Glossary

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

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

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

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

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

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

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

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

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

Claims administrator (from *Vision*) — VSP.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Regence — refers to Regence BlueCross BlueShield of Oregon.

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

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

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

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

Skilled nursing facility — Any of the following:

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

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

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

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

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

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

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

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

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

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

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

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

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

Coordination of Benefits Definitions

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

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

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

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