

# PLAN SPECIFICATIONS

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<b>PARTICIPATING GROUP</b>	City of Seattle Local 77
<b>PLAN ADMINISTRATOR</b>	City of Seattle Personnel Department 700 Fifth Ave, Suite 5500 PO Box 34028 Seattle, WA 98124-4028 206-684-7832
<b>EMPLOYER ID NUMBER</b>	91-6001275
<b>NAME OF PLAN</b>	City of Seattle Local 77 Employee Health Care Plan
<b>EMPLOYEES</b>	Eligible Employees of City of Seattle Local 77
<b>GROUP NUMBER</b>	020185
<b>CONTRIBUTION REQUIRED</b>	Employee Coverage - Yes Dependent Coverage - No
<b>TYPE OF PLAN</b>	Employee Health Care Plan providing Medical and Prescription benefits
<b>TYPE OF PLAN ADMINISTRATION</b>	Contract Administration
<b>ORIGINAL PLAN EFFECTIVE DATE</b>	January 1, 2001
<b>LAST AMENDED DATE</b>	January 1, 2006
<b>ANNIVERSARY DATE OR PLAN YEAR</b>	January 1 through December 31
<b>PLAN SUPERVISOR</b>	Healthcare Management Administrators, Inc. PO Box 85008 Bellevue, Washington 98015 425-462-1000 Seattle Area 800-700-7153 All Other Areas

This booklet is the Master Plan Document. This booklet and any amendments constitute the plan document for this benefit plan. This Plan is maintained for the exclusive benefit of the Plan Employees and each Participant's rights under this Plan are legally enforceable.

**The Plan Administrator has the right to amend this Plan at any time.** The Plan Administrator will make a good faith effort to communicate to the Plan participants all Plan amendments on a timely basis. For further information, see the section titled Amendment of Plan Document located in the General Provisions section of this Plan.

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## Important Information - Please Read

When contacting our Customer Service Department, answers for benefits and eligibility will be provided to any participant and to providers of service. The benefits quoted by the Plan Supervisor (HMA) are not a guarantee of claim payment. Claim payment will be dependent upon eligibility at the time of service and all terms and conditions of the Plan. This disclaimer will be provided to the caller when benefits are quoted over the telephone.

For a written pre-estimate of benefits, a provider of service must submit to the Plan Supervisor their proposed course of treatment, including diagnosis, procedure codes, place of service and proposed cost of treatment. In some cases, medical records or additional information may be necessary to complete the pre-estimate.

When the Utilization Review (UR) Coordinator pre-authorizes any confinement, procedure, service or supply, it is only for the purpose of reviewing whether the service is determined to be medically necessary for the care or the treatment of an illness. Pre-authorization does not guarantee payment of benefits. All charges submitted for payment are subject to all other terms and conditions of the Plan, regardless of authorization by the UR Coordinator whether by telephone or in writing.

### PRE-AUTHORIZATION OF INPATIENT MEDICAL FACILITY ADMISSIONS

This plan requires pre-authorization of all inpatient medical facility. To avoid a penalty, pre-authorization is required for all scheduled admissions. Notify your doctor that his or her failure to call for pre-authorization **ten days prior** to an admission into a medical facility or, in the case of an emergency admission, failure to obtain authorization either within 48 hours after the emergency admission or on the next business day, if later, will result in the following reductions and losses:

- The amount of the coinsurance payment will be reduced to 50% of the Preferred Provider payment level or the amount that would have been paid had the services been received in an appropriate alternative setting, whichever is greater, if an inpatient level of care is determined not to be medically necessary; and
- The penalty will not apply towards the out-of-pocket maximum.

At the time that your doctor recommends an inpatient admission for you, you or your doctor should contact the Plan's Utilization Review (UR) Coordinator to request the pre-authorization. All inpatient and all non-emergency admissions (excluding normal vaginal deliveries where the length of stay is 48 hours or less and cesarean section deliveries where the length of stay is 96 hours or less) must be pre-authorized in advance. You or your doctor must call no later than ten days prior to the medical facility admission. Surgeries performed in the doctor's own office do not need to be pre-authorized. Emergency medical facility admissions must be authorized within 48 hours after the medical facility admission, or by the next business day, if later.

**Special Note Concerning Mothers and Newborns:** Hospital stays that extend beyond 48 hours for a normal vaginal delivery, or beyond 96 hours for a cesarean section must be pre-authorized at the time your provider recommends the extended stay.

**Pre-authorization does not guarantee payment of benefits.** The Medical Management Department should be contacted at the following numbers:

**HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.  
425/462-1000 - SEATTLE  
800/700-7153 - OTHER AREAS NATIONWIDE**

## **CERTIFICATION OF ADDITIONAL DAYS**

If your physician is considering lengthening a stay, you, your physician, the hospital or the medical facility must call HMA's Medical Management Department to request certification for additional days. Call no later than the last day previously certified. If medically necessary, additional days of confinement may be certified at that time.

## **STEPS TO TAKE**

When an inpatient admission is recommended, the patient, the physician or a family member must call the Medical Management Department at least ten days prior to the admission to obtain authorization. If an emergency admission occurs, the patient or a family member should ask the attending physician or the medical facility to contact the Medical Management Department within 48 hours of admission, or by the next business day, if later. Please be prepared to give the Medical Management Department the following information when you make the call for authorization:

- Name and age of patient.
- Subscriber Identification Number.
- Group Number (020185).
- Medical Facility name and address.
- Name and phone number of admitting physician.
- Admission date.
- Diagnosis.
- Procedure being performed.

The Medical Management Department will send written confirmation of the approved admission to the patient once authorized.

## **CASE MANAGEMENT/ALTERNATE TREATMENT**

In cases where the covered participant's condition is expected to be or is of a serious nature, case management services from a professional qualified to perform such services may be recommended. The medical management case manager will work with you, the Plan Administrator, your physician and other health care providers to help assure that the care you receive is provided in the most appropriate and cost effective manner. The case managers are your advocates to help improve the quality of your health care and to lower the cost of health care to you and the Plan.

Alternate care will be determined on the merits of each individual case and any care or treatment provided will not be considered setting any precedent or creating any future liability, with respect to that covered participant or any other covered participant.

Home Health Care, Hospice Care, Skilled Nursing Facility, and Rehabilitation are provided in lieu of and as an alternative to inpatient admissions. Coverage will be limited to the maximum benefit payable for hospital or other inpatient expenses under this Plan and will be subject to any applicable deductible, coinsurance and Plan limits. Benefits will only be provided when the patient's condition is serious enough to require inpatient care and the member could qualify for inpatient benefits.

## **HOW TO FILE A CLAIM**

- All providers should send bills to the address listed on your medical identification card.
- You must provide the provider of service with the information listed on your medical identification card. The provider must attach itemized bills to a claim form. An itemized bill is one that contains the provider's name, address, Federal Tax ID Number and the nature of the accident or illness being treated.

**All claims for reimbursement must be submitted within 15 months of the date incurred.**

## **CONTINUATION OF COVERAGE PROVISIONS (COBRA)**

Both employees and dependents should take the time to read the Continuation of Coverage Provisions. Under certain circumstances, participants may be eligible for a temporary extension of health coverage, at group rates, where coverage under the plan would otherwise end. The information in this section is intended to inform you, in a summary fashion, of your rights and obligations under the Continuation of Coverage provisions. To find out more about your Continuation of Coverage rights refer to the COBRA Section of this Summary Plan Description.

## **CONTACT FOR QUESTIONS ABOUT THE PLAN BENEFITS**

Healthcare Management Administrators, Inc. (HMA) is the Plan Supervisor. You are encouraged to contact HMA with questions you have regarding this Plan. HMA's Customer Service Department is available to answer questions about claims and how your benefits work. You may contact HMA's Customer Service Department at:

**HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.  
PO Box 85008; Bellevue, WA 98015-5008  
425/462-1000 - Seattle  
800/700-7153 - Other Areas Nationwide**

## SCHEDULE OF BENEFITS

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The level of benefits received is based upon the participant's decision at the time treatment is needed to access care through either preferred or non-preferred providers. Benefits are payable at the preferred level by accessing your care through a Preferred Provider, Preferred Medical Facility or from a Preferred Hospital. Your Preferred Provider Organization is:

**WA Employees:  
HMA Preferred  
800/700-7153**

OR

[www.wa.regence.com](http://www.wa.regence.com) (in Western WA) and  
[www.asurisnorthwesthealth.com](http://www.asurisnorthwesthealth.com) (in Eastern Washington)

Charges from a Participating Provider will be paid at the participating network level of benefits. ***Charges from a provider who is not a Preferred Provider or a Participating Provider are not eligible for payment.***

Eligible expenses will be paid at the preferred level when:

- The services are billed by a preferred provider, hospital or medical facility.
- The services are for a non-preferred assistant surgeon or anesthesiologist, where the medical facility and the primary surgeon are both preferred providers.

Eligible expenses will be paid at the preferred level, but any additional charges that the provider may bill you will be your responsibility when:

- You live outside the area serviced by the preferred provider organization.
- You are traveling or receive emergency services inside or outside the network area.

This Schedule of Benefits is a summary of the benefits provided under this Plan. **Please read the entire booklet for details on specific benefit limitations and maximums, waiting periods and exclusions.**

## **MEDICAL BENEFITS**

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	<b>Preferred Network</b>	<b>Participating Network</b>
<b>INDIVIDUAL DEDUCTIBLE</b> Per calendar year.	\$100	\$150
<b>FAMILY DEDUCTIBLE</b> Per calendar year.	\$300	\$450
<b>INDIVIDUAL OUT-OF-POCKET MAXIMUM</b> Per calendar year.	\$200	\$1,200

Amounts credited to the deductibles and out-of-pocket maximums are applied to both the Preferred and Participating eligible expense limits. The benefit maximums (calendar year and lifetime) are combined for both the Preferred and Out-of-Network eligible expenses

Once the out-of-pocket maximum is reached, eligible expenses are paid at 100% of allowable charges for the remainder of the calendar year. There are some benefits that are not payable at the 100% coinsurance rate. The following expenses do not apply to the out-of-pocket maximum 1) Deductibles; 2) Prescription Drug Card Expenses (copays); 3) Penalties; 4) Ineligible charges; 5) Outpatient Rehabilitation treatment; 6) Neurodevelopmental therapy treatment; and 7) Outpatient Mental Health treatment.

**PRE-AUTHORIZATION FOR MEDICAL FACILITY ADMISSIONS** is required for full benefits. Failure to pre-authorize will result in a reduction of coinsurance to 50%, which will not apply towards the out-of-pocket maximum. See section titled Pre-authorization of Inpatient Medical Facility Admissions.

	<b>Preferred Network Payment Level</b>	<b>Participating Network Payment Level</b>
<b>ACUPUNCTURE</b> Limited to 12 visits per calendar year, excluding those for chemical dependency treatment.	80%	60%
<b>ALLERGY INJECTIONS/TESTING</b>	80%	60%
<b>AMBULANCE (AIR AND GROUND)</b>	80%	80%
<b>ANESTHESIOLOGIST</b>	80%	60%
<b>ASSISTANT SURGEON</b>	80%	60%
<b>BIOFEEDBACK</b>	80%	60%
<b>BLOOD BANK</b>	80%	80%
<b>CHEMICAL DEPENDENCY TREATMENT</b> Limited to \$13,000 every 2 calendar years. Including acupuncture expenses.	80%	80%
<b>CHIROPRACTIC SERVICES AND X-RAYS</b> Limited to 10 visits per calendar year.	80%	80%
<b>CONTRACEPTIVE DEVICES AND INJECTIONS</b>	80%	80%
<b>DENTAL SERVICES (ACCIDENTAL INJURY)</b> Limited to \$600 maximum per occurrence.	80%	80%
<b>DIETARY/DIABETIC EDUCATION</b>	80%	60%
<b>DIAGNOSTIC X-RAY AND LABORATORY</b>	80%	60%
<b>DURABLE MEDICAL EQUIPMENT</b>	80%	80%
<b>EMERGENCY ROOM &amp; SERVICES</b> Emergency Treatment Non-Emergency Treatment	80% 80%	80% 60%
<b>HOME HEALTH CARE</b> Limited to 130 visits per calendar year.	90%	90%
<b>HOME PHOTOTHERAPY</b>	80%	80%
<b>HOSPICE CARE</b> Lifetime maximum six months. Inpatient limited to 14 days per calendar year.	90%	90%
<b>INFUSION THERAPY</b>	90%	60%
<b>INPATIENT PHYSICIAN VISIT</b>	80%	60%

	<b>Preferred Network Payment Level</b>	<b>Participating Network Payment Level</b>
<b>INPATIENT PRESCRIPTION DRUGS</b>	80%	60%
<b>MAMMOGRAM</b> Preventive mammogram limited to one per calendar year. Deductible waived.	80%	60%
<b>MEDICAL FACILITY SERVICES</b>		
<b>Inpatient</b>	80%	60%
<b>Outpatient</b>		
Outpatient Surgical Facility	80%	60%
Miscellaneous Services	80%	60%
<b>MENTAL HEALTH TREATMENT</b>		
<b>Inpatient</b>	80%	60%
<b>Outpatient</b>	50%*	50%*
<b>NATUROPATHY</b>	80%	60%
<b>NEURODEVELOPMENTAL THERAPY</b> Limited to \$2,000 per calendar year (combined with Outpatient Rehabilitation). Limited to dependent children to age seven.	80%*	80%*
<b>OFFICE VISIT</b>	80%	60%
<b>ORTHOTICS</b>	80%	60%
<b>PHENYLKETONURIA FORMULA</b>	100%	100%
<b>PRE-ADMISSION TESTING</b> Confinement must occur within 7 days. Deductible waived.	100%	100%
<b>PREVENTIVE CARE</b> Limited to \$300 per calendar year.	100% deductible waived	<b>Not Covered</b>
<b>PROSTHETICS</b>	80%	80%
<b>REHABILITATION SERVICES</b>		
<b>Inpatient</b> Limited to \$50,000 per condition.	80%	60%
<b>Outpatient</b> Limited to \$2,000 per calendar year (combined with Neurodevelopmental therapy). Extension of benefits may be available if condition is related to an inpatient admission and \$50,000 Inpatient Rehabilitation services limit is not exhausted.	80%*	80%*

	<b>Preferred Network Payment Level</b>	<b>Participating Network Payment Level</b>
<b>SECOND SURGICAL OPINION</b>	80%	60%
<b>SKILLED NURSING FACILITY CARE</b> Limited to 90 days per calendar year.	80%	80%
<b>SUPPLIES</b>	80%	80%
<b>SURGEON</b>	80%	60%
<b>TRANSPLANTS</b>	80%	60%
<b>Donor Benefits</b> Inpatient services limited to 10 days.	80%	60%
<b>OTHER MISCELLANEOUS ELIGIBLE CHARGES</b>	80%	60%

\*Remains at a constant coinsurance level and does not apply to the out-of-pocket maximum.

*Benefit maximums described herein are combined for both the Preferred Network and Out-of-Network.*

#### **CALENDAR YEAR MAXIMUM BENEFITS**

Acupuncture	12 visits
Chemical Dependency (every 2 calendar years)	\$13,000
Chiropractic Services & X-Rays	10 visits
Home Health Care	130 visits
Hospice Care – Inpatient	14 days
Neurodevelopmental Therapy (combined with Outpatient Rehabilitation)	\$2,000
Preventive Care	\$300
Preventive Mammography	1 exam
Rehabilitation Services - Outpatient (combined with Neurodevelopmental therapy)	\$2,000
Skilled Nursing Facility	90 days

#### **LIFETIME MAXIMUM BENEFITS**

Hospice Care (inpatient and outpatient combined)	six months
Major Medical	\$1,000,000

## PRESCRIPTION BENEFITS

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### Caremark - Retail Pharmacies

Generic Drugs	\$8 Copay
Brand Name Drugs*	
On Preferred Drug List	\$8 Copay
Not On Preferred Drug List	<b>Not Covered</b>

Dispensing limit is the greater of 34 days or 100 units.

### Caremark MailService - Mail Order Prescriptions

Generic Drugs	\$16 Copay
Brand Name Drugs*	
On Preferred Drug List	\$16 Copay
Not On Preferred Drug List	<b>Not Covered</b>

Dispensing limit 90 days.

*\* This plan requires the pharmacist to fill the prescription with a generic product whenever it is available. If the prescription is filled with a name brand prescription at the request of either the provider or the Plan participant, then the copay **plus** the difference between the ingredient cost of the generic drug and the brand name drug will be charged.*

# ELIGIBILITY AND ENROLLMENT PROVISIONS

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## ELIGIBILITY

### Employee Eligibility

Employees eligible for coverage under this plan are:

An active, full-time, regular employee of City of Seattle Local 77 who works a minimum of 80 hours per month, or a temporary employee in a benefits-eligible assignment who works at least 80 hours per month is eligible to obtain City-paid contributions for coverage. A temporary employee who has worked at least 1,040 hours cumulative non-overtime hours and at least 800 non-overtime hours in the previous 12 month period, and is not in a benefits-eligible assignment is eligible for coverage. The employee must not be represented by a bargaining group for which a separate summary of coverage is available.

### Dependent Eligibility

Dependents eligible for coverage under this plan are:

- An employee's legally married spouse (unless legally separated).
- An employee's domestic partner as defined in the Affidavit of Marriage/Domestic Partnership Agreement on file with the Employer.
- An employee's, spouse's, or domestic partner's unmarried dependent child(ren) under age 21 who depends primarily on the employee for support.
- An employee's, spouse's, or domestic partner's unmarried child under age 23 who depends primarily on the employee for support if that child is enrolled as a full-time student in an accredited school, college, university, vocational school, or educational institution.

Cessation of full-time school attendance shall terminate dependent status EXCEPT that:

- If cessation is due to school vacation (either summer vacation or a semester/quarter chosen by the dependent during the school year), dependent status shall terminate on the last day of the month prior to the month the school reconvenes if attendance does not resume. Coverage for a dependent who graduated prior to the school vacation will cease at the end of that semester/quarter unless documentation of enrollment in the next academic year is provided.
- If cessation is due to disability which prevents full-time school attendance, dependent status shall terminate on the last day of the month in which the dependent was no longer a full-time student, unless the child is incapable of self-support and proof of incapacity is submitted to the Plan Supervisor (see next paragraph for more information).
- An employee's, spouse's, or domestic partner's unmarried dependent child(ren) who is incapable of self-support because of mental retardation, mental illness, or physical incapacity that began prior to the date on which the child's eligibility would have terminated due to age. Proof of incapacity must be received within 31 days after the date on which the maximum age is attained. Subsequent evidence of disability or dependency may be required not more frequently than one time per year to verify continued eligibility for benefits. If the incapacitated child's coverage ceases for any reason, he or she will not thereafter be eligible for coverage.

- An employee's, spouse's, or domestic partner's unmarried child for whom the employee elected coverage when the child was first eligible, but whose coverage terminated due to a loss of dependency status, and the child later meets the definition of a dependent again as defined in this Dependent Eligibility section.
- An employee's unmarried dependent child(ren) whose coverage is required pursuant to a valid court, administrative order or Qualified Medical Child Support Order (QMCSO).
- Adopted children or legally placed for adoption children are eligible under the same terms and conditions that apply to dependent, natural children of parents covered under this Plan.
- Any individual who is covered as an employee can also be covered as a dependent. Dependents can be covered as a dependent of more than one employee.

The term "dependent children" means any of the employee's natural children, legally adopted children, or children who have been placed for adoption with the employee, or step-children/domestic partner's children who depend on the employee for support and for whom the employee's home is their permanent residence, or children who have been placed under the legal guardianship of the employee or the employee's spouse or domestic partner by a court decree. Placement for adoption is defined as the assumption and retention of an obligation for total or partial support of a child in anticipation of adoption irrespective of whether the adoption has become final. The child's eligibility terminates upon termination of the legal obligation.

A dependent is defined as an individual who is: (1) listed on the employee's application as a dependent of the employee; (2) eligible for dependent coverage (based on the criteria above); (3) whose application has been accepted by the Plan Supervisor; and (4) for whom the applicable rate of coverage has been paid.

## ENROLLMENT

### Regular Enrollment

To apply for coverage under this plan, the employee must complete and submit an enrollment form within 31 days of the date the individual first becomes eligible for coverage. The completed enrollment form shall list all eligible dependents to be covered. Individuals not enrolled during the enrollment eligibility period will be required to wait until the next open enrollment period unless they become eligible to enroll as a result of a special enrollment period. The employee's contribution, if any, toward the cost of the coverage will be deducted from the employee's pay and is subject to change.

Temporary employees and their dependents who are not in a benefits-eligible assignment may apply for enrollment in writing to the Plan Administrator within ninety (90) days of becoming eligible.

When the employee acquires an eligible dependent (birth, marriage, adoption etc.), the dependents must be enrolled within the enrollment eligibility periods specified below:

**Newly acquired dependent:** A newly acquired dependent (except a newborn child or a child placed for adoption) must be enrolled within 31 days of the date of acquisition.

**Newborn:** A newborn child may be covered from birth provided the child is enrolled within 60 days of the date of birth.

**Adopted Child or Legal Guardianship:** An adopted child, a child placed for adoption, or a child for whom the employee becomes a legal guardian may be covered from the date of placement or legal guardianship provided the child is enrolled within 60 days of the date of placement or legal guardianship.

### **Special Enrollment for Loss of Other Coverage**

A special enrollment period is available for current employees and their dependents who lose coverage under another group health plan or had other health insurance coverage if the following conditions are met:

- The employee or dependent is eligible for coverage under the terms of the Plan, but not enrolled.
- Enrollment in the Plan was previously offered to the employee and dependent.
- The employee declines the coverage under the Plan because, at the time, the employee and/or dependent was covered by another group health plan or other health insurance coverage.
- The employee has declared in writing that the reason for the declination was the other coverage.

The current employee or dependent may request the special enrollment within 31 days of loss of other health coverage under the following circumstances.

- If the other group coverage is not COBRA continuation coverage, special enrollment can only be requested after losing eligibility for the other coverage due to a COBRA qualifying event or after cessation of employer contributions for the other coverage. Loss of eligibility of other coverage does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause. COBRA continuation does not have to be elected in order to preserve the right to a special enrollment.
- If the other group coverage is COBRA continuation coverage, the special enrollment can only be requested after exhausting COBRA continuation coverage.
- If the other individual or group coverage does not provide benefits to individuals who no longer reside, live, or work in a service area, and in the case of group coverage, no other benefit packages are available.
- If the other plan no longer offers any benefits to the class of similarly situated individuals.

Effective date of coverage will be the first of the month following the date the request is received by the Plan Administrator.

### **Special Enrollment for Loss of Eligibility Due to Reaching Lifetime Maximum Benefits**

A special enrollment period is available for current employees and their dependent, if an individual incurs a claim that causes the individual to meet or exceed a lifetime maximum on all benefits. The current employee or dependent may request the special enrollment within 30 days from the date that the claim putting the individual over the lifetime maximum has been denied.

If the other coverage is COBRA continuation coverage, meeting or exceeding a lifetime maximum on all benefits, shall also result in the exhaustion of COBRA continuation coverage. Special

enrollment must be requested within 30 days from the date the claim putting the individual over the lifetime maximum has been incurred.

Effective date of coverage will be the first of the month following the date the request is received by the Plan Administrator.

### **Special Enrollment for New Dependents**

A special enrollment period is available for current employees who acquire a new dependent by birth, marriage, domestic partnership, legal guardianship, adoption, or placement for adoption. This special enrollment applies to the following events:

- When an employee marries or forms a domestic partnership, a special enrollment period is available for the employee and newly acquired dependents. As long as the proper enrollment material is received by the Plan Administrator within the 31 day enrollment period, the effective date of coverage will be the date of marriage or domestic partnership.
- When an employee or spouse/domestic partner acquire a child through birth, legal guardianship, adoption or placement for adoption, a special enrollment period is available for the employee, the spouse/domestic partner and the dependent. As long as the proper enrollment material is received by the Plan within the 60 day enrollment period, the effective date of coverage will be the date of the birth, legal guardianship, adoption or placement of adoption.

### **Special Enrollment for New Dependents through Qualified Medical Child Support Order:**

A special enrollment period is available for employees who are required to provide health care coverage for a child who is not in the employee's custody to comply with a Qualified Medical Child Support Order (QMCSO) issued as a part of the judgment, order of decree, a divorce settlement agreement or a legal separation proceeding. Agreement made by the parties, but not formally approved by a court are not acceptable. To be considered qualified, a medical child support order must include:

- Name and last known address of the parent who is covered under this plan;
- Name and last known address of each child to be covered under this plan;
- Type of coverage to be provided to each child; and
- Period of time the coverage is to be provided.

QMCSOs should be sent to the Plan Administrator/Plan Sponsor. Upon receipt, the Plan Administrator/Plan Sponsor will notify you if the order is qualified. If the order is qualified, you may cover your child(ren) under the plan. As long as the proper enrollment material is received by the Plan Administrator/Plan Sponsor within the 31-day enrollment period, the effective date of coverage will be the date of the order.

### **Open Enrollment**

An open enrollment period is held approximately once per year to allow eligible employees to change their participation. Coverage becomes effective the date specified by the Plan Administrator.

## **EFFECTIVE DATE OF COVERAGE**

### **Employee Effective Date**

The effective date of coverage for eligible active, full-time, regular employees and temporary employees in a benefits-eligible assignment is the later of: (a) the first calendar day of the month designated as a City business day, or (b) the first calendar day of the month designated/recognized as the first working day for the shift to which the employee is assigned. If your employment begins after said date, your coverage will begin the following month.

If you are a temporary employee who is not in a benefits-eligible assignment, the effective date of your coverage is the first day of the calendar month following the date application is made and the rate is paid, or the date designated by the Plan Administrator if application is made during an open enrollment period.

An employee for whom coverage already became effective, but who is absent without pay on the first day of the calendar month and returns by the 15<sup>th</sup> of the month will not have a lapse in coverage. Coverage for an employee who returns after the 15<sup>th</sup> of the month will begin the first day of the following calendar month. However, an employee who is absent without pay for fifteen (15) consecutive calendar days or less will not have a lapse in coverage.

### **Dependent Effective Date**

If the employee elects coverage for dependents during the first 31 days of eligibility, the dependents' effective date will be the same as the employee's effective date.

If the covered employee marries or forms a domestic partnership, the employee must add the newly acquired dependents within 31 days of the date of marriage or domestic partnership and the effective date of coverage is the date of marriage or domestic partnership.

If the covered employee acquires a child through birth, legal guardianship, adoption or placement for adoption, the employee must add the child within 60 days of the date of birth, legal guardianship, adoption or placement for adoption and the effective date of coverage for the child is the date of birth, legal guardianship, adoption or placement for adoption.

The effective date of coverage for a child who is added to comply with a Qualified Medical Child Support Order is the date of the order.

## **TERMINATION OF COVERAGE**

Except as provided in the Plan's Continuation of Coverage provisions, coverage will terminate on the earliest of the following occurrences:

### **Employee**

- The date the Employer terminates the Plan.
- The last day of the month in which the employee ceases to meet the eligibility requirements of the Plan.
- The last day of the month in which the employee's employment ends.
- The date the employee fails to make any required contribution when coverage is contributory.

- The first day an employee fails to return to work following an approved leave of absence.
- The last day of the month in which the employee retires.

#### **Dependent(s)**

- The date the Employer terminates the Plan.
- The date the employee's coverage terminates.
- The last day of the month in which such individual ceases to meet the eligibility requirements of the Plan.
- The last day of the month in which contributions have been made on their behalf.
- The date the dependent becomes an active, full-time member of the armed forces of any country.
- The date dependent coverage is discontinued under the Plan.

#### **POSTPONEMENT OF TERMINATION IN CASES OF DISABILITY**

If the participant is totally disabled due to a condition covered under this Plan at the time this coverage would otherwise terminate for any reason, termination from the Plan may be postponed for the disabled patient only, without payment of the monthly rate. This provision will not apply if the participant elects the continuation of coverage provision, or if the participant is covered under another group Plan with the Plan Administrator, or a contract with another carrier that provides benefits for the disability at the time coverage would terminate except for this section.

The remaining benefits of this Plan that are available to the participant at the time the coverage would have terminated (except for the provisions of this section) will continue to be available for treatment of the disability (but without any renewal of benefits by virtue of extension into a new year) until the first of the following occurs:

- The expiration of six consecutive months for the subscriber or three months for the dependent.
- The remaining benefits of this Plan are exhausted.
- The participant becomes covered under another group Plan with the Plan Administrator that provides benefits for the disability.
- The participant is enrolled under a plan with another company that would provide benefits for the disability if this Plan did not exist.

The participant must specifically apply for this disability provision in writing to the Plan Supervisor within three months after the date this Plan would otherwise terminate except for the provisions of this section. The submission of a claim will not be considered valid notification. The participant must also submit proof of such disability whenever requested by the Plan Supervisor.

"Totally disabled" means that the participant is prevented, solely because of non-occupational illness or accidental injury, from engaging in any occupation for which the participant is reasonably qualified by education, training, or experience, and is performing no work for

compensation; or, if not previously employed, is prevented from engaging in most of the normal activities of a person of like age and sex in good health.

## **POSTPONEMENT OF TERMINATION IN CASES OF CONTINUOUS CONFINEMENT**

If the participant is an inpatient at a facility covered under this Plan at the time this coverage would otherwise be terminated for any reason, the effective date of termination will be postponed for the inpatient only, without payment of the monthly rate. Coverage will not be terminated for that participant until the first of the following events occurs:

- The participant ceases to be an Inpatient at the facility.
- The remaining benefits available under this Plan for the confinement are exhausted, but without any renewal of benefits by virtue of extension into a new year.
- The participant becomes covered under another Group plan with the Plan Administrator that provides benefits for the confinement.
- The participant is enrolled under a plan with another company that would provide benefits for this confinement if this Plan did not exist.

This provision will not apply if the participant transfers to a retiree medical plan provided by the Plan Administrator. In addition, the provision will not apply if the participant is covered under a Plan with the Plan Administrator or a plan with another carrier that provides benefits for the confinement at the time coverage would terminate except for this section, or if the participant is eligible for the continuation coverage provisions of the Consolidated Omnibus Reconciliation Act of 1985 (COBRA.)

## **CERTIFICATE OF CREDITABLE COVERAGE**

Under the Health Insurance Portability and Accountability Act of 1996, former Plan participants and their eligible dependents have the right to request and receive a Certificate of Creditable Coverage for any coverage, including COBRA coverage that was in effect June 1, 1996 or after. The right to receive this certificate continues for 24 months following the date of termination of coverage under this Plan.

If a participant loses coverage under this Plan they will be sent a Certificate of Creditable Coverage. This is an important document and you should keep it in a safe place. The Certificate of Creditable Coverage will be important proof of coverage under the plan that you may need to reduce any subsequent health plan's pre-existing condition limitation period which might otherwise apply to you and/or your dependents.

## **APPROVED FAMILY AND MEDICAL LEAVE**

If an employee is absent from work because of an approved leave of absence under the City of Seattle Family and Medical Leave Ordinance, enacted to comply with the federal Family and Medical leave Act of 1993, coverage under the Plan shall be continued for the employee and covered dependents for up to 90 calendar days in a 12-month period, provided the employee has satisfied the City's Family and Medical Leave requirements and makes any required contributions. The Employer may require employees who fail to return from Family and Medical Leave to repay any health plan premiums paid on their behalf during that leave. If the employee's leave extends more than 90 calendar days, the employee will be eligible to continue coverage under the (COBRA) Continuation of Coverage provision to the plan. Please contact your departmental

Human Resources office for information on how to qualify for a Family and Medical Leave of Absence.

### **APPROVED LEAVE OF ABSENCE (OTHER THAN FEDERAL FAMILY AND MEDICAL LEAVE OF ABSENCE)**

An employee (and covered dependents) for whom an approved leave of absence is granted (other than a Family and Medical Leave of Absence), and for whom coverage already became effective, but who is absent without pay on the first day of the calendar month and returns by the 15<sup>th</sup> of that month will not have a lapse in coverage. Coverage for an employee who returns after the 15<sup>th</sup> of the month will begin the first day of the following calendar month. However, an employee who is absent without pay for fifteen (15) consecutive calendar days or less will not have a lapse in coverage. The employee will be responsible for paying his/her contribution, if any, toward the cost of this coverage during the leave of absence.

The employee and dependents will be eligible to continue coverage under the (COBRA) Continuation of Coverage Provisions of the Plan if eligibility is lost. There will be no lapse in coverage for employees and dependents that have continued coverage while on the approved leave of absence. If the employee did not continue coverage while on the leave of absence, then coverage will be reinstated on the first day of the calendar month following the return to active status.

### **REINSTATEMENT OF COVERAGE**

If an employee who was covered under this Plan terminates employment and is rehired at a later date, the employee will have coverage on the first day of employment provided it is not later than: (a) the first calendar day of the month designated as a City business day, or (b) the first calendar day of the month designated/recognized as the first working day for the shift to which the employee is assigned. If employment begins after said date, coverage will begin the following month.

### **SELF-PAYMENT IN THE EVENT OF A LABOR DISPUTE**

If a covered employee's compensation is suspended as a result of a strike, lockout or other labor dispute, the employee may continue coverage for himself or herself and any covered dependents for up to six months. The covered employee must pay the full cost of coverage directly to the Company. If the covered employee is not back at work at the end of the six-month extension period, coverage may be continued as described in "Termination of Coverage - COBRA." The six-month labor dispute period counts towards the maximum COBRA continuation period.

# CONTINUATION COVERAGE RIGHTS UNDER COBRA

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## INTRODUCTION

### City of Seattle Local 77 Employee Healthcare Plan

The following information about your right to continue your health care coverage in the Plan is important. Please read it very carefully.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse/domestic partner and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. **The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

In general, COBRA requires that a “qualified beneficiary” covered under the Employer’s group health plan who experiences a “qualifying event” be allowed to elect to continue that health coverage for a period of time. ***Qualified beneficiaries are employees and dependents who were covered by the Plan on the day before the qualifying event occurred.*** Coverage is elected on the election form provided by the Plan Administrator. Both employees and dependents should take the time to read the Continuation of Coverage Rights provisions.

COBRA (and the description of COBRA coverage contained in this booklet) applies only to the group health plan benefits offered under the Plan and not to any other benefits offered under the Plan or by City of Seattle Local 77 (such as life insurance, disability, or accidental death or dismemberment benefits). The Plan provides no greater COBRA rights than what COBRA requires—nothing in this booklet is intended to expand your rights beyond COBRA’s requirements.

#### The Plan Administrator is:

**City of Seattle Personnel Department  
Benefits Unit  
700 5<sup>th</sup> Ave., Suite 5500  
PO Box 34028  
Seattle, WA 98124-4028**

The party responsible for administering COBRA continuation coverage (“COBRA Administrator”) is:

**City of Seattle Personnel Department  
Benefits Unit  
700 5<sup>th</sup> Ave., Suite 5500  
PO Box 34028  
Seattle, WA 98124-4028**

## **WHAT IS COBRA COVERAGE?**

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who Is Entitled to Elect COBRA?"

After a qualifying event occurs and any required notice of that event is properly provided to the employee's departmental Benefits Representative, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse/domestic partner, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under Qualified Medical Child Support Orders (QMCSO) may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

COBRA coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

## **WHO IS ENTITLED TO ELECT COBRA COVERAGE?**

If you are an employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under the Plan because either one of the following qualifying events happens:

- your hours of employment are reduced; or
- your employment ends for any reason .

If you are the spouse/domestic partner of an employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- your spouse/domestic dies;
- your spouse's/domestic partner's hours of employment are reduced;
- your spouse's/domestic partner's employment ends for any reason ; or
- you become divorced or legally separated from your spouse, or you terminate your domestic partnership. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs within three months of the reduction or elimination of coverage, then the divorce or legal separation will be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

If you are the dependent child of an employee, you will be entitled to elect COBRA coverage if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- your parent-employee dies;
- your parent-employee's hours of employment are reduced;
- your parent-employee's employment ends for any reason;
- you stop being eligible for coverage under the Plan as a "dependent child."

If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee's spouse/domestic partner and dependent children, if any) will be entitled to elect COBRA coverage if they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave. COBRA coverage elected in these circumstances will begin the first calendar day of the month following FMLA leave ends, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section below entitled "Length of COBRA Coverage.")

### **WHEN IS COBRA COVERAGE AVAILABLE?**

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You do not need to notify the Benefits Representative in your department of the occurrence of any of these three qualifying events.

For the other qualifying events (divorce or legal separation of the employee and spouse, termination of domestic partnership, or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you complete and submit a *Health Care Benefits Change Form* to the Benefits Representative for your department within 60 days after the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

In providing this notice, you must use the *Health Care Benefits Change Form* and you must follow the procedures specified in the section below entitled "Notice Procedures for Notice of Qualifying Event." If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, **YOU WILL LOSE YOUR RIGHT TO ELECT COBRA coverage.** (You may obtain a copy of the *Health Care Benefits Change Form* from your department's Benefits Representative.)

### **ELECTING COBRA COVERAGE**

**To elect COBRA coverage, you must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the COBRA Administrator** (An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from the COBRA Administrator.)

**Under federal law, you have 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event to decide whether you want to elect COBRA coverage under the Plan. Mail or hand-deliver the completed Election Form to:**

**If mailing:**

**Personnel Department/Benefits Unit  
COBRA Administrator  
PO Box 34028  
Seattle, WA 98124-4028**

**If hand-deliver:**

**Personnel Department/Benefits Unit  
COBRA Administrator  
700 5<sup>th</sup> Avenue, Suite 5400  
Seattle WA 98104**

**The Election Form must be completed in writing and mailed or hand-delivered to the individual and address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail and faxed communications.**

If mailed, your election must be postmarked (and if hand-delivered, your election must be received by the individual at the address specified above) no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event. **IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA COVERAGE.**

If you reject COBRA coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

You do not have to send any payment with your Election Form when you elect COBRA coverage. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA coverage. For example, the employee's spouse may elect COBRA even if the employee does not. COBRA coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. Covered employees and spouses/domestic partners (if the spouse/domestic partner is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. **Any qualified beneficiary for whom COBRA coverage is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

When you complete the Election Form, you must notify the COBRA Administrator if any qualified beneficiary has become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the Election Form, immediately notify the COBRA Administrator of the date of your Medicare entitlement at the address specified above for delivery of the Election Form.

Qualified beneficiaries may be enrolled in one or more group health plans offered by the City of Seattle at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as the result of a qualifying event, he or she may elect COBRA under any or all of the group health plans under which he or she was covered on the day before the qualifying event. (For

example, if a qualified beneficiary was covered under the Medical Plan and Dental/Vision Plan on the day before a qualifying event, he or she may elect COBRA under the Dental/Vision Plan only, the Medical Plan only, or under both the Medical Plan and the Dental/Vision Plan.

Qualified beneficiaries who are entitled to elect COBRA coverage may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA coverage is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA coverage, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied). See the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

## **SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA COVERAGE**

In considering whether to elect COBRA coverage, you should take into account that a failure to elect COBRA coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

## **LENGTH OF COBRA COVERAGE**

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

When Plan coverage is lost due to the death of the employee, the covered employee's divorce, legal separation, or termination of domestic partnership; or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months. However, COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred. (See the paragraph below entitled "Health FSA Component.")

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan for his spouse/domestic partner and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

## EXTENSION OF MAXIMUM COVERAGE PERIOD

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage.

### ***Disability extension of 18-month period of continuation coverage***

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if you complete and submit a *Notice of Disability* and a copy of the Social Security Administration's determination of disability to the COBRA Administrator within 60 days after the latest of:

- the date of the Social Security Administration's disability determination; and
- the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

In providing this notice, you must use the *Notice of Disability* and you must follow the procedures specified in the section below entitled "Notice Procedures for Notice of Disability." **If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.** (You may obtain a copy of the *Notice of Disability* from the COBRA Administrator.)

### ***Second qualifying event extension of COBRA coverage***

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours.

The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, termination of domestic partnership, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available to the spouse/domestic partner and any dependent children under the Plan when a covered employee becomes entitled to Medicare after electing COBRA coverage.)

This extension due to a second qualifying event is available only if you notify the COBRA Administrator by completing and submitting a *Notice of Second Qualifying Event* within 60 days after the later of the date of the second qualifying event.

In providing this notice, you must use the form entitled *Notice of Second Qualifying Event* and you must follow the procedures specified in the section below entitled "Notice Procedures for Notice of Second Qualifying Event." **If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.** (You may obtain a copy of the *Notice of Second Qualifying Event* from the COBRA Administrator.)

## **TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD**

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA coverage, under another group health plan (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA coverage;
- the employer ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period."

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA coverage, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). You must use the form entitled *Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability*, and you must follow the procedures specified below in the section entitled "Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability." (You may obtain a copy of the *Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability* from the COBRA Administrator.)

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary). The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the COBRA Administrator of Medicare entitlement or other group health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination. You must use the Plan's form entitled *Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability* and you must follow the procedures specified below in the section entitled "Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability." (You may obtain a copy of the *Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability* from the COBRA Administrator.)

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the COBRA Administrator that the disabled qualified beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period.")

### **COST OF COBRA COVERAGE**

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

### **PAYMENT FOR COBRA COVERAGE**

All COBRA premiums must be paid by check or, if applicable, by pension check deduction.

If paying by check, your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to:

**COBRA Administrator  
City of Seattle Personnel Department  
Benefits Unit  
700 5<sup>th</sup> Ave, Suite 5500  
PO Box 34028  
Seattle, WA 98124-4028**

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand delivering a check if your check is returned due to insufficient funds or otherwise.

If you elect COBRA coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) See the section above entitled "Electing COBRA Coverage."

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator using the contact information provided below to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA coverage and made the first payment for it.

**If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.**

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the fifteenth day of the month for the following month's COBRA coverage. If you make a monthly payment on or before this day, your COBRA coverage under the Plan will continue for that month without any break. The COBRA Administrator will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill to you for your COBRA coverage—it is your responsibility to pay your COBRA premiums on time).

Although monthly payments are due on the fifteenth day of the month for the following month of COBRA coverage, you will be given a grace period of 30 days after the fifteenth day of the month to make each monthly payment. For example, the monthly payment for October coverage is due September 15. However, the grace period for payment for October coverage ends October 15. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment.

**If you fail to make a monthly payment before the end of the grace period, you will lose all rights to COBRA coverage under the Plan.**

## **MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES**

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the COBRA Administrator during the covered employee's period of employment with City of Seattle is entitled to the same rights to elect COBRA coverage as an eligible dependent child of the covered employee.

## IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA rights should be addressed to the :

**COBRA Administrator  
City of Seattle Personnel Department  
Benefits Unit  
700 5<sup>th</sup> Ave, Suite 5500  
PO Box 34028  
Seattle, WA 98124-4028  
206-684-7958**

## KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan and COBRA Administrators informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan and COBRA Administrators.

## NOTICE PROCEDURES

### City of Seattle Local 77 Employee Healthcare Plan

#### NOTICE PROCEDURES FOR NOTICE OF QUALIFYING EVENT

The deadline for providing this notice is 60 days after the date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the qualifying event.

You must mail or hand-deliver this notice to your department's Benefits Representative.

Your notice must be in writing (using the Plan's form described below) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand-delivered, your notice must be received by your department's Benefits Representative no later than the deadline described above.

**You must use the Plan's form entitled *Health Care Benefits Change Form* to notify your department's Benefits Representative of a qualifying event (i.e., a divorce or legal separation, termination of domestic partnership, or a child's loss of dependent status), and all of the applicable items on the form must be completed.** (You may obtain a copy of the *Health Care Benefits Change Form* from the COBRA Administrator.)

Your notice must contain the following information:

- the name of the Plan (City of Seattle Local 77 Employee Healthcare Plan);
- the name and address of the employee or former employee who is or was covered under the Plan;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the qualifying event (divorce, legal separation, termination of domestic partnership, or child's loss of dependent status);
- the qualifying event (divorce, legal separation, termination of domestic partnership, or child's loss of dependent status);

- the date that the divorce, legal separation, termination of domestic partnership, or child's loss of dependent status happened; and
- the signature, name, and contact information of the individual sending the notice.

If you are providing notice of a divorce, legal separation, or termination of domestic partnership, your notice must include a copy of the decree of divorce or legal separation, or *Statement of Termination of Marriage/Domestic Partnership*. (You may obtain a *Statement of Termination of Marriage/Domestic Partnership* from your department's Benefits Representative.)

If your coverage is reduced or eliminated and a divorce or legal separation occurs within three months of the reduction or elimination of coverage, and you are notifying the COBRA Administrator that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, you must provide notice within 60 days of the divorce or legal separation in accordance with these Notice Procedures for *Notice of Qualifying Event* and must in addition provide evidence satisfactory to the COBRA Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

If you provide a written notice that does not contain all of the information and documentation required by these Notice Procedures for *Notice of Qualifying Event*, or *Health Care Benefits Change Form* such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- the notice is mailed or hand-delivered to the individual and address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, the COBRA Administrator is able to determine that the notice relates to the Plan;
- from the written notice provided, the COBRA Administrator is able to identify the covered employee and qualified beneficiary(ies), the qualifying event (the divorce, legal separation, termination of domestic partnership, or child's loss of dependent status), and the date on which the qualifying event occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for *Notice of Qualifying Event*) within 15 business days after a written or oral request from the COBRA Administrator for more information (or, if later, by the deadline for the *Notice of Qualifying Event* described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA coverage will not be offered. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

If your notice was regarding a child's loss of dependent status, you must, if the COBRA Administrator requests it, provide documentation of the date of the qualifying event that is satisfactory to the COBRA Administrator (for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married,

or a transcript showing the last date of enrollment in an educational institution). This will allow the Plan Administrator to determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the COBRA Administrator that the child ceased to be a dependent on the date specified in your *Notice of Qualifying Event*, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have started. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

#### **NOTICE PROCEDURES FOR NOTICE OF DISABILITY**

The deadline for providing this notice is 60 days after the latest of (1) the date of the Social Security Administration's disability determination; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours. Your *Notice of Disability* must also be provided within 18 months after the covered employee's termination of employment or reduction of hours.

You must mail or hand-deliver this notice to:

**COBRA Administrator  
City of Seattle Personnel Department  
Benefits Unit  
700 5<sup>th</sup> Ave, Suite 5500  
PO Box 34028  
Seattle, WA 98124-4028**

**Your notice must be in writing (using the Plan's form described below) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline described above.**

**You must use the Plan's form entitled *Notice of Disability* to notify the Plan Administrator of a qualified beneficiary's disability, and all of the applicable items on the form must be completed.** (You may obtain a copy of the *Notice of Disability* from the COBRA Administrator.)

Your notice must contain the following information:

- the name of the Plan (City of Seattle Local 77 Employee Healthcare Plan);
- the name and address of the employee or former employee who is or was covered under the Plan;
- the initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction of hours);
- the date that the covered employee's termination of employment or reduction of hours happened;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;
- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary became disabled;

- the date that the Social Security Administration made its determination of disability;
- a statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name, and contact information of the individual sending the notice.

Your *Notice of Disability* must include a copy of the Social Security Administration's determination of disability.

If you provide a written notice to the COBRA Administrator that does not contain all of the information and documentation required by these Notice Procedures for *Notice of Disability*, such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- the notice is mailed or hand-delivered to the individual and address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, the COBRA Administrator is able to determine that the notice relates to the Plan and a qualified beneficiary's disability;
- from the written notice provided, the COBRA Administrator is able to identify the covered employee and qualified beneficiary(ies) and the date on which the covered employee's termination of employment or reduction of hours occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for *Notice of Disability*) within 15 business days after a written or oral request from the COBRA Administrator for more information (or, if later, by the deadline for the *Notice of Disability* described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the covered employee's termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the disability reported in the notice.

#### **NOTICE PROCEDURES FOR NOTICE OF SECOND QUALIFYING EVENT**

The deadline for providing this notice is 60 days after the date of the second qualifying event (i.e., a divorce or legal separation, termination of domestic partnership, the covered employee's death, or a child's loss of dependent status).

You must mail or hand-deliver this notice to the COBRA Administrator at:

**COBRA Administrator  
City of Seattle Personnel Department  
Benefits Unit  
700 5<sup>th</sup> Ave, Suite 5500  
PO Box 34028  
Seattle, WA 98124-4028**

**Your notice must be in writing (using the Plan's form described below) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline described above.**

**You must use the Plan's form entitled *Notice of Second Qualifying Event* to notify the COBRA Administrator of a second qualifying event (i.e., a divorce or legal separation, termination of domestic partnership, the covered employee's death, or a child's loss of dependent status), and all of the applicable items on the form must be completed. (You may obtain a copy of the *Notice of Second Qualifying Event* from the COBRA Administrator).**

Your notice must contain the following information:

- the name of the Plan (City of Seattle Local 77 Employee Healthcare Plan);
- the name and address of the employee or former employee who is or was covered under the Plan;
- the initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction of hours);
- the date that the covered employee's termination of employment or reduction of hours happened;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;
- the second qualifying event (a divorce, legal separation, termination of domestic partnership, the covered employee's death, or a child's loss of dependent status);
- the date that the divorce, legal separation, termination of domestic partnership, the covered employee's death, or a child's loss of dependent status happened; and
- the signature, name, and contact information of the individual sending the notice.

If you are notifying the COBRA Administrator of a divorce or legal separation or termination of domestic partnership, your notice must include a copy of the decree of divorce or legal separation, or Statement of Termination of Marriage/Domestic Partnership. (You may obtain a copy of the Statement of Termination of Marriage/Domestic Partnership from the COBRA Administrator.)

If you provide a written notice to the COBRA Administrator that does not contain all of the information and documentation required by these Notice Procedures for *Notice of Second Qualifying Event*, such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- the notice is mailed or hand-delivered to the individual and address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, the COBRA Administrator is able to determine that the notice relates to the Plan;
- from the written notice provided, the COBRA Administrator is able to identify the covered employee and qualified beneficiary(ies), the first qualifying event (the covered employee's termination of employment or reduction of hours), the date on which the first qualifying event occurred, the second qualifying event, and the date on which the second qualifying event occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for *Notice of Second Qualifying Event*) within 15 business days after a written or oral request from the COBRA Administrator for more information (or, if later, by the deadline for this *Notice of Second Qualifying Event* described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the covered employee's termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the second qualifying event reported in the notice.

If your notice was regarding a child's loss of dependent status, you must, if the COBRA Administrator requests it, provide documentation of the date of the qualifying event that is satisfactory to the COBRA Administrator (for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution). This will allow the COBRA Administrator to determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the COBRA Administrator that the child ceased to be a dependent on the date specified in your Notice of Second Qualifying Event, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to loss of dependent status. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

If your notice was regarding the death of the covered employee, you must, if the COBRA Administrator requests it, provide documentation of the date of death that is satisfactory to the COBRA Administrator (for example, a death certificate or published obituary). This will allow the COBRA Administrator to determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA coverage. If you do not provide

satisfactory evidence within 15 business days after a written or oral request from the COBRA Administrator that the date of death was the date specified in your *Notice of Second Qualifying Event*, the COBRA coverage of all qualified beneficiaries receiving an extension of COBRA coverage as a result of the covered employee's death may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to the covered employee's death. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

#### **NOTICE PROCEDURES FOR NOTICE OF OTHER COVERAGE, MEDICARE ENTITLEMENT, OR CESSATION OF DISABILITY**

If you are providing a *Notice of Other Coverage* (a notice that a qualified beneficiary has become covered, after electing COBRA coverage, under other group health plan coverage), the deadline for this notice is 30 days after the other coverage becomes effective or, if later, 30 days after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary.

If you are providing a *Notice of Medicare Entitlement* (a notice that a qualified beneficiary has become entitled, after electing COBRA, to Medicare Part A, Part B, or both), the deadline for this notice is 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).

If you are providing a *Notice of Cessation of Disability* (a notice that a disabled qualified beneficiary whose disability resulted in an extended COBRA coverage period is determined by the Social Security Administration to be no longer disabled), the deadline for this notice is 30 days after the date of the Social Security Administration's determination.

You must mail or hand-deliver this notice to the COBRA Administrator at:

**COBRA Administrator  
City of Seattle Personnel Department  
Benefits Unit  
700 5<sup>th</sup> Ave, Suite 5500  
PO Box 34028  
Seattle, WA 98124-4028**

Your notice must be provided no later than the deadline described above.

**You should use the Plan's form entitled *Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability* to notify the COBRA Administrator of any of these events, and all of the applicable items on the form should be completed.** (You may obtain a copy of the *Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability* from the COBRA Administrator.)

Your notice should contain the following information:

- the name of the Plan (City of Seattle Local 77 Employee Healthcare Plan);
- the name and address of the employee or former employee who is or was covered under the Plan;
- the name(s) and address(es) of all qualified beneficiary(ies);
- the qualifying event that started your COBRA coverage;
- the date that the qualifying event happened; and
- the signature, name, and contact information of the individual sending the notice.

If you are providing a *Notice of Other Coverage*, your notice should include the name and address of the qualified beneficiary who obtained other coverage, the date that the other coverage became effective (and, if there were any preexisting condition exclusions applicable to the qualified beneficiary, the date that these were exhausted or satisfied), and evidence of the effective date of the other coverage (such as a copy of the insurance card or application for coverage).

If you are providing a *Notice of Medicare Entitlement*, your notice should include the name and address of the qualified beneficiary who became entitled to Medicare, the date that Medicare entitlement occurred, and a copy of the Medicare card showing the date of Medicare entitlement.

If you are providing a *Notice of Cessation of Disability*, your notice must include the name and address of the disabled qualified beneficiary, the date of the Social Security Administration's determination that he or she is no longer disabled, and a copy of the Social Security Administration's determination.

The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the other coverage, Medicare entitlement, or cessation of disability reported in the notice.

If a qualified beneficiary first becomes covered by other group health plan coverage after electing COBRA, that qualified beneficiary's COBRA coverage will terminate (retroactively if applicable) as described above in the section entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period," regardless of whether or when a *Notice of Other Coverage* is provided.

If a qualified beneficiary first becomes entitled to Medicare Part A, Part B, or both after electing COBRA, that qualified beneficiary's COBRA coverage will terminate (retroactively if applicable) as described above in the section entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period," regardless of whether or when a *Notice of Medicare Entitlement* is provided.

If a disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled, COBRA coverage for all qualified beneficiaries whose COBRA coverage is extended due to the disability will terminate (retroactively if applicable) as described above in the section entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period," regardless of whether or when a *Notice of Cessation of Disability* is provided.

# PLAN PAYMENT PROVISIONS

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## DEDUCTIBLES

### Individual

The deductible is the amount of eligible medical expenses each calendar year that an employee or dependent must incur before any benefits are payable by the Plan. The individual deductible amount is listed in the Schedule of Benefits.

### Family

When the deductible amounts accumulated by all covered members of the family reach the family deductible shown in the Schedule of Benefits during one calendar year, no further deductibles will apply to any family member for the rest of that calendar year. **However, no single family member will be required to satisfy more than the individual deductible in a calendar year.**

### Family Accident

If two or more family members are injured in the same accident, only one deductible will be required during that calendar year as a result of the accident. This deductible waiver applies only to medical bills incurred as a result of the accident; for services not related to the accident, the regular deductible amount would apply.

## DEDUCTIBLE CARRYOVER

Although a new medical deductible will apply each calendar year, expenses incurred during October, November and December which are applied against that year's deductible will also be applied toward the deductible for the next year and thus reduce or eliminate the next year's deductible. Any amounts that satisfy an individual deductible will count toward satisfying the family deductible.

## AMOUNTS NOT CREDITED TOWARD THE DEDUCTIBLE

The following expenses will not be considered in satisfying the deductible requirement:

- Expenses for services or supplies not covered by this Plan.
- Charges in excess of the usual, customary and reasonable (UCR) charges.
- Employee's share of expenses partially covered, including but not limited to prescription drug expenses (copays).
- Expenses incurred for non-compliance with Plan pre-authorization requirements.

## **COINSURANCE PERCENTAGE**

The coinsurance is the percentage that the Plan will pay of the negotiated rate for preferred providers and participating providers. Once the deductible is satisfied, the Plan shall pay benefits for covered expenses incurred during the remainder of the calendar year at the applicable coinsurance as specified in the Schedule of Benefits. The participant's portion of the coinsurance represents their out-of-pocket expense. The participant is responsible for paying the remaining percentage until the out-of-pocket maximum is satisfied.

If you live inside the area serviced by the preferred provider organization, only those charges from a preferred (PPO) or participating (PAR) provider will be eligible for reimbursement. Charges from a non-PPO or non-PAR provider are not eligible for reimbursement, and are the responsibility of the participant.

## **COPAY**

This is the amount paid by you each time a prescription is filled.

## **EXTENDED HOSPITALIZATION**

If the participant is confined in a hospital or skilled nursing facility at the close of a year for which the deductible or maximum out-of-pocket expense limit has been satisfied and the confinement continues without interruption into the next year, the deductible or maximum out-of-pocket expense limit for the second year will not apply until the participant is discharged.

## **OUT-OF-POCKET MAXIMUM**

The amount of the coinsurance which is your responsibility is applied toward your out-of-pocket maximum. When you (or your family's) out-of-pocket total reaches the out-of-pocket maximum shown in the Schedule of Benefits during one calendar year, the Plan will pay 100% of allowable charges of the participant's incurred eligible medical expenses for the remainder of that calendar year.

Some benefits will remain at a constant coinsurance level, not applying toward the out-of-pocket maximum, and not payable at 100% when the out-of-pocket maximum is reached. These benefits are identified in the Schedule of Benefits.

The following expenses are not applied to the out-of-pocket:

- Deductibles.
- Prescription drug card expenses (copays).
- Expenses not covered under this Plan.
- Outpatient Mental Health expenses
- Neurodevelopmental therapy expenses.
- Outpatient Rehabilitation expenses.
- Expenses incurred as a result of failure to meet Plan pre-authorization requirements.

## **MAJOR MEDICAL LIFETIME MAXIMUM BENEFIT**

The Major Medical Lifetime Maximum Benefit per participant covered under this Plan is \$1,000,000.

## **REINSTATEMENT OF LIFETIME MAXIMUM**

The total benefits provided under this Plan for any participant for all illnesses, accidental injuries, and physical disabilities combined during the patient's lifetime shall not exceed a cumulative maximum cost of \$1,000,000; provided however, that on January 1 of each calendar year the cost of benefits received by the patient under this Plan and charges against the patient's lifetime maximum shall automatically be forgiven up to the amount of \$20,000.

# COMPREHENSIVE MAJOR MEDICAL BENEFITS

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## ELIGIBLE EXPENSES

When medically necessary for the diagnosis or treatment of an illness or an accident, the following services are eligible expenses for participants covered under this Plan. Eligible expenses are payable as shown in the Schedule of Benefits and are limited by certain provisions listed in the General Exclusions. Major Medical expenses are subject to all Plan conditions, exclusions and limitations. Visits used to satisfy the deductible count toward the benefit limits.

## ACUPUNCTURE

Acupuncture services when performed by a provider acting within the scope of their license are eligible for coverage by the Plan and are paid as shown in the Schedule of Benefits.

## ALLERGY INJECTIONS/TESTING

Eligible charges for the injections, testing, syringes and medication will be payable as shown in the Schedule of Benefits.

## AMBULANCE (AIR AND GROUND)

Services of a licensed ambulance company for transportation to the nearest medical facility where the required service is available, if other transportation would endanger the patient's health and the purpose of the transportation is not for personal or convenience reasons. *Any non-emergency use of an ambulance requires pre-authorization.*

## BIOFEEDBACK

Biofeedback therapy is an electronic method which allows the patient to monitor the functioning of the body's autonomic systems (e.g. body temperature, heart rate, etc.) and is payable under this Plan.

## BLOOD BANK

Eligible charges made by a blood bank for processing of blood and its derivatives, cross-matching, and other blood bank services; charges made for whole blood, blood components, and blood derivatives to the extent not replaced by volunteer donors. Storage of any blood and its derivatives are **not** covered under the Plan.

## **CHEMICAL DEPENDENCY**

Benefits will be provided for services of a physician and/or an approved chemical dependency treatment facility for medically necessary inpatient and outpatient treatment of chemical dependency, including detoxification and supportive services. Chemical dependency is defined as physical and/or emotional dependence on drugs, narcotics, alcohol, or other addictive substances to a debilitating degree. Eligible expenses for treatment of chemical dependency shall be paid according to the limitations shown in the Schedule of Benefits.

Treatment for chemical dependency includes:

- Medical and psychiatric evaluations.
- Inpatient room and board (including detoxification).
- Psychotherapy (individual and group), counseling (individual and group), behavior therapy for the covered participants.
- Prescription drugs prescribed by and administered while in an approved treatment facility.
- Supplies prescribed by an approved treatment facility, except for personal items.

Chemical dependency treatment does not include:

- Personal items.
- Items or treatment not necessary to the care or recovery of the patient.
- Custodial care.
- Education or training.
- Wilderness or outdoor treatment programs.
- Family counseling.

### **Inpatient Treatment**

When inpatient chemical dependency treatment is recommended, the participant must first contact the Plan Supervisor's Medical Management Department to pre-authorize the admission. In addition to pre-authorization the following is required:

- Treatment must be ordered in writing by a physician or certified by the Plan Supervisor's Medical Management Department, for the entire length of time the participant is confined.
- Under extenuating circumstances, such as emergency inpatient chemical dependency treatment, you must obtain authorization within 48 hours of admission, or by the next business day, by the Plan Supervisor's Medical Management Department. Written explanation of the extenuating circumstances should be submitted to support the need for the emergency admission.

## **Outpatient Treatment**

If treatment is provided on an outpatient basis, then treatment must be provided by a physician as defined under this Plan.

No benefits will be provided for information and referral services, information schools, Alcoholics Anonymous and similar chemical dependency programs, long-term care or custodial care and tobacco cessation programs.

## **CHIROPRACTIC CARE**

Covered chiropractic services include spinal manipulation, adjunctive therapy, vertebral alignment, subluxation, spinal column adjustments and other chiropractic treatment of the spinal column, neck, extremities or other joints, provided for as defined under the definition of physician. Examinations and x-rays in connection with chiropractic care are subject to the chiropractic limit shown in the Schedule of Benefits.

## **CONTRACEPTIVE DEVICES AND INJECTIONS**

Contraceptive devices and injections, including fittings and insertion, provided or prescribed by a physician, are covered at the coinsurance level shown in the Schedule of Benefits. Over-the-counter devices are not covered.

## **DENTAL SERVICES**

Dental services provided by a dentist, oral surgeon, or physician, including all related medical facility inpatient or outpatient charges, for only the following:

- Treatment for accidental injuries to natural teeth provided that the injury occurred while covered under this Plan. Treatment for up to 12 months from the date of the accident for accidental injuries is provided under this Plan, provided treatment begins within 30 days of the accident. Injuries caused by biting or chewing are not covered under the medical plan. Services are payable as shown in the Schedule of Benefits, will be based on the allowed amount and any additional charges will be the participant's responsibility.
- Benefits for outpatient hospitalization and anesthesia for dental services are covered the same as relevant services listed on your Schedule of Benefits. Services must be prior authorized by the Plan and are only provided for members with complicating medical conditions. Examples of these conditions include, but are not limited to:
  - mental handicaps.
  - physical disabilities.
  - a combination of medical conditions or disabilities that cannot be managed safely and efficiently in a dental office.
  - emotionally unstable, uncooperative, combative patients where treatment is extensive and impossible to accomplish in the office.
  - **All other dental services are excluded.**

## **DIABETIC/DIETARY EDUCATION**

Dietary/Diabetic education is a covered benefit, if provided by a physician as defined under this Plan. Benefit will be provided for diabetic self-management training and education, including nutritional therapy. The Plan Supervisor will be the final authority on which education programs will meet the criteria of eligibility.

## **DIAGNOSTIC X-RAY AND LABORATORY**

Benefits will be provided for medical services, administration and interpretation of diagnostic X-ray, pathology, and laboratory tests. Dental x-rays are excluded.

## **DURABLE MEDICAL EQUIPMENT**

Benefits are provided for rental or purchase (if more economical in the judgment of the Plan Supervisor's Medical Management Department) of medically necessary durable medical equipment. Durable medical equipment is equipment able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally used in the absence of illness or injury. The durable medical equipment must be prescribed by a physician for therapeutic use, and include the length of time needed, the cost of rental and cost of purchase prior to any benefits being paid. Examples of durable medical equipment include: crutches; wheelchairs; kidney dialysis equipment; hospital beds; traction equipment; and equipment for administration of oxygen. Repairs or replacement of eligible equipment shall be covered when necessary to meet the medical needs of the covered patient. Durable medical equipment ordered while the person is covered under this Plan and delivered within 30 days after termination of coverage will be provided. Repairs or replacement of eligible equipment shall be covered when necessary to meet the medical needs of the covered patient.

Benefits are **not** provided for certain equipment including, but not limited to, air conditioners, humidifiers, over-the-counter arch supports, corrective shoes, hearing aids, keyboard communication devices, adjustable beds, orthopedic chairs, personal hygiene items, purifiers, heating pads, enuresis (bed-wetting) training equipment, exercise equipment, whirlpool baths, weights, or hot tubs. The fact that an item may serve a useful medical purpose will not ensure that benefits will be provided.

## **EMERGENCY ROOM & SERVICES**

Benefits will be provided for emergency room treatment of an accidental injury or a medical emergency. Benefits are paid at the level shown in the Schedule of Benefits. If you are traveling or receive emergency services inside or outside the network area, eligible emergency room and services will be reimbursed at the preferred network benefit level.

## **HOME HEALTH CARE**

Services for Home Health Care must be ordered by a physician, include a treatment plan, and be pre-authorized by the Medical Management Department prior to services being rendered.

Charges made by a home health care agency (approved by Medicare or state certified) for the following services and supplies furnished to a participant in their home for care in accordance with a home health care treatment plan are included as covered medical expenses. Charges for home health care services described below will be applied to the home health care benefit and

subject to the home health care maximum as shown in the Schedule of Benefits. This benefit is not intended to provide custodial care but is provided for care in lieu of inpatient hospital, medical facility or skilled nursing facility care for patients who are homebound.

The following services will be considered eligible expenses:

- Part-time or intermittent nursing care by a registered nurse, a licensed vocational nurse or by a licensed practical nurse.
- Physical therapy by a licensed, registered or certified physical therapist.
- Speech therapy services by a licensed, registered or certified speech therapist.
- Occupational therapy services by a registered, certified or licensed occupational therapist.
- Nutritional guidance by a registered dietitian.
- Nutritional supplements such as diet substitutes administered intravenously or by enteral feeding.
- Respiratory therapy services by a certified inhalation therapist.
- Home health aide services by an aide who is providing intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist or speech therapist. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, completing appropriate records, and personal care or household services that are needed to achieve the medically desired results.
- Medical supplies, drugs and medicines prescribed by a physician, and laboratory services normally used by a patient in a skilled nursing facility, medical facility or hospital, but only to the extent that they would have been covered under this Plan if the participant had remained in the hospital or medical facility.
- Medical social services by a person with a master's degree in social work.

#### **Limitations to Home Health Care**

- Home Health Care benefits shall be limited to a maximum of 130 visits per alendar year.
- Any expenses for home health services that qualify both under this benefit and under any other benefit of this Plan will be covered only under the benefit the Plan Supervisor determines to be the most appropriate.
- If the participant exhausts the benefit, the participant may apply to the Plan Supervisor for an extension of benefits. Limited extensions will be granted by the Plan Supervisor if it determines the treatment to be Medically Necessary.

#### **Exclusions to Home Health Care**

- Non-medical or custodial services except as specifically included as an eligible expense.
- Meals on Wheels or similar home delivered food services.
- Services performed by a member of the patient's family or household.

- Services not included in the approved treatment plan.
- Supportive environmental materials such as handrails, ramps, telephones, air conditioners or similar appliances or devices.
- Homemaker or housekeeping services, except as specified under the home health aide benefits of this section.
- Hourly care services

## **HOME PHOTOTHERAPY**

Services and supplies provided for newborn hyper-billi-rubinemia (newborn jaundice) are eligible for payment under this Plan.

## **HOSPICE CARE**

Services for Hospice Care must be ordered by a physician, include a treatment plan, and be pre-authorized by the Plan Supervisor's Medical Management Department prior to services being rendered.

If a participant is terminally ill, the services of an approved hospice will be covered for medically necessary treatment or palliative care (medical relief of pain and other symptoms) for the terminally ill participant, subject to the conditions and limitations specified below. Services and supplies furnished by a licensed hospice (Medicare approved or state certified) for necessary treatment of the participant will be eligible for payment as shown in the Schedule of Benefits. The following services will be considered eligible expenses:

- Confinement in a hospice facility or at home.
- Ancillary charges furnished by the hospice while the participant is confined.
- Medical supplies and drugs prescribed by the attending physician, but only to the extent such items are necessary for pain control and management of the terminal condition.
- Physician services and/or nursing care by a registered nurse, licensed practical nurse, master in social work, or a licensed vocational nurse.
- Home health aide services and home health care.
- Nutritional advice by a registered dietitian, nutritional supplements, such as diet substitutes, administered intravenously or through hyperalimentation, subject to the Infusion Therapy benefit.
- Physical therapy, speech therapy, occupational therapy, respiratory therapy.
- Respite care up to a maximum of 120 hours in each three-month period of hospice care, to relieve anyone who lives with and cares for the terminally ill enrollee. The first three-month respite care period begins on the first day of covered hospice care.

With respect to hospice care, a treatment plan must include:

- A description of the medically necessary care to be provided to a terminally ill patient for palliative care or medically necessary treatment of an illness or injury but not for curative care.
- A provision that care will be reviewed and approved by the physician at least every 60 days.
- A prognosis of six months or less to live.

### **Limitations to Hospice Care**

- Hospice benefits shall be limited to a maximum of six months.
- Visits of four or more hours in which skilled care is required by a registered nurse, licensed practical nurse, or home health aide will be limited to a combined total of 120 hours.
- Respite care of four or more hours per day in which no skilled care is required will be limited to a combined total of 120 hours per three-month period.
- Any expenses for hospice care that qualify both under this benefit and under any other benefit of this Plan will be covered only under the benefit the Plan Supervisor determines to be the most appropriate.
- If the participant exhausts the above benefit limits, the participant may apply to the Plan Supervisor for an extension of benefits. Limited extensions will be granted by the Plan Supervisor if it determines the treatment to be Medically Necessary.
- When the participant is confined as an inpatient in an approved hospice that is not a Hospital or skilled nursing facility, the same benefits that are available in the participant's home will be available to the participant as an inpatient. In addition, a semi-private room allowance will be provided. This inpatient hospice benefit will be limited to a maximum of 14 (fourteen) days during the six-month benefit period. For services in a Hospital or skilled nursing facility, see the sections that describe those benefits.

### **Exclusions to Hospice Care**

- Non-medical or custodial services except as specifically included as an eligible expense.
- Meals on Wheels or similar home delivered food services.
- Services performed by a member of the patient's family or household.
- Services not included in the approved treatment plan.
- Supportive environmental materials such as handrails, ramps, telephones, air conditioners or similar appliances or devices.
- Hospice bereavement services.
- Homemaker or housekeeping services, except as specified under the home health aide benefit of this section.

## **INFUSION THERAPY BENEFIT**

Inpatient and outpatient services and supplies for infusion therapy are provided at the coinsurance level shown in the Schedule of Benefits. The attending physician must submit, and periodically review, a written treatment plan that specifically describes the infusion therapy services and supplies to be provided. The treatment plan must be approved in advance by the Plan Supervisor's Medical Management Department. Drugs and supplies used in conjunction with infusion therapy will be provided only under this benefit. Growth hormone treatment for growth hormone deficiency in children, Turner's syndrome, growth failure in children secondary to chronic renal insufficiency, prior to renal transplant, or for the promotion of wound healing in a participant with severe, acute burns is covered when authorized by the Plan Supervisor in advance.

## **MAMMOGRAPHY BENEFIT**

Preventive routine screening mammograms are covered by the Plan. Services are payable as shown in the Schedule of Benefits. Mammograms, other than routine screening mammograms, are covered when medically necessary if prescribed by your physician.

## **MATERNITY SERVICES**

Benefits for maternity care and services are available to a covered employee or spouse/domestic partner. Pregnancy and complications of pregnancy will be covered as any other medical condition. Medical facility, surgical and medical benefits are available on an inpatient or outpatient basis for the following maternity services:

- Normal delivery.
- Cesarean delivery.
- Routine prenatal and postnatal care.
- Prenatal diagnosis of congenital disorders of the fetus.
- Treatment for complications of pregnancy.
- Voluntary termination of pregnancy.

## **Newborns' and Mothers' Health Protection Act**

The Plan will at all times comply with the terms of the Newborns' and Mothers' Health Protection Act of 1996. The Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or to less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay for the mother or newborn child not in excess of the above periods.

## **MEDICAL FACILITY SERVICES**

### **Inpatient Care**

The following benefits will be provided for inpatient care in an accredited hospital or medical facility when the patient is under the care of a physician:

- Room and board in a semi-private room.
- Intensive care, cardiac care, isolation or other special care unit.
- Private room accommodations, if medically necessary.
- Nursing care services (private duty nursing is not covered).
- Prescribed drugs and medications administered in the hospital or the medical facility.
- Anesthesia and its administration.
- Oxygen and its administration.
- Dressings, supplies, casts and splints.
- Diagnostic services, including but not limited to x-ray, laboratory and radiological services.
- The use of durable medical equipment.

### **Outpatient Care**

Benefits will be provided for minor surgery, including x-ray, laboratory and radiological services, and for emergency room treatment of an accidental injury or a medical emergency.

### **Miscellaneous**

All other charges made by a hospital or the medical facility during an inpatient confinement are eligible, exclusive of: personal items; services not necessary for the treatment of an illness or injury; or services specifically excluded by the plan.

## **MEDICAL SUPPLIES**

When prescribed by a physician, and medically necessary, the following medical supplies are covered; including but not limited to: braces; surgical and orthopedic appliances; colostomy bags and supplies required for their use; catheters; syringes and needles necessary for diabetes or allergic conditions; dressings for surgical wounds, cancer, burns, or diabetic ulcers; oxygen; back brace; and cervical collars. An item ordered while the participant is covered under this Plan and delivered within 30 days after termination of coverage will be provided. Repair or replacement of a Medically Necessary item due to normal use or growth of a child will be provided.

## **MENTAL HEALTH TREATMENT**

Benefits will be provided for mental health care when treatment is rendered by a physician as defined herein. Mental health is defined as and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions and psychiatric conditions. This includes but is not limited to the following conditions: psychoses, neurotic disorders, schizophrenic disorders, affective disorders, attention deficit disorders, personality disorders and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

### **Inpatient Treatment**

When inpatient mental health disorder treatment is recommended, the patient must first contact the Plan Supervisor's Medical Management Department to pre-authorize admission. In addition to pre-authorization the following is required:

- Treatment must be ordered in writing by a physician or certified by the Plan Supervisor's Medical Management Department, for the entire length of time the patient is confined.
- Under extenuating circumstances, such as emergency inpatient mental disorder treatment, you must obtain authorization within 48 hours of admission, or by the next business day, by the Plan Supervisor's Medical Management Department.
- The patient must complete the approved course of treatment in a hospital or medical facility as defined by the Plan.

### **Outpatient Treatment**

If treatment is provided on an outpatient basis, then treatment must be provided by a physician as defined under this Plan.

Mental Health treatment does not include:

- Personal items.
- Items or treatment not necessary to the care or recovery of the patient.
- Custodial care.
- Education or training.
- Residential treatment facility.
- Wilderness or outdoor treatment programs.
- Marriage and family counseling.

## **NEURODEVELOPMENTAL THERAPY SERVICES**

Benefits will be provided for medically necessary neurodevelopmental therapy treatment to restore and improve bodily function for children to age seven. This benefit includes maintenance services where significant deterioration of the patient's condition would result without the service. Neurodevelopmental therapy means therapy designed to treat structural or functional abnormalities of the central or peripheral nervous system. Its purpose is to restore, maintain or develop age appropriate functions in a child.

Such therapy includes occupational therapy, physical therapy and speech therapy. The services of a physician, physical therapist, speech therapist, or occupational therapist will be provided in the office, medical facility, hospital outpatient department. Inpatient hospital, medical facility or skilled nursing facility expenses will be eligible when care cannot be safely provided on an outpatient basis.

Benefits are payable at the coinsurance level indicated in the Schedule of Benefits. Benefits for rehabilitative services or other treatment programs will not be available for the same condition.

## **NEWBORN NURSERY CARE BENEFIT**

Medical facility charges incurred by a well newborn during the initial period of confinement will be covered as charges of the baby. In addition, a circumcision performed in an outpatient setting within 31 days of the birth of the baby will be covered under this benefit.

- Medical facility nursery expenses for a healthy newborn, including circumcision.
- Routine pediatric care for a healthy newborn child while confined in a hospital or medical facility immediately following birth.
- Phenylketonuria (PKU) testing within the first seven days of life.

If the baby is ill, suffers an injury, premature birth, congenital abnormality or requires care other than routine care, benefits will be provided on the same basis as for any other eligible expense provided coverage is in effect.

Charges for preventive care (routine immunizations and examinations) will be considered eligible expenses only to the extent specifically shown in the Schedule of Benefits.

## **ORTHOTICS**

Benefits are payable, at the coinsurance level indicated in the Schedule of Benefits. Expenses for orthotic appliances include, but are not limited to, foot supports, supplies, devices and corrective shoes.

## **OUTPATIENT SURGICAL FACILITY**

An outpatient surgical facility refers to a lawfully operated facility that is established, equipped and operated to perform surgical procedures. Services rendered by an outpatient surgical facility are covered when performed in connection with a covered surgery.

## **PHENYLKETONURIA (PKU) DIETARY FORMULA**

Dietary formula which is medically necessary for the treatment of phenylketonuria.

## **PHYSICIAN SERVICES**

Physician's fees for medical and surgical services are covered.

## **PRE-ADMISSION TESTING**

Charges for laboratory and x-ray examinations to determine if the participant is suitable for surgery prior to admission.

## **PRESCRIPTION DRUGS**

Inpatient drugs are covered when administered to an individual for the treatment of a covered illness or accident, while confined. Inpatient prescription drugs will be paid as shown in the Schedule of Benefits and are subject to the deductible.

Outpatient prescription drugs are reimbursable through your prescription drug card plan.

## **PREVENTIVE CARE**

This benefit covers routine physician services and related diagnostic tests that are regularly performed without the presence of symptoms. Services are payable as shown in the Schedule of Benefits.

Eye exams and hearing exams are not covered under this benefit.

## **PROSTHETIC APPLIANCES**

Benefits are provided for artificial limbs and eyes. Benefits will also be payable for an external and the first permanent internal breast prosthesis following a mastectomy. External breast prostheses are limited to one replacement every three calendar years. A prosthesis ordered before your effective date of coverage will not be covered. A prosthesis ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be covered. Repair or replacement of prostheses due to normal use or growth of a child will be covered. Benefits are not provided for cosmetic prostheses except as stated in the Women's Health and Cancer Rights Act.

## **RADIATION THERAPY AND CHEMOTHERAPY**

X-ray, radium, radioactive isotope therapy, and chemotherapy are covered expenses under this Plan.

## REHABILITATION BENEFIT

The Plan covers charges for you on an inpatient or outpatient basis in a rehabilitation center or skilled nursing facility. Services for inpatient rehabilitation must be ordered by a physician, include a treatment plan and be pre-authorized by the Plan Supervisor's Medical Management Department. All services specified below will be provided if continued measurable progress is demonstrated at regular intervals.

Rehabilitative services are provided when medically necessary to restore and improve bodily function previously normal, but lost due to illness or injury, including function lost as a result of congenital anomalies.

Occupational, physical, respiratory, speech therapy, pulmonary rehabilitation and cardiac rehabilitation in the office, medical facility or hospital will be paid under the rehabilitation benefit as shown in the Schedule of Benefits.

**Cardiac Rehabilitation Therapy** - Benefits for an approved hospital-based cardiac rehabilitation program will be provided, when necessary to restore a bodily function lost or impeded due to illness or injury and such services are recommended by provider.

**Occupational Therapy** - Charges of a registered, certified or licensed occupational therapist are covered when necessary to restore a bodily function lost or impeded due to illness or injury.

**Physical Therapy** - Charges of a registered, certified or licensed physical therapist and massage therapist will be covered when necessary to restore a bodily function lost or impeded due to illness or injury.

**Pulmonary Rehabilitation Therapy** - Benefits for an approved hospital-based pulmonary rehabilitation program will be provided, when necessary to restore a bodily function lost or impeded due to illness or injury and such services are recommended by provider.

**Respiratory Therapy** - Charges of a registered, certified or licensed respiratory therapist are covered when necessary to restore a bodily function lost or impeded due to illness or injury.

**Speech Therapy** - Charges are covered when prescribed by a Physician and when necessary to restore a bodily function lost or impeded due to illness or injury. Excluded are speech therapy services that are educational in nature or due to: tongue thrust; stuttering; lisping; abnormal speech development; changing an accent; dyslexia; and hearing loss which is not medically documented.

### Inpatient Treatment

The eligible expenses for inpatient rehabilitation are payable as shown in the Schedule of Benefits for the following services and supplies furnished while the patient requires 24-hour care and is under continuous care of the attending physician.

- Room, board and other services and supplies furnished by the facility for necessary care (other than personal items and professional services).
- Use of special treatment rooms.
- X-ray and laboratory examinations.
- Cardiac rehabilitation, occupational, physical, pulmonary rehabilitation, respiratory, and speech therapy.

- Oxygen and other gas therapy.

No benefits will be provided for custodial care; maintenance, non-medical self-help, recreational, educational or vocational therapy; psychiatric care; learning disabilities or developmental delay, except as provided in the schedule of benefits for Neurodevelopmental Therapy benefits; chemical dependency rehabilitative treatment; gym or swim therapy.

## **SECOND SURGICAL OPINION**

A second surgical opinion is not normally required but may be requested by the patient, the Plan Supervisor's Medical Management Department. This benefit is paid as shown in the Schedule of Benefits.

**Please note that all non-emergency surgery other than surgery done in the doctor's own office must be pre-authorized by the Plan Supervisor's Medical Management Department to avoid a substantial penalty.** When requested, the Plan will pay the usual, customary and reasonably accepted fee for a second surgical opinion, and for a third and final opinion in case of conflict between the first two opinions.

**Second or Third Opinion:** Must be an opinion of an independent second or third surgeon acting on a consulting basis. A surgeon in association or practice with a prior surgical consultant will not be accepted.

## **SKILLED NURSING FACILITY CARE**

Services for Skilled Nursing Facility Care must be ordered by a physician, include a treatment plan, and must be pre-authorized by the Medical Management Department prior to services being rendered.

This Plan will pay benefits for confinement in a Skilled Nursing Facility, as specified in the Schedule of Benefits, provided such confinement is not for Custodial Care.

Charges for medically necessary services and supplies furnished by a licensed Skilled Nursing Facility will be applied to the Skilled Nursing Facility benefit and subject to the Skilled Nursing Facility maximum as shown in the schedule of benefits.

## **STERILIZATION - ELECTIVE**

The Plan pays for elective sterilization procedures such as tubal ligations and vasectomies. These procedures shall be paid under the Major Medical benefits for covered employees, spouses and domestic partners.

Eligible expenses under this Plan shall not include reversal or attempted reversal of these procedures.

## **SURGERY AND RELATED SERVICES**

Benefits are provided for the following inpatient or outpatient services:

- Surgeon's charges
- Assistant surgeon's charges
- Anesthesia

If two or more surgical procedures are performed through the same incision during an operation, full benefits are only provided for the primary procedure and one half for the lesser procedure.

## **TRANSPLANTS**

Benefits are payable for charges for organ or tissue transplant services which are incurred while the recipient is covered by this Plan. Such covered charges must be due to an accidental injury or sickness covered by this Plan.

You must contact the Plan Supervisor's Medical Management Department prior to any testing that may occur to determine whether you are a transplant candidate. A written treatment plan must be submitted in order to obtain pre-authorization.

Also remember that pre-authorization is required before any medical facility admission. See Pre-Authorization of Inpatient Medical Facility Admissions in the Important Information Section.

Organ or tissue transplant services include the following medically necessary services and supplies:

- Organ or tissue procurement. These consist of removing, preserving and transporting the donated part.
- Medical facility or Hospital room and board, and medical supplies.
- Diagnosis, treatment and surgery by a doctor.
- The rental of wheelchairs, hospital-type beds and mechanical equipment required to treat respiratory impairment.
- Local ambulance services, medications, x-rays and other diagnostic services, laboratory tests, and oxygen.
- Rehabilitative therapy consisting of: speech therapy (not for voice training or lisp), audio therapy, visual therapy, occupational therapy, and physiotherapy. Any of these must be in direct respect to rehabilitation from the covered transplant procedure.
- Surgical dressing and supplies.
- Other services approved by the Plan Supervisor's Medical Management Department.

Benefits for a donor are payable only in the absence of other coverage and shall not exceed the benefit limitation as shown in the Schedule of Benefits. Donor expenses are payable only when the organ recipient is covered under this Plan and are considered expenses of the recipient.

**No benefits will be provided for the following:**

- Any procedure that has not been proven effective or is experimental or investigative or is not standard of care for the community. (***See definition of Experimental and Investigative.***)
- When donor benefits are available through other group coverage.
- When government funding of any kind is available.
- When the recipient is not covered under this Plan.
- Transportation, lodging and meals.
- Private nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).
- Non-human organ transplants.

## GENERAL EXCLUSIONS TO THE MEDICAL PLAN

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This section of your booklet explains circumstances in which all the medical benefits of this Plan are limited or in which no benefits are provided. Benefits may also be affected by the Medical Management provisions of the plan, your eligibility and expenses are subject to all Plan conditions, exclusions and limitations, including medical necessity. In addition, some benefits have their own limitations.

In addition to the specific limitations stated elsewhere in this booklet, the Plan will not provide benefits for:

**Abortion** -- Voluntary termination of pregnancy for dependent children.

**Alcohol/Drug/Chemical Dependency** -- Except as provided under the Chemical Dependency Treatment section, any medical treatment required because of the use of narcotics or the use of hallucinogens in any form unless the treatment is prescribed by a physician.

**Alternative Medicine** -- Services rendered by homeopath, herbalist, and acupressurists. Services for acupressure, rolfing, faith healing services or reflexology.

**Adoption Expenses** -- Adoption expenses or any expenses related to surrogate parenting.

**Appointments (Missed, Cancelled, Telephonic and Electronic)** -- Missed or canceled appointments or for telephone and electronic consultations.

**Birth Control** -- Legend oral contraceptives, nonprescription drugs, and supplies related to birth control. Examples of what is not covered include, but not limited to, the following: oral contraceptives; condoms; sponges; contraceptive foam, jelly or other spermicidal item; and injections. Removal of IUD's, implants and other devices are not covered regardless of the reason for the removal. See the Prescription Drug Card Program section for additional information regarding contraceptives.

**Breast Implants** -- Charges for breast implants except as provided herein.

**Counseling, Education, or Training Services** -- Counseling, education, or training services, except as stated under the "Diabetic/Dietary Education", and "Chemical Dependency Treatment" benefits. This includes vocational assistance and outreach; job training such as work hardening programs; smoking cessation programs; family, marital, sexual, social, lifestyle, nutritional, and fitness counseling; and other services or supplies that are primarily educational in nature other than as defined herein.

**Cosmetic and Reconstructive Surgery** -- Cosmetic surgery or related medical facility admission, unless made necessary:

1. When related to an illness or accidental injury while covered under this plan.
2. Except as specifically excluded by this plan, for correction of congenital deformity.
3. A member receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will also receive coverage for:
  - Reconstruction of the breast on which the mastectomy has been performed
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance

- Prostheses
- Treatment of physical complications of all stages of mastectomy, including lymphedemas

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

**Court Ordered** -- Services and supplies that are court-ordered or are related to deferred prosecution, deferred or suspended sentencing, or driving rights, if those services are not deemed medically necessary under the Plan.

**Custodial Care** -- Charges for custodial care, except as specifically provided herein. Custodial care is care whose primary purpose is to meet personal rather than medical needs and which is provided by participants with no special medical skills or training. Such care includes, but is not limited to: helping a patient walk, getting in or out of bed, and taking normally self-administered medicine.

**Dental** -- Dental services including treatment of the mouth (other than a malignant tumor), gums, teeth, mouth tissues, jawbones or attached muscle, upper or lower jaw augmentation reduction procedures, orthodontic appliances, dentures and any service generally recognized as dental work. Hospital and Physician services rendered in connection with dental procedures are only covered if adequate treatment cannot be rendered without the use of hospital facilities, and if you have a medical condition besides the one requiring dental care that makes hospital care medically necessary. The only exceptions to this exclusion are the services and supplies covered under the Dental Services for Accidental Injuries Benefit.

**Environmental Services** -- Milieu therapy, and any other treatment designed to provide a change in environment or a controlled environment.

**Experimental, Investigative or Illegal** -- Services considered to be experimental, investigative (as defined in the Definition Section) or generally non-accepted medical practices at the time they are rendered. Charges for any illegal treatment or treatment listed by the American Medical Association (AMA) as having no medical value.

**Felony** -- Charges that are a result of any injury or illness incurred by a participant while that participant is participating in an activity that results in a felony conviction.

**Fertility and Infertility** -- Charges in association with infertility, and procedures to restore fertility or to induce pregnancy, including but not limited to: corrective or reconstructive surgery; hormone injections; in-vitro fertilization; embryo transfer; artificial insemination, gamma intra-fallopian transfer (G.I.F.T); fertility drugs (including but not limited to as Clomid, Pergonal or Serophene); or any other artificial means of conception. Family planning services.

**Gender Change** -- Charges for gender change or for procedures to change one's physical characteristics to those of the opposite gender.

**Government Facility** -- Charges by a facility owned or operated by the United States or any state or local government unless the participant is legally obligated to pay. This does not apply to covered expenses rendered by a medical facility owned or operated by the United States Veteran's Administration when the services are provided to a participant for a non-service related illness or injury. The exclusion also does not apply to covered expenses rendered by a United States military medical facility to participants who are not on active military duty.

**Habilitative, Education, or Training Services** -- Habilitative, education, or training services or supplies for dyslexia, and for disorders or delays in the development of a child's language, cognitive, motor, or social skills, including evaluations therefore, except as provided herein under the Neurodevelopmental Therapy and Mental Health benefits.

**Hearing Exams, Aids and Implants** -- Charges or supplies with regard to routine hearing exams, hearing aids. Charges or supplies with regard to cochlear implants, unless preauthorized by the Plan Supervisor.

**Hospice Bereavement** -- Charges for hospice bereavement treatment.

**Illegal Treatment** -- Charges for any illegal treatment or treatment listed by the American Medical Association (AMA) as having no medical value.

**Impotency** -- Charges associated with impotency and erectile dysfunction, and procedures to restore potency, including but not limited to: corrective or reconstructive surgery; hormone injections; penile implants; or impotency drugs whether or not they are the consequence of illness or injury.

**Jaw Augmentation/Reduction** -- The Plan does not cover congenital reconstructive or cosmetic upper or lower jaw augmentation or reduction procedures (orthognathic surgery).

**Licensed/Certified** -- Any services outside the scope of the provider's license, registration, or certification, or that is furnished by a provider that is not licensed, registered, or certified to provide the service or supply by the State in which the services or supplies are furnished. Treatment or services provided by anyone other than a physician operating within the scope of their license, as defined herein.

**Mail Expenses** -- Mailing and/or shipping and handling expenses.

**Massage Therapy** -- Charges for massage therapy treatment except as provided under the Rehabilitation benefit.

**Medical Facility** -- Medical facility services performed in a facility other than as defined herein.

**Mental Health** -- Treatment for mental health (psychiatric) conditions and eating disorders, such as anorexia nervosa, bulimia, or any other similar condition, except as specifically provided under the Mental Health benefits.

**Medical Records and Reports** -- Expenses for preparing medical reports, itemized bills or claim forms, except as expressly requested by or on behalf of the Plan.

**Military Services** -- Charges for the treatment of a condition resulting from war or an act of war, declared or undeclared, or an injury sustained or illness contracted while on duty with any military service for any country.

**Neurodevelopmental Therapy** -- Charges for neurodevelopmental therapy treatment except as provided herein.

**No Charge** - Charges that the employee is not legally required to pay for or for charges which would not have been made in the absence of this coverage.

**Non-Covered Services** -- Services or supplies directly related to any condition, service, or supply that are not covered by this plan. This includes any complications arising from any treatment, services or supplies not covered by this plan.

**Not Medically Necessary** -- Services and supplies not medically necessary (as defined in the Definition Section) for the diagnosis or treatment of an illness or injury, unless otherwise listed as covered.

**Obesity (and Morbid Obesity)** --Treatment for obesity (excessive weight and morbid obesity) including surgery or complications of such surgery, wiring of the jaw or procedures of similar nature, diet programs and/or other therapies, except as provided herein.

**Orthotics** -- Orthotics or other similar supportive devices for the feet, except as provided in the Orthotics benefits.

**Over-the-Counter** – Over the counter drugs, supplies, food supplements, infant formulas, and vitamins.

**Personal Items** -- Services for the convenience of the individual, family or physician. Personal comfort or service items while confined in a hospital, such as, but not limited to, radio, television, telephone, barber or beautician, and guest meals.

**Pregnancy (Dependent Children)** -- Services for pregnancy or complications of pregnancy for dependent children.

**Professional (and Semi-Professional) Athletics and Employment (Injury/Illness)** -- Charges in connection with any injury or illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

**Public Programs** -- Charges that are reimbursed, or that are eligible to be reimbursed by any public program except as otherwise required by law.

**Relatives** -- Charges incurred for treatment or care by any provider if he or she is a relative.

**Rest Home** - Any services rendered by an institution, which is primarily a place of rest, a place for the aged, a nursing home, sanitarium, or a convalescent home.

**Reversal of Sterilization** -- Charges for reversal or attempted reversal of sterilization.

**Routine Foot Care** -- Services for routine or palliative foot care, including hygienic care; fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, and toenails (except for ingrown toenail surgery), and other asymptomatic complaints of the foot. This includes foot-support supplies, devices, and shoes, except as stated under the "Medical Supplies", or "Orthotics", or "Prosthetic Appliances" benefits of the Plan.

**Routine Services** – Services or supplies that are not directly related to an illness, injury, or distinct physical symptoms. Examples of routine services include, but not limited to, routine physical exams, diagnostic surgery, premarital exams, insurance exams, routine pap smears and diagnostic screening. Preventive care charges provided by a provider other than Preferred Providers. These exclusions do not apply to services and supplies specified under the Preventive Care Benefit, or to routine mammograms.

**Self-Help Programs** – Non-medical, self-help programs such as "Outward Bound" or "Wilderness Survival", recreational or educational therapy.

**Smoking Cessation** - Treatment or classes to stop smoking, prescriptions and medications for smoking cessation will be limited to a 90-day supply per lifetime (covered under the Prescription Drug Card Program).

**Stem Cell Resuce and Bone Marrow Transplants** - Stem cell rescue, bone marrow transplants, and chemotherapy associated with stem cell rescue for bone marrow transplants will be provided only under the Transplant benefit. No other benefits related to stem cell rescue, bone marrow transplants, and chemotherapy associated with stem cell rescue or bone marrow transplants will be provided under this Plan.

**Third Party Liability** – Benefits payable under the terms of any automobile medical, personal injury protection, automobile no fault, homeowner, commercial premises or similar contract or insurance when such contract or insurance is issued to, or makes benefits available to, the covered participant whether or not application is duly made therefore. Any benefits provided by the Plan contrary to this exclusion are provided solely to assist the participant. By paying for such benefits, the Plan is not acting as a volunteer and is not waiving any right to reimbursement or subrogation. Reimbursement to the Plan shall be made without reduction for any attorney's fees or costs incurred.

**Temporomandibular Joint Disorder and Myofacial Pain Dysfunction** -- Medical treatment of Myofascial Pain Dysfunction, Temporomandibular Joint Dysfunction (TMJ) and other jaw disorders and services and/or appliances directly attributable to the TMJ dysfunction will not be covered.

**Training** -- Services or supplies for learning disabilities; vocational assistance and outreach; job training or other education or training services; except as provided herein.

**Transportation** -- Transportation by private automobiles or taxi service or other ground transportation, except as specifically provided herein. Air travel, whether or not recommended by a physician, except as provided herein under the Ambulance benefit.

**Travel Expenses** -- Travel, whether or not recommended by a physician, except as provided herein under the Ambulance Benefit.

**Usual, Customary and Reasonable (UCR)** -- Charges that are in excess of the usual, customary and reasonable (UCR) fees for the services or supplies provided; or that are not generally accepted medical procedures for the treatment of the diagnosed illness or injury..

**Vision Care** -- Eyeglasses, contact lenses, eye refractions or examinations for prescriptions or fitting of eyeglasses, contact lenses, routine eye exams or charges for radial keratotomy and Lasik sugery, except as provided under the Vision benefits. Dyslexia treatment, except as specified in the Neurodevelopmental Therapy benefits, or charges for vision analysis, therapy or training relating to muscular imbalance of the eye; orthoptics are also not covered under the Plan.

**War** -- Treatment made necessary as a result of war, declared or undeclared, or any act of war. An act of terrorism will not be considered an act of war, declared or undeclared.

**Worker's Compensation** -- Services covered by or for which the employee is entitled to benefits under any Worker's Compensation or similar law, or self-employment.

**Upon termination of this Plan, all expenses incurred prior to the termination of this Plan, but not submitted to the Plan Supervisor within 6 months of the effective date of termination of this Plan, but no later than 15 months after the date of service, will be excluded from any benefit consideration.**

## PRESCRIPTION DRUG CARD PROGRAMS

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Benefits will be provided as described below and as shown in the Schedule of Benefits for state and federal approved legend drugs requiring a prescription and for other items as specifically provided, when such drug or other items are furnished by an approved pharmacy or an approved mail order supplier. Benefits will be subject to any waiting periods, limitations and exclusions, except that prescription drug benefits will not be subject to Coordination of Benefits provisions or to any deductible or out of pocket maximums.

Legend Drugs are those drugs which cannot be purchased without a prescription written by a physician or other lawful prescriber.

### GENERIC SUBSTITUTION

Over 400 commonly prescribed drug products are now available in a generic form at an average cost of 50% less than the brand name products. This plan encourages the use of generic prescription drugs. By law, generic and brand name drugs must meet the same standards of safety, purity, strength, and effectiveness. At the same time, brand name drugs are often 2 to 3 times more expensive than generic drugs. Use of generics with this benefit will save you money and we encourage you to ask your provider to prescribe them whenever possible.

### BRAND NAME PERFORMANCE DRUGS

An important element of your Caremark Prescription Drug Card Program is the opportunity to select drugs from the Preferred Drug List. The Preferred Drug List is a guide to the best values within select therapeutic categories which helps the provider identify products that will provide optimal clinical results at a lower cost. The Preferred Drug List undergoes a thorough review and/or revision annually. Interim changes could occur to reflect changes in the market. These changes could include; entry of new products or other events that alter the clinical or economic value of the products on the Preferred Drug List. Please see your Human Resources Department for a copy of the Preferred Drug List, or visit the Caremark website address [www.caremark.com](http://www.caremark.com).

Other brand name drugs not listed on the Caremark Preferred Drug List are not covered under this Plan.

### PAYMENT SCHEDULE

A copay is payable for each prescription filled according to the amounts shown in the Schedule of Benefits. Prescription drugs and other covered items must be obtained at an approved pharmacy and will be provided in full after the participant pays the applicable copay.

This plan requires the pharmacist to fill the prescription with a generic product whenever it is available. If the prescription is filled with a name brand prescription at the request of either the provider or the Plan participant, then the copay **plus** the difference between the ingredient cost of the generic drug and the brand name drug will be charged.

## **DRUGS COVERED**

- Legend drugs. Exceptions: See Exclusions below.
- Insulin.
- Disposable needles/syringes.
- Disposable blood/urine glucose/acetone testing agents (e.g. Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes-Tape.) Glucose testing machines.
- Tretinoin, all dosage forms (e.g. Retin-A), for individuals through the age of 25 years.
- Compounded medication of which at least one ingredient is a legend drug.
- Any other drug which under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.
- Legend vitamins will be provided for prenatal care.
- Prescription drugs related to transplants are covered under this Prescription Drug benefit.
- Smoking Deterrent Medications containing nicotine or any other smoking cessation aids, all dosage forms (e.g. Nicorette, Nicoderm, etc.), limited to a 90 day supply per lifetime.
- Legend oral contraceptives, Nuvaring (vaginal ring) and Ortho-Evra (patch).

## **DRUGS EXCLUDED AND LIMITED**

The drugs listed below are excluded, limited or otherwise not covered, but may be eligible as a covered benefit when determined to be medically necessary and prescribed as part of an approved treatment plan.

- Anabolic steroids.
- Anti-obesity drugs and anorectics (any drug used for the purpose of weight loss, e.g., Didrex<sup>®</sup>, Meridia<sup>®</sup>, Xenical<sup>®</sup>).
- Anti-wrinkle agents (e.g. Renova<sup>®</sup>, Avage<sup>®</sup>).
- Over-the-counter contraceptives.
- Dietary supplements and health and beauty aids.
- Drugs used for cosmetic purposes (e.g., Botox<sup>®</sup>, Myobloc, Renova<sup>®</sup>, Eldoquin, Solage, Vaniqua<sup>®</sup>).
- Drugs used for treatment of acne (e.g., Acutane<sup>®</sup>, Trentenoin).
- Drugs used for the treatment of ADHD and Narcolepsy (e.g., Dexadrine, Ritalin, Cylert, Adderall).
- Drugs used for the treatment of impotency (e.g., Viagra<sup>®</sup>, Caverject<sup>®</sup>, Muse<sup>®</sup>, Levitra<sup>®</sup>, Yocon<sup>®</sup>, Edex<sup>®</sup>).

- Drugs used for the treatment of hair loss (e.g., Propecia®, Rogaine®).
- Fluoride preparations.
- Growth Hormone, except as specified in the Infusion Therapy Benefit..
- Injectables, except as specified in the Comprehensive Major medical benefits of the Plan.
- Immunization agents, biological sera, blood or blood plasma.
- Fertility medications, all dosage forms (e.g., Clomid®, Pergonal®, Metrodin®).
- Non-legend drugs other than insulin.
- Pigmenting and depigmenting agents.
- Tretinoin, all dosage forms (e.g. Retin-A), for individuals 26 years of age or older.
- Vitamins, singly or in combination Except prenatal legend vitamins.
- Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, except those listed above.
- Drugs dispensed by a pharmacy that is not an approved pharmacy, except when specifically provided for cases of emergency or outside of the Service Area.
- Any drugs or items obtained from an approved pharmacy when the participant failed to present the identification card.
- Over-the-counter medications (OTC) and any prescription medications with the same active ingredients as an OTC product.
- Replacement prescriptions resulting from loss, theft, or breakage.
- Oral progesterone compounded products.
- Any drugs or items in excess of the specified limits described above.
- Prescriptions which an eligible individual is entitled to receive without charge from any Worker's Compensation Laws.
- Drugs labeled Caution-limited by federal law to investigational use, or experimental drugs, even though a charge is made to the individual.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed medical facility, rest home, sanitarium, extended care facility, convalescent medical facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number specified by the provider, or any refill dispensed after one year from the provider's original order.
- Prescription drugs which have been obtained without charge under local, state or federal programs.

- Drugs purchased outside the U.S. that are not legal inside the U.S.

*If you would like to know more information about the drug coverage policies under this program, or if you have a questions or concern about your pharmacy benefit, please contact HMA at or 425/462-1000 or 800/700-7153.*

## **RETAIL PRESCRIPTION DRUG PROGRAM**

### **Caremark**

#### **Dispensing Limitations**

The amount normally prescribed by a physician or other lawful prescriber, but not to exceed a 34 day supply or 100 units, whichever is greater.

#### **Benefit Limitations**

The prescription card must be used by the participant at the time of the prescription purchase.

Prescription Drug benefits will not be subject to the Coordination of Benefits, Deductible or Maximum Out-of-Pocket Expense provisions of this Plan.

#### **Benefits For Employees And Dependents Without A Card**

Prescription drugs that are eligible for reimbursement by the prescription drug card program can be submitted to Caremark prior to the enrollee's receipt of the card. To claim this benefit, a receipt for the paid prescription with a Caremark claim form must be submitted to Caremark.

Caremark will reimburse eligible claims as if the card had been used (100% reimbursement following the applicable copay).

## **MAIL ORDER PRESCRIPTION DRUG PROGRAM**

### **Caremark MailService**

#### **When to Use Your Mail Order Prescription Drug Card Program**

You should continue to have non-maintenance prescriptions (prescribed for urgent illness or injury) filled at the local pharmacy. However, if you are ordering maintenance medications (those taken on a regular or long term basis such as heart, allergy, diabetes or blood pressure medications), use the Caremark MailService program and have the medications delivered directly to your home.

Using the Caremark MailService mail order program when purchasing prescriptions and paying the applicable copay, the Plan pays 100% of the eligible balance due direct to the pharmacy.

#### **Dispensing Limitations**

The amount normally prescribed by a physician or other lawful prescriber, but not to exceed a 90 day supply.

#### **Ordering Information**

For an existing prescription, provide Caremark MailService with the information requested on the initial order form and a Caremark MailService Pharmacist will transfer the existing prescription to the Caremark MailService Pharmacy. Order forms can be obtained from HMA, your Human Resources Department or at: [www.caremark.com](http://www.caremark.com). The physician can also phone in prescriptions to save time. Prescriptions can be ordered over the telephone with a credit card by 800/966-5772

Caremark MailService maintains a quick turnaround time. Orders which do not require a conversation with either the participant or the physician, prior to dispensing, will be filled and mailed within 1 or 2 days. Prescriptions that require communication with either the participant or the physician will not be filled until all questions have been answered.

## GENERAL DEFINITIONS

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**ACCIDENT/ACCIDENTAL INJURY** -- Shall mean an accidental bodily injury which is the direct result of a sudden, unexpected and unintended element, such as a blow or fall, that requires treatment by a Physician. It must be independent of sickness/illness or any other cause, including, but not limited to, complications from medical care.

**ALLOWABLE CHARGE** –The amount determined by the Preferred Provider Organization to be the appropriate payment pursuant to any applicable agreement between the Preferred Provider Organization and the provider of a service or supply. If no agreement exists, all charges are subject to Usual, Customary and Reasonable.

**APPROVED CHEMICAL DEPENDENCY TREATMENT FACILITY** - For the purpose of treatment of chemical dependency, the definition of the term facility includes any public or private treatment facility providing services for the treatment of chemical dependency that has been licensed or approved as a chemical dependency treatment facility by the State in which it is located.

**APPROVED TREATMENT PLAN** - A written outline of proposed treatment that is submitted by the attending physician to the Plan Supervisor for review and approval.

**BIOFEEDBACK THERAPY** - Biofeedback therapy is an electronic method which allows the patient to monitor the functioning of the body's autonomic systems (e.g., body temperature, heart rate) that were previously thought to be involuntary.

**CALENDAR YEAR** - The 12 months beginning January 1 and ending December 31 of the same year.

**CONTRIBUTORY** - The employee is required to pay a portion of the cost to be eligible to participate in the Plan.

**COVERED INDIVIDUAL OR PARTICIPANT** - An employee, spouse, domestic partner, child, or participating COBRA beneficiary meeting the eligibility requirements for coverage as specified in the Plan, and properly enrolled in the Plan.

**CREDITABLE COVERAGE** - The period of prior medical coverage that an individual had from any of the following sources, and that is not that is not followed by a Significant Break in Coverage: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the uniformed services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan (meaning any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan), a health benefit plan under the Peace Corps Act, or a State Children's Health Insurance Program. Creditable Coverage does not include coverage for liability, dental, vision, specified disease and/or other supplemental-type benefits.

**CUSTODIAL CARE** - Care or service which is not medically necessary, and is designed essentially to assist a participant in the activities of daily living. Such care includes, but is not limited to: bathing, feeding, preparation of special diets, assistance in walking, dressing, getting into or out of bed and supervision over taking of medication which can normally be self-administered.

**DEDUCTIBLE** - The deductible is the amount of eligible expenses each calendar year that a covered participant must incur before any benefits are payable by the Plan. The individual deductible amount is listed in the Schedule of Benefits.

**DEPENDENT** –Any individual who is or may be eligible for coverage according to Plan terms due to relationship to a participant.

**DIAGNOSIS** -- The act or process of identifying or determining the nature and cause of a disease or injury through evaluation of patient history, examination, and review of laboratory data.

**DISABILITY, TOTAL DISABILITY AND DISABLED** - The terms total disability and disabled mean for the:

- Employee - their inability to engage, as a result of accident or illness, from engaging in any occupation for which the participant is reasonably qualified by education, training, or experience, and is performing no work for compensation.
- Dependent - their inability to perform the usual and customary duties or activities of a participant in good health and of the same age.

**DOMESTIC PARTNER** – Defined by the Plan Administrator in the Affidavit of Marriage/Domestic Partnership Agreement, which can be obtained from the employee's Human Resources representative.

**DONOR** - A donor is the individual who provides the organ for the recipient in connection with organ transplant surgery. A donor may or may not be a covered participant under the provisions of this Plan.

**DURABLE MEDICAL EQUIPMENT** - Equipment prescribed by the attending Physician which meets all of the following requirements:

- Is medically necessary;
- Is designed for prolonged and repeated use;
- Is for a specific purpose in the treatment of an Illness or Injury and not solely for patient convenience;
- Would have been covered if provided in a medical facility;
- Is necessary for activities of daily living; and
- Is appropriate for use in the home.

**EFFECTIVE DATE** - The effective date shall mean the first day this Plan was in effect as shown in the Plan Specifications. As to the participant, it is the first day the benefits under this Plan would be in effect, after satisfaction of the waiting period and any other provisions or limitations contained herein.

**ELECTIVE SURGICAL PROCEDURE** - A surgical procedure that need not be performed on an emergency basis because reasonable delay will not cause life endangering complications.

**EMERGENCY TREATMENT** – Medically necessary care to safeguard the member’s life or limb immediately after the sudden and unexpected onset of a condition or the exacerbation of an existing condition. For the purpose of benefit determination, consideration will be given by the Plan Supervisor to the symptoms of the condition and to the actions that would have been taken by a prudent person under such circumstances.

**ENROLLMENT DATE** - The enrollment date is the first day of coverage or, if there is a waiting period for coverage to begin under the Plan, the first day of the waiting period. The term “waiting period” refers to the period after employment starts and the first day of coverage under the Plan. For a person who is a late enrollee or who enrolls on a special enrollment date, the “enrollment date” will be the first date of actual coverage. If an individual receiving benefits under a group health plan changes benefit packages, or if the Plan changes group health insurance issuers, the individual’s enrollment date does not change.

**EXPERIMENTAL OR INVESTIGATIVE** - This Plan does not consider eligible for benefits any treatment, procedure, facility, equipment, drug, drug usage, device or supply which, at the time rendered, does not meet the criteria listed below:

- Approval has been granted by the Federal Food and Drug Administration (FDA), or by another United States governmental agency, for general public use for treatment of a condition.
- It has been scientifically demonstrated by the medical profession to have efficacy in terms of:
  - When the prognosis for the patient's condition is terminal, that the treatment substantially extends the probabilities of the participant's survival.
  - When deterioration of a body system is progressive and reasonably certain to (or has) disabled or incapacitated the patient, that the treatment can be substantially expected to improve the probabilities of arresting the condition's progress.
  - When the body function has been lost by the patient, that the treatment has been shown to restore the body function to usefulness at least sixty percent of the time treatment has been utilized.
- Treatment must be ordered by an institution or provider within the United States that has scientifically demonstrated proficiency in such treatment. All services directly connected with a non-approved experimental or investigational procedure are not covered.

Upon receipt of a Fully Documented claim or request for preauthorization related to a service, supply, drug, device or other item, a decision will be rendered and communicated to the participant within 20 working days. If a decision is made to deny benefits, the written denial shall identify by name and job title the individual making the decision. The written denial shall also contain the basis for the decision, as well as an explanation of the participant’s right to appeal the decision. “Fully documented” means that all of the following are included with the claim or request:

a. Participant’s hard copy clinical history, including all relevant hospital and office chart notes, and records of all laboratory and diagnostic procedures.

b. All reasonably available relevant medical literature, including peer-reviewed articles, that support or relate to the claim or request.

c. If the request is for a drug or supply, the booklet describing the function, indications and FDA approval notification. If the drug is not FDA-approved for a

specific condition, documentation showing whether the drug is Group A, B, or C, with supporting data.

d. If the treatment or procedure is part of a research protocol, copies of the research protocol and any informed consent that the participant has signed or will be asked to sign in connection with the treatment or procedure that is the subject of the claim or request. Copies of all documents created by the institutional review board of the institution at which the treatment or procedure will be performed that relate to the treatment or procedure, including without limitation minutes and approvals.

**FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)** - A leave of absence granted to an eligible participant by the Employer in accordance with the City of Seattle Family and Medical Leave ordinance, enacted to comply with the federal Family and Medical Leave Act of 1993, for the birth or adoption of the participant's child, placement in the participant's care of a foster child, the serious health condition of the participant's spouse, domestic partner, child or parent, and the participant's own disabling serious health condition.

**GENERAL ANESTHESIA** - A drug/gas which produces unconsciousness and insensitivity to pain.

**GENERIC DRUG** - A drug that is generally equivalent to a higher-priced brand name drug and meets all FDA bioavailability standards.

**HIPAA** – Health Insurance Portability and Accountability Act. This plan is subject to and complies with HIPAA rules and regulations.

**HOMEBOUND** - A patient is homebound when leaving the home could be harmful, involves a considerable and taxing effort, and the patient is unable to use transportation without the assistance of another.

**ILLNESS** - The term "illness" means an illness causing loss to the participant whose illness is the basis of the claim. For the purposes of this Plan only, "illness" shall also be deemed to include disability caused or contributed to by pregnancy of the covered employee or spouse, including miscarriage, childbirth and recovery therefrom. It shall only mean illness or disease which requires treatment by a physician.

**INCURRED CHARGE** - The charge for a service or supply is considered to be incurred on the date it is furnished or delivered. In the absence of due proof to the contrary, when a single charge is made for a series of services, each service will be considered to bear a pro rata share of the charge.

**INJURY** – See Accident/Accidental Injury.

**INPATIENT** - Anyone admitted to an inpatient status in a medical facility or other institutional facility.

**LIFE ENDANGERING CONDITION** - An injury or illness which requires immediate medical attention, without which death or serious impairment to a participant's bodily functions could occur.

**LIFETIME** - While covered under this Plan or any other Company plan. Wherever this word appears in this document in reference to benefit maximums and limitations. Under no circumstances does lifetime mean during the lifetime of the covered person.

**MEDICAL EMERGENCY** - An illness or injury which is life threatening or one that must be treated promptly to avoid serious adverse health consequences to the participant.

**MEDICAL FACILITY (HOSPITAL)** - An institution accredited by the Joint Commission on Accreditation of Healthcare Organizations and which receives compensation from its patients for services rendered. On an inpatient basis, it is primarily engaged in providing all of the following:

- Diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and ill participants.
- Services performed by or under the supervision of a staff of physicians who are duly licensed to practice medicine.
- Continuous 24 hours a day nursing services by registered nurses.

For the services covered under this Plan and for no other purpose, inpatient treatment of mental illness or chemical dependency, provided by any psychiatric medical facility licensed by the State Board of Health or the Department of Mental Health, will be considered services rendered in a medical facility as defined subject to the limitations shown in this booklet.

The term 'Hospital' or 'Medical Facility' will **not** include an institution which is primarily: a place for rest or retirement; a residential treatment center; a health resort; a place for the aged; a convalescent home; juvenile boot camps (e.g., Outward Bound, wilderness survival programs); or a nursing home.

**MEDICAL MANAGEMENT SERVICES** - The individual or organization designated by the Plan Administrator to authorize medical facility admissions and surgeries and to determine the medical necessity of treatment for which Plan benefits are claimed.

**MEDICALLY NECESSARY** - Medical services and/or supplies which are absolutely needed and essential to diagnose or treat an illness or injury of a covered participant while covered by this Plan. The following criteria must be met. The treatment must be:

- Consistent with the symptoms or diagnosis and treatment of the participant's condition.
- Appropriate with regard to standards of good medical practice.
- Not solely for the convenience of the participant, family members or a provider of services or supplies.
- The most appropriate of the alternative supplies or levels of service which can be safely provided to the participant. When specifically applied to a medical facility inpatient, it further means that the service or supplies cannot be safely provided in other than a medical facility inpatient setting without adversely affecting the participant's condition or the quality of medical care rendered.

**MEDICARE** - The programs established by Title XVIII of the U.S. Social Security Act as amended and as may be amended, entitled Health Insurance for the Aged Act, and which includes Part A - Hospital Insurance Benefits for the Aged; and Part B - Supplementary Medical Insurance Benefits for the Aged.

**NON-EMERGENCY MEDICAL FACILITY ADMISSIONS** - A medical facility admission (including normal childbirth) which may be scheduled at the convenience of a participant without endangering such participant's life or without causing serious impairment to that participant's bodily functions.

**ORDER OF BENEFITS DETERMINATION** - The method for ascertaining the order in which the Plan renders payment. The principle applies when another plan has a Coordination of Benefits provision.

**ORTHOTICS** - An orthopedic appliance or apparatus used to support, align, prevent or correct deformities or to improve function of movable parts of the body.

**OUTPATIENT SURGICAL FACILITY** - A licensed surgical facility, surgical suite or medical facility surgical center in which a surgery is performed and the patient is not admitted for an overnight stay.

**PARTICIPANT** – Any employee or former employee who is or may become eligible to receive a benefit under the Plan.

**PARTICIPATING (PAR) PROVIDER** - A provider who is part of a network of providers who has entered into a current participating agreement with the Plan Supervisor, or a contractor for the Plan Supervisor.

**PHYSICIAN/PROVIDER** -- The following individuals who are legally qualified and appropriately licensed, and providing service within their lawful scope of practice are considered physicians and/or providers when acting within the scope of their license for services covered by this Plan:

- Advanced Registered Nurse Practitioner (A.R.N.P.)
- Certified Mental Health Counselor (C.M.H.C.)
- Certified Nurse Midwife (C.N.M.) and Licensed Midwife
- Chiropractor (D.C.)
- Denturist
- Doctor of Dental Surgery (D.D.S.)
- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Medicine (M.D.)
- Doctor of Optometry (O.D.)
- Doctor of Osteopathy (D.O.)
- Doctor of Podiatry (D.P.M.)
- Licensed Acupuncturist (L.Ac.)
- Licensed Massage Therapist (L.M.P.)
- Licensed Masters in Social Work (M.S.W.)
- Licensed Masters of Counseling (M.C.)
- Licensed Masters of Education (M. Ed.)
- Licensed Naturopathic Physicians (N.D.)
- Licensed Practical Nurse (L.P.N.)
- Licensed Speech Therapist
- Licensed Vocational Nurse (L.V.N.)
- Master of Arts (M.A.)
- Occupational Therapist (O.T.L./O.T.R.)
- Physician's Assistant (P.A.)

- Registered Clinical Social Worker (R.C.S.W.)
- Registered Dental Assistant (R.D.A.)
- Registered Dental Hygienist (R.D.H.)
- Registered Dietitian (R.D.C.)
- Registered Nurse (R.N.)
- Registered Physical Therapist (R.P.T.)
- Registered Psychologist
- Registered Respiratory Therapist (R.R.P.)

**PLAN** - Shall mean the Benefits described in the Plan Document. The Plan is the Covered Entity as defined in HIPAA (§160.103).

**PLAN ADMINISTRATOR/PLAN SPONSOR** - The individual, group or organization responsible for the day-to-day functions and management of the Plan. The Plan Administrator/Plan Sponsor may employ individuals or firms to process claims and perform other Plan connected services. The Plan Administrator/Plan Sponsor is as shown in the Plan Specifications.

**PLAN DOCUMENT** - The term Plan Document whenever used herein shall, without qualification, mean the document containing the complete details of the benefits provided by this Plan. The Plan Document is kept on file at the office of the Plan Administrator.

**PLAN SUPERVISOR** - The individual or group providing administrative services to the Plan Administrator in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it by the Plan Administrator.

**PLAN YEAR** - The term Plan Year means an annual period beginning on the effective date of this Plan and ending twelve (12) calendar months thereafter or upon termination of the Plan, whichever occurs earliest.

**PREFERRED PROVIDER** - A provider who is part of a network of providers contracted to accept a negotiated rate as payment in full for services rendered.

**PROTECTED HEALTH INFORMATION (PHI)** – Individually Identifiable Health Information, as defined in HIPAA §164.501 (see §164.514(2)(b)(i) for individual identifiers), whether it is in electronic, paper or oral form that is created or received by or on behalf of the Plan Sponsor or the Plan Supervisor.

**RECIPIENT** - The recipient is the participant who receives the organ for transplant from the organ donor. The recipient shall be a participant covered under the provisions of this Plan. Only those organ transplants not considered experimental in nature and specifically covered herein are eligible for coverage under this Plan.

**RELATIVE** - When used in this document shall mean a husband, wife, domestic partner, son, daughter, mother, father, sister or brother of the employee, or any other person related to the employee through blood, marriage, domestic partnership or adoption.

**ROOM AND BOARD CHARGES** - The institution's charges for room and board and its charges for other necessary institutional services and supplies, made regularly at a daily or weekly rate as a condition of occupancy of the type of accommodations occupied.

**SEMI-PRIVATE RATE** - The daily room and board charge which an institution applies to the greatest number of beds in its semi-private rooms containing 2 or more beds. If the institution has no semi-private rooms, the semi-private rate will be the daily room and board rate most

commonly charged for semi-private rooms with two or more beds by similar institutions in the area. The term "area" means a city, a county, or any greater area necessary to obtain a representative cross section of similar institutions.

**SERVICE AREA** – The geographic area designated by the Preferred Provider Organization as its preferred service area.

**SIGNIFICANT BREAK IN COVERAGE** - Any period of 63 days or more without Creditable Coverage. Periods of no coverage during an HMO affiliation period, a waiting period, or for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period, shall not be taken into account for purposes of determining whether a Significant Break in Coverage has occurred.

**SKILLED NURSING/REHABILITATION FACILITY** - An institution, or a distinct part of an institution meeting all of the following tests:

- It is licensed to provide and is engaged in providing, on an inpatient basis, for participants convalescing from injury or disease, professional nursing services rendered by a Registered Graduate Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Graduate Nurse, physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
- Its services are provided for compensation from its patients and patients are under the full-time supervision of a physician or Registered Graduate Nurse (R.N.).
- It provides 24 hours per day nursing services by a licensed nurse, under the direction of a full-time Registered Graduate Nurse (R.N.).
- It maintains a complete medical record on each patient.
- It has an effective utilization review plan.
- It is not, other than incidentally, a place for rest for the aged, chemical dependency services, the mentally handicapped, custodial or educational care, or care of mental disorders.

**SPOUSE** - The man or woman to whom the employee is legally married, not including a common-law marriage.

**SUBSCRIBER** – An employee of the Plan Administrator/Group who is covered/enrolled under/in the Plan.

**SUMMARY PLAN DESCRIPTION** – This document contains a summary of the benefits provided under the Plan. In the event of a discrepancy between the summary and the Plan Document, the provisions stated in the Plan Document will supersede.

**SURGICAL PROCEDURE** - A surgical procedure is defined as:

- A cutting operation.
- Treatment of a fracture.
- Reduction of a dislocation.
- Radiotherapy if used in lieu of a cutting operation for removal of a tumor.

- Electrocauterization.
- Injection treatment of hemorrhoids and varicose veins.
- Diagnostic and therapeutic endoscopic procedures.

**TEMPOROMANDIBULAR JOINTS (TMJ)** - The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

**TREATMENT** -- Administration or application of remedies to a patient or for a disease or injury; medicinal or surgical management; therapy.

**USUAL, CUSTOMARY AND REASONABLE (UCR)** - A reasonable fee that is commonly accepted as payment for a given service by physicians or suppliers of services in a geographical area.

**WAITING PERIOD** – The period that must pass before coverage for an employee or dependent that is otherwise eligible to enroll under the terms of the Plan can become effective. Periods of employment in an ineligible classification are not part of a waiting period.

# GENERAL PROVISIONS

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## ADMINISTRATION OF THE GROUP MEDICAL PLAN

The Plan is administered through the Plan Administrator. The Plan Administrator has retained the services of an Independent Plan Supervisor experienced in claims processing. The Plan Administrator has the right to determine eligibility for benefits and to construe the terms of the plan. The Plan Administrator has made the Plan Supervisor its minister to carry out its decisions.

Legal notices may be filed with, and legal process served upon the Plan Administrator.

## AMENDMENT OF PLAN DOCUMENT

The Plan Administrator may terminate, modify or amend the Plan in its sole discretion without prior notice. The Plan Administrator must notify the Plan Supervisor in writing requesting an amendment to the Plan. The Plan Supervisor will prepare an amendment to be signed by the Plan Administrator. Once the Plan Administrator has signed the amendment, such termination, amendment or modification which affects covered employees and their dependents will be communicated to the employees in the manner of a new Plan document or employer communication. The amended Plan Benefits shall be the basis for determining all Plan payments for all expenses incurred on or after the effective date of such amendment. Plan payments made under the Plan prior to amendment shall continue to be included as Plan payments in determining the total benefits remaining toward satisfaction of any benefit maximums calculated on either a Plan year, calendar year or lifetime basis.

## APPEALING A CLAIM

### Timely Payment of Claims

The period of time within which your claim will be processed depends upon whether it is a Pre-Service claim or a Post-Service claim and whether or not it is an Urgent Pre-Service claim.

- Urgent Pre-Service Claim. You will be notified as soon as possible but not later than 72 hours after receipt of the claim unless you or your physician provide insufficient information.
- Other Pre-Service Claims. You will be notified not later than 15 days after receipt of the claim by the HMA.
- Post-Service Claims. You will be notified not later than 30 days after receipt of the claim by HMA.

Urgent Care Claims are defined as claims that involve a decision that, if treated as non-urgent, could seriously jeopardize the claimant's life, health or ability to regain maximum function; or would, according to a physician, subject the claimant to severe pain.

### Appeal Procedures:

If your claim is denied in whole or in part, you will receive an Explanation of Benefits showing the calculation of the total amount payable, charges not payable, the reason for the determination,

and if applicable, a description of any additional information needed. If additional information is needed, you may be requested to provide the information prior to payment of your claim.

You may request a review **within 180 days** by filing a written appeal with the Plan Supervisor. The written appeal must clearly state that it is an appeal, and clearly state the reason for appeal. You must supply any additional information to support your appeal reason. Please review the steps outlined in the chart below:

Type of Claim	Steps to Take	
<b>Urgent Health Care Claim</b>		
<p>Claims for conditions that could jeopardize life, health, or ability to regain maximum function, or would subject you to severe pain.</p> <p>The reasonable layperson standard is used for these claims, except that if a physician determines the condition is urgent, the Plan must accept the physician's determination.</p>	<b>Step 1:</b>	The Plan has <b>72 hours</b> after receiving your initial claim to approve or deny the claim.
	<b>Step 2:</b>	If denied, you have <b>180 days</b> after receiving the claim denial to appeal the Plan's decision.
	<b>Step 3:</b>	The Plan has <b>72 hours</b> after receiving your appeal to notify you of its appeal decision.
	<b>IF YOUR CLAIM IS IMPROPER OR INCOMPLETE</b>	
	<b>Step 1:</b>	The Plan has <b>24 hours</b> after receiving your initial claim to notify you that your claim is improper or incomplete.
	<b>Step 2:</b>	You have <b>48 hours</b> after receiving notice from the Plan to correct or complete your claim.
	<b>Step 3:</b>	The Plan has <b>48 hours</b> to notify you if your claim is approved or denied. The Plan must do so within the earlier of 48 hours of: Receiving your completed claim, or Your deadline to complete the claim.
	<b>Step 4:</b>	If denied, you have <b>180 days</b> after receiving the claim denial to appeal the Plan's decision.
<b>Pre-Service Health Claim</b>		
<p>Group health claims where treatment must be preauthorized before it is performed.</p>	<b>Step 1:</b>	The Plan has <b>15 days</b> after receiving your initial claim to notify you if your claim is approved or denied.
	<b>Step 2:</b>	You have <b>180 days</b> after receiving the claim denial to appeal the Plan's decision.
	<b>Step 3:</b>	The Plan has <b>30 days</b> after receiving your appeal to notify you of the appeal decision. If the Plan allows two levels of appeal, it has <b>15 days</b> after receiving your appeal to notify you of its decision. Both levels of appeal must be completed within the 30-day deadline.
	<b>IF YOUR CLAIM IS IMPROPER OR INCOMPLETE</b>	
	<b>Step 1:</b>	The Plan has <b>5 days</b> after receiving your initial claim to notify you that your claim is an improper claim.
	<b>Step 2:</b>	The Plan has <b>15 days</b> after receiving your claim to notify you of its decision to approve or deny the claim. If the Plan needs more information and provides an extension notice during the initial 15-day period, the Plan has 30 days after receiving the claim to notify you of its decision. (The time the plan waits for claimant information is not counted in totals.)
	<b>Step 3:</b>	You have <b>45 days</b> after receiving the extension notice to provide additional information or complete the claim.
	<b>Step 4:</b>	If your claim is denied, you have <b>180 days</b> after receiving the claim denial to appeal the Plan's decision.

Type of Claim	Steps to Take
	<p><b>Step 5:</b> The Plan has <b>30 days</b> after receiving your appeal (<b>15 days</b> if the Plan allows two levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 30-day deadline.</p>

Type of Claim	Steps to Take	
<b>Post-Service Health Claim</b>		
Group health claims where you request reimbursement after treatment has been performed.	<p><b>Step 1:</b> The Plan has <b>30 days</b> after receiving your initial claim to notify you if your claim is denied.</p>	
	<p><b>Step 2:</b> If your claim is denied, you have <b>180 days</b> after receiving the claim denial to appeal the Plan's decision.</p>	
	<p><b>Step 3:</b> The Plan has <b>60 days</b> after receiving your appeal (<b>30 days</b> if the Plan allows two levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 60-day deadline.</p>	
	<b>IF THE PLAN NEEDS FURTHER INFORMATION OR AN EXTENSION</b>	
	<p><b>Step 1:</b> The Plan has <b>30 days</b> after receiving the initial claim to notify you if your claim is denied. If the Plan needs more information and provides an extension notice during the initial 30-day period, the Plan has <b>45 days</b> after receiving the claim to notify you if your claim is denied. (The time the plan waits for claimant information is not counted in totals.)</p>	
	<p><b>Step 2:</b> You have <b>45 days</b> after receiving the extension notice to provide additional information or complete your claim.</p>	
	<p><b>Step 3:</b> If your claim is denied, you have <b>180 days</b> after receiving the claim denial to appeal the Plan's decision.</p>	
<p><b>Step 4:</b> The Plan has <b>60 days</b> after receiving your appeal (<b>30 days</b> if the Plan allows two levels of appeal) to notify you of the appeal decision. Both levels of appeal must be completed within the 60-day deadline.</p>		

**Claim Denials.** If your claim for benefits is wholly or partially denied, any notice of adverse benefit determination under the plan will:

- state the specific reasons for the determination;
- reference specific plan provisions on which the determination is based;
- describe additional material or information necessary to complete the claim and why such information is necessary;
- describe plan procedures and time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court;
- disclose any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or state that such information will be provided free of charge upon request);
- if the denial is based on medical necessity or experimental treatment, provide an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical condition (or state that such information will be provided free of charge upon request);
- for urgent care claims, the denial notice will include a description of the expedited review process applicable to such claims. This denial may be given orally, provided that a

written or electronic notification is furnished to you no later than 3 days after the oral notification.

**Appeals.** If you believe your claim was denied in error, you may appeal this decision to the plan. You have 180 days after receiving the claim denial to appeal the plan's decision. You may submit written comments, documents, or other information in support of your appeal and have access, upon request, to all relevant documents free of charge. The review of the claim denial will take into account all new information, whether or not presented or available at the initial claim review, and will not be influenced by the initial claim decision.

A different person than the one who made the initial claim determination will conduct the appeal review and such person will not work under the original decision maker's authority. If your claim was denied on the grounds of medical judgment, the plan will consult with a health professional with appropriate training and experience. This health care professional will not be the individual who was consulted during the initial determination or work under their authority. If the advice of a medical or vocational expert was obtained by the plan in connection with the denial of your claim, we will provide you with the names of each such expert, regardless of whether the advice was relied upon.

If your claim involves urgent care, a request for an expedited appeal may be submitted orally or in writing and all necessary information shall be transmitted between the plan and you by telephone, fax, or other similar method.

If your appeal is denied, the denial notice will contain the following information:

- the specific reasons for the appeal determination;
- a reference to the specific plan provisions on which the determination was based;
- a statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all document, records, or other information relevant to the determination;
- a statement describing any voluntary appeal procedures offered by the plan and your right to obtain information about these procedures;
- a statement describing your right to bring a civil lawsuit under federal law;
- a statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request);
- if the denial is based on medical necessity or experimental treatment, an explanation of the scientific or clinical judgment for the determination, applying plan terms to your medical condition (or state that such information will be provided free of charge upon request);

The appeal determination notice may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

**Subsequent Action:** Upon exhaustion of the full member appeals process, you have no further rights to review of your claim. However, you are entitled to seek redress in the court system.

## **APPLICABLE LAW**

This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a federal law regulating employee welfare and pension plans. Your rights as a participant in the Plan are governed by the plan documents and applicable state law and regulations.

## **APPLICATION AND IDENTIFICATION CARD**

To obtain coverage, an eligible employee must complete and deliver to the Plan Administrator an application on the enrollment form supplied by the Plan Administrator.

Acceptance of this application will be evidenced by the delivery of an identification card showing the employee's name, by the Plan Supervisor to the Plan Administrator or employee.

## **ASSIGNMENT OF PAYMENT**

The Plan will pay any benefits accruing under this Plan to the employee unless the employee shall assign benefits to a Medical facility, physician or other provider of service furnishing the services for which benefits are provided herein. No assignment, however, shall be binding on the Plan unless the Plan Supervisor is notified in writing of such assignment prior to payment. Preferred providers normally bill the Plan directly. If service has been received from a preferred provider, benefits are automatically paid to that provider. Any balance due after the Plan payment will then be billed to the patient by the preferred provider.

## **AUDIT AND REVIEW FEES**

Reasonable charges made by an audit and/or independent or peer review organization firm when the services are requested by the Plan Supervisor and approved by the Plan Administrator shall be payable.

## **CANCELLATION**

An employee may cancel their coverage by giving written notice to the Plan Administrator who will notify the Plan Supervisor.

No person shall acquire a vested right to receive benefits after the date this Plan is terminated.

In the event of the cancellation of this Plan, or the cancellation of the Participating Group's participation in the Plan, all employees' and dependents' coverage shall cease automatically without notice. Employees and dependents shall not be entitled to further coverage or benefits, whether or not any medical condition was covered by the Plan prior to termination or cancellation.

The Plan may be canceled or terminated at any time without advance notice by the Participating Group or Groups. Any Participating Group may cancel its participation at any time without notice and without effect on any remaining Participating Group.

Upon termination of this Plan, or the cancellation of the Participating Group's participation in the Plan, all claims incurred prior to termination, but not submitted to the Plan Supervisor within 15 months from the date of service or 6 months from contract termination, will be excluded from any benefit consideration.

## **CONDITIONS PRECEDENT TO THE PAYMENT OF BENEFITS**

The employee or dependent shall present the Plan identification card to the provider of service upon admission to a medical facility or upon receiving service from a physician.

Written proof of the nature and extent of service performed by a physician or other provider of service shall be furnished to the Plan Supervisor within 15 months after the service was rendered. Claim forms are available through the Plan Supervisor, and are required along with an itemized statement with a diagnosis, the employee's name and Social Security number and the name of the Plan Administrator or the Participating Group.

The employee and all dependents agree that in order to receive benefits, any physician, nurse, medical facility or other provider of service, having rendered service or being in possession of information or records relating thereof, is authorized and directed to furnish the Plan Supervisor, at any time, upon request, any and all such information and records, or copies thereof.

The Plan Supervisor shall have the right to review these records with the Plan's Insurance Company and with any medical consultant or with the Plan Supervisor's Medical Management Department as needed to determine the medical necessity of the treatment being rendered.

## **COORDINATION OF BENEFITS**

### **Definitions**

The term "allowable expense" shall mean the usual, customary and reasonable (UCR) expense, at least a portion of which is paid under at least one of any multiple plans covering the participant for whom the claim is made. In no event will more than 100% of total allowable expenses be paid between all plans, nor will total payment by this Plan exceed the amount which this Plan would have paid as primary Plan.

Coordination of Benefits does not apply to outpatient prescription drug card programs.

The term "order of benefits determination" shall mean the method for ascertaining the order in which the Plan renders payment. The principle applies when another plan has a Coordination of Benefits provision.

### **Application**

Under the order of benefits determination method, the plan that is obligated to pay its benefits first is known as the primary Plan. The plan that is obligated to pay additional benefits for allowable expenses not paid by the primary Plan is known as the secondary Plan. When a participant is enrolled under two or more plans (policies), an order of benefits determination will be made regarding which plan will pay first. The order of benefit determination is as follows:

1. The plan which does not include a Coordination of Benefits provision will be primary.
2. The plan covering the person as the employee (or insured, member, subscriber, or retiree) of the policy will be primary.
3. This Plan will pay secondary to any individual policy.
4. If this Plan is covering the participant as a COBRA participant or a participant of continuation coverage pursuant to state law, this plan is secondary to the participant's other plan.

5. When a dependent child is covered under more than one plan, the following rules apply. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

~~(a)~~( ) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

~~(i)~~( ) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

~~(ii)~~( ) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

~~(b)~~( ) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

~~(i)~~( ) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

~~(ii)~~( ) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;

~~(iii)~~( ) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits; or

~~(iv)~~( ) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

~~I.~~ . The plan covering the custodial parent;

~~II.~~ . The plan covering the custodial parent's spouse;

~~III.~~ . The plan covering the non-custodial parent; and then

~~IV.~~ . The plan covering the non-custodial parent's spouse.

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

~~6.1.~~ Where the order of payment cannot be determined in accordance with (1), (2), (3), (4), or (5) above, the primary Plan shall be deemed to be the plan which has covered the patient for the longer period of time.

~~7.2.~~ Where the order of payment cannot be determined in accordance with (1), (2), (3), (4), (5), or (6) above, the primary Plan shall be deemed to be the plan which has covered the employee for the longest time.

Coordination of benefits with Medicare is governed by the Medicare Secondary Payer rules.

## **CREDIT FOR PRIOR GROUP COVERAGE**

This Plan amends and replaces the prior Plan. Employees and dependents who were covered under the prior Plan sponsored by the Employer immediately prior to the time this Plan became effective shall not lose their eligibility or benefits due to the change in Plans. All charges incurred on or after the effective date of this Plan will be subject to the benefits available under this Plan and not the prior Plan. Credit will be given for time enrolled under the prior Plan in meeting the pre-existing waiting periods and for payments towards coinsurance and deductibles.

## **EFFECT OF TERMINATION OF THE PLAN**

Upon complete or partial termination of the Plan, the Plan Administrator may, after the payment or provision for payment of all benefits to each employee who has incurred covered expenses and charges properly payable, including all expenses incurred and to be incurred in the liquidation and distribution of the Trust Fund or separate account, direct the disposition of all assets held in the Trust Fund or separate account to the Participating Group or Groups, subject to any applicable requirement of an accompanying Trust Document or applicable law or regulation.

## **FACILITY OF PAYMENT**

If, in the opinion of the Plan Supervisor, a valid release cannot be rendered for the payment of any benefit payable under this Plan, the Plan Supervisor may, at its option, make such payment to the individuals as have, in the Plan Supervisor's opinion, assumed the care and principal support of the covered person and are therefore equitably entitled thereto. In the event of the death of the covered person prior to such time as all benefit payments due him/her have been made, the Plan Supervisor may, at its sole discretion and option, honor benefit assignments, if any, prior to the death of such covered person.

Any payment made by the Plan Supervisor in accordance with the above provisions shall fully discharge the Plan and the Plan Supervisor to the extent of such payment.

## **FIDUCIARY OPERATION**

Each fiduciary shall discharge their duties with respect to the Plan solely in the interest of the employees and beneficiaries and: (1) for the exclusive purposes of providing benefits to employees and their beneficiaries and defraying reasonable expenses of administering the Plan, (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a like character and with like aims, and (3) in accordance with the documents and instruments governing the Plan.

## **FREE CHOICE OF PHYSICIAN**

The employee and dependents shall have free choice of any Preferred or Participating licensed physician or surgeon, and the physician-patient relationship shall be maintained. Please refer to the Schedule of Benefits for the appropriate coinsurance reimbursement level.

Nothing contained herein shall confer upon an employee or dependent any claim, right, or cause of action, either at law or in equity, against the Plan for the acts of any medical facility in which he/she receives care, for the acts of any physician from whom he/she receives service under this Plan, or for the acts of the Plan Supervisor's Medical Management Department in performing their duties under this Plan.

## **FUNDING**

If contributions are required of employees or dependents covered under this Plan, the Plan Administrator will maintain a general assets account for the receipt of money and property to fund the Plan, for the management and investment of such funds and for the payment of claims and expenses from such funds.

The Participating Group(s) shall deliver from time to time to the Plan Administrator such amounts of money and property as shall be necessary to provide sufficient funds to pay all claims and reasonable expenses of administering the Plan as the same shall be due and payable. The Plan Administrator may provide for all or any part of such funding by insurance issued by a company duly qualified to issue insurance for such purpose in the state of situs, and may pay the premiums therefore directly or by funds deposited in the general assets account.

Any fiduciary, employee, agent, representative or other individual performing services to or for the Plan shall be entitled to reasonable compensation for services rendered, unless such individual is the Plan Administrator, and for reimbursement of expenses properly and actually incurred.

## **HIPAA PRIVACY (Effective April 14, 2003)**

### **Use and Disclosure of Protected Health Information**

Under the HIPAA privacy rules **effective April 14, 2003**, the Plan Sponsor must establish the permitted and required uses of Protected Health Information (PHI).

### **Plan Sponsor's Certification of Compliance**

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Enrollees' Protected Health Information to the Employer (Plan Sponsor) unless the Employer (Plan Sponsor) certifies its compliance with 45 Code of Federal Regulations §164.504(f)(2) (collectively referred to as The Privacy Rule) as set forth in this Article, and agrees to abide by any revisions to The Privacy Rules.

## **Restrictions on Disclosure of Protected Health Information to Employer (Plan Sponsor)**

The Plan and any health insurance issuer or business associate servicing the Plan will disclose Plan Enrollees' Protected Health Information to the Employer (Plan Sponsor) only to permit the Employer (Plan Sponsor) to carry out plan administration functions for the Plan consistent with the requirements of the Privacy Rule. Any disclosure to and use by the Employer (Plan Sponsor) of Plan Enrollees' Protected Health Information will be subject to and consistent with the provisions of paragraphs on **Employer (Plan Sponsor) Obligations Regarding Protecting Health Information** and **Adequate Separation Between the Employer (Plan Sponsor) and the Plan** of this Article.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Enrollees' Protected Health Information to the Employer (Plan Sponsor) unless the disclosures are explained in the Notice of Privacy Practices distributed to the Plan Enrollees.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Enrollees' Protected Health Information to the Employer (Plan Sponsor) for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (Plan Sponsor).

The Plan incorporates the following provisions to enable it to disclose the Protected Health Information to the Employer (Plan Sponsor) and acknowledges receipt of written confirmation from the Plan Sponsor that the Plan has been so amended:

### **Employer (Plan Sponsor) Obligations Regarding Protecting Health Information**

The Employer (Plan Sponsor) will:

- Neither use nor further disclose Plan Enrollees' Protected Health Information, except as permitted or required by the Plan Documents, as amended, or required by law.
- Ensure that any agent, including any subcontractor, to whom it provides Plan Enrollees' Protected Health Information received from the group health plan, agrees to the restrictions and conditions of the Plan Documents, including this Article, with respect to Plan Enrollees' Protected Health Information.
- Not use or disclose Plan Enrollees' Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (Plan Sponsor).
- Report to the Plan any use or disclosure of Plan Enrollees' Protected Health Information that is inconsistent with the uses and disclosures allowed under this HIPAA Section promptly upon learning of such inconsistent use or disclosure.
- Make Protected Health Information available to the Plan Enrollee who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524.
- Make Plan Enrollees' Protected Health Information available for amendment, and will upon receipt of written notice amend Plan Enrollees' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526.
- Track disclosures it may make of Plan Enrollees' Protected Health Information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.

- Make available its internal practices, books, and records, relating to its use and disclosure of Plan Enrollees' Protected Health Information from the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.
- If feasible, return or destroy all Plan Enrollee Protected Health Information, in whatever form or medium (including in any electronic medium under the Employer's (Plan Sponsor's) custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Enrollee who is the subject of the Protected Health Information, when the Plan Enrollees' Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan Enrollee Protected Health Information, the Employer (Plan Sponsor) will limit the use or disclosure of any Plan Enrollee Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.
- Ensure that adequate separation between the Plan and the Employer, as required by 45 Code of Federal Regulations 164.504(f)(2)(iii) is established and maintained.

#### **Adequate Separation Between the Employer (Plan Sponsor) and the Plan**

The following classes of employees or other workforce members under the control of the Employer (Plan Sponsor) may be given access to Plan Enrollees' Protected Health Information received from the Plan or a health insurance issuer or business associate servicing the Plan:

- ***Director/Manager of the Personnel Department Benefits Unit and/or designee, and***
- ***Departmental Benefits Representative/Coordinator and/or designee***

This list includes every class of employees or other workforce members under the control of the Employer (Plan Sponsor) who may receive Plan Enrollees' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The identified classes of employees or other workforce members will have access to Plan Enrollees' Protected Health Information only to perform the plan administration functions that the Employer (Plan Sponsor) provides for the Plan.

The identified classes of employees or other workforce members will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer (Plan Sponsor), for any use or disclosure of Plan Enrollees' Protected Health Information in breach or violation of or noncompliance with the provisions of this Article to the Plan Documents. Employer (Plan Sponsor) will promptly report such breach, violation or noncompliance to the Plan, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Enrollee, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

## **Employer (Plan Sponsor) Obligations Regarding Electronic Protecting Health Information**

**Effective April 21, 2005**, the Employer (Plan Sponsor) will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.
- Ensure that the adequate separation between the Plan and Plan Sponsor with respect to electronic PHI is supported by reasonable and appropriate security measures.
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI.
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

### **INADVERTENT ERROR**

Inadvertent error by the Plan Administrator in the keeping of records or in the transmission of employee's applications shall not deprive any employee or dependent of benefits otherwise due. The Plan Supervisor shall only be liable to the Company and to the employees of the Company for its actions or failure to act with regard to processing and payment of claims as provided in the Plan Agreement at the level expected of a professional claim administrator; or for its gross negligence or willful misconduct.

### **MEDICARE**

**Medicare** - As used in this section shall mean Title XVIII (Health Insurance for the Aged) of the United States Social Security Act, as added to by the Social Security Amendments of 1965, the Tax Equity and Fiscal Responsibility Act of 1982, or as later amended.

**Person** - As used in this section means a person who is eligible for benefits as an employee in an eligible class of this Plan and who is or could be covered by Medicare Parts A and B, whether or not actually enrolled.

**Eligible Expenses** - As used in this section with respect to services, supplies and treatment shall mean the same benefits, limits and exclusions as defined in this Plan Document. However, if the provider accepts Medicare assignment as payment in full, then Eligible Expenses shall mean the lesser of the total amount of charges allowable by Medicare, whether enrolled or not, and the total eligible expenses allowable under this Plan exclusive of coinsurance and deductible.

**Order of Benefits Determination** - As used in this section shall mean the order in which Medicare benefits are paid, in relation to the benefits of this Plan.

Total benefits of this Plan shall be determined as follows:

**Active Employees** - For active employees and/or non-working spouses of active employees age 65 or over: This Plan will be primary and Medicare will be secondary.

**Disabled Employees with Medicare (Except those with End-Stage Renal Disease)** -For persons eligible for Medicare by reason of Disability the order of determination will be as shown below:

***If employed by a company with 100 or more employees:*** This Plan will be primary and Medicare will be secondary. The Employer will remain the primary payor of medical benefits until the earliest of the following events occurs: (1) the group coverage ends for all employees; (2) the group coverage as an active individual ends.

***If employed by a company with less than 100 employees:*** This Plan will be secondary and Medicare will be primary.

The Omnibus Budget Reconciliation Act of 1986 defines a large group health plan as one that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year. A typical business day is defined as 50 percent or more of the employer's regular business days during the previous calendar year.

### **Disabled Employees with End-Stage Renal Disease (ESRD)**

This Plan shall be primary for ESRD Medicare beneficiaries during the initial 30 months of Medicare coverage, in addition to the usual three month waiting period, or a maximum of 33 months. ESRD Medicare Entitlement usually begins on the fourth month of renal dialysis, but can start as early as the first month of dialysis for individuals who take a course in self-dialysis training during the three month waiting period.

### **MISREPRESENTATION**

Any material misrepresentation on the part of the Plan Administrator or the employee in making application for coverage, or any application for reclassification thereof, or for service thereunder shall render the coverage null and void.

### **NOTICE**

Any notice given under this Plan shall be sufficient, if given to the Plan Administrator when addressed to it at its office; if given to the Plan Supervisor, when addressed to it at its office; or if given to an employee, when addressed to the employee at their address as it appears on the records of the Plan Supervisor on the employee's enrollment form and any corrections made to it.

### **PHOTOCOPIES**

Reasonable charges made by a provider for photocopies of medical records when the copies are requested by the Plan Supervisor shall be payable.

### **PLAN ADMINISTRATION**

The Plan Administrator shall be responsible for compliance by the Plan.

## **PLAN IS NOT A CONTRACT OF EMPLOYMENT**

The Plan shall not be deemed to constitute a contract of employment between the Plan Administrator or Participating Company and any employee or to be a consideration for, or an inducement to or condition of the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Plan Administrator or Participating Company or to interfere with the right of the Plan Administrator or Participating Company to discharge any employee at any time; provided however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the Plan Administrator or Participating Company with the bargaining representative of any employees.

## **~~PLAN SUPERVISOR NOT A FIDUCIARY~~**

~~The Plan Supervisor is not a fiduciary with respect to this engagement and shall not exercise any discretionary authority or control over the management or administration of the Plan, or the management or disposition of the Plan's Assets. The Plan Supervisor shall limit its activities to carrying out ministerial acts of notifying Plan Participants and making benefit payments as required by the Plan. Any matters for which discretion is required shall be referred by Plan Supervisor to the Plan Administrator, and Plan Supervisor shall take direction from Plan Administrator in all such matters. The Plan Supervisor shall not be responsible for advising the Company or Plan Administrator with respect to their fiduciary responsibilities under the Plan nor for making any recommendations with respect to the investment of Plan Assets. The Plan Supervisor may rely on all information provided to it by the Company, Plan Administrator, and the Trustees, as well as the Plan's other vendors. The Plan Supervisor shall not be responsible for determining the existence of Plan Assets.~~

## **PRIVILEGES AS TO DEPENDENTS**

The employee shall have the privilege of adding or withdrawing the name or names of any dependent(s) to or from this coverage, as permitted by the Plan, by submitting to the Plan Administrator an application for reclassification on the enrollment form furnished by the Plan Supervisor. Each dependent added to the coverage shall be subject to all conditions and limitations contained in this Plan.

## **RIGHT OF RECOVERY**

Whenever payments have been made (or benefits have been quoted) by the Plan Supervisor in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Plan, the Plan Supervisor shall have the right to recover such payment (or avoid making such payment), to the extent of such excess, from among one or more of the following as the Plan Supervisor shall determine: any individuals to or for, or with respect to whom such payments were made, and/or any insurance companies and other organizations.

## **SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT – THE PLANS RIGHT TO RESTITUTION**

The Plan does not provide benefits for any accident, Injury or sickness for which you or your eligible Dependents have, or may have, any claim for damages or entitlement to recover from another party or parties arising from the acts or omissions of such third party (for example, an auto accident). In the event that another party fails or refuses to make prompt payment for the medical expenses incurred by you or your eligible Dependents which expenses arise from an accident, Injury or sickness, subject to the terms of the Plan, the Plan may conditionally advance the payment of the eligible medical benefits.

## **Benefits Conditional Upon Cooperation**

The Plan's payment of eligible benefits is conditional upon:

- The cooperation of you and eligible Dependents, or your respective agent(s) (including your attorneys) or guardian (of a minor or incapacitated individual) working on your behalf to recover damages from another party. You may be asked to complete, sign, and return a questionnaire and possibly a restitution agreement.

If you or your eligible Dependents, or your agent(s) or guardian (of a minor or incapacitated individual) refuse to sign and return a restitution agreement, or to cooperate with the Plan or its assignee, the Plan and/or its assignee, such refusal and non-cooperation may be grounds to deny payment of any medical benefits.

By participating in the Plan, you and your eligible Dependents acknowledge and agree to the terms of the Plan's equitable or other rights to full restitution. You will take no action to prejudice the Plan's rights to restitution. You and your eligible Dependents agree that you are required to cooperate in providing and obtaining all applicable documents requested by the Plan Administrator or the Company, including the signing of any documents or agreements necessary for the Plan to obtain full restitution.

You and your eligible Dependents are also required to:

- Notify the Plan Supervisor at 800/700-7153 as soon as possible, that the Plan may have a right to obtain restitution of any and all benefits paid by the Plan. You will later be contacted by HMA, and you must provide the information requested. If you retain legal counsel, your counsel must also contact HMA;
- Inform HMA in advance of any settlement proposals advanced or agreed to by another party or another party's insurer;
- Provide the Plan Administrator all information requested by the Plan Administrator regarding an action against another party, including an insurance carrier; this includes responding to letters from the Plan Supervisor (and other parties designated by Plan Administrator acting on behalf of the Plan) on a timely basis;
- Not settle, without the prior written consent of the Plan Administrator, or its designee, any claim that you or your eligible Dependents may have against another party, including an insurance carrier; and
- Take all other action as may be necessary to protect the interests of the Plan.

In the event you or your eligible Dependents do not comply with the requirements of this section, the Plan may deny benefits to you or your eligible Dependents or take such other action as the Plan Administrator deems appropriate.

## **Right of Full Restitution**

If you or your eligible Dependents are eligible to receive benefits from the Plan for injuries caused by another party or as a result of any accident or personal Injury, or if you or your eligible Dependents receive an overpayment of benefits from the Plan, the Plan has the right to obtain full restitution of the benefits paid by the Plan from:

- Any full or partial payment which an insurance carrier makes (or is obligated or liable to make) to you or your eligible Dependents; and

- You or your eligible Dependents, if any full or partial payments are made to you or your eligible Dependents by any party, including an insurance carrier, in connection with, but not limited to, your or another party's:
  - Uninsured motorist coverage;
  - Under-insured motorist coverage;
  - Other medical coverage;
  - No fault coverage;
  - Workers' compensation coverage;
  - Personal injury coverage;
  - Homeowner's coverage; or
  - Any other insurance coverage available.

This means that, with respect to benefits which the Plan pays in connection with an Injury or accident, the Plan has the right to full restitution from any payment, settlement or recovery received by you or your eligible Dependents from any other party, regardless of whether the payment, recovery or settlement terms state that there is a separate allocation of an amount for the restitution of medical expenses or the types of expenses covered by the Plan or the benefits provided under the Plan.

#### **Payment Recovery to be Held in Trust**

You, your eligible Dependents, your agents (including your attorneys) and/or the legal guardian of a minor or incapacitated person agree by request for and acceptance of the Plan's payment of eligible medical benefits, to maintain 100% of the Plan's payment of benefits or the full extent of any payment from any one or combination of any of the sources listed above in trust and without dissipation except for reimbursement to the Plan or its assignee.

Any payment or settlement from another party received by you or your eligible Dependents must be used first to provide restitution to the Plan to the full extent of the benefits paid by or payable under the Plan. The balance of any payment by another party must, first, be applied to reduce the amount of benefits which are paid by the Plan for benefits after the payment and, second, be retained by you or your eligible Dependents. You and your eligible Dependents are responsible for all expenses incurred to obtain payment from any other parties, including attorneys' fees and costs or other lien holders, which amounts will not reduce the amount due to the Plan as restitution.

The Plan is entitled to obtain restitution of any amounts owed to it either from funds received by you or your eligible Dependents from other parties, regardless of whether you or your eligible Dependents have been fully indemnified for losses sustained at the hands of the other party. A Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Plan's equitable (or other) right to obtain full restitution.

#### **SUMMARY PLAN DESCRIPTION**

This document is the Summary Plan Description.

## **TAXES**

Charges for surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) and other state imposed surcharges (as applicable to the Plan), will be considered covered expenses by this Plan. Local, State and Federal taxes, associated with supplies or services covered under this Plan, will also be considered covered expenses by this Plan.



## PLAN ACCEPTANCE

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The City of Seattle hereby establishes this Plan for the payment of certain expenses for the benefit of its eligible employees to be known as City of Seattle Local 77 Employee Health Care Plan.

The City of Seattle assures its covered employees that during the continuance of the Plan, all benefits herein described shall be paid to or on behalf of the employees in the event they become eligible for benefits.

The Plan is subject to all the terms, provisions and conditions recited on the preceding pages hereof.

This Plan is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

The City of Seattle has caused this Plan to take effect as of 12:01 A.M. on January 1, 2006 at Seattle, Washington.

### **The City of Seattle**

\_\_\_\_\_  
Authorized Signature

\_\_\_\_\_  
Date

**Plan Effective January 1, 2001**

**Plan Restated and Amended January 1, 2006**

**Claim Administration By:**

**HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.  
PO Box 85008  
Bellevue, WA 98015-5008**

**425/462-1000 Seattle Area  
800/700-7153 All Other Areas**