Health Benefit Handbook

School District No. 1 | Health and Welfare Trust

For PAT employees

Rev. August 2016

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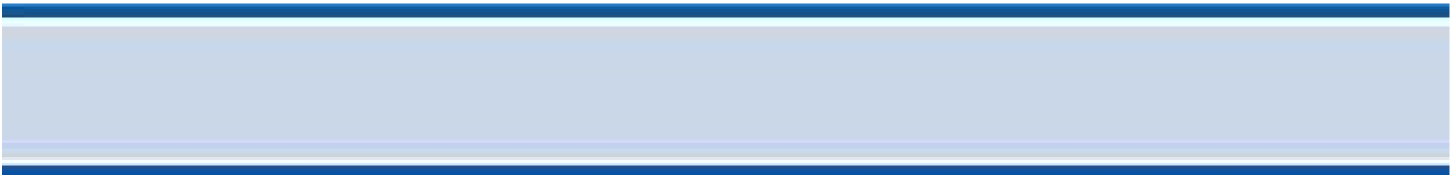


Welcome

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

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

The Trust offers employees multiple medical and prescription drug options depending on the individual employee's bargaining group. Medical benefits provided through Kaiser or the Providence Personal Option Plan are described in separate booklets available from the Trust Office or the health plan. Dental and vision coverage is provided to most employees and dependents. Long-term disability, life and accidental death and dismemberment (AD&D), voluntary AD&D and optional life benefits are also available to most employees; separate booklets describing plan details are available from the Trust Office or The Standard. (See "Enrollment Options" 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.

Enrollment Options

Your bargaining agreement determines which benefit options are available to you. The following options are available to the different groups of employees participating in the Trust and their dependents.

The actual benefits provided under each option are described in the *Medical*, *Prescription Drugs*, *Dental*, *Vision*, *Life/AD&D*, and *LTD* sections.

Medical Coverage Options

The medical coverage options vary based on your bargaining unit and the terms of the bargaining agreement applicable to you.

Portland Association of Teachers (PAT)

Full-Time/Part-Time Option 1

- Trust Preferred Provider Plan
- Kaiser Permanente HMO
- Providence Personal Option Plan

Part-Time Option 2

- Trust Indemnity Medical Plan
- Kaiser Permanente HMO
- Providence Personal Option Plan

Substitute Teachers

- Kaiser Permanente HMO
- Providence Personal Option Plan

Prescription Drug Coverage

All employees and dependents with Trust-provided medical coverage under the Providence Personal Option Plan medical coverage participate in the Trust Prescription Drug Plan. (See *Prescription Drugs* for details about prescription drug coverage.) If you are enrolled in Kaiser Permanente HMO, prescription drug benefits are through Kaiser.

Dental Coverage

All employees and dependents with dental coverage participate in the Trust Dental Plan. Part-Time Option 2 members under all collective bargaining agreements do not have dental coverage. Substitute teachers under the PAT agreement have dental coverage for the substitute teacher only. (See *Dental* for details about dental coverage.)

Vision Coverage

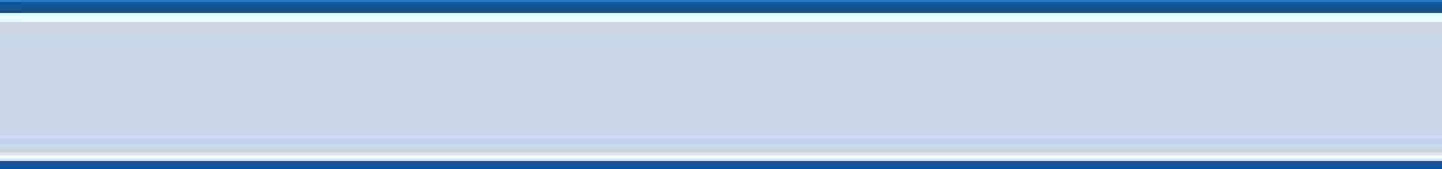
All employees and dependents have vision coverage except substitute teachers under the PAT agreement and Part-Time Option 2 members under all eligible collective bargaining agreements. Full-Time and Part-Time Option 1 participants under all eligible bargaining agreements who participate in a Kaiser medical option receive vision coverage through Kaiser. All other Trust participants with vision coverage receive vision benefits through the Trust Vision Plan administered by Vision Service Plan (VSP). (See *Vision* for details about vision coverage.)

Life Insurance and Accidental Death and Dismemberment

All employees who are eligible for the Life and AD&D Plan participate in the same plan. Substitute teachers under the PAT agreement and Part-Time Option 2 members under all collective bargaining agreements are not eligible for these benefits. Benefits are provided through The Standard and are described in separate booklets. For plan details, see *Your Benefit Plan Booklet — Basic-Term Life, Basic Accidental Death and Dismemberment* and *Your Benefit Plan Booklet — Optional Life and Voluntary Accidental Death & Dismemberment Insurance Plan.*

Long-Term Disability

All employees who are eligible for long-term disability participate in the same plan. Substitute teachers under the PAT agreement and Part-Time Option 2 members under all collective bargaining agreements are not eligible for this benefit. Benefits are provided through The Standard and are described in separate booklets. For plan details of this benefit, see *Your Benefit Plan Booklet — Long-Term Disability*.



Participating in the Plans

This section describes the eligibility and enrollment provisions that apply to all Trust employees of the PAT bargaining group members. It also describes the Trust's continuation of coverage provisions. Eligibility, enrollment and benefit information that applies to early retirees is described in a separate handbook.

Eligibility

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

> **Early Retirees**
>
> The eligibility requirements for early retirees are described in the Retiree Membership Handbook. If you have other questions about the retiree benefit options, please contact the Trust Office.

Employees

The collective bargaining agreement you work under governs your eligibility to participate in the Trust. Employees are eligible if they meet the requirements contained in their bargaining agreement and the required monthly contribution is made to the Trust. This book addresses the benefits covered by the Portland Association of Teachers (PAT) bargaining agreements. The applicable collective bargaining agreement in place at the time your eligibility is determined shall govern.

Portland Association of Teachers (PAT)

Full-Time/Part-Time Option 1

You are eligible for Full-Time/Part-Time Option 1 if you are a member of the PAT bargaining unit and a regular full-time or part-time employee of the District, as defined in a PAT collective bargaining agreement that requires contributions to the Trust. A full-time employee is defined as one regularly working thirty (30) or more hours a week under a PAT bargaining agreement. A part-time employee is defined as one regularly working at least twenty (20) hours a week, but less than thirty (30) hours a week, under a PAT bargaining agreement. Eligible employees may choose between Kaiser, the Providence Personal Option Plan and the Trust Preferred Provider Plan (Regence) for medical and prescription drug coverage.

Full-Time and Part-Time Option 1 employees are eligible for medical, dental, vision, prescription drug, long-term disability, life, AD&D, optional life and voluntary AD&D coverage from the Trust.

PART-TIME OPTION 2

The Trust also provides a Part-Time Option 2 Plan if you are a member of the PAT bargaining and a part-time employee of the District, as defined in a PAT collective bargaining agreement that requires contributions to the Trust. Eligible employees may choose between Kaiser, the Providence Personal Option Plan and the Part-Time Option 2 Trust Indemnity Medical Plan (Regence) for medical and prescription drug coverage.

Part-Time Option 2 members are eligible for medical and prescription drug coverage and optional life and voluntary AD&D. They are not eligible for dental, vision, life, AD&D and long-term disability coverage.

SUBSTITUTE TEACHERS

You are eligible as a substitute teacher if you have worked the equivalent of 70 or more days in the preceding school year, are fully available to work as a substitute teacher during the current school year and the required contributions are made to the Trust. Eligible substitute teachers may choose between Kaiser and the Providence Personal Option medical plans. Substitute teachers are eligible for medical and prescription drug coverage for themselves and their dependents and dental coverage for themselves only. They are also eligible for optional life and voluntary AD&D. Substitute teachers are not eligible for vision, life, AD&D or long-term disability coverage or a waiver of premium.

Full- and part-time employees hired September 15 or before who work the entire standard school year will have eligibility through September 30 following the end of the school year. Full- and part-time employees hired after September 15 who work the entire standard school year will have eligibility through July 31 following the end of the school year.

EXCLUDED INDIVIDUALS

Generally, employees working less than the required number of hours and temporary and seasonal employees are not eligible for Trust benefits unless specified by a collective bargaining agreement. Non-represented employees and employees covered by a collective bargaining agreement that does not require contributions to the Trust. If your bargaining unit does not provide for specific benefit plans, employees are also not eligible for those benefits from the Trust.

Dependents

If you enroll yourself in one of the medical plans listed above, you may enroll your eligible dependents in the same medical plan. 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 and 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.

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. Click *Forms*, then *Other Forms*.

Enrolling Domestic Partners

To enroll a domestic partner or the 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
- 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

You can elect medical coverages offered by the Trust at the following times:

- **Initial enrollment** — when you and/or a dependent first becomes eligible or first enrolls for coverage
- **Annual open enrollment** — during a period each fall when you may make benefit elections for the upcoming plan year
- **Mid-year enrollment** — following a qualifying change in family status, you may make mid-year benefit changes related to the status change

Initial Enrollment

If you are eligible, you may enroll yourself and your eligible dependents within 60 days of notification of eligibility.

If You Decline Initial Enrollment

If you don't enroll within 60 days of notification of eligibility, you generally won't have another chance to enroll until the next annual open enrollment period. However, there are two situations in which you may enroll before the next open enrollment.

- **If other coverage ends** — If you decline initial 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 (or the employer's contribution towards it) ends. To enroll, you must complete and submit a *Benefits Enrollment Form* to District HR/Benefits within a reasonable period of time after the other coverage ends.
- **If you acquire a new dependent** — If you decline initial enrollment for yourself and/or your eligible dependents and later acquire one or more new dependents as a result of marriage, domestic partnership, birth, adoption or placement for adoption, you may enroll your new dependent(s) *and yourself*, if you are not already enrolled. To do so, you must submit a *Benefits Enrollment Form* to District HR/Benefits within a reasonable period of time after the Dependent is eligible for coverage. In this case, coverage for new dependents (and you, if you are newly enrolling yourself) begins as follows:
  - *Newborn infants* are automatically covered for 31 days from the date of birth, except for employees who have selected Providence. To continue coverage beyond this period, you **must** submit a *Benefits Enrollment Form* to District HR/Benefits. To have coverage from birth for a newborn under an option provided by Providence, you must submit a Benefits Enrollment Form within 31 days of birth. In addition, an employee must submit a copy of the birth certificate to the Trust office within 62 days of the birth (31 days after the *Benefits Enrollment Form*).
  - *Adopted children* are automatically covered for 31 days from the date of placement for adoption. To continue coverage beyond this period, you must submit a *Benefits Enrollment Form* and a copy of the adoption papers to District HR/Benefits.

Benefits Enrollment Forms Are Available…

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

Full-time and part-time members: Submit completed form to District HR/Benefits.

Substitute teachers: Submit form to the Trust Office.

– *Eligible dependents acquired through marriage or domestic partnership* (and you, if you are newly enrolling yourself) are covered starting the first day of the month after enrollment, provided you submit a Benefits Enrollment Form (and if applicable, an Affidavit of Domestic Partnership) to District HR/Benefits by the payroll cutoff date in the month of enrollment. To find out the cutoff date, contact District HR/Benefits at (503) 916-3544. If you miss the payroll cutoff date in the month of enrollment, coverage will begin the first day of the second following month.

Enrollment for Newborn and Adopted Children

Newborn infants are automatically covered for 31 days from the date of birth except with Providence. Adopted children are automatically covered for 31 days from the date of placement for adoption. To continue coverage beyond this time period, you must submit a *Benefits Enrollment Form*. In the case of adoption, you must also provide a copy of the adoption papers.

- **Full-time and part-time members:** Submit form to District HR/Benefits.
- **Substitute teachers:** Submit form to the Trust Office.

Annual Open Enrollment

The Trust holds an open enrollment period for all eligible employees other than substitute teachers prior to the beginning of each plan year. During the open enrollment period, you have the opportunity to change your medical benefit elections and add or drop dependents. The elections you make during the 2016 open enrollment period take effect January 1, 2017 and continue through December 31, 2017. Thereafter, the elections will take effect January 1 and continue through December 31.

The open enrollment period for substitute teachers is conducted in September with the elections made being effective October 1. The election is effective October 1 and will continue through until the following September 30.

Midyear Enrollment or Status Changes

Normally you may change your benefit elections — your plan choices and who you enroll — only during annual open enrollment. However, certain changes in your family or employment status qualify you to make mid-year 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 creation of a 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
  - The child reaches age 26 or otherwise ceases to meet the definition of an eligible dependent
  - The child dies
- Become disabled
- Have a change in your or your spouse's/domestic partner's employment status that affects you, your spouse's/domestic partner's or your children's benefits eligibility—for example, you or your spouse/domestic partner:
  - Start employment
  - Change from full-time to part-time or vice versa
  - Resign or are laid off
  - Retire
- Take a leave of absence (see "Unpaid Leave" on page 15 for details)
- Gain or lose eligibility for Medicaid or CHIP coverage or become newly eligible for state premium assistance
- Lose other health care coverage (for example, through your spouse's employer) or the employer's contribution towards it.

When you experience any of these qualifying status changes, you may make related enrollment changes.

To make changes, submit a *Benefits Enrollment Form* to District HR/Benefits before the next payroll cutoff date. To find out the next cutoff date, contact District HR/Benefits at (503) 916-3544 as soon as possible.

Cost of Your Coverage

Benefits Enrollment Forms Are Available…

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

Full-time and part-time members: Submit completed form to District HR/Benefits.

Substitute teachers: Submit form to the Trust Office.

Your monthly contribution rate (if any) is determined by your collective bargaining agreement. Some bargaining agreements require a contribution from all employees. Others require contributions if a certain number of dependents are covered or if a particular option is chosen. If you are required to pay a portion of the cost of your coverage, it will be handled through a pre-tax payroll deduction unless you are a substitute teacher. Substitute teachers pay their portion of the monthly contributions with after-tax earnings. For details on contribution rates, contact the Trust Office or visit the Trust web site at www.sdtrust.com.

Contribution rates may change from year to year. During each open enrollment, you'll be notified of the rates for the upcoming plan year.

When Coverage Begins

Your coverage starts the first day of the month after you have worked half the working days in a month and submitted a completed *Benefits Enrollment Form* to District HR/Benefits, provided you submit the form by the mid-month payroll cutoff date during the month you enroll. If you submit the *Benefits Enrollment Form* after the payroll cutoff date, your coverage will start the first day of the second month following the month in which you submit the form.

For example: Let's say you are hired on February 1 and the monthly payroll cutoff date is February 15. If you submit a completed *Benefits Enrollment Form* by February 15, your coverage will start March 1. If you submit the form later than February 15, your coverage will start April 1.

To find out the exact cutoff date (which varies from month to month), contact District HR/Benefits at (503) 916-3544.

When Coverage Ends

Your coverage under any of the options available through the Trust automatically ends for you and your covered dependents on the last day of the month that you fail to meet the Trust's eligibility requirements.

Medical coverage for you and your dependents will end (subject to the exceptions noted below) when:

- You lose eligibility for coverage under the terms of the plan or your collective bargaining agreement
- Your employment ends due to voluntary or involuntary termination
- You terminate your employment due to total and permanent disability (see "If You Become Totally Disabled" on page 14 for more information)

- You retire (you may be eligible to continue under the Early Retiree Plan)
- You die while covered (see "If You Die While Covered by the Trust" on page 15 for benefits available to surviving eligible covered Dependents). If you die while covered by the plan, coverage ends on the date of death
- The plan is terminated.

You may continue coverage on a self-pay basis if the Trust's requirements for continuing coverage on a self-pay basis are met. ("Continuing Coverage on a Self-Pay Basis" on page 16 for more information.)

Coverage for dependents ends on the date your coverage ends or if any of the following events occur, if earlier:

- **Spouse** — Coverage ends on 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 he or she meets the Trust's requirements for continuing coverage on a self-pay basis. (See "Continuing Coverage on a Self-Pay Basis" on page 16 for more information.)
- **Domestic partner** — Coverage ends for a domestic partner and his or her covered children 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 they meet the Trust's requirements for continuing coverage on a self-pay basis.
- **Dependent children** — Coverage automatically ends on the last day of the month in which a dependent child reaches age 26. Coverage ends earlier if a dependent otherwise no longer qualifies as a dependent under the plan. Coverage can be continued past age 25 if a dependent child is incapable of self-support due to a physical or mental disability. To qualify as a disabled child past age 25, your child must be unmarried, financially dependent on you and incapable of supporting himself or herself. However, a dependent child whose coverage ends may continue coverage on a self-pay basis if the dependent meets the Trust's requirements for continuing coverage on a self-pay basis.

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

If your dependent dies, coverage ends for that dependent on the date of death.

If You Become Totally Disabled

> **Important!**
>
> Paid leave provisions do not apply to substitute teachers.

Waiver of Premium While Receiving Disability Benefits

If you, as the employee, are unable to work because of a total, ongoing disability, your coverage will continue until the *earlier* of:

- Your recovery from the disability; or
- The end of 30 calendar months from the date your total disability started.

Total disability is a covered employee's complete inability to perform the principal duties of his or her occupation. You will be required to provide a physician's certification of your disability.

Any of your dependents who were covered on the date your total disability started will continue to be covered while your coverage continues and they continue to meet the definition of an eligible dependent.

Extension of Coverage While Totally Disabled

If you, as the employee, or a covered dependent are receiving treatment for a totally disabling condition at the time your coverage ends, the plan will continue to provide medical coverage for treatment of that specific condition. To receive this extension of coverage, you must provide the Trust Office with proof of the continuing total disability within 90 days after your coverage ends. Call the Trust Office at (844) 203-0239 for instructions on how to submit this proof.

> **Total Disability**
>
> A covered employee is considered totally disabled if he or she is completely unable to perform the principal duties of his or her occupation or employment.
>
> Dependents are considered totally disabled if illness or injury prevents them from engaging in all regular activities that are customary for their age.

The plan will provide these extended benefits for the *lesser* of:

- The number of months you (or your dependent) were covered under the plan before your coverage ended; or
- 12 months for you (as the covered employee) or six months for any covered dependent.

However, extended coverage will stop before these time limits if you or your dependent ceases to be totally disabled.

Extension of coverage is not available if you elect to continue coverage through self-payment.

Note: Extension of coverage for total disability will not apply if the plan terminates within 31 days after your coverage ends.

If You Retire Before Age 65

If you retire before age 65, you may be eligible for coverage under the Trust's Early Retiree Medical Plans or the District's Retirement Benefit Plan. Contact the Trust Office at (844) 203-0239 for more information.

If You Die While Covered by the Trust

If you die while covered by the Trust, your eligible covered dependents — including your surviving spouse or domestic partner, your children, or your spouse's/domestic partner's children — will be covered for three additional months after your death *at no cost to them*. At the end of three months, any of your eligible covered survivors may elect to continue coverage on a self-pay basis. (See "Continuing Coverage on a Self-Pay Basis" on page 16 for details.)

Important!

Paid leave provisions do not apply to substitute teachers.

If You Take a Leave of Absence

Paid Leave

If you take an approved, paid leave of absence, benefits coverage for you and your eligible dependents will continue as if you were still working. When you return to work from a paid leave, you do not need to re-enroll for benefits. However, it's a good idea to check with the Trust Office to make sure your records are in order — especially if you've been gone for any length of time.

Unpaid Leave

If you take an approved, unpaid leave of absence, generally you'll have the option of continuing medical/prescription drug, dental and vision coverage for yourself and/or your dependents on a self-pay basis. Certain exceptions may apply based on collective bargaining agreements. Call the Trust Office at (844) 203-0239 for more information.

Upon returning to work from an unpaid leave, you must re-enroll for benefits before your coverage can resume or continue, even if you have been self-paying for coverage. You'll need to submit a new *Benefits Enrollment Form* to District HR/Benefits. You can request the form by calling the Trust Office at (844) 203-0239. You can also download and print the form from the Trust web site at www.sdtrust.com (*Library/Forms*).

Uniformed Service Leave

If your leave is for voluntary or involuntary duty with certain uniformed services (e.g., the U.S. armed forces, National Guard, or commissioned members of the Public Health Service), medical, prescription drug, dental and vision coverage will remain in effect for you and your enrolled dependents for the lesser of the period of your leave or 24 months as long as you continue to pay your portion of any required monthly payments.

For authorized duty leaves of 31 days or more, your right to continue medical coverage will be the same as described in "How Long Coverage May Continue" on page 19. Your right to continuation coverage does not end due to coverage under TriCare or other military coverage.

Continuing Coverage on a Self-Pay Basis

You and each of your covered dependents may have the independent right to elect to continue the health coverages available through the Trust on a self-pay basis beyond the time coverage under the Trust would otherwise end. The Trust has no other self-payment options.

Qualifying Events

You (as the participating employee) have the right to elect continuation coverage if you lose your coverage because of a reduction in your work hours or the termination of your employment.

Your eligible spouse or domestic partner has the right to elect continuation coverage if he/she loses Trust coverage due to:

- Your reduction in your work hours or termination of your employment
- Divorce, legal separation or termination of a domestic partnership
- You becoming entitled to Medicare
- Your death.

Your dependent child has the right to elect continuation coverage if he/she loses Trust coverage due to:

- Your reduction in your work hours or termination of your employment
- Divorce, legal separation or termination of a domestic partnership
- You becoming entitled to Medicare
- Your death
- The child no longer qualifying as an eligible dependent under the plan.

Continuation of coverage is not available to covered employees or dependents who become entitled to Medicare after electing continuation coverage.

Notices to Trust Concerning Continuation Coverage

The School District No. 1 Health and Welfare Trust's Trust Office is responsible for administering continuation rights for the Trust. All communications must be made in writing; identify you; the eligible employee, if different; the Trust's name (School District No. 1 Health and Welfare Trust) and be sent to the Trust Office at the following address:

School District No. 1 Health and Welfare Trust
c/o NW Administrators
700 Multnomah St, Suite 350
Portland, OR 97232
(844) 203-0239

Notification Responsibilities

The Trust offers continuation coverage only after it has been notified of a qualifying event.

You or your eligible dependents are responsible for notifying the Trust Office of a loss of coverage resulting from a divorce, legal separation, termination of domestic partnership or a child losing dependent status. If you or your eligible dependents have a loss of coverage because of these events, you must notify the Trust Office in writing at the address listed above within 60 days of the date of the qualifying event. The notice must identify the individual who experienced the qualifying event, the eligible employee's name and the qualifying event which occurred. Failure to provide timely notice will result in your coverage ending as it normally would under the plan.

The District is responsible for notifying the Trust Office of any other qualifying event once you notify the District. The Board of Trustees reserves the right to determine whether coverage has in fact been lost due to a qualifying event.

Election of Continuation Coverage

Once the Trust Office has received proper notice that a qualifying event has occurred, it will notify you, your spouse or domestic partner and/or your eligible dependents of your right to elect continuation coverage. Your written election must be sent to the Trust Office at the address listed above and must be received or postmarked within 60 days from the *later* of:

- The date you or your covered dependent's coverage would otherwise end, or
- The date notification from the Trust Office is furnished.

Unless stated otherwise on the election form, an election of continuation coverage by one family member covers all other eligible members of the same family.

If you or any of your covered dependents do not elect continuation coverage within this 60-day period, eligibility will end as it normally would under the plan.

If you or any of your covered dependents elect continuation coverage within the 60-day period, it will be retroactive to the first day after the date coverage otherwise would have ended provided you or your covered dependents pay for the cost of coverage retroactive to the date your coverage ended.

Available Coverage

The continuation coverage offered is the same as provided to other plan participants. You can only continue the coverages you had the day before your qualifying event.

You and your eligible dependents may elect the following coverages:

- Medical and prescription drug only; or
- Medical, prescription drug, dental and vision coverage.

Substitute teachers and Part-Time Option 2 employees may only elect medical and prescription drug coverage.

Continuation coverage is not available for long-term disability or life, accidental death and dismemberment or survivor benefits. Once you choose the types of coverage you want, it cannot be changed. If you elect to continue medical and prescription drug coverage only, you can only add dental and vision coverage (or drop it) at the time of open enrollment. You can change between the medical options available to you during the annual open enrollment period.

Adding New Dependents

Continuation coverage is only available to individuals who were covered under the plan at the time of the qualifying event. If you elect to continue coverage and acquire a new dependent through marriage, domestic partnership, birth, adoption or placement for adoption, you may add the new dependent to your continuation coverage by providing written notice to the Trust Office within 60 days of acquiring the new dependent. The written notice must identify the employee, the new dependent, the date the new dependent was acquired and be mailed to the Trust Office at the address listed previously. Children acquired through birth, adoption or placement for adoption are entitled to extend their continuation coverage up to a maximum of 36 months from the original qualifying event if a second qualifying event occurs.

Continuous Coverage Required

Your continuation coverage must be continuous from the date your Trust coverage would have ended if self-payments were not made.

Cost of Continuation Coverage

You or your dependents are responsible for paying the full cost of continuation coverage plus a 2% administrative fee. The cost for the coverages available through the Trust is set annually. If you have a qualifying event, you will be notified of the applicable monthly self-payment premium for the coverage options available to you.

Monthly Self-Payments Required

The Trust requires that payments for continuation coverage be received by the 5th of the month. You must send payments to the Trust Office or enroll for Electronic Funds Transfer (EFT). Coverage will be terminated if payment is not received by the Trust Office within 30 days of the due date. The only exception is that the self-payment for the period preceding the initial election of continuation coverage may be made up to 45 days after the date of the election. Your initial payment must cover all months for which you want coverage and be retroactive to when your Trust coverage ended. If your initial payment is not received or postmarked within 45 days of when you elected coverage, your right to continuation coverage will be lost.

How Long Coverage May Continue

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

- *If your employment ends or your hours are reduced,* coverage for you and your eligible dependents may continue for up to 24 months. The 24-month period may be extended as explained in "How Long Coverage May Continue — Disabled Individuals" on page 20, "How Long Coverage May Continue — Second Qualifying Event" on page 21 and "How Long Coverage May Continue — Medicare Entitlement" on page 21.
- *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 — he or she may continue self-paid coverage until reaching age 65 or otherwise becoming entitled to or eligible for Medicare.
- *If your dependent child ceases to qualify as a dependent under the plan,* he or she may continue coverage for up to 36 months.
- *If coverage is lost as a result of your becoming eligible for Medicare,* your eligible dependents may continue coverage for up to a maximum of 36 months.

Continuation coverage ends on the last day of the monthly premium payment period if any one of the following occurs before the maximum available continuation period:

- Payment for continuation coverage is not made to the Trust Office on a timely basis for the next monthly coverage period

- You or your dependent becomes covered under any other group health plan after electing continuation coverage unless the other group health plan limits or excludes coverage for a pre-existing condition of the individual seeking continuation coverage
- You or your dependent provides written notice that you wish to terminate your coverage
- You or your dependent becomes entitled to Medicare benefits after electing continuation coverage.

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.

How Long Coverage May Continue — Disabled Individuals

If you or one of your dependents covered by the Trust is determined by the Social Security Administration (SSA) to be disabled either before a 24-month qualifying event or within the first 60 days of continuation coverage, the entire family of the disabled individual can receive an additional five months of continuation coverage for up to a maximum of 29 months. To obtain the additional months of coverage, you must notify the Trust Office in writing as follows:

- Within 60 days of the later of:
  - Your qualifying event; or
  - Your receipt of your Social Security Disability Determination; and
- Prior to the end of your initial 24-month period of continuation coverage.

If the disabled individual is subsequently found to not be disabled, you must notify the Trust Office within 30 days of that determination. The extension of continuation coverage available to a disabled individual will end the first of the month that begins more than 30 days from the date of the final determination that you are no longer disabled. (For example, if the determination is made June 15, coverage would end August 1.)

How Long Coverage May Continue — Second Qualifying Event

Eligible dependents who are entitled to continuation coverage as the result of your termination of employment or reduction of hours can extend their coverage up to a total of 36 months if a second qualifying event occurs during the initial 24 months of continuation coverage.

Possible second qualifying events during the initial 24 months of continuation coverage are:

- Divorce or legal separation
- A child's loss of dependent status under the plan
- You becoming entitled to Medicare
- Your death.

If an eligible dependent wants extended coverage as a result of a second qualifying event, he or she must notify the Trust Office in writing within 60 days of the second qualifying event. Failure to give such timely written notice of a second qualifying event will cause the individual's coverage to end as it normally would under the terms of the plan. In no event will continuation coverage extend beyond a total of 36 months from the original qualifying event.

How Long Coverage May Continue — Medicare Entitlement

If you have a 24-month qualifying event after becoming entitled to Medicare, your dependents may continue coverage until the later of 24 months from the date coverage would normally end or 36 months from the date you became entitled to Medicare.

USERRA Continuation Rights

If you lose coverage because you have entered military service for longer than 31 days and are covered by the Uniform Services Employment and Reemployment Rights Act (USERRA), you may elect to self-pay for coverage up to a maximum of 24 months. The maximum period of continuation coverage is the lesser of 24 months or the day after you fail to return to employment within the time frame provided by USERRA.

Relationship Between Continuation Coverage and Other Coverage

Your continuation coverage will terminate if you become entitled to Medicare or other group health coverage after your continuation coverage election. The only exception is if the other medical coverage contains a pre-existing condition which applies to the individual seeking to continue coverage. If your Medicare or other group health coverage already existed when you elect continuation coverage, however, you can be eligible for both.

Generally, if you have coverage under a Trust-sponsored plan, based on the continuation coverage, and you are entitled to Medicare based on age or disability and no longer have current employment status, Medicare will pay first and the Trust will only pay secondary and coordinate with Medicare. Current employment status means you are still at work or have received short-term disability benefits for less than six months. If you have Medicare coverage based on end stage renal disease and have Trust coverage, the Trust will pay primary during the 30-month coordination period provided for by applicable law. If you have other group health coverage, that coverage will pay primary and the Trust's continuation coverage will be secondary.

If you participate in Kaiser or Providence, the terms of those policies will govern the relationship between your health coverage and other coverage.

Alternative Ways to Continue Coverage

If you participate in the Kaiser or Providence Personal Option Plan options available through the Trust, you may have alternative coverage options including a conversion option and self-payment rights under state continuation laws which may differ from the continuation coverage described here. If you participate in the Kaiser or Providence option, please contact your plan:

Providence Health Plans
(503) 574-7500 Portland
(800) 878-4445

Kaiser Permanente HMO
(503) 813-2000 Portland
(800) 813-2000

Generally, you must apply for conversion coverage within strict time limits (often 30 days or less). If you elect continuation coverage, you may elect to participate in another option for which you are eligible during the Trust's annual open enrollment period.

Effect of Not Electing Continuation Coverage

In considering whether to elect continuation coverage, please be aware that a failure to continue your group health coverage can affect your rights under federal law.

You should be aware that federal law gives you special enrollment rights. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a spouse's plan) within 30 days after your group health coverage from the Trust ends because of your qualifying event. You will also have the same special 30-day enrollment right at the end of the maximum continuation coverage period available to you.

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 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.

Your medical coverage options vary depending on your employment status with the District, as shown below:

PAT

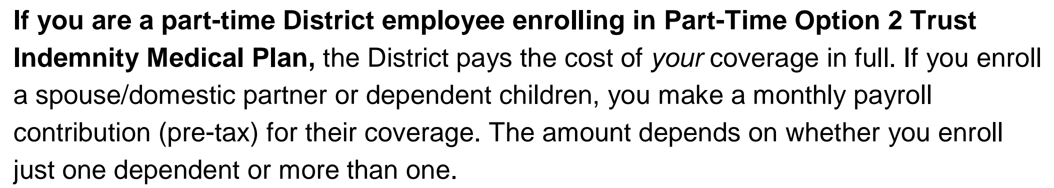
- Full-Time/Part-Time Option 1
  - Trust Preferred Provider Plan
  - Kaiser Permanente HMO
  - Providence Personal Option Plan
- Part-Time Option 2
  - Trust Indemnity Medical Plan
  - Kaiser Permanente HMO
  - Providence Personal Option Plan
- Substitute Teachers
  - Kaiser Permanente HMO
  - Providence Personal Option Plan

Highlights of the Plans

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

Your Cost for Coverage

If you are a full-time or part-time District employee enrolling in Full-Time/Part-Time Option 1 Trust Preferred Provider Plan, you must make a monthly contribution toward your coverage. This is done through pre-tax payroll deductions. The amount is the same regardless of the medical plan you choose or the number of dependents you enroll.



If you are a part-time District employee enrolling in Part-Time Option 2 Trust Indemnity Medical Plan, the District pays the cost of *your* coverage in full. If you enroll a spouse/domestic partner or dependent children, you make a monthly payroll contribution (pre-tax) for their coverage. The amount depends on whether you enroll just one dependent or more than one.

Prescription Drug

You are covered under the Trust Prescription Drug Plan if you are a 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:

- **Full-Time/Part-Time Option 1** — Trust Preferred Provider Plan (Regence) or Providence Personal Option Plan.
- **Part-Time Option 2** — Trust Indemnity Medical Plan (Regence) or Providence Personal Option Plan.
- **Substitute Teachers** — Providence Personal Option Plan.

If you are enrolled in the Kaiser Permanente HMO, prescription drug benefits are provided through Kaiser. 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	Members of the **PAT** bargaining unit covered by the Trust and enrolled in: • **Full-Time/Part-Time Option 1** — Trust Preferred Provider Plan (Regence) or Providence Personal Option Plan • **Part-Time Option 2** — Trust Indemnity Medical Plan (Regence) or Providence Personal Option Plan • **Substitute Teachers** — 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 the plan pays	• **Participating retail pharmacies** —100% after you pay a copayment for each monthly supply (See "Copayments at Participating Retail Pharmacies" on page 27 for details) • **Nonparticipating retail pharmacies** — 80% after you pay an annual deductible of $50 per covered person. You must pay the entire cost at the time of purchase and file a claim for reimbursement • **Mail order service** — 100% after you pay a copayment for each 90-day supply (See "CVS Caremark Mail Order Service Copayments" on page 29 for details)

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 a 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. You will pay the following copayments:

Copayments at Participating Retail Pharmacies

If you are enrolled in this medical plan:	Your retail pharmacy prescription drug copayments are:
Full-Time/Part-Time Option 1: • Trust Preferred Provider Plan (Regence) • Providence Personal Option Plan	**Providence Personal Option Plan, Trust Preferred Provider Plan (Regence)** • **Participating CVS Caremark network pharmacies** — For each 30-day supply, you will pay the following copayments: – $10 for generic drugs – $20 for brand-name drugs You may purchase up to 90-day supply • **Nonparticipating pharmacies** — Plan pays 80% after you pay a $50 per person annual deductible
Part-Time Option 2: • Trust Indemnity Medical Plan (Regence) • Providence Personal Option Plan	**Providence Personal Option Plan, Trust Indemnity Plan (Regence)** • **Participating CVS Caremark network pharmacies** — For each 34-day supply, you will pay the following copayments: – $5 for generic drugs – $10 for brand-name drugs You may purchase up to 90-day supply • **Nonparticipating pharmacies** — Plan pays 80% after you pay a $50 per person annual deductible
Substitute Teachers: • Providence Personal Option Plan	**Providence Personal Option Plan** • **Participating CVS Caremark network pharmacies** — For each 34-day supply, you will pay the following copayments: – $5 for generic drugs – $10 for brand-name drugs You may purchase a 90-day supply • **Nonparticipating pharmacies** — Plan pays 80% after you pay a $50 per person annual deductible

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 a copayment, you'll need to file a claim form to receive a benefit. Your benefit will be the in-network charge minus the copayment.

AUTOMATIC GENERIC SUBSTITUTION

Unless your doctor specifies your prescription must be "dispensed as written," a CVS Caremark network pharmacist 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 copayment *plus* the difference in cost between the brand-name drug and its generic equivalent. Compounded prescriptions are covered as a brand-name drug.

For example — For members whose retail prescription drug copayments are $5 for generic drugs and $10 for brand-name drugs:

> If the generic drug costs $15 and the brand-name drug costs $60, you would pay the $10 copayment for the brand-name drug plus $45 (the difference in cost between the $60 brand name and the $15 generic drug). In this case, you would pay a total of $55 for the brand-name drug (instead of a $5 copayment for the generic drug).

For example — For members whose retail prescription drug copayments are $10 for generic drugs and $20 for brand-name drugs:

> If the generic drug costs $40 and the brand-name drug costs $100, you would pay the $20 copayment for the brand-name drug, plus $60 (the difference in cost between the $100 brand-name drug and the $40 generic drug). In this case, you would pay a total of $80 for the brand-name drug (instead of the $10 copayment for the generic drug).

If the cost of a prescription is less than the copayment, you pay the lesser amount.

For example — If the in-network charge for a generic drug is $20, you'll be reimbursed as follows:

- If your generic drug copayment is $5, you'll be reimbursed $15 ($20 minus the $5 copayment).
- If your generic drug copayment is $10, you'll be reimbursed $10 ($20 minus the $10 copayment).

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.

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.

The plan will reimburse 80% of the cost of covered prescriptions *after* you pay an annual deductible of $50 per person. 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. You will pay the following copayments:

CVS Caremark Mail Order Service Copayments

If you are enrolled in this medical plan:	Your CVS Caremark Mail Order Service copayments are:
Full-Time/Part-Time Option 1: • Trust Preferred Provider Plan (Regence) • Providence Personal Option Plan	For each 90-day supply, you'll pay: • $20 for generic drugs • $40 for brand-name drugs
Part-Time Option 2: • Trust Indemnity Medical Plan (Regence) • Providence Personal Option Plan	For each 90-day supply, you'll pay: • $5 for generic drugs • $10 for brand-name drugs
Substitute Teachers: • Providence Personal Option Plan	For each 90-day supply, you'll pay: • $5 for generic drugs • $10 for brand-name drugs

These copayments apply only to the mail order service. The Trust Prescription Drug Plan does not cover prescription drugs purchased through any other mail order service.

Generic Substitution

Unless your doctor specifies your prescription must be "dispensed as written," 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 copayment *plus* the difference in cost between the brand-name drug and its generic equivalent.

For example — For members whose mail order service copayments are $5 for generic and $10 for brand-name drugs:

> If the generic drug costs $50 and the brand-name drug costs $150, you would pay a $10 copayment for the brand-name drug *plus* the $100 difference in cost, or a total of $110 (instead of a $5 copayment for the generic drug).

For example — For members whose mail order service copayments are $20 for generic and $40 for brand-name drugs:

> If the generic drug costs $50 and the brand-name drug costs $150, you would pay a $40 copayment for the brand-name drug *plus* the $100 difference in cost, or a total of $140 (instead of a $20 copayment for the generic drug).

If the cost of a prescription is less than the copayment, you pay the lesser amount.

How to Order Initial Prescriptions

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)

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 copayment 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 copayment must be charged to a credit card.

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 employees 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.

Special Coordination of Benefits

If you are enrolled in the Trust Preferred Provider Plan (Regence) or Trust Indemnity Medical Plan (Regence), the copayments and deductibles you pay for covered prescription drugs under the Trust Prescription Drug Plan may be eligible for reimbursement under your medical plan. You may be reimbursed for a portion of eligible prescription drug expenses if the total amount of your eligible medical expenses and eligible prescription drug expenses (copayments and deductibles) exceed the annual deductible and/or out-of-pocket maximum for the Trust Indemnity Medical Plan (Regence) or Preferred Provider Plan (Regence).

To claim these expenses, you must submit proof of the expenses to the Trust Office as you incur them. You can do this by sending a copy of your prescription drug purchase receipts or your explanations of benefits (if you file prescription drug claims with CVS Caremark) to:

School District Trust Office
700 NE Multnomah St, Suite 350
Portland, OR 97232

The Trust Office will determine whether your total out-of-pocket expenses exceed the Trust Indemnity Medical Plan's annual out-of-pocket maximum. If they do, you'll be reimbursed for the eligible expenses.

Medications Purchased Outside the United States

Medications purchased outside the United States are generally not covered. However, if you are enrolled in the Trust Indemnity Medical Plan (Regence) or Trust Preferred Provider Plan (Regence) and you need to purchase a prescription due to an urgent medical need while traveling outside the country, you may be reimbursed at the out-of-network level if the medication has FDA approval in the United States. Contact the Trust Office for more information if this applies to you. (This benefit does not apply to Providence Personal Option Plan.)

What’s Not Covered

The Trust Prescription Drug Plan has a number of limitations and exclusions (See “Limitations” on page 33 and “Exclusions” on page 34 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

Full-Time and Part-Time Option 1 members and dependents with dental coverage participate in the Trust Dental Plan. Part-Time Option 2 members under all collective bargaining agreements do not have dental coverage. Substitute teachers under the PAT agreement have dental coverage for the substitute teacher only. (See *Participating in the Plans — Eligibility* for details on who is eligible for coverage.)

Highlights of the Plan

The following chart provides highlights of the Trust Dental Plan.

Features	
How the plan works	You may visit any licensed dentist. The plan pays a percentage of covered services, based on usual and customary or reasonable rates (UCR)
Annual deductible	None
Maximum plan benefits	$1,750 per person per calendar year

Covered Services	
Class I services: Preventive services, including: • Cleaning two times per calendar year • Fluoride application, age 14 and under, two times per calendar year • Sealants, through age 18, once every five calendar years • Space maintainers Diagnostic services, including: • Routine exams, two times per calendar year • Bitewing X-ray, two times per calendar year • Full mouth X-rays or panoramic film, once every five years	Plan pays 100% of UCR

Covered Services	
Class II services: • Oral surgery, including surgical extractions, minor surgical procedures • Restorative, including treatment of tooth decay with amalgam and synthetic porcelain • Endodontic, including procedures for pulpal therapy, root canal filling • Periodontic, including treatment of tissues supporting the teeth, scaling	Plan pays 80% of UCR
Class III services: • Restorative, including crowns, jackets, gold or cast restorations, onlays and implants	Plan pays 80% of UCR
Class IV services: • Prosthodontic, including bridges, partials, complete dentures	Plan pays 50% of UCR
Class V services (Substitute teachers are not eligible for this benefit): • Orthodontics, including exams, X-rays, surgery, installation of appliance	Plan pays 50% of UCR up to a lifetime maximum benefit of $1,250 per person

Extension of Benefits

If coverage is terminated, benefits may be extended beyond that date for the following:

- Crowns and prosthetic devices that were ordered and fitted prior to the date your coverage was terminated provided they are delivered within 60 days of terminating coverage.
- Services listed on a pre-treatment planning form submitted to the Trust while still enrolled in the plan, provided the services are rendered within 60 days of your termination date. (See “How the Trust Dental Plan Works” on page 36.)

How the Trust Dental Plan Works

Under the Trust Dental Plan, you and your enrolled dependents may go to any licensed dentist for dental care. During your initial appointment, tell your dentist that you have dental benefits through the Trust Dental Plan. Give your member identification 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 Plan Pays Benefits

The Trust Dental Plan pays a percentage of covered expenses, based on usual and customary or reasonable rates (UCR), up to $1,750 per person 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. The plan pays orthodontic benefits up to a lifetime maximum of $1,250 per person. Substitute teachers are not eligible for the orthodontic benefit.

There is no annual deductible for the Trust Dental Plan. However, you are responsible for paying coinsurance for covered services, costs exceeding the UCR, and all expenses over the annual maximum and lifetime orthodontic maximum.

If you select a more expensive plan of treatment than is UCR, the Trust Dental Plan 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.

Maximum Benefits

The Trust Dental Plan's annual maximum benefit is $1,750 per eligible person per calendar year. The dollar amount that the plan pays toward covered dental services for you or a 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 calendar-year maximum of $1,750 per person.

What the Plan Covers

The Trust Dental Plan covers 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.

Class I Services

The plan pays 100% of UCR for the following preventive and diagnostic services:

Preventive services, including:

- Cleaning (prophylaxis) two per calendar year, two additional cleanings per year with periodontic issues
- Fluoride application for dependents age 14 and under, two per calendar year
- Sealants for dependents through age 18, once every five years
- Space maintainers.

Diagnostic services, including:

- Routine examination two per calendar year
- Bitewing X-rays two per calendar year
- Full mouth X-rays or panoramic film once every five years.

Class II Services

The following services are paid at 80% of UCR:

- 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” on page 39 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.

Class III Services

The plan pays the following services at 80% of UCR:

- 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 40.)

Class IV Services

The plan pays the following services at 50% of UCR:

- Prosthodontic: Procedures for construction or repair of fixed bridges, partials and complete dentures. (See “Limitations” on page 40.)

Class V Services

Orthodontic: Benefits will be provided to eligible employees and their covered dependents. The plan pays the following services at 50% of UCR up to a lifetime maximum benefit of $1,250 per person.

Orthodontia benefits are not covered for substitute teachers.

What’s Not Covered

The Trust Dental Plan has a number of exclusions and limitations. (See “Exclusions” on page 39 and “Limitations” on page 40 for details.)

Exclusions

The Trust Dental Plan does not cover:

- All other services or supplies not specifically covered (See “What the Plan Covers” on page 38 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
- 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 Dental Plan has 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 of the plan to make payments for orthodontic treatment will cease upon termination of treatment for any reason prior to completion of the case
- The obligation of the 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 plan's obligation to make monthly or other periodic payments for orthodontics shall 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 Dental Plan, make sure that *your* member identification 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

All employees and dependents have vision coverage except substitute teachers under the PAT agreement and Part-Time Option 2 members under all collective bargaining agreements. Full-Time and Part-Time Option 1 participants under all bargaining agreements who participate in a Kaiser medical option receive vision coverage through Kaiser. All other Trust participants with vision coverage receive vision benefits through the Trust Vision Plan, which Vision Service Plan (VSP) administers. (See *Participating in the Plans — Eligibility* for details on who is eligible for coverage and *Medical* for additional vision-related information.)

Highlights of the Trust Vision Plan

These are brief highlights of the Trust Vision Plan, including plan features and some of the expenses covered by the plan.

Features	
How the plan works	The plan pays covered expenses for vision care received from any qualified vision provider. The plan pays the highest level of benefits for vision services received from a VSP preferred provider. Under the plan, network providers include doctors participating in the VSP network
Covered services	The plan covers: • Routine eye exams • Eyeglass lenses and frames • Contact lenses (in lieu of eyeglass lenses and frames) The plan pays up to a maximum benefit for each covered vision care expense. There is no deductible to satisfy

How the Trust Vision Plan Works

Qualified Vision Providers

Qualified vision providers include any licensed optometrist or ophthalmologist.

The Trust Vision Plan gives you the choice of receiving care from any vision provider. However, the plan pays higher benefits if you receive care from one of the VSP preferred providers who participate in the Trust Vision Plan network. No matter which provider you choose, there is no annual deductible to satisfy.

VSP Preferred Providers

Under the Trust Vision Plan, VSP preferred providers include VSP optometrists or ophthalmologists. These doctors have contracted with VSP to provide vision care services and eyewear at discounted prices.

For a List of Participating VSP Preferred Providers…

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

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 to a maximum benefit amount. (See "How the Plan Pays Benefits" on page 45 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 a VSP preferred provider. You will, however, be responsible for any charges above the maximum benefit amount.

If You Use a Non-VSP Provider

Under the Trust Vision Plan, you can always see a covered provider outside of 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
P.O. Box 385018
Birmingham, AL 35238-5018
Phone: (800) 877-7195

Claims must be submitted within 180 days from the date of service. The itemized receipt must include the following information:

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

How the Plan Pays Benefits

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

Trust Vision Plan		
Benefits	**VSP Preferred Provider**	**Non-VSP Provider Reimbursement**
Exam	Covered in full	Up to $70
Lenses		
• Single vision	Covered in full*	Up to $50
• Lined bifocal	Covered in full*	Up to $75
• Lined trifocal	Covered in full*	Up to $100
• Polycarbonate lenses (for dependent children)	Covered in full	Not covered
• Progressive	35-40% discount off usual and customary charges for progressive lens option	Up to $100
Frame	Covered up to $100, 20% off any out-of-pocket costs	Up to $75
Contacts in lieu of lenses and a frame	Covered up to $137	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	
Benefit Frequency		
Exam	Every 12 months for children up to age 17, every 24 months for adults	
Lenses	Every 12 months for children up to age 17, every 24 months for adults	
Frame	Every 24 months for children and adults	

* Average 35%-40% savings on all noncovered lens options.

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 liable.

What the Plan Covers

The Trust Vision Plan covers the following vision services:

- "Complete Routine Eye Exams" on page 46
- "Standard Eyeglass Lenses" on page 46
- "Frames" on page 47
- "Contact Lenses" on page 47
- "Low Vision Benefit" on page 48

Complete Routine Eye Exams

Routine eye exams are covered by the plan once every 24 months for adults and once every 12 months for children under age 17. Benefits are provided as follows:

- **VSP preferred providers** — The plan covers an exam in full. No copayment applies.
- **Non-VSP providers** —The plan covers an eye exam up to the benefit maximum of $70.

You are responsible for paying any expenses in excess of the plan's maximum benefit.

Standard Eyeglass Lenses

Standard eyeglass lenses are covered once every 24 months for adults and once every 12 months for children under age 17. Under the plan, standard eyeglass lenses are quality clear glass or plastic. The plan pays for standard eyeglass lenses as follows:

- **VSP preferred providers** — Standard eyeglass lenses are covered up to a benefit maximum of:
  - Single vision: Paid in full
  - Lined bifocal: Paid in full
  - Lined trifocal: Paid in full
  - Average of 35%-40% savings on all noncovered lens options.

- **Non-VSP providers** — Standard eyeglass lenses are covered up to a benefit maximum of:
  - Single vision: Up to $50
  - Lined bifocal: Up to $75
  - Lined trifocal: Up to $100
  - Progressive: Up to $100.

You are responsible for paying the vision services in full and submitting a claim for reimbursement.

Frames

Frames are covered once every 24 months when necessary for newly prescribed eyeglass lenses. The plan covers a wide variety of quality frames as follows:

- **VSP preferred providers** — Frames are covered up to a benefit maximum of $100.
- **Non-VSP providers** — Frames are covered up to a benefit maximum of $75.

You are responsible for paying the vision services in full and submitting a claim for reimbursement.

Contact Lenses

Contact lenses are provided in lieu of eyeglass lenses and frames, and are covered once every 24 months for adults and once every 12 months for children under age 17. The plan pays for contact lenses as follows:

- **VSP preferred providers** — Contact lenses, including the contact lens exam, are covered up to a benefit maximum of $137. A 15% discount is available for contact lens evaluation and fitting.
- **Non-VSP providers** — Contact lenses are covered up to a benefit maximum of $137.

You are responsible for paying the vision services in full and submitting a claim for reimbursement.

Low Vision Benefit

A low vision benefit is provided by the plan 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 visually necessary or appropriate as deemed 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

You may also 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:

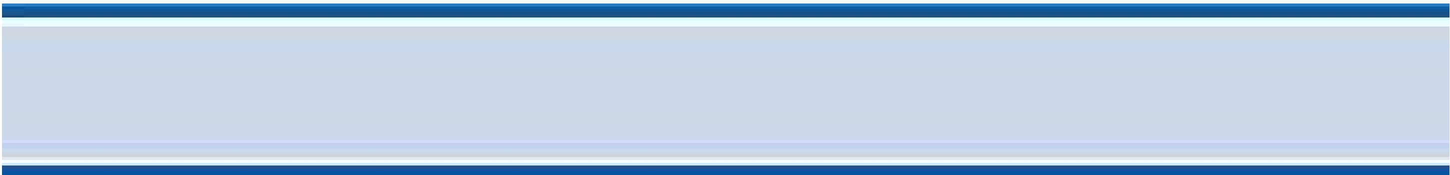
Additional Service/Eyewear Not Covered by the Plan	Discount
Lasik eye surgery	Average of 15% off the regular price or 5% off the promotional price. Discounts are available from participating Lasik surgery providers. For more information, contact VSP at (800) 877-7195
Additional pairs of prescription 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 they are 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 Vision Plan 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 that exceed usual, customary or reasonable charges
- Charges for complications from services not covered by the plan
- 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 Full-Time/Part-Time Option 1 Trust Indemnity Medical Plan (Regence), Trust Preferred Provider Plan (Regence) or Providence Personal Option Plan
- Services or eyewear covered under workers’ compensation or similar laws
- Services or supplies 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.



Life and AD&D

The Trust offers group life and accidental death and dismemberment (AD&D) insurance through The Standard for Full-Time and Part-Time Option 1 Trust members only. Part-Time Option 2 Trust members do not receive these benefits. The life insurance benefit is $50,000, and the AD&D benefit is $50,000. For plan details, see *Your Benefit Plan Booklet — Basic-Term Life, Basic Accidental Death and Dismemberment*.

Optional life and voluntary AD&D insurance are also available from The Standard. For plan details, see *Your Benefit Plan Booklet — Optional Life and Voluntary Accidental Death & Dismemberment Insurance Plan*.

Long-Term Disability

The Trust offers group long-term disability (LTD) coverage through The Standard for Full-Time and Part-Time Option 1 Trust members only. Part-Time Option 2 Trust members do not receive these benefits. LTD coverage provides you with long-term income protection if you become disabled as the result of a covered injury, sickness or pregnancy. You can receive 60% of your earnings up to $3,500 per month. For plan details of this benefit, see *Your Benefit Plan Booklet — Long-Term Disability*.

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 Preferred Provider Medical Plan for PAT participants, the Trust Prescription Drug Plan and the Trust 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 this plan are paid before or after the benefits of another plan. The benefits of this plan will *not* be reduced when, under these rules, this plan pays benefits first. The benefits of this plan may be reduced when another plan pays benefits first.

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

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

This 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 this 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 inactive employee, 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 employee 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 Preferred Provider and Indemnity Medical Plans (Regence), the Trust Dental Plan and the Trust Vision Plan may be reduced.

THE TRUST MEDICAL AND DENTAL PLANS

If you have other health care coverage, the benefits payable under the Trust Preferred Provider and Indemnity Medical Plans (Regence) and the Trust Dental Plan may be reduced as follows:

- *If the other plan providing health care coverage does not have a coordination of benefit provision:* The Trust Preferred Provider and Indemnity Medical Plans (Regence) and the Trust Dental 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 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 Preferred Provider or Indemnity Medical Plans (Regence) or the Trust Dental 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 Preferred Provider and Indemnity Medical Plans (Regence) or the Trust Dental Plan was 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 this plan and cannot be carried forward beyond the calendar year in which the savings were recognized.

THE TRUST VISION PLAN

If you have other vision coverage, the benefits payable under the VSP Plan may be reduced, as follows*:*

- *If the other plan providing vision coverage does **not** have a coordination of benefit provision:* The VSP 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 vision coverage has a coordination of benefits provision:* The coordination of benefits provision will be followed to determine which plan pays secondary. If the VSP plan pays secondary, it will not pay more than the amount of benefits it would have paid for the covered service or supply had it been the primary plan. VSP, however, will keep a record of the difference between what was paid and what would have been paid if VSP was 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 this 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 them 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 which 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.

Dual Coverage Under the Plan — The Trust Vision Plan

If you and your spouse or domestic partner are both employed by the School District and participate in the Full-Time/Part-Time Option 1 Trust Indemnity Medical Plan (Regence), Trust Preferred Provider Plan (Regence) or Providence Personal Option Plan, coordination of benefits also applies under the Trust Vision Plan.

Plan Not Responsible for Quality of Medical Care — The Trust Medical and Vision Plans

You and your covered dependents have the exclusive right to select medical providers. The plan is not responsible for the quality of medical services you receive, because all medical 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 medical 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

In certain situations, listed below, this plan is primary and Medicare is secondary. If you are enrolled in Medicare and this plan at the same time, this plan pays benefits for covered expenses first and Medicare pays second. This applies if:

- You are an active, covered employee age 65 or older and, by law, Medicare is secondary to this plan
- You incur covered expenses for a kidney transplant or kidney dialysis and, by law, Medicare is secondary to this plan
- You are entitled to benefits under the Social Security Act (Medicare disability) and, by law, Medicare is secondary to this plan.

In all other cases, this plan will not pay benefits for any part of a covered expense that is paid, or would have been paid, under Medicare Part A or B had you applied for those benefits.

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.

- This provision applies to any illness or injury subject to the Trust's third party liability where the benefits the Trust seeks to recover begin on or after 12 months. Any dispute regarding the interpretation, application or administration of the Trust's third party reimbursement provision shall be resolved through arbitration. Arbitration shall be conducted in accordance with the Oregon Uniform Arbitration Act, ORS 36.600, et. seq. The parties shall split the cost of arbitration unless the Arbitrator orders otherwise. Each party shall bear its own attorneys' fees. In reviewing any issue, the Arbitrator's scope of review shall 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 which would be covered as primary by personal injury protection benefits where such coverage is required by law. This exclusion shall 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.
- 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 shall 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.

Alternative Coverage

The Trust's self-funded medical, prescription drug, dental and vision plans offer no conversion option or alternative self-pay coverage.

If you or a covered dependent are receiving treatment for a totally disabling condition at the time your coverage ends, the plan will continue to provide Major Medical benefits for the treatment of that specific condition only. These benefits will be provided for the lesser of: the number of months you (or your dependent) were covered under the plan before your coverage ended; or 12 months for you (as the covered employee); or, six months for any covered dependent. Extended coverage will stop before these time limits if you or your dependent cease to be totally disabled, the Plan terminates within 31 days of your coverage ending or you reach the maximum lifetime benefit of $1 million. To receive this extension, you must provide the Trust Office written documentation of your disability within 90 days of your coverage ending.

- Trust Prescription Drug Plan (for members enrolled in the Trust Preferred Provider Plan (Regence), Trust Indemnity Medical Plan (Regence) and Providence Personal Option EPO)
- Providence Open Option POS
- Kaiser Permanente HMO.

Creditable Prescription Drug Coverage

This notice is most relevant for people who are eligible for Medicare or those who soon will be eligible for Medicare. Medicare prescription drug coverage became available in 2006 to everyone who is eligible for Medicare. All Medicare prescription drug plans must 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 Trust prescription drug coverage for Trust members and their dependents (Full-Time/Part-Time Option 1, Part-Time Option 2, substitute teachers and self-pay continuation) enrolled in the following Trust plans is, on average for all plan participants, expected to pay out at least as much as the standard Medicare prescription drug coverage will pay:

- Trust Prescription Drug Plan (for members enrolled in the Trust Preferred Provider Plan (Regence), Trust Indemnity Medical Plan (Regence) and Providence Personal Option Plan)
- Kaiser Permanente HMO.

Therefore, if you are or become eligible for Medicare, you can keep the Trust's plan coverage and not pay a penalty if you later decide to enroll in a Medicare prescription drug plan.

Individuals can first 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, you may also continue your Trust prescription drug coverage. The Trust coverage will continue to pay primary as it had before you enrolled in a Medicare prescription drug plan. 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. If you are eligible, you can re-enroll in Trust coverage at annual enrollment or if you have a special enrollment event.

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's 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'll 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 which 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 which 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 which 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 above, 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 73 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 73 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 professional's 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 proceeding. 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 73 for details.) If you request a copy of your health information, the Trust may charge a reasonable fee for copying, assembling 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 only communicate with you at a certain telephone number or by e-mail. If you wish to receive confidential communications, please make your request in writing to the Privacy Contact Person. (See "Privacy Contact Person" on page 73 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 73 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. 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 listed below. 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. (See "Privacy Contact Person" on page 73 for details.)

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 written 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 Employees 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 provides general information about the Trust to participants covered by a collective bargaining agreement between School District No. 1 and the Portland Association of Teachers (PAT) who have elected to receive medical coverage from the Trust Indemnity Plan (Regence), Kaiser or Providence.

Type of Plan

The plan is a health and welfare plan that provides benefits to persons covered under certain Trust-provided plans. This handbook describes benefits provided under the plan.

Administrative Information

- 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
- Substitute teachers: October 1 through September 30
- 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 NW Administrators, a contract administration organization. NW Administrators is referred to as the Trust Office throughout this handbook and may be contacted at the following address:

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 shall 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 premiums to the following entities:

Kaiser Foundation Health Plan of the Northwest
Kaiser Permanente Building
500 NE Multnomah Street, Suite 100
Portland, OR 97232
(503) 813-2000
(800) 813-2000

Providence Health Plans
P.O. Box 5548
Portland, OR 97228-5548
(503) 574-8000
(800) 603-2340

The Standard Insurance Company
1001 SW Fifth Ave., Suite 1350
Portland, OR 97204
(800) 521-8780

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 participants 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.

Beneficiary — A Trust member's eligible dependent who is listed on the Trust member's completed enrollment form and who is enrolled under the plan.

Brand name drug — A drug marketed under a trademark name, usually created by the manufacturer that holds the patent on the drug. A brand name drug cannot be distributed by another manufacturer (for example, as a generic drug) until the patent expires.

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.

Claimant — A Trust member or a beneficiary.

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

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.

Copayment — The dollar amount you must pay upon receipt of services or supplies covered by the plan.

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 — An employee of the District or a dependent of the employee 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.

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.

Employee — Any person employed by School District No. 1, Multnomah County, Oregon, who is eligible to participate in the plan.

Generic drug — A drug that is chemically and therapeutically equivalent to a brand name drug whose patent has expired. Generic drugs are typically less expensive than their brand name counterparts and are sold under the drugs' common names.

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.

Health outcome — An outcome that affects health status as measured by the length or quality of a person's life. The Health Intervention's overall beneficial effects on health must outweigh the overall harmful effects on health.

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.

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.

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.

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.

Nonparticipating pharmacy — A retail pharmacy not participating in the CVS Caremark retail pharmacy network.

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.

Option 1 — The Trust Plan for eligible full-time and part-time employees and their eligible dependents (part-time employees have a choice of Option 1 or Option 2). Option 1 includes medical, prescription drug, dental, vision, disability, life and survivor benefits.

Option 2 — The Trust Plan for eligible part-time employees and their eligible dependents (part-time employees have a choice of Full-Time/Part-Time Option 1 or Part-Time Option 2). Part-Time Option 2 includes medical and prescription drug benefits.

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.

Participating pharmacy — A retail pharmacy participating in the CVS Caremark retail pharmacy network.

Pharmacist — A person who is licensed to prepare and dispense drugs.

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 Trust Group Medical Plan (the Trust Indemnity Medical Plan (Regence) and Trust Preferred Provider Plan (Regence)) described in this document.

Plan — The School District No. 1 Health and Welfare Trust Prescription Drug Plan described in this document

Plan (from *Vision*) — The School District No. 1 Health and Welfare Trust Vision Plan described in this document.

Plan (from *Dental*) — The School District No. 1 Health and Welfare Trust Dental Plan described in this document.

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 Trust Indemnity Medical Plan (Regence) and Trust Preferred Provider Plan (Regence) document.

Plan document (from *Prescription Drugs*) — The written Trust Prescription Drug Plan document.

Plan document (from *Vision*) — The written Trust Vision Plan document.

Plan document (from *Dental*) — The written Trust Dental 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.

Prescription — A written order for dispensing and administering a drug, signed by a professional provider who is licensed to prescribe drugs.

Prescription drugs — Medicines, drugs or supplies that are used for the treatment of illness or injury and cannot be legally dispensed without a written prescription.

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.

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.

Refill — The continuation of an original prescription, as authorized by the prescribing professional provider.

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.

Regence — refers to Regence BlueCross BlueShield of Oregon.

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.

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.

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.

Coordination of Benefits Definitions

Following are definitions of some of the terms used throughout the Coordination of Benefits section.

- **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 Full-Time/Part-Time Option 1 Trust Vision Plan
  - The Full-Time/Part-Time Option 1 Dental Plan
  - The Full-Time/Part-Time Option 1 Trust Preferred Provider Plan (Regence) and Part-Time Option 2 Trust Indemnity Medical Plan (Regence)
  - The Full-Time/Part-Time Option 1, Part-Time Option 2 and Substitute Teachers Trust Prescription Drug Plan.

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			
Trust Preferred Provider Plan (for Full-Time/Part-Time Option 1) Claims and Benefits Trust Indemnity Medical Plan (for Part-Time Option 2) Claims and Benefits	Regence	www.Regence.com	(866) 240-9580
Special Beginnings (Maternity Care) Program (for Trust Preferred Provider Plan and Trust Indemnity Medical Plan)	Regence	Email:OR_Special_Beginnings@regence.com	(866) 569-2229
Care Management (for Trust Preferred Provider Plan and Trust Indemnity Medical Plan)	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 (Trust Preferred Provider Plan and Trust Indemnity Medical Plan)	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

For Questions About:	Contact:	Web Site/Email	Phone Number
Trust Prescription Drug Plan			
Retail Pharmacy	CVS Caremark		(800) 552-8159
Mail Order	Caremark.com	https://www.caremark.com/wps/portal	(800) 552-8159
Dental Plan			
Trust Dental Plan	Regence	www.regence.com	(866) 240-9580
Vision Plan			
Trust Vision Plan	VSP	www.vsp.com	(800) 877-7195
Insurance Benefits			
Life, AD&D, Optional Life, Voluntary AD&D or Long-Term Disability Benefits	The Standard Life or LTD Benefits Department PO Box 2800 Portland, OR 97208	www.standard.com	**Life/AD&D** Phone: (800) 628-8600 Fax: (888) 414-0389 **LTD** Phone: (800) 368-1135 Fax: (971) 321-8400
Continued Benefits (Portability and Conversion)	The Standard Continued Benefits PSB3A 920 SW Sixth Ave Portland, OR 97201-1244	www.standard.com	Phone: (800) 378-4668 Fax: (800) 331-3397

For PAT employees

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