 100% of the allowed amount for the covered service. The Trust, however, will keep a record of the difference between what was paid and what would have been paid if the Trust Early Retiree Voluntary Dental/Vision Plan were the primary payer. These savings will be applied to other covered expenses you incur during the same calendar year. These savings cannot be used for expenses other than covered expenses under the Trust Early Retiree Voluntary Dental/Vision Plan and cannot be carried forward beyond the calendar year in which the savings were recognized.

Right to Receive and Release Necessary Information

Certain information is needed to coordinate benefits. The plan has the right to determine what facts are needed and may obtain them from, or provide it to, any other organization or person. Your consent is not required to obtain necessary information or provide it to a third party. Each person claiming benefits under this plan must give the Plan Administrator any information needed to pay the claim.

Facility of Payment

Any payment made under another plan may include an amount that should have been paid under this plan. If so, the Plan Administrator may pay that amount to the plan that made the payment, which will then be treated as a benefit paid under this plan. The Plan Administrator will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the plan pays benefits exceeding what should have paid under the coordination of benefits provision, the plan may recover the excess from one or more of:

- The person it has paid or for whom it has paid
- Insurance companies
- Other organizations.

The amount of the payments includes the reasonable cash value of any benefits provided in the form of services.

A secondary plan that provides benefits in the form of services may recover the reasonable cash value of the services from the primary plan if the services are covered, but not paid or provided, by the primary plan. However, a plan is not required to reimburse a covered person in cash for the value of benefits provided in the form of services.

Plan Not Responsible for Quality of Medical Care

You and your covered dependents have the exclusive right to select dental and vision providers. The plan is not responsible for the quality of dental and vision services you receive, because all providers are independent contractors who are not employees of the plan or related to the plan in any way. The plan cannot be held liable for any claim or damages related to injuries suffered by a covered person while receiving dental or vision services or supplies.

Benefits Not Transferable

Only you and your enrolled dependents are entitled to benefits under the plan. These benefits may not be assigned or transferred to anyone else. Any attempt to assign or transfer the benefits will not be binding on the plan.

Uncashed Checks

Checks issued to participants or providers which are not negotiated within 12 months of issuance will be re-credited to the Trust general assets. If a participant or other appropriate payee requests a reissuance of the check within 12 months of the re-crediting of the check to the Trust's general assets, a new check will be issued. If a request is not made within this time period, the participant or payee's right to payment will be deemed forfeited.

Important Information About Your Trust Medical Benefits

Please review this section carefully, as it explains important information about your medical plan benefits.

Medicare

If you enroll in Medicare because of end-stage renal disease (ESRD) and have coverage under a Trust Early Retiree Medical Plan, Medicare is the secondary payer for the first 30 months that you qualify for Medicare because of ESRD, and Medicare is primary thereafter.

Benefits from Other Sources

Please review this section carefully. It provides information on benefits from other sources.

THIRD-PARTY LIABILITY

There may be situations in which you have a legal right to recover the cost of medical care from a third party who may be responsible for the illness or injury. For example, if you are injured in a store, the owner may be responsible for expenses related to the injury.

If you have such a claim against a third party, the following rules apply (as used in this section, “you” means you or your covered dependent):

- If the plan has paid any benefits to you (or on your behalf), the plan is entitled to recover the amount paid from the proceeds of any settlement or recovery you receive from the third party or by one or more insurers whose insurance policies have become applicable. Insurance includes, but is not limited to, automobile liability, automobile no-fault, uninsured or underinsured motorist, business or commercial liability or umbrella liability regardless of whether such insurance is maintained by the third party, you or any other person or entity. If you continue to receive medical treatment for the illness or injury after obtaining the settlement or recovery, benefits will not be paid for the continuing treatment unless you can prove that the total cost of treatment (including the cost of obtaining the settlement or recovery) is more than the amount you have recovered or expect to recover.
- If you recover any amount from the third party, the plan is entitled to full reimbursement for all related benefits paid to you (or on your behalf) immediately upon the recovery (whether by action of law, settlement or otherwise), regardless of whether you have been made whole. The plan will reduce its reimbursement amount only by a proportionate share of your actual attorneys’ fees and costs up to a maximum reduction of one-third. You must hold the proceeds of the recovery in trust for the plan, which will have a security interest in, and lien on, any recovery you make, to the extent of the benefits the plan has paid and the expenses it has incurred in obtaining the recovery.
- The Trust may require you to sign and deliver any legal documents necessary to secure the plan’s rights of subrogation. If the Trust asks you to sign an agreement to hold the proceeds of any recovery in trust, you must do so before any benefits will be paid.
- If you do not take legal action against a third party, the plan may initiate such action, and you must authorize the plan to sue, compromise or settle any third-party claim in your name. You must cooperate fully with the plan in any proceeding against a third party to reimburse the plan for benefits that were paid to you (or on your behalf) and related to the third-party claim.
- Any dispute regarding the interpretation, application or administration of the Trust’s third-party reimbursement provision will be resolved through arbitration. Arbitration will be conducted in accordance with the Oregon Uniform Arbitration Act, ORS 36.600, et. seq. The parties will split the cost of arbitration unless the Arbitrator orders otherwise. Each party will bear its own attorneys’ fees. In reviewing any issue, the Arbitrator’s scope of review will be whether the Board of Trustees was in error on an issue of law, acted arbitrarily or capriciously in the exercise of its direction, or its findings of fact were unsupported by substantial evidence.

Motor Vehicle Accidents

A motor vehicle accident in which you may have a legal right to recovery is a form of third-party liability. Therefore, the above rules on claims against the third party apply. Before benefits will be paid, you must provide the Trust with the name and address of the other vehicle's driver and his or her insurance company.

Additionally, if you are injured in or by a motor vehicle operated by you or a dependent, the plan will not pay expenses that would be covered as primary by personal injury protection benefits where such coverage is required by law. This exclusion will apply even if you failed to obtain such mandatory coverage. Amounts recovered under any auto insurance policy including automobile liability, automobile no-fault, uninsured and underinsured motorist, business or commercial liability or umbrella liability regardless of whether such insurance is maintained by a third party, you or any other person or entity, are subject to the Trust's third-party reimbursement provisions. Coverage under this plan will be secondary where allowed by law.

Before the plan pays benefits:

- You must have the minimum legally required motor vehicle insurance
- You must provide the Trust with information about any motor vehicle insurance payments made available to you or your covered dependent
- If the Trust requests, you must sign an agreement to hold the proceeds of any recovery in trust for the plan.

Workers' Compensation

The plan does not pay benefits for illness or injury covered under workers' compensation law. For example, if you become ill or are injured as a result of, or in the course of, your employment, your employer or a workers' compensation insurer may be responsible for health care expenses related to the illness or injury. If you filed a claim for workers' compensation that was denied and are in the process of appealing the denial, benefits will be paid to you subject to the following conditions:

- Prior to paying benefits, the plan must receive notice of the denial from your workers' compensation insurer;
- You must provide the Trust Office with a signed agreement to reimburse the plan in the event your workers' compensation claim is paid or settled; and
- You must reimburse the plan for all benefits paid to you for the illness or injury for which you are entitled to compensation by the settlement or disposition of your workers' compensation claim.

Recovery of Benefits Paid in Error

If the Trust mistakenly pays benefits to which you are not entitled or pays a person who is not eligible for payment, the plan has the right to recover that payment from the person paid or from anyone who has benefited from the payment. The plan may recover the improperly paid benefits from any individual who has provided misinformation to the Trust or from you if you have failed to notify the Trust of your dependent's loss of eligibility and these actions have resulted in the payment of improper benefits. The plan may recover improperly paid benefits by deducting future benefits payable to the employee through whom the recipient of the improper benefits has eligibility or any dependents of the employee. The Trust's right to deduct future benefits will apply to any failure to reimburse the plan from any settlement or recovery when benefits have been advanced pursuant to the plan's third-party liability provisions.

Notice of Creditable Prescription Drug Coverage

This notice is most relevant for people who are eligible for Medicare or those who will soon become eligible for Medicare. As an early retiree of the School District No. 1 Health and Welfare Trust, in most cases you and your spouse or domestic partner are not eligible for the Trust's early retiree plans if you are eligible for Medicare, so this information does not affect you. However, this notice would apply to the following Medicare-eligible people who are covered by the Trust's early retiree plans:

- Disabled dependent children
- People who have end-stage renal disease and are in the first 30 months of Medicare eligibility.

Medicare prescription drug coverage became available in 2006 to everyone who is eligible for Medicare. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

The Trust has determined that the prescription drug coverages for early retirees and their dependents enrolled in the following Trust plans are on average expected to pay out at least as much as the standard Medicare prescription drug coverage will pay:

- Trust Early Retiree Prescription Drug Plan (for members enrolled in the Providence Personal Option Plan)
- Trust Early Retiree Indemnity Medical Plan (Plan 1)
- Trust Early Retiree PPO Plan (Plan 2).

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from October 15 through December 7. However, because you have existing prescription drug coverage through the Trust that, on average, is as good as Medicare coverage, you can choose to keep the Trust's prescription drug coverage as long as you are eligible for it, and join a Medicare prescription drug plan later. You may also be eligible for a special enrollment period to sign up for a Medicare prescription drug plan at the time you lose eligibility for Trust coverage.

If you decide to enroll in a Medicare prescription drug plan and you are still eligible for Trust early retiree coverage according to plan eligibility and as summarized above, you may also continue your Trust prescription drug coverage. If you decide to enroll in a Medicare prescription drug plan and drop your Trust coverage, be aware that you will drop both medical and prescription drug coverage, and Medicare will be your only payer.

You should also know that if you drop or lose your coverage with the Trust and don't promptly enroll in Medicare prescription drug coverage after your Trust coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If you go 63 days or longer without prescription drug coverage that is at least as good as Medicare's prescription drug coverage, your monthly premium for a Medicare prescription drug plan will go up at least 1% per month for every month after your initial enrollment period that you did not have that coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what most other people pay. You will have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

The Trust will provide you with a notice of creditable coverage. You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, if this coverage changes, or upon your request.

Notice of Privacy Practices

The HIPAA Privacy Rules require that the School District No. 1 Health and Welfare Trust not use or disclose Protected Health Information ("PHI") unless it is for Payment, Treatment or Health Care Operations or authorized by the affected Individual. Under the Privacy Rules, all disclosures of PHI shall be limited to the minimum necessary requirements.

This Policy and Procedures is enacted to document School District No. 1 Health and Welfare Trust's compliance with the requirements of the HIPAA Privacy Rules and to provide guidance for handling issues which may arise under the HIPAA Privacy Rules. Other Covered Entities with which the Trust contracts will follow their own privacy policies adopted pursuant to the HIPAA Privacy Rules. This Policy and Procedures will be interpreted in accordance with the governing regulations and other legal requirements. This notice is also available on the Trust's web site, www.sdtrust.com.

Use and Disclosure of Health Information

Your health information may be used and disclosed without an authorization in the following situations.

To Make or Obtain Payment

The Trust may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Trust may use health information to pay your claims or share information regarding your coverage or health care treatment with other health plans to coordinate payment of benefits.

To Facilitate Treatment

The Trust may disclose information to facilitate treatment that involves providing, coordinating or managing health care or related services. For example, the Trust may disclose the name of your treating physician to another physician so that the physician may ask for your X-rays.

To Conduct Health Care Operations

The Trust may use or disclose health information for its own operations, to facilitate the administration of the Trust and as necessary to provide coverage and services to all of the Trust's participants. Health care operations include making eligibility determinations; contacting health care providers; providing participants with information about health-related issues or treatment alternatives; developing clinical guidelines and protocols; conducting case management; medical review and care coordination; handling claim appeals; reviewing health information to improve health or reduce health care costs; participating in drug or disease management activities; conducting underwriting; premium rating or related functions to create, renew or replace health insurance or health benefits; and performing the general administrative activities of the Trust (such as providing customer service, conducting compliance reviews and auditing, responding to legal matters and compliance inquiries, handling quality assessment and improvement activities, business planning and development including cost management and planning related analyses and formulary development, and accreditation, certification, licensing or credentialing activities). For example, the Trust may use your health information to conduct case management of ongoing care or to resolve a claim appeal you file.

For Disclosure to the Plan Trustees

The Trust may disclose your de-identified health information to the Board of Trustees (which is the plan sponsor) and to necessary advisors who assist the Board of Trustees in performing plan administration functions, such as handling claim appeals.

The Trust also may provide summary health information to the Board of Trustees so that it may solicit bids for services or evaluate its benefit plans. Summary health information is information that summarizes participants' claims information but from which names and other identifying information have been removed. The Trust may also disclose information about whether you are participating in the Trust or one of its available options.

Disclosure Where Required by Law

In addition, the Trust will disclose your health information where applicable law requires. This includes:

- **In connection with judicial and administrative proceedings —** The Trust will, in response to an order from a court or administrative tribunal, disclose protected health information in accordance with the express terms of such an order. The Trust may also disclose protected health information in response to a subpoena or other lawful process if the Trust receives satisfactory documentation that you have received notice of the subpoena or legal process, the notice provided sufficient information to allow you to raise an objection and the time for raising an objection has passed and either no objections were filed or were resolved by the court or administrative tribunal. Alternatively, the party requesting disclosure may provide satisfactory documentation you have agreed to the disclosure or that it has obtained a qualified protective order which meets the requirements of the Privacy Rules and which allows for disclosure. For example, if the Trust receives a court order requiring it to disclose certain information, it will respond to the court order.
- **When legally required and for law enforcement purposes —** The Trust will disclose your protected health information when it is required to do so for law enforcement purposes. This may include compliance with laws which require reporting certain types of injuries, pursuant to court issued legal process; or a grand jury subpoena or other administrative requests if satisfactory documentation is provided that the request is relevant to a legitimate law enforcement purpose, the request is reasonably tailored to meet this legitimate law enforcement purpose and de-identified information cannot be reasonably provided as an alternative. Additionally, limited disclosure may be made for purposes of identifying or locating a suspect, fugitive, material witness or missing person, identifying a victim of a crime or in connection with a criminal investigation that occurred on Trust premises. For example, the Trust could upon request of a law enforcement agency provide information concerning the address of a fugitive.
- **To conduct public health and health oversight activities —** The Trust may disclose your health information to a health oversight agency for authorized activities (including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action), government benefit programs for which health information is relevant, or to government agencies authorized by law to receive reports of abuse, neglect or domestic violence as required by law. The Trust, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

- **In the event of a serious threat to health or safety —** The Trust may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Trust, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public. For example, the Trust may disclose evidence of a threat to harm another person to the appropriate authority.
- **For specified government functions —** In certain circumstances, federal regulations require the Trust to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.
- **For workers' compensation —** The Trust may release your health information to the extent necessary to comply with laws related to workers' compensation or similar programs.
- **To your personal representative —** The Trust may disclose your health information to an individual who is authorized by you or applicable law to serve as your personal representative.

Authorization to Use or Disclose Health Information

Other than as stated earlier, the Trust will not disclose your health information without your written authorization. Generally, you will need to submit an Authorization if you wish the Trust to disclose your health information to someone other than yourself. Authorization forms are available from the Privacy Contact Person or from the Trust web site, www.sdtrust.com. (See "Privacy Contact Person" on page 59 for details.)

If you have authorized the Trust to use or disclose your health information, you may revoke that authorization in writing at any time. The revocation should be in writing, include a copy of or reference to your Authorization and be sent to the Privacy Contact Person. (See "Privacy Contact Person" on page 59 for details.)

Special rules apply about disclosure of psychotherapy notes. Your written authorization generally will be required before the Trust will use or disclose psychotherapy notes. Psychotherapy notes are a mental health professionals' separately filed notes which document or analyze the contents of a counseling session. They do not include summary information about your mental health treatment or information about medications, session stop and start times, the diagnosis and other basic information. The Trust may use and disclose psychotherapy notes when needed to defend against litigation filed by you or as necessary to conduct treatment, payment and health care operations.

Your Rights with Respect to Your Health Information

You have the following rights regarding your health information that the Trust maintains.

Right to Request Restrictions

You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Trust's disclosure of your health information to someone involved in payment for your care. However, the Trust is not required to agree to your request.

Right to Inspect and Copy Your Health Information

You have the right to inspect and copy your health information. This right, however, does not extend to psychotherapy notes or information compiled for civil, criminal or administrative proceedings. The Trust may deny your request in certain situations subject to your right to request review of the denial. A request to inspect and copy records containing your health information must be made in writing to the Privacy Contact Person. (See "Privacy Contact Person" on page 59 for details.) If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembly costs and postage, if applicable, associated with your request.

Right to Receive Confidential Communications

You have the right to request that the Trust communicate with you in a certain way if you feel the disclosure of your health information through regular procedures could endanger you. For example, you may ask that the Trust communicate with you only at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Privacy Contact Person. (See "Privacy Contact Person" on page 59 for details.) The Trust will attempt to honor reasonable requests for confidential communications.

Right to Amend Your Health Information

If you believe that your health information records are inaccurate or incomplete, you may request that the Trust amend the records. That request may be made as long as the information is maintained by the Trust. A request for an amendment of records must be made in writing to the Trust's Privacy Contact Person. (See "Privacy Contact Person" on page 59 for details.) The Trust may deny the request if it does not include a reasonable reason to support the amendment. The request also may be denied if your health information records were not created by the Trust, if the health information you are requesting to amend is not part of the Trust's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Trust determines the records containing your health information are accurate and complete.

Right to an Accounting

You have the right to request a list of disclosures of your health information made by the Trust. The request must be made in writing to the Privacy Contact Person. (See “Privacy Contact Person” on page 59 for details.) The request should specify the time period for which you are requesting the information. No accounting will be given of disclosures made: to you; for treatment, payment or health care operations; disclosures made before April 14, 2003; disclosures for periods of time going back more than six years; or in other limited situations. The Trust will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Trust will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice

You have a right to request and receive a paper copy of this notice at any time, even if you have received this notice previously or agreed to receive the notice electronically. To obtain a paper copy, please contact the Privacy Contact Person. (See “Privacy Contact Person” on page 59 for contact information.) You also may obtain a copy of the current version of the Trust’s notice at its web site, www.sdtrust.com. If this notice is modified, you will be mailed a new copy.

Privacy Contact Person/Privacy Official

To exercise any of these rights related to your health information you should contact the Privacy Contact Person listed below. The Trust has also designated a Privacy Official to oversee its compliance with the privacy rules.

Privacy Contact Person

Ms. Charlene Lind
Northwest Administrators, Inc.
2323 Eastlake Ave. E
Seattle, WA 98102
Phone: (206) 726-3281
E-mail: clind@nwadmin.com

Privacy Official

Ms. Charlene Lind
Northwest Administrators, Inc.
2323 Eastlake Ave. E
Seattle, WA 98102
Phone: (206)726-3281
E-mail: clind@nwadmin.com

Duties of the Trust

The Trust is required by law to maintain the privacy of your health information as set forth in this notice and to provide to you this notice summarizing its privacy practices and duties. The Trust is required to abide by the terms of this notice, which may be amended from time to time. The Trust reserves the right to change the terms of this notice and to make the new notice provisions effective for all health information that it maintains. If the Trust changes its policies and procedures, the Trust will revise the notice and will provide you a copy of the revised notice within 60 days of the change. You have the right to request a paper copy of the notice at any time. You may also obtain it from the Trust web site at www.sdtrust.com.

You have the right to express complaints to the Trust and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Trust should be made in writing to the Privacy Official identified above. The Trust encourages you to express any concerns you may have regarding the privacy of your health information. You will not be retaliated against in any way for inquiring about or filing a complaint about privacy matters.

Post-Mastectomy Reconstruction Surgery Notice

The Women's Health and Cancer Act requires the Trust to notify retirees of the reconstructive surgery benefit following a mastectomy. All Trust provided medical plans cover post-mastectomy reconstructive surgery, including:

- Reconstruction of the breast on which a mastectomy has been performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Physical complications of all stages of mastectomy (including lymphedema).

Plan Information

Plan Name

The legal name of this plan is the School District No. 1 Health and Welfare Trust. This handbook describes the eligibility, enrollment, appeal and general administrative provisions that apply to the Trust's early retiree plans. It also describes your continuation rights and provides notices required by the benefit program commonly known as the Trust Early Retiree Medical Plan.

Type of Plan

The plan is a health and welfare plan that provides medical, prescription drug, dental and vision benefits to certain eligible early retirees and their eligible dependents. This handbook describes the hospital, medical and surgical benefits provided under the plan.

Administrative Administrator

- Employer Identification Number (EIN) of the plan sponsor: 93-6090239
- Plan Number (PN): 001
- Benefit Year: January 1 through December 31
- 2016 Open Enrollment Year: February 1 through December 31
- 2017 Open Enrollment Year: January 1 through December 31
- Financial Plan Year: November 1 through October 31

Plan Administrator

The plan is sponsored and administered by a joint labor-management Board of Trustees with the assistance of Northwest Administrators, a contract administration organization. Northwest Administrators is referred to as the Trust Office throughout this booklet and may be contacted at the following address:

School District Trust Office
700 NE Multnomah St., Suite 350
Portland, OR 97232
(844) 203-0239

Board of Trustees

Leonard Anderson	Emma Ford	Jack Roy
Michelle Batten	Le Huynh	Michelle Riddell
John Berkey	Paul Anthony	Gwen Sullivan
Terri Burton	Marty Pavlik	Kerry Young
Siobhan Murphy	Russ Peterson	Yousef Awwad
Pat Christensen	Belinda Reagan	Kathy Muir

All Trustees can be contacted through:

School District Trust Office
700 NE Multnomah St, Suite 350
Portland, OR 97232
(844) 203-0239

Agent for Service of Legal Process

The person designated as the plan's agent for service of legal process is:

David Barlow
McKenzie Rothwell Barlow & Coughran
1325 Fourth Avenue, Suite 910
Seattle, WA 98101
(206) 224-9900

In addition, legal process on the plan may be served on the Board of Trustees at the above address or on any individual Trustee listed above.

Type of Administration

The plan is administered directly by the Board of Trustees of the School District No. 1 Health and Welfare Trust.

Future of the Plan and Trust Fund

The Board of Trustees has the authority to terminate the Trust Fund. The Trust Fund will also terminate upon the expiration of all collective bargaining agreements requiring the payment of contributions to the Trust Fund. In the event of termination of the Trust Fund, any and all monies and assets remaining in the Trust Fund after payment of expenses will be used for the continuation of the benefits provided by the then existing benefit plans, until such monies and assets have been exhausted.

Funding of Benefits

The plan pays benefits directly from the general assets of the School District No. 1 Health and Welfare Trust.

Source of Contributions

The plan is funded by contributions the District makes to the Trust for eligible employees, retirees and their dependents, and payments made by individuals eligible for benefits under this Trust, on a month-to-month basis, according to collective bargaining agreements or special agreements.

Interpretation of the Plan

The Board of Trustees has the discretionary authority to interpret and construe the terms of its benefit plans and to determine an individual's eligibility for benefits. In administering the plan, the Trust's claims administrator, or medical review organization, may use internal guidelines and medical protocols to determine if specific services are covered under the terms of the plan.

Collective Bargaining Agreements

The plan is maintained according to one or more collective bargaining agreements. Upon written request to the unions and payment of any copying charges, plan participants and beneficiaries may obtain copies of any such agreements. They may also inspect the agreements at the unions' principal offices.

Status as a Grandfathered Plan

School District No. 1 Health and Welfare Trust believes the medical plans it offers to the PAT retirees constitute "grandfathered health plans" under the Patient Protection and Affordable Care Act (the Affordable Care Act). If this status changes in the future, you will receive a notice of the change. As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans; for example, the requirement for the provisions of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act; for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Trust Office. You may also contact the U.S. Department of Health and Human Services at www.healthreform.gov.

Glossary

Accidental injury — A bodily injury to a covered person that is caused solely by external, violent and accidental means and results directly in a covered expense, independently of other causes. Intentionally self-inflicted injuries are not covered.

Allowed amount (or allowable charge) — For Regence preferred and participating providers, it's the amount that the provider has contractually agreed to accept as payment in full for a service or supply.

For Regence non-contracted providers who *are not* accessed through the BlueCard Program, the allowed amount is the amount the Claims Administrator has determined to be reasonable charges for a covered service or supply.

For Regence non-contracted providers who *are* accessed through the BlueCard Program, the allowed amount is the lower of the Provider's billed charges and the amount that the Host Blue identifies to the Claims Administrator as the amount on which it would base a payment to that provider.

Affiliate — A company with which the Claims Administrator has a relationship that allows access to providers in the state in which the affiliate serves and includes the following companies: Regence BlueShield of Idaho in the state of Idaho, Regence BlueCross BlueShield of Utah in the state of Utah and Regence BlueShield in parts of the state of Washington.

Ambulatory service facility — A facility, licensed by the state in which it is located, that is equipped and operated mainly to do surgeries or obstetrical deliveries that allow patients to leave the facility the same day the surgery or delivery occurs.

Calendar year — Each year, January 1 through December 31.

Chemical dependency (under the mental health and chemical dependency benefit) — An addictive relationship with alcohol or any drug, excluding tobacco products. The dependency may be physical or psychological or both. It must interfere with a person's social, psychological or physical adjustment. Food addictions are not considered chemical dependency.

Claims administrator —Regence for the Trust Indemnity Medical Plan, Trust Preferred Provider Medical Plan and the Trust Dental Plan, otherwise the Trust Office.

Claims administrator (from *Vision*) — VSP.

Collective bargaining agreement — A collectively bargained agreement between the District and a labor organization that requires contributions to the Trust.

Contracted rate — The contracted rate is based on a negotiated fee for services rather than billed charges. The use of a contracted rate rather than actual billed charges can result in you paying a different amount under the plan.

Contribution — The amount paid to the Trust by the District or a participating employee, by payroll deduction or otherwise, to provide benefits for participating employees and their dependents

Cosmetic procedures — Procedures (including surgery) that are not medically necessary and are primarily for the enhancement of physical appearance or self-esteem. Cosmetic procedures may be covered only if used to correct functional disorders or repair damage resulting from an accidental injury, or for breast reconstruction (of either breast) following a mastectomy or lumpectomy, if medically necessary.

Covered person — A retiree of the District or a dependent of the retiree who meets the plan's eligibility and enrollment requirements.

Custodial care — Care that helps a person conduct activities of daily living and that can be provided by people without medical or paramedical skills. Custodial care also includes care primarily for separating a patient from others or preventing a patient from harming him/herself.

Deductible — The portion of covered expenses a covered person must pay each year before the plan pays benefits.

Dentist — A doctor of medical dentistry or dental surgery (DMD or DDS) acting within the scope of his or her license to treat accidental injury to natural teeth or a fractured jaw, or to perform surgery (such as surgical treatment of tumors of the mouth) that does not involve repair, removal or replacement of teeth, gums or supporting tissue.

Dental Services — Services or supplies (including medications) provided to prevent, diagnose, or treat diseases or conditions of the teeth and adjacent supporting soft tissues, including treatment that restores the function of the teeth

Dependent — The spouse or domestic partner of a covered employee or any unmarried child of the employee, spouse or domestic partner who meets the plan's eligibility requirements.

District — School District No. 1, Multnomah County, Oregon.

Each occurrence — A covered person may be hospitalized more than once, and more than one surgical procedure may be performed on a covered person at one time. Each occurrence is separated as follows:

- In case of pregnancy, if a later hospital stay or surgical procedure is due to a different pregnancy
- For dependents, if the disability that causes a later hospital stay or surgical procedure is different from the disability that caused the first hospital stay or surgical procedure
- If you are readmitted due to a new injury, regardless of when you were previously discharged

- If your dependent is readmitted 90 or more days after his or her previous discharge.

Early retiree — A retired District employee eligible for coverage under this plan.

Effective date — The date your coverage under the agreement begins after acceptance for enrollment under the plan.

Eligible provider — Any of the following who provide medically necessary services within the scope of his or her license:

- Physician (doctor of medicine or osteopathy)
- Podiatrist
- Dentist (doctor of medical dentistry or doctor of dental surgery)
- Psychologist
- Licensed clinical social worker, but only for services provided upon the written referral of a physician or psychologist
- Nurse practitioner
- Registered physical, occupational, speech or audiological therapist, but only for rehabilitative services provided upon the written referral of a physician or doctor of osteopathy
- Registered nurse or licensed practical nurse, but only for services provided upon the written referral of physician or doctor of osteopathy and for which nurses customarily bill patients
- Chiropractor
- Naturopath
- Christian Science practitioner.

Emergency medical condition — A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who has an average knowledge of medicine and health would reasonably expect the absence of immediate medical attention at a hospital emergency room to result in any one of the following:

- Placing the plan participant's health, or with respect to a pregnant plan participant, her health or the health of her unborn child, in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part.

Health Intervention — A medication, service or supply provided to prevent, diagnose, detect, treat or palliate the following: Disease, illness, injury, genetic or congenital anomaly, pregnancy or biological or psychological condition that lies outside the range of normal, age-appropriate human variation, or to maintain or restore functional ability. A Health Intervention is defined not only by the intervention itself, but also by the medical condition and patient indications for which it is being applied. A Health Intervention is considered to be new if it is not yet in widespread use for the medical condition and the patient indications being considered.

Home health care — Care provided through a qualified, licensed or certified home health care agency or program to provide medical support services in a patient's home.

Hospice facility — A licensed facility primarily engaged in providing care, counseling and incidental medical services to terminally ill patients with a life expectancy of six or less months and to the patient's immediate family.

Hospital — A facility that provides diagnostic and therapeutic facilities for inpatient medical and surgical treatment of persons who are ill or injured. It must be licensed under applicable laws as a general hospital by the state in which treatment is provided, accredited by the Joint Commission on Accreditation of Hospitals or approved by Medicare as a hospital. Its services must be supervised by a staff of physicians and must include 24-hour-a-day nursing services by registered nurses or other nursing staff under the supervision of a registered nurse. It must be operated continuously with organized facilities for surgery on the premises.

Facilities that are primarily for rest, old age or custodial care are not considered hospitals. Similarly, facilities for the treatment of chemical dependency (including alcoholism) and mental disorders are not considered hospitals. This includes facilities within hospitals that may be used for such treatment. It is not a place of rest, a nursing home or a facility for convalescence.

Illness — A condition, disease, ailment or bodily disorder (other than an injury and pregnancy), or physical disorder that causes functional impairment. Illness does not include any state of mental health or mental disorder (which is otherwise defined in this handbook).

Injury — Physical damage to the body inflicted by a foreign object, force, temperature or corrosive chemical or that is the direct result of an accident, independent of illness or any other cause. Injury does not mean bodily injury caused by routine or normal body movements such as stooping, twisting, bending or chewing and does not include any condition related to pregnancy.

Inpatient treatment (under the mental health and chemical dependency benefit) — Treatment in a hospital or other facility licensed to provide care under state law or accredited by the Joint Commission on Accreditation of Hospitals or the Commission on the Accreditation of Rehabilitation Facilities. The facility must be licensed to admit patients who require 24-hour skilled nursing care and must provide full-day or partial-day treatment for mental illness, acute alcoholism or drug addiction.

Investigational — A Health Intervention that the Claims Administrator has classified as investigational. The Claims Administrator will review scientific evidence from well-designed clinical studies found in peer-reviewed medical literature, if available, and information obtained from the treating physician or practitioner regarding the Health Intervention to determine if it is investigational. A Health Intervention not meeting all of the following criteria, is considered investigational:

- If a medication or device, the Health Intervention must have final approval from the United States Food and Drug Administration as being safe and efficacious for general marketing. However, if a medication is prescribed for other than its FDA-approved use and is recognized as effective for the use of a particular diagnosed condition, benefits for the medication may be provided when so used. To be considered effective for other than its FDA-approved use, the Oregon Health Resources Commission must have determined that the medication is effective for the treatment of that condition; or is determined to be in an investigational status.
- The scientific evidence must permit conclusions concerning the effect of the Health Intervention on health outcomes, which include the disease process, injury or illness, length of life, ability of function and quality of life.
- The Health Intervention must improve net health outcome.
- The scientific evidence must show that the Health Intervention is as beneficial as any established alternatives.
- The improvement must be attainable outside the laboratory or clinical research testing.

Licensed clinical social worker — A person who specializes in clinical social work and is licensed or certified as a social worker by the appropriate authority.

Medicare — The Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act.

Mental or nervous disorder (under the mental health and chemical dependency benefit) — A psychological disorder characterized by psychological pain or distress and substantial impairment of basic functioning, including psychoneurosis, psychopathy, psychosis and mental or emotional disorder or disease of any kind.

Non-contracted providers — Under this plan, providers who do not have an effective participating contract with the Claims Administrator or one of the Claims Administrator's affiliates to provide services and supplies. Reimbursement for these providers is generally the lowest payment level, and you may be billed for balances beyond any deductible and/or coinsurance for covered services.

Non-VSP provider — Any optometrist, optician, ophthalmologist or other licensed and qualified vision care provider who has not contracted with VSP to provide vision care services and/or vision care materials to covered persons of VSP.

Nurse practitioner — A person certified to practice as a nurse practitioner who:

- Is licensed by a board of nursing as a registered nurse; and
- Has completed a state-approved program for the education and training of nurse practitioners.

Out-of-pocket maximum — The maximum amount a covered person will need to pay out-of-pocket for covered expenses within a calendar year.

Outpatient program — A program of medical care and treatment that:

- Is provided outside of a hospital setting or at a hospital without the need for room and board
- Provides treatment of chemical dependency (including alcoholism) and mental or nervous disorders
- Is licensed or approved by the appropriate authority
- Has a staff that is directly supervised by a physician, psychologist, nurse practitioner or licensed clinical social worker
- Provides an individual treatment plan that is approved by a physician, psychologist, nurse practitioner or licensed clinical social worker.

Outpatient treatment (under the mental health and chemical dependency benefit) — Treatment through a program that meets the standards of the Oregon Mental Health Division or the Oregon Office of Drug and Alcohol Abuse Programs (or equivalent agency if services are provided in another state). Treatment must be provided by one of the following:

- Physician
- Psychologist
- Nurse practitioner
- Licensed clinical social worker (upon written referral of a physician or psychologist)
- Health facility
- Residential, partial hospitalization or day care facility.

Person eligible under Medicare — A covered person who is entitled to enroll in and be covered under the voluntary portion of Medicare.

Plan — The School District No. 1 Health and Welfare Early Retiree Trust Plan 1 (Closed) or the Early Retiree Trust Plan 2 (Open) described in this handbook.

Plan (from *Dental* and *Vision*) — The School District No. 1 Health and Welfare Trust Early Retiree Voluntary Dental/Vision Plans described in this handbook.

Plan administrator — The administrator retained by the Board of Trustees to administer the plan under the Board's direction and control. Administrative duties include (but are not limited to) maintaining eligibility records and processing claims.

Plan document — The written Early Retiree Trust Plan 1 (Closed) or the Early Retiree Trust Plan 2 (Open) document.

Plan document (from *Dental* and *Vision*) — The written Trust Early Retiree Voluntary Dental/Vision Plan document.

Plan year (2016) — February 1 to December 31.

Plan year (2017) — January 1 to December 31.

Portland Association of Teachers (PAT) — The collective bargaining agreement you work under that governs your eligibility to participate in the Trust. (See *Participating in the Plans — Eligibility* for details).

Preauthorization — Prior authorization needed from the prescribing physician before certain prescriptions will be filled by a retail pharmacy or the mail-order service. Preauthorization may be required due to the specific drug, the supply size or dosage, or the timing of the prescription or refill.

Preferred provider (Regence) — Doctors and hospitals who have contracted with a preferred provider organization (PPO) and agreed to accept preferred payment rates for eligible persons. For Full-Time/Part-Time Option 1 and Part Time Option 2 Trust Preferred Provider Plan, review the Regence Provider Directory at www.myRegence.com.

Preferred provider organization (PPO) — A group of health care providers who have agreed to offer services and supplies at contracted rates.

Psychologist — A person who specializes in clinical psychology and who is:

- Licensed or certified as a psychologist; or
- A member or fellow of the American Psychological Association, if there is no government licensing or certification required.

Reasonable charges — An amount determined by the Claims Administrator, that falls within the range of average payments they make to providers, who have an effective participating contract with them, for the same or similar service or supply in the Claims Administrator's service area.

Reconstructive surgery — Surgery to repair damage due to an accidental injury or amputation, including reconstructive surgery on one or both breasts following a mastectomy or a lumpectomy, if medically necessary.

Regence — refers to Regence BlueCross BlueShield of Oregon.

Required contribution — the amount of money determined by the Trustees according to the terms of the Trust Agreement and collective bargaining agreement to provide benefits for participating early retirees.

Residential, partial hospitalization or day care facility (under the mental health and chemical dependency benefit) — A residential facility, hospital or other facility that provides an organized full-day or partial-day treatment program for chemical dependency (including alcoholism) or mental/nervous disorders. The facility must be licensed under state law or accredited by the Oregon Mental Health Division or the Oregon Office of Drug and Alcohol Abuse Programs (or equivalent agency if services are provided in another state) to provide the level of care for which benefits are claimed.

Room and board — Room, board, general duty nursing, intensive nursing care and any other charges for services regularly provided by a hospital for the class of accommodations occupied. Room and board does not include professional services of physicians or special nursing services provided outside an intensive care unit.

Services and supplies — Services and supplies for which coverage is provided by this plan that are required for treatment of a medical condition and which are furnished to a covered person. Services and supplies does not include the professional services of any physician and any private duty or special nursing services including intensive nursing care by whatever name called.

Skilled nursing facility — Any of the following:

- A facility owned and operated by a hospital or under written contract with a hospital
- A distinct part of a hospital
- A facility or distinct part of a facility that meets Medicare's requirements for operation.

Facilities approved by Medicare as skilled nursing facilities are covered by the plan. If not approved by Medicare, a facility may be covered if it:

- Is operated under the applicable licensing and other laws
- Is under the supervision of a licensed physician, registered nurse (R.N.) or nurse practitioner who supervises it full-time
- Regularly provides room and board and continuously provides 24-hour-a-day skilled nursing care to ill and injured persons at the patient's expense during the convalescent stage of an illness or injury
- Maintains a daily medical record of each patient under the care of a provider

- Is authorized to administer medication to patients on the order of a provider
- Is not, other than incidentally, a home for the aged, blind or deaf; a hotel, custodial care facility, maternity home or home for persons with mental or nervous disorders or chemical dependency (including alcoholism).

Treatment center (under the mental health and chemical dependency benefit) — Centers that provide a program of effective medical and therapeutic treatment of chemical dependency (including alcoholism). Some states have laws requiring group insurance plans to cover such centers. In those states, this plan covers treatment centers that are licensed by the state. In other states, a treatment center may be covered if it:

- Is established and operated according to applicable state law
- Provides a program of treatment approved by a physician and the plan
- Maintains a written, specific and detailed regimen requiring full-time residence and full-time participation of the patient
- Provides at least the following basic services:
  - Room and board (if the plan provides inpatient benefits)
  - Evaluation and diagnosis
  - Counseling
  - Referral and orientation to specialized community resources.

A treatment center that qualifies as a hospital under this plan is covered as a hospital, not treatment center.

Trust — The School District No. 1 Health and Welfare Trust.

Trust agreement — The Trust Agreement of the School District No. 1 Health and Welfare Trust Fund and any valid amendments.

Usual and customary or reasonable (UCR) rates (from *Dental)* — The fees and prices regularly charged by your dentist and other dentists in your area for the dental services and supplies generally furnished for cases like yours.

Usual and customary or reasonable (UCR) rates (from *Vision)* — The rates charged for a given vision service or supply by similar providers in your geographic area.

Visually necessary or appropriate — Services and materials medically or visually necessary to restore or maintain a patient's visual acuity and health and for which there is no less expensive professionally acceptable alternative, as determined by VSP.

VSP preferred provider — An optometrist or ophthalmologist licensed and qualified to practice vision care and/or provide eyewear who has contracted with VSP to provide vision care services and/or eyewear to VSP members.

Coordination of Benefits Definitions

Following are definitions of some of the terms used throughout *Administrative Information — Coordination of Benefits*.

- **Plan —** Any of the following that provide benefits or services for, or because of, medical, dental, vision or prescription drug care:
  - Group, blanket or franchise health insurance policies issued by insurers including health care service contractors
  - Group prepaid coverage under service plan contracts or under group or individual practice plans
  - Labor management trusteed plans, labor organization plans, employer organization plans or employee benefit organization plans
  - Medical coverage in government programs
  - Other group-type coverage that is not available to the general public and can be obtained and maintained only through membership in, or connection with, a particular organization or group.

  Each contract or other arrangement for coverage described above is a separate plan. If an arrangement has two or more parts and coordination of benefits applies only to one part, each part is considered a separate plan.

  The term “plan” does not include the following:
  - Individual or family benefits provided through insurance contracts, subscriber contracts, coverage through health maintenance organizations or other prepayment, service, group practice or individual practice plans
  - Group or group-type hospital indemnity benefits of $100 per day or less paid on other than an expense-incurred basis and reimbursement-type benefits where the insured has the right to elect indemnity-type benefits in lieu of reimbursement benefits at the time of the claim. However, the term “plan” does include the amount of benefits exceeding $100 per day
  - School accident-type coverage for elementary school, high school or college students for accidents only, including athletic injuries, either on a 24-hour basis or on a to-and-from-school basis.
- **This plan**
  - The Trust Early Retiree Voluntary Dental/Vision Plan.
  - The Early Retiree Trust Plan 1 (Closed) and the Early Retiree Trust Plan 2 (Open).

Contacts

For Questions About:	Contact:	Web Site/Email	Phone Number
General Benefit Information (including eligibility, coverage and procedures)	The Trust Office 700 NE Multnomah St. Suite 350 Portland, OR 97232	www.sdtrust.com	(844) 203-0239
Medical			
Claims and Benefits for the Early Retiree Trust Plan 1 (Closed) and Early Retiree Trust Plan 2 (Open)	Regence	www. Regence.com	(866) 240-9580
Special Beginnings (Maternity Care) Program for the Early Retiree Trust Plan 1 (Closed) and Early Retiree Trust Plan 2 (Open)	Regence	Email:OR_Special_Beginnings@regence.com	(866) 569-2229
Care Management for the Early Retiree Trust Plan 1 (Closed) and Early Retiree Trust Plan 2 (Open)	Regence	www.Regence.com	(866) 543-5765
Kaiser Permanente HMO	Customer Service	www.kaiserpermanente.org	(503) 813-2000 (Portland) or (800) 813-2000
Providence Personal Option Plan	Customer Service	www.providence.org/healthplans	(503) 574-7500 (Portland) or (800) 878-4445
Medical Provider Networks			
Regence Provider Network (Early Retiree Trust Plan 1 (Closed) and Early Retiree Trust Plan 2 (Open))	Customer Service	www.Regence.com	(866) 240-9580
Providence Personal Option Network (Providence Personal Option Plan)	Customer Service	www.providence.org/healthplans	(503) 574-7500 (Portland) or (800) 878-4445
Trust Prescription Drug Plan			
Retail Pharmacy	CVS Caremark		(800) 552-8159
Mail Order	Caremark.com	https://www.caremark.com/wps/portal	(800) 552-8159

For Questions About:	Contact:	Web Site/Email	Phone Number
Trust Basic or Buy-up Dental Plan			
(On a self-pay basis)	Trust Office Claims Department	www.sdtrust.com	(844) 203-0239
Trust Basic or Buy-up Vision Plan			
(On a self-pay basis for the Early Retiree Indemnity Medical Plan (Plan 1) and PPO Plan (Plan 2) and the Providence Personal Option Plan)	VSP	www.vsp.com	(800) 877-7195

For PAT Early Retirees