City of Seattle Preventive Plan

Directory

• Aetna's Customer Service number:	1-877-292-2480
• Aetna's website address:	www.aetna.com/docfind/custom/ cityofseattle
• Where to submit claims:	Aetna P.O. Box 14089 Lexington, KY 40512-4089
• Plan sponsor:	City of Seattle Personnel Department benefits.unit@ci.seattle.wa.us 206-615-1340
• Claims Administrator	Aetna

Please note: We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between this booklet and other legal documents, the legal documents will always govern. The City of Seattle intends to continue these plans indefinitely but reserves the right to amend or terminate them at any time, in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. This booklet does not create a contract of employment with the City of Seattle.

Table of Contents

PART I—SUMMARY OF COVERAGE

Eligibility **1**
Retirees 1
Dependents 3
Special Rules Which Apply to an Adopted Child 5
Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order 5

Enrollment Procedure **6**

Effective Date of Coverage **7**
Retirees 7
Dependents 7

Health Expense Coverage **7**
Prescription Drug Expense Coverage 8
Comprehensive Medical Expense Coverage 9
Certification Requirement 9
Benefits Payable 9
Deductible Amounts 10
Copayment Amounts 11
Payment Percentage 11
In-network Payment Limit 14
Out-of-network Payment Limit 14
Benefit Maximums 14
Pregnancy Coverage 16
Sterilization Coverage 17
Adjustment Rule 17
General 17

Additional Information Provided by The City of Seattle **17**
Statement of Rights under the Newborns' and Mothers' Health Protection Act 17
Notice regarding Women's Health and Cancer Rights Act 18

PART II—HEALTH EXPENSE COVERAGE

Prescription Drug Expense Coverage **19**

Comprehensive Medical Expense Coverage **21**
Covered Medical Expenses 21
Hospital Expenses 22
Convalescent Facility Expenses 22
Home Health Care Expenses 23
Hospice Care Expenses 23
Routine Physical Exams 25
Neurodevelopmental Therapy Expenses 26
Other Medical Expenses 26

Durable Medical Equipment Expenses....28
National Medical Excellence Program ® (NME)....28
Explanation of Some Important Plan Provisions....29
Inpatient Copayment....29
Calendar Year Deductible....30
Deductible Carryover....30
Family Deductible Limit....30
Hospital Emergency Room Copayment....30
Lifetime Maximum Benefit....30
Limitations....30
Routine Screening for Cancer....30
Infertility Services....31
Acupuncture Expenses....31
Mouth, Jaws, and Teeth....31
Rehabilitation Services....32
Manipulation Treatment....33
Certification For Hospital Admissions....34
Certification For Convalescent Facility Admissions, Home Health Care Expenses, Hospice Care Expenses, and Skilled Nursing Care....35
Certification For Hospital and Treatment Facility Admissions for Chemical Dependency or Mental Disorders....35
Treatment of Chemical Dependency or Mental Disorders....36

General Exclusions....38

Effect of Benefits Under Other Plans....42
Other Plans Not Including Medicare....42
Effect of Medicare....45

General Information About Your Coverage....46
Termination of Coverage....46
Disabled Dependent Children....47
Health Expense Benefits After Termination....47
Conversion of Medical Expense Coverage....47
Type of Coverage....49
Physical Examinations....49
Legal Action....50
Additional Provisions....50
Assignments....49
Subrogation and Right of Recovery....53
Recovery of Overpayment....53
Reporting of Claims....5353
Claim Filing and Appeal Procedure....5353
Payment of Benefits....5656
Records of Expenses....57

Glossary (Defines the terms shown in bold type in the text of this document)....57

Continuation of Coverage under Federal Law....70

Health Insurance Portability & Account Act of 1996....83

Part I
Summary of Coverage

Employer: The City of Seattle

ASA: 100290

SOC: 11A

Issue Date: April 10, 2006

Effective Date: October 1, 2005

The benefits shown in this Summary of Coverage are available for you and your eligible dependents. The Plan described in the following pages of this Booklet is a benefit plan of the Employer. These benefits are not insured with Aetna Life Insurance Company ("Aetna") but will be paid from the Employer's funds. Aetna will provide certain administrative services under the Plan as outlined in the Administrative Services Agreement between Aetna and the Customer (Plan Sponsor).

Eligibility

Retirees

You are in an Eligible Class if you are a former employee of The City of Seattle, and you:

1. retired before the Effective Date of this Plan and were covered under prior coverage through the Employer for Health Expense Coverage on the day before that date; or

2. retired on or after the Effective Date of this Plan and you:
    - are under the age of 65;
    - had coverage under a medical plan for active employees offered by the Employer at the time of your retirement; and
    - elected to receive retirement benefits immediately after terminating your employment with the Employer, and are a:
        - retired member of the Seattle Employees' Retirement System;

- retired LEOFF I (only dependent coverage provided) or LEOFF II Local 27, International Association of Fire Fighters member;
- retired LEOFF I (only dependent coverage provided) or LEOFF II member of Local 2898, Fire Chiefs;
- retired Fire Department or Police Department non-represented LEOFF I (dependent only coverage) or LEOFF II member;
- retired LEOFF I (only dependent coverage provided) or LEOFF II Seattle Police Officers' Guild (SPOG) member; or a
- retired Seattle Housing Authority employee; or

3. are a LEOFF II former SPOG member and vested for retirement on or after January 1, 2004, under the age of 65, and had coverage under a medical plan for active employees offered by the Employer at the time you separated from employment. (You will be referred to as a "retiree" in this document.)

Your Eligibility Date is the first day of the first calendar month following the later of: (a) the date you retire (or the date you separate from employment and vest for retirement if you are a former SPOG member), or (b) the date your COBRA coverage through the Employer ends without a break in coverage. However, this date shall not be before the later of the Effective Date of this Plan or the date you enter the Eligible Class.

You must not have been previously represented by a bargaining group for which a separate Summary of Coverage is available. Your Employer will provide you with this information.

Dependents

Dependents are eligible to be enrolled at the time the Retiree enrolls if:

- the Retiree is in an Eligible Class;
- the Retiree enrolls in a timely manner;
- the Dependent had coverage under a plan for active employees through the Employer at the time of the employee's retirement; and
- the Dependent is under age 65

Dependents are eligible to be enrolled if the Retiree is not enrolled, if one of the following conditions is met:

- the Retiree is age 65 or older and meets the Eligibility requirements, except for the age requirement; or
- the Retiree is under age 65, a LEOFF I member and meets the Eligibility requirements; or
- the Employee died while still employed, but was eligible for a service retirement at the time of death.
- the Retiree died after retiree medical coverage through the Employer began for himself/herself and/or the Dependent, and the Dependent continues to receive pension benefits.

You may cover your:

- lawful wife or husband (unless legally separated);
- domestic partner who you have named in an Affidavit of Marriage/Domestic Partnership on file with your employer; and
- unmarried children who are under 21 years of age.

Any other unmarried child under age 23 who goes to school on a regular full-time basis at an accredited school and depends primarily on you for support will be covered as a dependent.

Your children include:

- Your biological children.
- Your adopted or legally placed for adoption children.
- Your stepchildren for whom your home is their permanent residence.
- Your domestic partner's children for whom your home is their permanent residence.
- Children for whom you are a legal guardian and for whom your home is their permanent residence.
- Disabled Dependent Children (see General Information Section).

Proof of dependency may be periodically required by Aetna.

Exceptions
A dependent may be enrolled after you are first eligible if all of the following are met:

- you did not elect Health Expense Coverage for the person involved within 31 days of the date you were first eligible because at that time:
  - the person had coverage through his/her employer; and
  - you stated, in writing, at the time you submitted the refusal that the reason for the refusal was because the person had such coverage; and

- the person loses such coverage because:
  - of termination of employment in a class eligible for such coverage;
  - of reduction in hours of employment;
  - your spouse or domestic partner dies;
  - you and your spouse divorce or are legally separated;
  - you and your domestic partner dissolve your domestic partnership;
  - such coverage was COBRA continuation and such continuation was exhausted; or
  - the other plan terminates due to the employer's failure to pay the premium or for any other reason.

Application for coverage must be made within 31 (thirty-one) days of the loss of other coverage. Health Expense Coverage will become effective the first day of the calendar month following receipt of your application and proof of loss of other coverage.

Additional Exceptions
Also, a dependent may be enrolled after you are first eligible if the person is:

- A spouse or child who meets the definition of a dependent by court order, and you elect coverage within 31 days of a court order requiring you to provide such coverage for your dependent spouse or child. Such coverage will become effective on the date of the court order.
- A dependent you acquire after you were first eligible, who meets the definition of a dependent, through marriage or domestic partnership, and you subsequently elect coverage for any such dependent within 31 days of acquiring such dependent. Such coverage will become effective on the date of the marriage or domestic partnership.
- A dependent you acquire after you were first eligible, who meets the definition of a dependent, through birth, legal guardianship, adoption, or placement for adoption, and you subsequently elect

coverage for any such dependent within 60 days of acquiring such dependent. Such coverage will become effective on the date of the child's birth, the date of legal guardianship, the date of the child's adoption, or the date the child is placed with you for adoption, whichever is applicable.

Special Rules Which Apply to an Adopted Child

This Plan does not limit coverage for a preexisting condition for a child who meets the definition of dependent as of the date the child is "placed for adoption" (this means the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of the child), provided:

- such placement takes effect after the date your coverage becomes effective; and
- you make written request for coverage for the child within 60 days of the date the child is placed with you for adoption.

Coverage for the child will become effective on the date the child is placed with you for adoption. If a request is not made within such 60 days, coverage for the child will be subject to all of the terms of this Plan.

Special Rules Which Apply to a Child Who Must Be Covered Due to a Qualified Medical Child Support Order

Any provision in this Plan that limits coverage as to a preexisting condition will not apply to affect the initial health coverage for a child who meets the definition of dependent and for whom you are required to provide health coverage as the result of a qualified medical child support order (QMSCO) issued as a part of a judgment, order of decree, a divorce settlement agreement or a legal separation proceeding. Agreements made by the parties, but not formally approved by a court are not acceptable.

You must make written request for such coverage. Coverage for the child will become effective on the date of the court order or the date specified in the court order provided application for coverage is submitted within 31 days of the court order. 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 Employer. Upon receipt, the Employer will notify you if the order is qualified. If the order is qualified, you may cover your child(ren) under the Plan.

If you are the non-custodial parent, proof of claim for such child may be given by the custodial parent. Benefits for such claim will be paid to the custodial parent.

Enrollment Procedure

You will get a form to complete. Sign and return it to the Employer within 31 (thirty-one) days of the later of: (a) your date of retirement (or date you separate from employment and vest for retirement if you are a former SPOG member), or (b) the date COBRA coverage ends. Dependents of a deceased employee must sign and return the form to the Employer within 31 (thirty-one) days of the date of the employee's death.

Your contribution toward the cost of this coverage will be deducted from your pension check, if any, and is subject to change. If the contribution amount exceeds the amount of your pension check or you are vested for retirement, you must pay by personal check by no later than the first of the month for that month's coverage.

Delayed Enrollment
You may delay enrollment in this Plan if you are;

- covered as a dependent under a medical plan for active employees with the Employer after retiring, or after separating from employment with the Employer and are vested for retirement; or
- a former SPOG member who is retired or vested for retirement under the LEOFF system and reemployed by the Employer in a civilian capacity and have coverage with the Employer; and

you meet the eligibility criteria listed above for enrollment when first eligible, and you have continuous medical coverage with the Employer from the date of your retirement or the date you vested for retirement.

When that coverage ends, you must apply for coverage under this Plan within 31 days of the end of the other coverage or COBRA coverage through the Employer ends without a break in coverage, whichever is later. Your Eligibility Date is the first day of the first calendar month

following the later of the date your other coverage ends or COBRA coverage through the Employer ends.

Effective Date of Coverage

Retirees

Your coverage will take effect on your Eligibility Date.

Dependents

Coverage for your dependents will take effect on the date yours takes effect if you elected dependent coverage for them on your enrollment form. Also, in order to be sure coverage is in force for any new dependents you acquire, you should report any changes within 31 days following the date of marriage or formation of a domestic partnership, or within 60 days following the date of acquisition of a dependent child. In these instances, coverage will begin on the date of acquisition. This may affect your contributions.

Health Expense Coverage

Retirees and Dependents

Your Booklet spells out the period to which each maximum applies. These benefits apply separately to each covered person. Read the coverage section in your Booklet for a complete description of the benefits payable.

If a hospital or other health care facility does not separately identify the specific amounts of its room and board charges and its other charges, Aetna will use the following allocations of these charges for the purposes of the group contract:

Room and board charges:	40%
Other charges:	60%

This allocation may be changed at any time if Aetna finds that such action is warranted by reason of a change in factors used in the allocation.

Prescription Drug Expense Coverage

Payment Percentage
100% as to:

Retail In-network Pharmacy

Generic Drugs	after a copay of 30% of the cost of each 31-day prescription or refill*
Brand Name Drugs	after a copay of 40% of the cost of each 31-day prescription or refill*

*Minimum of $10 (or actual cost of the drug if less) and maximum of $100 per prescription.

Mail Order In-network Pharmacy

Generic Drugs	after a copay of 30% of the cost of each 90-day prescription or refill*
Brand Name Drugs	after a copay of 40% of the cost of each 90-day prescription or refill*

*Minimum of $20 (or actual cost of the drug if less) and maximum of $200 per prescription.

No benefits will be provided for drugs dispensed by a pharmacy that is not an In-network Pharmacy, except when specifically provided for in cases of emergency.

Prescription Drug Payment Limit
This limit applies only to Covered Prescription Drug Expenses, except those expenses which are applied against any deductible, fee, or copay amount. Eligible expenses for Retail and Mail Order drugs will accumulate toward the Payment Limit listed below.

Payment Limit which Applies to Expenses for a Person
When a person's Covered Prescription Drug Expenses dispensed by an In-network Pharmacy for which no benefits are paid because of the Payment Percentage reach $1,500 in a calendar year, benefits will be payable at 100% for all his or her Covered Prescription Drug Expenses dispensed by

an In-network Pharmacy to which this limit applies and which are incurred in the rest of that calendar year.

Payment Limit which Applies to Expenses for a Family
When a family's Covered Prescription Drug Expenses dispensed by an In-network Pharmacy for which no benefits are paid because of the Payment Percentage reach $ 4,500 in a calendar year, benefits will be payable at 100% for all their Covered Prescription Drug Expenses dispensed by an In-network Pharmacy to which this limit applies and which are incurred in the rest of that calendar year.

Comprehensive Medical Expense Coverage

All maximums included in this Plan are combined maximums between In-network Care and Out-of-network Care, where applicable, unless specifically stated otherwise.

Certification Requirement
Hospital Admissions, Mental Disorder Treatment Facility Admissions, Chemical Dependency Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice care (inpatient and outpatient), and Skilled Nursing Care must be certified as necessary to avoid a reduction in the benefits payable. If certification is not obtained and the care is not medically necessary, no benefits will be paid. If certification is not obtained and the care is determined to be medically necessary, payment will be based on the appropriate Payment Percentage for the type of service and provider used.

Read the Comprehensive Medical Expense Coverage section of this Booklet for details of the types of care affected, how to get certification and the effect on your benefits of failure to obtain certification.

Benefits Payable
After any applicable deductible or copayment, the Health Expense Benefits payable under this Plan in a calendar year are paid at the Payment Percentage which applies to the Negotiated Charge or Recognized Charge for the type of Covered Medical Expense which is incurred, except for any different benefit level which may be provided later in this Booklet. Benefits may vary depending upon whether an In-network Provider is utilized. An In-network Provider is a health care provider who has agreed to provide services or supplies at a "Negotiated Charge." See your Employer for a copy of the Directory which lists these health care providers or access this information at www.aetna.com/docfind/custom/cityofseattle.

If any expense is covered under one type of Covered Medical Expense, it cannot be covered under any other type.

Deductible Amounts	
In-network Care and Other Health Care Calendar Year Deductible	$100
Out-of-network Care Calendar Year Deductible	$450
In-network Care and Other Health Care Family Deductible Limit	$300
Out-of-network Care Family Deductible Limit	$1,350

This Calendar Year Deductible applies to all expenses except expenses paid under Prescription Drug Expense Coverage; expenses for which an office visit, inpatient, or emergency room copayment applies; Routine Physical Exam Expenses; In-Network Routine Cancer Screening Expenses; or National Medical Excellence Travel and Lodging Expenses.

The Calendar Year Deductible is the amount of covered medical expenses you pay each calendar year before the Plan pays benefits. Besides an individual deductible, there is a maximum calendar year deductible for families. Once your expenses reach the family deductible amount, you will not have to satisfy any more individual deductibles for the rest of the calendar year, regardless of the size of your family.

Eligible expenses for In-network Care, Out-of-network Care, and Other Health Care will accumulate toward **both** the In-network Care Calendar Year Deductible and the Out-of-network Care Calendar Year Deductible.

The In-network Care and Other Health Care benefits of this Plan will become available to each person after the In-network Care and Other Health Care Calendar Year Deductible of $100 ($300 for family) has been satisfied, unless specifically stated otherwise. The Out-of-network benefits of this Plan will become available to each person after the Out-of-network Calendar Year Deductible of $450 ($1,350 family) has been satisfied, unless specifically stated otherwise.

To satisfy the deductible requirement for a calendar year, the person must incur eligible deductible expenses equal to the deductible amount during the Calendar Year or the last three months of the preceding calendar year, while covered by this contract. The expenses must be for services and supplies that are within the benefits of this contract.

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

- Expenses for services or supplies not included in the Plan.
- The member's share of expenses partially covered by this Plan, including but not limited to any Copayments.
- Expenses for Out-of-network services or supplies in excess of the Recognized Charge.
- Expenses for services not subject to the deductible.

If two or more covered family members are injured in a common accident, only a single deductible amount needs to be satisfied for all of them to receive coverage for injuries resulting from that accident in the calendar year in which the accident occurred.

If a member is confined as an inpatient at the close of a calendar year for which the deductible has been satisfied and the confinement continues without interruption into the next calendar year, the deductible for the second calendar year will not apply until the member is discharged.

Coordination of Benefits will not apply until after your deductible has been satisfied.

Copayment Amounts	
Inpatient Hospital	$200 per admission
Inpatient Convalescent Facility	$200 per admission
Inpatient Chemical Dependency Facility	$200 per admission
Inpatient Mental Disorder Treatment Facility	$200 per admission
Hospital Emergency Room	$150 per admission, waived if admitted
Office Visit (In-network & non-surgical)	$15 per visit

The Hospital Emergency Room Copayment applies to all Hospital Expenses for emergency room care. This Copayment is waived if the person is admitted within 24 hours for the same condition.

However, for a confinement of a well newborn child that starts on the day of birth, the Inpatient Hospital Copayment will not exceed the hospital's actual charge for board and room for the first day of confinement on which the child's coverage is in force.

Payment Percentage

The Payment Percentage applies to the Negotiated Charge or Recognized Charge for the incurred expense after any deductible or copayment amounts.

	In-	**Out-of-**	**Other**

	network Care	network Care	Health Care
Acupuncture			
Inpatient	90%	60%	90%
Outpatient	100%	60%	100%
Ambulance	90%	90%	90%
Blood bank charges	N/A	N/A	90%
Chemical dependency			
Inpatient	90%	60%	90%
Outpatient	100%	60%	100%
Chiropractic	100%	60%	100%
Convalescent facility	90%	60%	90%
Durable medical equipment	90%	60%	90%
Emergency room fees for emergency care	90%	90%	90%
Emergency room fees for non-emergency care	90%	60%	90%
Home health care	90%	60%	90%
Hospice			
Inpatient	90%	N/A	90%
Outpatient	90%	N/A	90%
Hospital fees	90%	60%	90%
Infertility			
Office Visit (non-surgical)	100%	N/A	100%
Drugs	80%	N/A	N/A
Other	90%	N/A	90%
Lab & X-ray	90%	60%	90%
Mammography and Pap smears	100%	60%	100%
Mental disorders			
Inpatient	90%	60%	90%
Outpatient	100%	60%	100%
National Medical Excellence Travel & Lodging Expenses(for organ transplants)	100%	N/A	N/A
Neurodevelopmental Therapy			
Inpatient	90%	60%	90%
Outpatient	100%	60%	100%
Phenylketonuria formula	N/A	N/A	90%
Physician fees			
Non-surgical office visits	100%	60%	100%
Physician fees for			

	In-network Care	Out-of-network Care	Other Health Care
services not provided in an office visit setting in the following specialty areas: cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics/gynecology, neurology, neurosurgery, orthopedics, otolaryngology, plastic surgery, urology, and vascular surgery.			
Aexcel Designated In-Network Specialists	90%	N/A	N/A
Non-Designated In-Network Specialists	80%	N/A	N/A
Other	N/A	60%	90%
Other physician fees	90%	60%	90%
Routine Physical Exams	100%	N/A	100%
Prostheses	90%	60%	90%
Rehabilitative care (includes physical, speech, occupational, cardiac/pulmonary, and massage therapy)			
Inpatient	90%	60%	90%
Outpatient	100%	60%	100%

To be sure that you will receive the In-network benefit available under this Plan, you should verify the provider's status by calling either the provider or the toll-free number shown on your ID card. In addition, if your In-network provider is coordinating your care with other providers, ask your In-network provider to use other In-network providers.

Payment Limits which Apply to Expenses for a Person

Eligible expenses for In-network Care, Out-of-network Care, and Other Health Care will accumulate toward **both** of the Payment Limits listed below: $2,000 ($4,000 for a family) and $3,000 ($6,000 for a family).

In-network Payment Limit

The In-network Payment Limit applies to eligible Covered Medical Expenses which are subject to a Payment Percentage of less than 100%. When such Covered Medical Expenses for which no benefits are paid reach $2,000 for a person ($4,000 for a family) in a calendar year, benefits will be payable at 100% for all In-network Covered Medical Expenses and 100% of the Recognized Charge for Other Health Care Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year. **Any amount over the Recognized Charge for Other Health Care Medical Expenses is the responsibility of the member.**

The following items do not count toward the In-network Payment Limit: the annual deductible; the copayment amounts; the difference between the Negotiated Charge and an In-network actual charge; the difference between the Recognized Charge and Other Health Care actual charges; Covered Medical Expenses for infertility drugs for which no benefits are paid; and any balances remaining after a benefit limit has been expended.

Documentation of costs, for which no benefits were provided, must be submitted to Aetna each time a request for reimbursement of any expenses is made that exceeds the above $2,000 ($4,000 for a family) limit.

Out-of-network Payment Limit

When a person's Out-of-network Covered Medical Expenses for which no benefits are paid reach $3,000 ($6,000 family) in a calendar year, benefits will be payable at 100% of the Recognized Charge for all of his or her Out-of-network Covered Medical Expenses to which this limit applies and which are incurred in the rest of that calendar year.

Out-of-network providers do not have a participating contract with Aetna. They have not agreed to waive expenses for covered services that are over the Recognized Charge. Benefits will be paid at the appropriate Out-of-network payment level once the claim is submitted. **You will be responsible for services or supplies which are not covered, any amounts over the benefit maximums, and any costs over the Recognized Charge.**

The following items do not count toward the Out-of-network Payment Limit: the annual deductible; the copayment amounts; the difference between the Recognized Charge and an Out-of-network actual charge; and any balances remaining after a benefit limit has been expended.

Benefit Maximums

Read the coverage section in your Booklet for a complete description of the benefits available. Services used to satisfy the deductible count toward the Benefit Maximums.

Acupuncture Treatment Maximum	No limit, provided treatment is **Necessary**
Convalescent Maximum	120 days per calendar year
Home Health Care Maximum	130 visits per calendar year
Hospice Care Maximum	
Inpatient and Outpatient Combined	6 months, 6 additional months if authorized
Respite Care	10 days within 6 consecutive months
Neurodevelopmental Therapy Maximum	$3,000 per calendar year
Chemical Dependency Combined Inpatient & Outpatient Maximum	$13,000 within 24 consecutive months for Inpatient and outpatient combined (note: effective 1/1/2006)
Durable Medical and Surgical Equipment Maximum	$5,000 per calendar year
Infertility Services & Drugs Maximum	$2,000 per calendar year
Rehabilitation Services	
Inpatient Maximum	120 days per calendar year
Physical and Massage Therapy Outpatient Maximum	20 visits per calendar year
Speech Therapy Outpatient Maximum	20 visits per calendar year
Occupational Therapy Outpatient Maximum	20 visits per calendar year
Cardiac/Pulmonary Therapy Outpatient Maximum	20 visits per calendar year
Manipulation Treatment Maximum	20 visits per calendar year
National Medical Excellence	
Lodging Expenses Maximum	$50.00 per day per person
Travel and Lodging Maximum	$10,000 per episode of care
Private Room Limit	The institution's semiprivate rate
Lifetime Maximum Benefit	$2,000,000 – City of Seattle Traditional Plan and City of Seattle

	Preventive Plan have a combined Lifetime Maximum Benefit that applies to in- and out-of-network expenses.

Except for the Lifetime Maximum Benefit, benefits received from one of the employer's medical plans for active employees shall not be used in computing benefit limits under this Plan.

Pregnancy Coverage

Benefits are payable for pregnancy-related expenses of female members and dependents on the same basis as for a disease.

In the event of an inpatient confinement:

- Such benefits will be payable for inpatient care of the covered person and any newborn child for: a minimum of 48 hours following a vaginal delivery; and a minimum of 96 hours following a cesarean delivery. If, after consultation with the attending physician, a person is discharged earlier, benefits will be payable for 2 post-delivery home visits by a health care provider.

- Certification of the first 48 hours of such confinement following a vaginal delivery or the first 96 hours of such confinement following a cesarean delivery is not required. Any day of confinement in excess of such limits must be certified. You, your physician, or other health care provider may obtain such certification by calling the number shown on your ID card.

Any pregnancy benefits payable by previous group medical coverage will be subtracted from medical benefits payable for the same expenses under this Plan.

Sterilization Coverage

Benefits are payable for charges made in connection with any procedure performed for sterilization of a person, including voluntary sterilization, on the same basis as for a disease.

Adjustment Rule

If, for any reason, a person is entitled to a different amount of coverage, coverage will be adjusted. Benefits for claims incurred after the date the adjustment becomes effective are payable in accordance with the revised plan provisions. In other words, there are no vested rights to benefits based upon provisions of this Plan in effect prior to the date of any adjustment.

General
This Summary of Coverage replaces any Summary of Coverage previously in effect under your plan of health benefits. Requests for coverage other than that to which you are entitled in accordance with this Summary of Coverage cannot be accepted.

Additional Information Provided by The City of Seattle

Statement of Rights under the Newborns' and Mothers' Health Protection Act

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may 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 vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Notice regarding Women's Health and Cancer Rights Act

Under this health plan, coverage will be provided to a person who is receiving benefits for a medically necessary mastectomy and who elects breast reconstruction after the mastectomy, for:

(1) reconstruction of the breast on which a mastectomy has been performed;
(2) surgery and reconstruction of the other breast to produce a symmetrical appearance;
(3) prostheses; and
(4) 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.

If you have any questions about our coverage of mastectomies and reconstructive surgery, please contact the Member Services number on the back of your ID card.

Part II
Health Expense Coverage

Employer: City of Seattle

ASA: 100290

Booklet Base: 11

Issue Date: April 10, 2006

Effective Date: October 1, 2005

Health Expense Coverage is expense-incurred coverage only and not coverage for the disease or injury itself. This means that this Plan will pay benefits only for eligible expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for health expenses incurred before coverage has commenced or after coverage has terminated; even if the expenses were incurred as a result of an accident, injury, or disease which occurred, commenced, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro rata share of the expense. The pro rata share will be determined by Aetna. Only that pro rata share of the expense will be considered to have been an expense incurred on the date of such service.

Aetna assumes no responsibility for the outcome of any covered services or supplies. Aetna makes no express or implied warranties concerning the outcome of any covered services or supplies.

Prescription Drug Expense Coverage

Prescription Drug Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all **prescription drugs**. There are exclusions, copayment features, and, if applicable to this Plan, deductible and maximum benefit features. They are described in this Booklet. Certain drugs may be limited to a lesser supply as indicated on the Member's prescription or as determined by Aetna.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Prescription Drug Expenses described below.

Covered Prescription Drug Expenses

This Plan pays the benefits shown below for certain **prescription drug** expenses incurred for the treatment of a disease or injury. These benefits apply separately to each covered person.

If a **prescription drug** is dispensed by an **In-network pharmacy** to a person for treatment of a disease or injury, a benefit will be paid, determined from the Benefit Amount subsection, but only if the **In-network pharmacy's** charge for the drug is more than the **copay** per **prescription** or refill. If a member's card is not presented at the pharmacy, no benefit applies, except in the event of an emergency.

Benefit amounts provided under this section will not be subject to any provision under this Plan for coordination of benefits with other plans, except the provision for coordinating benefits under this Plan with any Medicare benefits.

Benefit Amount

The benefit amount for each covered **prescription drug** or refill dispensed by an **In-network pharmacy** will be an amount equal to the Payment Percentage of the total charges. The total charge is determined by:

- the **In-network pharmacy**; and
- Aetna.

Any amount so determined will be paid to the **In-network pharmacy** on your behalf.

No benefit will be paid for a **prescription drug** dispensed by an **Out-of-network pharmacy** under this benefit section except for an **emergency condition**, in which case the benefit will be payable at the In-network level of coverage.

Limitations
No benefits are paid under this section:

- For a device of any type unless specifically included as a **prescription drug**.
- For any drug entirely consumed at the time and place it is prescribed.
- For less than a 31 day supply of any drug dispensed by a **mail order pharmacy**.
- For more than a 31 day supply per **prescription** or refill. However, this limitation does not apply to a supply of up to 90 days per **prescription** or refill for drugs which are provided by a **mail order pharmacy**.
- For the administration or injection of any drug.
- For the following injectable drugs:
  - allergy sera or extracts; and
  - Imitrex, if it is more than the 48th such kit or 96th such vial dispensed to the person in any year.

- For any refill of a drug if it is more than the number of refills specified by the **prescriber**. Before recognizing charges, Aetna may require a new **prescription** or evidence as to need:
  - if the **prescriber** has not specified the number of refills; or
  - if the frequency or number of **prescriptions** or refills appears excessive under accepted medical practice standards.

- For any refill of a drug dispensed more than one year after the latest **prescription** for it or as permitted by the law of the jurisdiction in which the drug is dispensed.
- For any drug provided by or while the person is an inpatient in any health care facility; or for any drug provided on an outpatient basis in any health care facility to the extent benefits are paid for it under any other part of this Plan or under any other medical or **prescription drug** expense benefit plan carried or sponsored by your Employer.
- For any **prescription drug** also obtainable without a **prescription** on an "over the counter" basis.
- For immunization agents (covered under Medical Expenses).
- For biological sera and blood products.
- For nutritional supplements.
- For any fertility drugs (covered under Medical Expenses).
- For any drugs or supplies, other than up to 6 unit doses per 30 day supply of Viagra or sildenafil citrate, used for the treatment of erectile

dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to:

- phentolamine;
- apomorphine;
- alprostadil; or
- any other **prescription drug** that
  - is in a similar or identical class,
  - has a similar or identical mode of action or exhibits similar or identical outcomes.

This limitation applies whether or not the **prescription drug** is delivered in oral, injectable, or topical (including, but not limited to, gels, creams, ointments, and patches) forms. If the drug is not taken orally, the dosage covered will be determined by Aetna based on the comparable cost for a 30 day supply of pills.

- For any smoking cessation aids or drugs.
- For appetite suppressants and drugs for weight loss.
- For drugs or medications used for cosmetic purposes.
- For replacement prescriptions resulting from loss, theft or breakage.
- For general and injectable vitamins, except legend vitamins will be provided for prenatal care.
- For growth hormones (covered under Medical Expenses for certain conditions only).
- For drugs provided for chemical dependency treatments (covered under Medical Expenses).
- For a **prescription drug** dispensed by a **mail order pharmacy** that is not an **In-network pharmacy**.

Comprehensive Medical Expense Coverage

Comprehensive Medical Expense Coverage is merely a name for the benefits in this section. It does not provide benefits covering expenses incurred for all medical care. There are exclusions, deductibles, copayment features and stated maximum benefit amounts. These are all described in the Booklet.

The Summary of Coverage outlines the Payment Percentages that apply to the Covered Medical Expenses described below.

Covered Medical Expenses

They are the expenses for certain **hospital** and other medical services and supplies. They must be for the treatment of an injury or disease.

Here is a list of Covered Medical Expenses.

Hospital Expenses

Inpatient Hospital Expenses

Charges made by a **hospital** for giving **board and room** and other **hospital** services and supplies to a person who is confined as a full-time inpatient.

Not included is any **charge** for daily **board and room** in a Semi-private room over the Semi-Private Room Limit.

Outpatient Hospital Expenses

Charges made by a **hospital** for **hospital** services and supplies which are given to a person who is not confined as a full-time inpatient.

Convalescent Facility Expenses

Charges made by a **convalescent facility** for the following services and supplies. They must be furnished to a person while confined to convalesce from a disease or injury.

- Board and room. This includes charges for services, such as general nursing care, made in connection with room occupancy. Not included is any **charge** for daily **board and room** in a Semi-private room over the Semi-Private Room Limit.
- Use of special treatment rooms.
- X-ray and lab work.
- Physical, occupational or speech therapy.
- Oxygen and other gas therapy.
- Other medical services usually given by a **convalescent facility**. This does not include private or special nursing, or **physicians** services.
- Medical supplies.

Benefits will be paid up to the Convalescent Maximum during any one calendar year.

Limitations To Convalescent Facility Expenses

This section does not cover charges made for treatment of:

- Drug addiction.
- Chronic brain syndrome.
- Chemical Dependency.
- Senility.
- Mental retardation.
- Any other mental disorder.

Home Health Care Expenses
Home health care expenses are covered if:

- the charge is made by a **home health care agency**; and
- the care is given under a **home health care plan**; and
- the care is given to a person in his or her home.

Home health care expenses are charges for:

- Part-time or intermittent care by an **R.N.** or by an **L.P.N.** if an **R.N.** is not available.
- Part-time or intermittent home health aide services for patient care.
- Physical, occupational, and speech therapy.
- The following to the extent they would have been covered under this Plan if the person had been confined in a **hospital** or **convalescent facility**:
    - medical supplies;
    - drugs and medicines prescribed by a **physician**; and
    - lab services provided by or for a **home health care agency**.

Benefits will be paid up to the number of visits of the Home Health Care Maximum during any one calendar year. Each visit by a nurse or therapist is one visit. Each visit of up to 4 hours by a home health aide is one visit.

Limitations To Home Health Care Expenses
This section does not cover charges made for:

- Services or supplies that are not a part of the **home health care plan**.
- Services of a person who usually lives with you or who is a member of your or your wife's or husband's family.
- Services of a social worker.
- Transportation.
- Custodial care.

Hospice Care Expenses
Charges made for the following furnished to a person for **Hospice Care** when given as a part of a **Hospice Care Program** are included as Covered Medical Expenses.

Facility Expenses
The charges made in its own behalf by a:

- **hospice facility**;
- **hospital**;
- **convalescent facility**;

which are for:

- Board and room and other services and supplies furnished to a person while a full-time inpatient for pain control; and other acute and chronic symptom management.
- Not included is any **charge** for daily **board and room** in a semi-private room over the Semi-Private Room Limit.
- Services and supplies furnished to a person while not confined as a full-time inpatient.

Other Expenses
Charges made by a **Hospice Care Agency** for:

- Part-time or intermittent nursing care by an **R.N.** or **L.P.N.**
- Medical social services under the direction of a **physician**. These include: assessment of the person's social, emotional, and medical needs; the home and family situation; identification of the community resources which are available to the person; and assisting the person to obtain those resources needed to meet the person's assessed needs.
- Psychological and dietary counseling.
- Consultation or case management services by a **physician**.
- Physical and occupational therapy.
- Part-time or intermittent home health aide services. These consist mainly of caring for the person.
- Medical supplies.
- Drugs and medicines prescribed by a **physician**.
- Respite care up to the Hospice Care Respite Maximum when the person’s family or usual caretaker cannot, or will not, attend to the person’s needs.

Charges made by the providers below, but only if: the provider is not an employee of a **Hospice Care Agency**; and such Agency retains responsibility for the care of the person.

- A **physician** for consultant or case management services.
- A physical or occupational therapist.
- A **Home Health Care Agency** for:
  - physical and occupational therapy;
  - part-time or intermittent home health aide services; these consist mainly of caring for the person;
  - medical supplies;
  - drugs and medicines prescribed by a **physician**; and
  - psychological and dietary counseling.

Hospice Lifetime Maximum
Not more than the Hospice Care Maximum will be paid for all Hospice Care Expenses. If authorized, an additional 6 months is available.

However, not included are charges incurred in excess of 12 months for all Hospice Care Expenses.

Not included are charges made:

- For bereavement counseling.
- For funeral arrangements.
- For pastoral counseling.
- For financial or legal counseling. This includes estate planning and the drafting of a will.
- For homemaker or caretaker services. These are services which are not solely related to care of the person. These include: sitter or companion services for either the person who is ill or other members of the family; transportation; housecleaning; and maintenance of the house.
- For respite care, except as stated under Other Expenses.

Routine Physical Exams

The charges made by a **physician** for a routine physical exam given to you, your spouse, your domestic partner, or your dependent child may be included as Covered Medical Expenses. If charges made by a **physician** in connection with a routine physical exam given to a dependent child are Covered Medical Expenses under any other benefit section, no charges in connection with that physical exam will be considered Covered Medical Expenses under this section. A routine physical exam is a medical exam given by a **physician** for a reason other than to diagnose or treat a suspected or identified injury or disease. Included as a part of the exam are:

- X-rays, lab, and other tests given in connection with the exam; and
- materials for the administration of immunizations for infectious disease and testing for tuberculosis.
- a review and written record of the patient's complete medical history
- a review and discussion of the exam results with the patient or with the parent or guardian.

Not covered are charges for:

- Services and supplies furnished by an **Out-of-network Provider**, except for mammography and routine obstetrics/gynecological exams, including pap smears.
- Services which are for diagnosis or treatment of a suspected or identified injury or disease.
- Exams given while the person is confined in a **hospital** or other facility for medical care.
- Services which are not given by a **physician** or under his or her direct supervision.
- Medicines, drugs, appliances, equipment, or supplies.

- Psychiatric, psychological, personality or emotional testing or exams.
- Exams in any way related to employment.
- Premarital or dental exams.

For your dependent child, the following Covered Medical Expenses will be covered:

- All exams given to your dependent child under age 6.
- All exams given to your dependent child age 6 up to age 12, Covered Medical Expenses will not include charges for more than 2 exams in a calendar year.
- All exams given to your dependent child age 12 and over, Covered Medical Expenses will not include charges for more than one exam in a calendar year.

For all exams given to you, your spouse, or your domestic partner, Covered Medical Expenses will not include charges for more than one exam in a calendar year for each covered person.

Neurodevelopmental Therapy Expenses
The charges made for the services of a **physician** for rendering Neurodevelopmental Therapy Services are included as Covered Medical Expenses for your dependent child under age 7.

Neurodevelopmental Therapy Services means speech therapy, physical therapy, or occupational therapy given to:

- restore or improve a speech or body function; or
- develop a speech or body function delayed by a neurological disease; or
- maintain a speech or body function if, without therapy, a neurological disease would cause significant deterioration in the person's condition.

Not more than the Neurodevelopmental Therapy Maximum will be considered Covered Medical Expenses for each person during any calendar year.

Not included are charges for services rendered by a person who resides with you or who is part of your family.

The dependent child is not eligible for both this benefit and the rehabilitative benefits of this Plan for the same condition and services.

Other Medical Expenses
- Charges made by a **physician**.
- Charges made by an **R.N.** or **L.P.N.** or a nursing agency for skilled nursing care. As used here, "skilled nursing care" means visiting nursing care by an **R.N.** or **L.P.N.** Visiting nursing care means a visit of not more than 4 hours for the purpose of performing specific skilled

nursing tasks.
Not included as "skilled nursing care" is:

a. that part or all of any nursing care that does not require the education, training, and technical skills of an **R.N.** or **L.P.N.**; such as transportation, meal preparation, charting of vital signs, and companionship activities; or
b. any private duty nursing care given while the person is an inpatient in a **hospital** or other health care facility; or
c. care provided to help a person in the activities of daily life; such as bathing, feeding, personal grooming, dressing, getting in and out of bed or a chair, or toileting; or
d. care provided solely for skilled observation except as follows:
   - for no more than one 4-hour period per day for a period of no more than 10 consecutive days following the occurrence of:
   - change in patient medication;
   - need for treatment of an **emergency condition** by a **physician** or the onset of symptoms indicating the likely need for such treatment;
   - surgery; or
   - release from inpatient confinement; or
   - any service provided solely to administer oral medicines; except where applicable law requires that such medicines be administered by an **R.N.** or **L.P.N.**

- Charges for the following:
  a. Diagnostic lab work and X-rays.
  b. X-ray, radium, and radioactive isotope therapy.
  c. Anesthetics and oxygen.
  d. Professional ambulance service to transport a person from the place where he or she is injured or stricken by disease to the first **hospital** where treatment is given. Air ambulance is covered. Benefits for licensed air ambulance service will be provided to the nearest Hospital equipped to render the necessary treatment as determined by Aetna, upon review and approval by Aetna. Non-emergency use of ambulance services must be pre-authorized.
  e. Artificial limbs and eyes and other medically necessary prosthetic devices are limited to a single purchase of each type of prosthetic. Except when necessitated due to a change in your medical condition or to improve physical function, no coverage is provided for repair, replacement or duplicates; or for services related to the repair or replacement. Not included are such things as eyeglasses; vision aids; hearing aids; communication aids; and orthopedic shoes, foot orthotics, or other devices to support the feet.

Durable Medical Equipment Expenses
Charges for rental of **durable medical and surgical equipment** are Covered Medical Expenses. In lieu of rental, the following may be covered:

- The initial purchase of such equipment if Aetna is shown that: long term care is planned; and that such equipment: either cannot be rented; or is likely to cost less to purchase than to rent.
- Repair of purchased equipment.
- Replacement of purchased equipment if Aetna is shown that it is needed due to a change in the person's physical condition; or it is likely to cost less to purchase a replacement than to repair existing equipment or to rent like equipment.

Durable Medical Equipment for which a claim has been submitted and paid while the person is covered under this Plan and delivered within 30 days after termination of coverage will be provided. Benefits will not be payable for more than the Durable Medical and Surgical Equipment Maximum for a person in any calendar year.

National Medical Excellence Program ® (NME)
The NME Program coordinates all solid organ and bone marrow transplants and other specialized care that can not be provided within an **NME Patient's** local geographic area. When care is directed to a facility ("Medical Facility") more than 100 miles from the person's home, this Plan will pay a benefit for Travel and Lodging Expenses, but only to the extent described below.

Travel Expenses
These are expenses incurred by an **NME Patient** for transportation between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

Also included are expenses incurred by a **Companion** for transportation when traveling to and from an **NME Patient's** home and the Medical Facility to receive such services.

Lodging Expenses
These are expenses incurred by an **NME Patient** for lodging away from home while traveling between his or her home and the Medical Facility to receive services in connection with a procedure or treatment.

The benefit payable for these expenses will not exceed the Lodging Expenses Maximum per person per night.

Also included are expenses incurred by a **Companion** for lodging away from home:

- while traveling with an **NME Patient** between the **NME Patient's** home and the Medical Facility to receive services in connection with any listed procedure or treatment; or
- when the **Companion's** presence is required to enable an **NME Patient** to receive such services from the Medical Facility on an inpatient or outpatient basis.

For the purpose of determining NME Travel Expenses and Lodging Expenses, a **hospital** or other temporary residence from which an **NME Patient** travels in order to begin a period of treatment at the Medical Facility, or to which he or she travels after discharge at the end of a period of treatment, will be considered to be the **NME Patient's** home.

Travel and Lodging Benefit Maximum
For all Travel Expenses and Lodging Expenses incurred in connection with any one procedure or treatment type:

- The total benefit payable will not exceed the Travel and Lodging Maximum per episode of care.
- Benefits will be payable only for such expenses incurred during a period which begins on the day a covered person becomes an **NME Patient** and ends on the earlier to occur of:
    - one year after the day the procedure is performed; and
    - the date the **NME Patient** ceases to receive any services from the facility in connection with the procedure.

Benefits paid for Travel Expenses and Lodging Expenses do not count against any person's Lifetime Maximum Benefit.

Limitations
Travel Expenses and Lodging Expenses do not include, and no benefits are payable for, any charges which are included as Covered Medical Expenses under any other part of this Plan.

Travel Expenses do not include expenses incurred by more than one **Companion** who is traveling with the **NME Patient**.

Lodging Expenses do not include expenses incurred by more than one **Companion** per night.

Explanation of Some Important Plan Provisions

Inpatient Copayment
This is the amount of Inpatient Expenses you pay for each **hospital, convalescent facility, mental disorder treatment facility,** and/or **chemical dependency treatment facility** confinement of a person. Expenses used to meet the Inpatient Copayment cannot be used to meet

any other applicable deductible. Expenses used to meet any other applicable deductible cannot be used to meet the Inpatient Copayment.

Calendar Year Deductible
This is the amount of Covered Medical Expenses you pay each calendar year before Out-of-network benefits are paid. There is a Calendar Year Deductible that applies to each person.

Deductible Carryover
Effective 2002, Covered Medical Expenses incurred during the last 3 months of the calendar year will be applied to the deductible for the following calendar year.

Family Deductible Limit
If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductible equal the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductible for the rest of that calendar year.

Hospital Emergency Room Copayment
A separate Hospital Emergency Room Copayment applies to each visit by a person in a **hospital** emergency room unless the person is admitted to the **hospital** as an inpatient within 24 hours after a visit to a **hospital** emergency room.

Lifetime Maximum Benefit
This is the most that will be payable for any person in his or her lifetime for expenses incurred under both the City of Seattle Traditional Plan and the City of Seattle Preventive Plan combined.

Limitations

Routine Screening for Cancer
Even though not incurred in connection with a disease or injury, Covered Medical Expenses include charges incurred for:

- a routine mammogram; and
- a routine Pap smear;

for routine screening for cancer per calendar year.

Infertility Services
Even though not incurred for treatment of a disease or injury, Covered Medical Expenses will include expenses incurred by a covered female for the diagnosis and treatment of the underlying cause of infertility.

In-network expenses will be covered on the same basis as for disease. Benefits will not be payable for more than the Infertility Services and Drugs Maximum for a person in any one calendar year. Covered Medical Expenses for Infertility Drugs for which no benefits are paid do not apply toward the In-network Payment Limit. Out-of-network infertility services are not covered.

Acupuncture Expenses
The charges made for acupuncture services given to a person by:

- a **physician**; or
- an acupuncturist certified by the American Association of Acupuncture and Oriental Medicine who is practicing within the scope of both the certification and the laws of the jurisdiction where treatment is given;

are Covered Medical Expenses.

Acupuncture services are those services rendered:

- as a form of anesthesia in connection with surgery that is covered under this Plan;
- to treat a **disease** or injury; or
- to alleviate chronic pain.

Mouth, Jaws, and Teeth
Expenses for the treatment of the mouth, jaws, and teeth are Covered Medical Expenses, but only those for:

Repair of teeth due to accidental injury—The services of a licensed dentist for repair of accidental injury to natural teeth that are whole and functionally sound or have been restored to a sound functional capacity will be covered, for the treatment of the injury for a period of 12 consecutive months after the date of injury. Dental implants are not covered. The services of a licensed denturist will also be covered if the service would be covered if provided by a licensed dentist (D.M.D. or D.D.S.). A licensed denturist means a person licensed as a denturist under RCW Chapter 18 and acting within the scope of his or her license. Payment will be based on the Recognized Charge, any additional charges will be the person's responsibility. This benefit will not be provided for injury caused by biting or chewing. No other charges of a dentist will be covered under this Plan, except when specifically provided otherwise.

Hospitalization for dentistry—The physician and hospital benefits of this Plan will be provided to an inpatient for dentistry if hospitalization is medically necessary for direct treatment of acute traumatic injury or cancer, subject to the precertification approval procedures. No benefits will be provided for charges of a dentist; or hospitalization for myofascial pain syndrome and any related appliances; or hospitalization for malocclusions or other abnormalities of the jaw, including but not limited to services for temporomandibular joint disorders.

Surgery needed to treat a fracture, dislocation, or wound, or to cut out cysts, tumors, or other diseased tissues.

Non-surgical treatment of infections or diseases. This does not includes those of or related to the teeth.

Rehabilitation Services
Covered Medical Expenses incurred for rehabilitative services are subject to certain limitations. Rehabilitative services are:

- speech therapy;
- occupational therapy;
- cardiac/pulmonary therapy; and
- physical and massage therapy

provided by a:
- hospital or licensed health care facility
- physician
- licensed or certified physical, occupational, massage, speech, or cardiac/pulmonary therapist

Rehabilitation Services are therapy which are expected to result in the improvement of a body function (including the restoration of the level of an existing speech function), which has been lost or impaired due to an injury, disease or a congenital defect.

Benefits will not be payable for more than the Rehabilitation Services Inpatient Maximum for a person who is confined as a full-time inpatient. As to services which are provided while a person is not confined as a full-time inpatient benefits will not be payable for more than the:

- Rehabilitation Services Physical and Massage Therapy Outpatient Maximum for Physical and Massage Therapy;
- Rehabilitation Services Speech Therapy Outpatient Maximum for Speech Therapy;
- Rehabilitation Services Occupational Therapy Outpatient Maximum for Occupational Therapy; and
- Rehabilitation Services Cardiac/Pulmonary Therapy Outpatient Maximum for Cardiac/Pulmonary Therapy.

A Physician's medical order is required prior to the receipt of outpatient services for Physical, Massage and/or Occupational Therapy.

Not covered are charges for:

- Services which are covered to any extent under any other part of this Plan.
- Services received while the person is confined in a **hospital** or other facility for medical care.
- Services rendered by a physical, massage, occupational, speech, or cardiac/pulmonary therapist who resides in the person's home or who is a part of the family of either the person or the person's spouse.
- Services rendered for the treatment of delays in speech development, unless resulting from disease; injury; or congenital defect.
- Special education, including lessons in sign language, to instruct a person whose ability to speak has been lost or impaired to function without that ability.
- Treatment for which a benefit is or would be provided under the Manipulation Treatment section, whether or not benefits for the maximum number of visits under that section have been paid.

Also, not covered are any services unless they are provided in accordance with a specific treatment plan which:

- details the treatment to be rendered and the frequency and duration of the treatment.
- provides for ongoing reviews and is renewed only if therapy is still necessary.

Manipulation Treatment
There is a calendar year benefit maximum which applies to Covered Medical Expenses incurred for:

- manipulative (adjustive) treatment; or
- other physical treatment;

of any condition caused by or related to biomechanical or nerve conduction disorders when performed by an approved provider if the service is within the lawful scope of the provider's license.

Benefits will not be payable for more than the Manipulation Treatment Maximum in any one calendar year.

The maximum does not apply to expenses incurred:

- while the person is a full-time inpatient in a **hospital**;
- for treatment of scoliosis;

- for fracture care; or
- for surgery. This includes pre and post surgical care given or ordered by the operating **physician**.

Certification For Hospital Admissions

If a person becomes confined in a **hospital** as a full-time inpatient, and
- certification has been requested and denied, or
- certification has not been requested and the confinement is not **necessary**;

no benefits will be paid for any expenses, including hospital room and board and physician services.

If a person becomes confined in a hospital as a full-time inpatient, and
- certification has not been requested, and
- the confinement is **necessary**,

benefits will be paid at the Payment Percentage.

Whether or not a day of confinement is certified, no benefit will be paid for Covered Medical Expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan or are determined to be not **necessary**.

Certification of days of confinement can be obtained as follows:

If the admission is a **non-urgent admission**, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an **emergency admission** or an **urgent admission**, you, the person's **physician**, or the **hospital** must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission**; or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible. (In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.)

  If, in the opinion of the person's **physician**, it is necessary for the person to be confined for a longer time than already certified, you, the **physician**, or the **hospital** may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital**. A copy will be sent to you and to the **physician**.

Certification For Convalescent Facility Admissions, Home Health Care Expenses, Hospice Care Expenses, and Skilled Nursing Care

If a person incurs expenses while confined in a **convalescent facility**; or for home health, hospice, or skilled nursing care, and

- certification has been requested and denied, or
- certification has not been requested and the convalescent facility confinement, or home health care services, hospice care services, or skilled nursing care services are **not necessary**;

no benefits will be paid for any expenses.

If a person becomes confined in a convalescent facility or incurs expenses for home health care services, hospice care services or skilled nursing care services, and

- certification has not been requested, and
- the convalescent facility confinement, home health care, hospice care, or skilled nursing care services are **necessary**,

benefits will be paid at the Payment Percentage.

Whether or not a day of confinement or a service or supply has been certified, no benefit will be paid if the charges for such confinement or service or supply are excluded by any other terms of this Plan, or are determined to be not **necessary**.

To get certification, you must call the number shown on your ID card. Such certification must be obtained before an expense is incurred.

If a person's **physician** believes that the person needs more days of confinement or services or supplies beyond those which have been already certified, you, the provider or the facility must call to certify more days of confinement or services or supplies. This must be done no later than on the last day that has already been certified.

Prompt written notice will be provided to you and your provider of the days of confinement and services or supplies which have been certified.

Certification For Hospital and Treatment Facility Admissions for Chemical Dependency or Mental Disorders

If a person becomes confined as a full-time inpatient in a **hospital** or **treatment facility** for treatment of chemical dependency or mental disorder, and

- certification has been requested and denied, or
- certification has not been requested and the confinement is not **necessary**;

no benefits will be paid for any expenses, including hospital or facility room and board and physician services.
If a person becomes confined in a hospital or treatment facility as a full-time inpatient, and

- certification has not been requested, and
- the confinement is **necessary**,

benefits will be paid at the Payment Percentage.

Whether or not a day of confinement is certified, no benefits will be payable for Covered Medical Expenses incurred on any day of confinement as a full-time inpatient if excluded by any other terms of this Plan or are determined to be not necessary.

Certification of days of confinement can be obtained as follows:
If the admission is a **non-urgent admission**, you must get the days certified by calling the number shown on your ID card. This must be done at least 14 days before the date the person is scheduled to be confined as a full-time inpatient. If the admission is an **emergency admission** or an **urgent admission**, you, the person's **physician**, or the **hospital** must get the days certified by calling the number shown on your ID card. This must be done:

- before the start of a confinement as a full-time inpatient which requires an **urgent admission**; or
- not later than 48 hours following the start of a confinement as a full-time inpatient which requires an **emergency admission**; unless it is not possible for the **physician** to request certification within that time. In that case, it must be done as soon as reasonably possible. (In the event the confinement starts on a Friday or Saturday, the 48 hour requirement will be extended to 72 hours.)

If the person's **physician** believes that the person needs more days of confinement beyond those which have already been certified, you, the **physician**, or the **hospital** or **treatment facility** may request that more days be certified by calling the number shown on your ID card. This must be done no later than on the last day that has already been certified.

Written notice of the number of days certified will be sent promptly to the **hospital** or **treatment facility**. A copy will be sent to you and to the **physician**.

Treatment of Chemical Dependency or Mental Disorders
Certain expenses for the treatment shown below are Covered Medical Expenses.

Inpatient Treatment
If a person is a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

Hospital
Expenses for the following are covered:

- Treatment of the medical complications of chemical dependency. This means things such as cirrhosis of the liver, delirium tremens, or hepatitis.
- **Treatment of chemical dependency**.
- Treatment of **mental disorders**.

Treatment Facility
Certain expenses for the **treatment of chemical dependency** or the treatment of **mental disorders** are covered. The expenses covered are those for:

- Board and room. Not covered is any **charge** for daily **board and room** in a semi-private room over the Semi-Private Room Limit.
- Other **necessary** services and supplies.

.

A separate Chemical Dependency Combined Inpatient and Outpatient Maximum applies to all expenses for the **treatment of chemical dependency** incurred in any 24 consecutive month period.

Outpatient Treatment
If a person is not a full-time inpatient either:

- in a **hospital**; or
- in a **treatment facility**;

then the coverage is as shown below.

- Expenses for the **treatment of chemical dependency** or the treatment of **mental disorders** are covered.
- A separate Chemical Dependency Combined Inpatient and Outpatient Maximum applies to all expenses for the **treatment of chemical dependency** incurred in any 24 consecutive month period.

General Exclusions

General Exclusions Applicable to Health Expense Coverage

Coverage is not provided for the following charges:

- Those for services and supplies not **necessary**, as determined by Aetna, for the diagnosis, care, or treatment of the disease or injury involved. This applies even if they are prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those for care, treatment, services, or supplies that are not prescribed, recommended, or approved by the person's attending **physician** or **dentist**.
- Those to the extent they are not Recognized Charges, as determined by Aetna.
- Those for or in connection with services or supplies that are, as determined by Aetna, to be experimental or investigational. A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:
  - there are insufficient outcomes data available from controlled clinical trials published in the peer reviewed literature to substantiate its safety and effectiveness for the disease or injury involved; or
  - if required by the FDA, approval has not been granted for marketing; or
  - a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational, or for research purposes; or
  - the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure, or treatment states that it is experimental, investigational, or for research purposes.
- Those for or related to services, treatment, education testing, or training related to learning disabilities or developmental delays, except as stated under the Neurodevelopmental Therapy Expenses benefit.
- Those for care furnished mainly to provide a surrounding free from exposure that can worsen the person's disease or injury.
- Those for or related to the following types of treatment: primal therapy; rolfing; hypnotism, aromatherapy, psychodrama; megavitamin therapy; bioenergetic therapy; vision perception training; or carbon dioxide therapy.

- Those for treatment of covered health care providers who specialize in the mental health care field and who receive treatment as a part of their training in that field.
- Those for services of a resident **physician** or intern rendered in that capacity.
- Those that are made only because there is health coverage.
- Those that a covered person is not legally obliged to pay.
- Those, as determined by Aetna, to be for **custodial care**.
- Those for services and supplies:
    - Furnished, paid for, or for which benefits are provided or required by reason of the past or present service of any person in the armed forces of a government.
    - Furnished, paid for, or for which benefits are provided or required under any law of a government. (This exclusion will not apply to "no fault" auto insurance if it: is required by law; is provided on other than a group basis; and is included in the definition of Other Plan in the section entitled Effect of Benefits Under Other Plans Not Including Medicare. In addition, this exclusion will not apply to: a plan established by government for its own employees or their dependents; or Medicaid.)

- Those for or related to any eye surgery mainly to correct refractive errors.
- Those for education or special education or job training whether or not given in a facility that also provides medical or psychiatric treatment.
- Those for therapy, supplies, or counseling for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.
- Those for any drugs or supplies, other than up to 6 unit doses per 30 day supply of Viagra or sildenafil citrate, used for the treatment of erectile dysfunction, impotence, or sexual dysfunction or inadequacy, including but not limited to:
    - phentolamine;
    - apomorphine;
    - alprostadil; or
    - any other drug that
        - is in a similar or identical class,
        - has a similar or identical mode of action or exhibits similar or identical outcomes.

This exclusion applies whether or not the drug is delivered in oral, injectable, or topical (including but not limited to gels, creams, ointments, and patches) forms, except to the extent coverage for such drugs or supplies is specifically provided in your Booklet.

- Those for performance, athletic performance or lifestyle enhancement drugs or supplies, except to the extent coverage for such drugs or

supplies is specifically provided in your Booklet.

- Those for or related to sex change surgery or to any treatment of gender identity disorders.
- Those for or related to artificial insemination, in vitro fertilization, or embryo transfer procedures or other artificial means of contraception, except to the extent coverage for such procedures is specifically provided in your Booklet.
- Those for routine physical exams, routine vision exams, routine dental exams, routine hearing exams, immunizations, or other preventive services and supplies, except to the extent coverage for such exams, immunizations, services, or supplies is specifically provided in your Booklet. Excluded are services (a) for purposes of obtaining, maintaining or otherwise relating to career, education, sports or camp, travel, employment, insurance, marriage or adoption; (b) relating to judicial or administrative proceedings or orders; (c) conducted for purposes of medical research; and (d) to obtain or maintain a license of any type.
- Those for or in connection with marriage, family, child, career, social adjustment, pastoral, or financial counseling.
- Those for or in connection with speech therapy, except as provided under the Neurodevelopmental Therapy Expenses benefit. This exclusion does not apply to charges for speech therapy that is expected to restore speech to a person who has lost existing speech function (the ability to express thoughts, speak words, and form sentences) as the result of a disease or injury.
- Those for plastic surgery, reconstructive surgery, cosmetic surgery, or other services and supplies which improve, alter, or enhance appearance, whether or not for psychological or emotional reasons; except to the extent needed to:
    a. Improve the function of a part of the body that is not a tooth or structure that supports the teeth; and is malformed as a result of a severe birth defect; including harelip, webbed fingers, or toes; or as a direct result of disease; or surgery performed to treat a disease or injury.
    b. Repair an injury. Surgery must be performed in the calendar year of the accident which causes the injury, or in the next calendar year.
- Those for the reversal of a sterilization procedure.
- Those for repair or replacement for any otherwise covered implant.
- Penile implants for the treatment of impotence having a psychological origin.
- Those for cochlear implants and hearing aids
- Those for dyslexia treatment, except as provided under the Neurodevelopmental Therapy Expense benefit, visual analysis, therapy or training, orthoptics.
- Those for Mental Disorders and/or Chemical Dependency services for the following: (1) services utilizing methadone treatment as

maintenance, L.A.A.M. (1-Alpha-Acetyl-Methadol), Cyclazocine, or their equivalents; and (2) services and treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by Aetna as medically necessary.

- Those for equipment such as whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; corrective shoes; enuresis equipment; hearing aids; heating pads; weights; over-the-counter arch supports; orthotics; personal hygiene items; and telephone alert systems.
- Those for outpatient prescribed or non-prescribed medical supplies including but not limited to elastic stockings, ace bandages, gauze and like products; over the counter drugs and treatment.
- Those for weight control services including: surgical procedures; medical treatments; weight control/loss programs; dietary regimens and supplements; appetite suppressants and other medications; food or food supplements; exercise programs; exercise or other equipment; and other services and supplies that are primarily intended to control weight or treat obesity, including morbid obesity, or for the purpose of weight reduction, regardless of the existence of comorbid conditions.
- Those for the treatment of temporomandibular joint syndrome, whether the services are considered to be medical or dental in nature.
- Those for upper and lower jaw bone surgery, except as needed for acute traumatic injury or cancer; orthognathic surgery; jaw alignment; myofascial pain syndrome; malocclusions or other abnormalities of the jaw.
- Those for services and supplies for smoking cessation programs and the treatment of nicotine addiction.
- Those for services provided by a family member.
- Those for a service or supply furnished by an **In-network Provider** in excess of such provider's **Negotiated Charge** for that service or supply. This exclusion will not apply to any service or supply for which a benefit is provided under Medicare before the benefits of the group contract are paid.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.

These excluded charges will not be used when figuring benefits.

The law of the jurisdiction where a person lives when a claim occurs may prohibit some benefits. If so, they will not be paid.

Effect of Benefits Under Other Plans

Other Plans Not Including Medicare

Some persons have health coverage in addition to coverage under this Plan. Under these circumstances, it is not intended that a plan provide duplicate benefits. For this reason, many plans, including this Plan, have a "coordination of benefits" provision.

Under the coordination of benefits provision of this Plan, the amount normally reimbursed under this Plan is reduced to take into account payments made by "other plans".

When this and another health expenses coverage plan applies, the order in which the various plans will pay benefits must be figured. This will be done as follows using the first rule that applies:

1. A plan with no rules for coordination with other benefits will be deemed to pay its benefits before a plan which contains such rules.

2. A plan which covers a person other than as a dependent will be deemed to pay its benefits before a plan which covers the person as a dependent; except that if the person is also a Medicare beneficiary and as a result of the Social Security Act of 1965, as amended, Medicare is:

   - secondary to the plan covering the person as a dependent; and
   - primary to the plan covering the person as other than a dependent;

   the benefits of a plan which covers the person as a dependent will be determined before the benefits of a plan which:

   - covers the person as other than a dependent; and
   - is secondary to Medicare.

3. Except in the case of a dependent child whose parents are divorced or separated; the plan which covers the person as a dependent of a person whose birthday comes first in a calendar year will be primary to the plan which covers the person as a dependent of a person whose birthday comes later in that calendar year. If both parents have the same birthday, the benefits of a plan which covered one parent longer

are determined before those of a plan which covered the other parent for a shorter period of time.

If the other plan does not have the rule described in this provision (3) but instead has a rule based on the gender of the parent and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

4. In the case of a dependent child whose parents are divorced or separated:

   a. If there is a court decree which states that the parents shall share joint custody of a dependent child, without stating that one of the parents is responsible for the health care expenses of the child, the order of benefit determination rules specified in (3) above will apply.
   b. If there is a court decree which makes one parent financially responsible for the medical, dental or other health care expenses of such child, the benefits of a plan which covers the child as a dependent of such parent will be determined before the benefits of any other plan which covers the child as a dependent child.
   c. If there is not such a court decree:
      - If the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody.
      - If the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent. The benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

5. If 1, 2, 3 and 4 above do not establish an order of payment, the plan under which the person has been covered for the longest will be deemed to pay its benefits first; except that:

   The benefits of a plan which covers the person on whose expenses claim is based as a:

   - laid-off or retired employee; or
   - the dependent of such person;

shall be determined after the benefits of any other plan which covers such person as:

- an employee who is not laid-off or retired; or
- a dependent of such person.

If the other plan does not have a provision:

- regarding laid-off or retired employees; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The benefits of a plan which covers the person on whose expenses claim is based under a right of continuation pursuant to federal or state law shall be determined after the benefits of any other plan which covers the person other than under such right of continuation.

If the other plan does not have a provision:

- regarding right of continuation pursuant to federal or state law; and
- as a result, each plan determines its benefits after the other;

then the above paragraph will not apply.

The general rule is that the benefits otherwise payable under this Plan for all expenses processed during a single "processed claim transaction" will be reduced by the total benefits payable under all "other plans" for the same expenses. An exception to this rule is that when the coordination of benefits rules of this Plan and any “other plan” both agree that this Plan is primary, the benefits of the other plan will be ignored in applying this rule. As used in this paragraph, a "processed claim transaction" is a group of actual or prospective charges submitted to Aetna for consideration, that have been grouped together for administrative purposes as a "claim transaction" in accordance with Aetna's then current rules.

In order to administer this provision, Aetna can release or obtain data. Aetna can also make or recover payments.

Other Plan

This means any other plan of health expense coverage under:

- Group insurance.
- Any other type of coverage for persons in a group. This includes plans that are insured and those that are not.
- No-fault auto insurance required by law and provided on other than a group basis. Only the level of benefits required by the law will be counted.

This definition does not include accident-only coverage for preschool,

grammar school, high school, or college students, including athletic injuries, either on a 24-hour basis or a “to and from school” basis.

Effect of Medicare

Coverage will not be changed at any time when your Employer's compliance with federal law requires this Plan's benefits for a person to be figured before benefits are figured under Medicare.

Health Expense Coverage will be changed for any person while eligible for Medicare.

A person is "eligible for Medicare" if he or she:

- is covered under it;
- is not covered under it because of:
  - having refused it;
  - having dropped it;
  - having failed to make proper request for it.

These are the changes:

- The total amount of "regular benefits" under all Health Expense Benefits will be figured. (This will be the amount that would be payable if there were no Medicare benefits.) If this is more than the amount Medicare provides for the expenses involved, this Plan will pay the difference. Otherwise, this Plan will pay no benefits. This will be done for each claim.
- Charges used to satisfy a person's Part B deductible under Medicare will be applied under this Plan in the order received by Aetna. Two or more charges received at the same time will be applied starting with the largest first.
- Medicare benefits will be taken into account for any person while he or she is eligible for Medicare. This will be done whether or not he or she is entitled to Medicare benefits.
- Any rule for coordinating "other plan" benefits with those under this Plan will be applied after this Plan's benefits have been figured under the above rules.
- Any benefits under Medicare will not be deemed to be an "Allowable Expenses".

If it is necessary in order to administer this provision, Aetna has the right to:

- release or obtain data; and
- make or recover any payments.

General Information About Your Coverage

Termination of Coverage

Coverage under this Plan terminates at the first to occur of:

- When the group contract terminates as to the coverage.
- When you are no longer in an Eligible Class. (This may apply to all or part of your coverage.)
- When you fail to make any required contribution.

Your Employer will notify Aetna of the date your eligibility ceases for the purposes of termination of coverage under this Plan. This date will be the later of the date you cease to be in an Eligible Class or the day before the next premium due date following the date you cease to be in an Eligible Class.

Dependents Coverage Only
A dependent's coverage will terminate at the first to occur of:

- Termination of all dependents' coverage under the group contract.
- When a dependent becomes covered as an employee, unless dependent status is maintained under this Plan through a spouse's or domestic partner's coverage.
- When such person is no longer a defined dependent.
- When your coverage terminates.

Disabled Dependent Children

Health Expense Coverage for your fully disabled child may be continued past the maximum age for a dependent child if the child has not been issued a personal medical conversion policy.

Your child is fully disabled if:

- he or she is not able to earn his or her own living because of developmental or physical disability which started prior to the date he or she reaches the maximum age for dependent children; and
- he or she depends chiefly on you for support and maintenance.

Proof that your child is fully disabled must be submitted to Aetna no later than 31 days after the date your child reaches the maximum age.

Coverage will cease on the first to occur of:

- Cessation of the disability.
- Failure to give proof that the disability continues.
- Failure to have any required exam.
- Termination of Dependent Coverage as to your child for any reason other than reaching the maximum age.

Aetna will have the right to require proof of the continuation of the disability. Aetna also has the right to examine your child as often as needed while the disability continues at its own expense. An exam will not be required more often than once each year after 2 years from the date your child reached the maximum age.

Health Expense Benefits After Termination

If a person is hospitalized when his or her Health Expense Coverage ceases, benefits will be available to such person while he or she continues to be hospitalized up to the applicable period shown below.

Health Expense benefits will be available to him or her while hospitalized for up to 12 months.

Health Expense benefits will cease on the first to occur of the following:

- The person's Lifetime Maximum Benefit is paid.
- The person ceases to be hospitalized.
- The person becomes covered under any group plan with like benefits. (This does not apply if his or her coverage ceased because the benefit section ceased as to your Eligible Class.)

If this provision applies to you or one of your covered dependents, see the Conversion of Medical Expense Coverage section and the Continuation of Coverage under Federal Law section for information which may affect you.

Conversion of Medical Expense Coverage

This Plan permits certain persons whose Medical Expense Coverage has ceased to convert to a personal conversion policy. No medical exam is needed. Your dependents who are under age 65 can apply if they cease to be a dependent as defined in this Plan.

The personal policy must be applied for within 31 days after coverage ceases. The 31 days start on the date coverage actually ceases even if the person is still eligible for benefits because the person is hospitalized.

Aetna may decline to issue the personal policy if:

- It is applied for in a jurisdiction in which Aetna cannot issue or

deliver the policy.

- On the date of conversion, a person is covered, eligible or has benefits available under one of the following:
  - any other hospital or surgical expense insurance policy;
  - any hospital service or medical expense indemnity corporation subscriber contract;
  - any other group contract;
  - any statute, welfare plan or program;
  - and that with the converted policy, would result in overinsurance or match benefits.

No one has the right to convert if you have been covered under this Plan for less than 3 months. Also, no person has the right to convert if:

- he or she has used up the maximum benefit; or
- he or she becomes eligible for any other Medical Expense Coverage under this Plan.

The personal policy form, and its terms, will be of a type, for group conversion purposes:

- as required by law or regulation; or
- as then offered by Aetna under your Employer's conversion plan.

It will not provide coverage which is the same as coverage under this Plan. The level of coverage may be less and an overall Lifetime Maximum Benefit will apply.

The personal policy may contain either or both of:

- A statement that benefits under it will be cut back by any like benefits payable under this Plan after the person's coverage ceases.
- A statement that Aetna may ask for data about the person's coverage under any other plan. This may be asked for on any premium due date of the personal policy. If the person does not give the data, expenses covered under the personal policy may be reduced by expenses which are covered or provided under those plans.

The personal policy will state that Aetna has the right to refuse renewal under some conditions. These will be shown in that policy.

If your dependent wants to convert:

- Ask your Employer for a copy of the "Notice of Conversion Privilege and Request" form.
- Send the completed form to the address shown.

If a person is eligible to convert, information will be sent about the personal policy for which he or she may apply.

The first premium for the personal policy must be paid at the time the person applies for that policy. The premium due will be Aetna's normal rate for the person's class and age, and the form and amount of coverage.

The personal policy will take effect on the day after coverage terminates under this Plan.

Type of Coverage

Coverage under this Plan is **non-occupational**. Only **non-occupational** accidental **injuries** and **non-occupational diseases** are covered. Any coverage for charges for services and supplies is provided only if they are furnished to a person while covered.

Conditions that are related to pregnancy may be covered under this Plan. The Summary of Coverage will say if they are.

Physical Examinations

Aetna will have the right and opportunity to have a physician or dentist of its choice examine any person for whom certification or benefits have been requested. This will be done at all reasonable times while certification or a claim for benefits is pending or under review. This will be done at no cost to you.

Legal Action

No legal action can be brought to recover under any benefit after 3 years from the deadline for filing claims.

Additional Provisions

In the event of a misstatement of any fact affecting your coverage under this Plan, the true facts will be used to determine the coverage in force.

This document describes the main features of this Plan. If you have any questions about the terms of this Plan or about the proper payment of benefits, you may obtain more information from your Employer.

Your Employer hopes to continue this Plan indefinitely but, as with all group plans, this Plan may be changed or discontinued as to all or any class of employees.

Assignments

Coverage may be assigned only with the written consent of Aetna.

Subrogation & Right of Recovery Provision

Definitions
As used throughout this provision, the term "Responsible Party" means any party actually, possibly, or potentially responsible for making any payment to a Covered Person due to a Covered Person's injury, illness, or condition. The term "Responsible Party" includes the liability insurer of such party or any insurance coverage.

For purposes of this provision, the term "Insurance Coverage" refers to any coverage providing medical expense coverage or liability coverage including, but not limited to, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no-fault automobile insurance coverage, or any first party insurance coverage.

For purposes of this provision, a "Covered Person" includes anyone on whose behalf the plan pays or provides any benefit including, but not limited to, the minor child or dependent of any plan member or person entitled to receive any benefits from the plan.

Subrogation
Immediately upon paying or providing any benefit under this plan, the plan shall be subrogated to (stand in the place of) all rights of recovery a Covered Person has against any Responsible Party with respect to any payment made by the Responsible Party to a Covered Person due to a Covered Person's injury, illness, or condition to the full extent of benefits provided or to be provided by the plan.

Reimbursement
In addition, if a Covered Person receives any payment from any Responsible Party or Insurance Coverage as a result of an injury, illness, or condition, the plan has the right to recover from, and be reimbursed by, the Covered Person for all amounts this plan has paid and will pay as a result of that injury, illness, or condition, up to and including the full amount the Covered Person receives from any Responsible Party.

Constructive Trust
By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that if he or she receives any payment from any Responsible Party as a result of an injury, illness, or condition, he or she will serve as a constructive trustee over the funds that constitutes such payment. Failure to hold such funds in trust will be deemed a breach of the Covered Person's fiduciary duty to the plan.

Lien Rights
Further, the plan will automatically have a lien to the extent of benefits paid by the plan for the treatment of the illness, injury, or condition for which the Responsible Party is liable. The lien shall be imposed upon any recovery whether by settlement, judgment, or otherwise related to treatment for any illness, injury, or condition for which the plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, the Covered Person, the Covered Person's representative or agent; Responsible Party; Responsible Party's insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the plan.

First-Priority Claim
By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person acknowledges that this plan's recovery rights are a first priority claim against all Responsible Parties and are to be paid to the plan before any other claim for the Covered Person's damages. This plan shall be entitled to full reimbursement on a first-dollar basis from any Responsible Party's payments, even if such payment to the plan will result in a recovery to the Covered Person which is insufficient to make the Covered Person whole or to compensate the Covered Person in part or in whole for the damages sustained. The plan is not required to participate in or pay court costs or attorney fees to any attorney hired by the Covered Person to pursue the Covered Person's damage claim.

Applicability to All Settlements and Judgments
The terms of this entire subrogation and right of recovery provision shall apply and the plan is entitled to full recovery regardless of whether any liability for payment is admitted by any Responsible Party and regardless of whether the settlement or judgment received by the Covered Person identifies the medical benefits the plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages, and/or general damages only.

Cooperation
The Covered Person shall fully cooperate with the plan's efforts to recover its benefits paid. It is the duty of the Covered Person to notify the plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of the Covered Person's intention to pursue or investigate a claim to recover damages or obtain compensation due to injury, illness, or condition sustained by the Covered Person. The Covered Person and his or her agents shall provide all information requested by the plan, the Claims Administrator or its representative

including, but not limited to, completing and submitting any applications or other forms or statements as the plan may reasonably request. Failure to provide this information may result in the termination of health benefits for the Covered Person or the institution of court proceedings against the Covered Person.

The Covered Person shall do nothing to prejudice the plan's subrogation or recovery interest or to prejudice the plan's ability to enforce the terms of this plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the plan.

The Covered Person acknowledges that the plan has the right to conduct an investigation regarding the injury, illness, or condition to identify any Responsible Party. The plan reserves the right to notify responsible Party and his or her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

Interpretation
In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction
By accepting benefits (whether the payment of such benefits is made to the Covered Person or made on behalf of the Covered Person to any provider) from the plan, the Covered Person agrees that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the plan may elect. By accepting such benefits, the Covered Person hereby submits to each such jurisdiction, waiving whatever rights may correspond to him or her by reason of his or her present or future domicile.

Exclusion
This plan does not cover services and supplies, in the opinion of the Claims Administrator or its authorized representative, that are associated with injuries, illness, or conditions suffered due to the acts or omissions of a third party.

–

– uto insurance coverage.

- The covered person (or person authorized by law to represent the covered person if he or she is not legally capable) shall:
  - execute and deliver any documents that are required; and
  - do whatever else is necessary to secure such rights.

Recovery of Overpayment

If a benefit payment is made by Aetna, to or on behalf of any person, which exceeds the benefit amount such person is entitled to receive in accordance with the terms of the group contract, this Plan has the right:

- to require the return of the overpayment on request; or
- to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of that person or another person in his or her family.

Such right does not affect any other right of recovery this Plan may have with respect to such overpayment.

Reporting of Claims

A claim must be submitted to Aetna in writing. It must give proof of the nature and extent of the loss. Your Employer has claim forms.

All claims should be reported promptly. The deadline for filing a claim for any benefits is 90 days after the date of the loss causing the claim.

If, through no fault of your own, you are not able to meet the deadline for filing a claim, your claim will still be accepted if you file as soon as possible. Unless you are legally incapacitated, late claims will not be covered if they are filed more than 15 months after the date of service.

Claim Filing and Appeal Procedure

Filing Health Claims under the Plan

You may file claims for Plan benefits, and appeal adverse claim decisions, either yourself or through an authorized representative. If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna Life Insurance Company. The notice will explain the reason for the denial and the review procedures.

An "authorized representative" means a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf, except that in the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Urgent Care Claims

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if the Plan or your physician determines that it is an urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received.

“A claim involving urgent care” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or, in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

For claims which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan’s procedures for filing “urgent care” claims, you will be notified of the failure within 24 hours and of the proper procedures to be followed. The notice may be oral unless you request written notification.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

Other Claims (Pre-Service and Post-Service)

If the Plan requires you to obtain advance approval of a service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to a Plan representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days and of the proper procedures to be followed. The notice may be oral unless you request written notification.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside the Plan's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of the Plan's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

Ongoing course of treatment
If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the Plan intends to terminate or reduce benefits for the previously authorized course of treatment so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

Appeal Procedure – Standard Appeals
You have the right to file an appeal about coverage for service(s) you have received from your health care provider or Aetna if you are not satisfied with the outcome of the initial determination and the appeal is regarding a change in the decision for the following:

- Certification of health care services
- Claim payment
- Plan interpretation
- Benefit determination
- Eligibility

You may file an appeal in writing to Aetna at the address provided in this booklet, or, if your appeal is of an urgent nature, you may call Aetna's Member Services Unit at the toll-free phone number on the back of your ID card. Your request should include the group name (that is, your

employer), your name, Social Security Number or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

Your appeal will be acknowledged within five working days of receipt. An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an adverse benefit decision to appeal the decision to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the adverse benefit determination will be provided free of charge upon request by you or your authorized representative. You may also request that the Plan provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on a claim involving urgent care, you may file a second level appeal with Aetna. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with Aetna within 60 days of receipt of the level one appeal decision. Aetna will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

Payment of Benefits

Benefits will be paid as soon as the necessary written proof to support the claim is received.

All benefits are payable to you. However, this Plan has the right to pay any health benefits to the service provider. This will be done unless you have told Aetna otherwise by the time you file the claim.

This Plan may pay up to $1,000 of any benefit to any of your relatives whom it believes fairly entitled to it. This can be done if the benefit is payable to you and you are a minor or not able to give a valid release. It can also be done if a benefit is payable to your estate.

Records of Expenses

Keep complete records of the expenses of each person. They will be required when a claim is made.

Very important are:
- Names of **physicians**, **dentists** and others who furnish services.
- Dates expenses are incurred.
- Copies of all bills and receipts.

Glossary

The following definitions of certain words and phrases will help you understand the benefits to which the definitions apply. Some definitions which apply only to a specific benefit appear in the benefit section. If a definition appears in a benefit section and also appears in the Glossary, the definition in the benefit section will apply in lieu of the definition in the Glossary.

Aexcel Designated In-Network Specialists
Aexcel Designated In-Network Specialists are In-Network Providers who have met designation criteria for thresholds for:
- performance; and
- effectiveness;

as established by Aetna.

They will be shown:
- in the Directory; and
- on DocFind;

as Aexcel Designated In-Network Specialists for the specialty care involved for the class of employees of which you are a member.

Aexcel Designated In-Network Specialists include Specialists in the following areas: Cardiology, Cardiothoracic Surgery, Gastroenterology,

General Surgery, Neurology, Neurosurgery, Obstetrics/Gynecology, Orthopedics, Otolaryngology, Plastic Surgery, Urology, and Vascular Surgery.

Board and Room Charges
Charges made by an institution for board and room and other **necessary** services and supplies. They must be regularly made at a daily or weekly rate.

Brand Name Drug
A **prescription drug** which is protected by trademark registration

Chemical Dependency Treatment Facility
This is an institution that:

- Mainly provides a program for diagnosis, evaluation, and **treatment of chemical dependency**.
- Makes charges.
- Meets licensing standards.
- Prepares and maintains a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. It must be supervised by a **physician**.
- Provides, on the premises, 24 hours a day:
  - Detoxification services needed with its treatment program.
  - Infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical services that may be required.
  - Supervision by a staff of **physicians**.
  - Skilled nursing care by licensed nurses who are directed by a full-time **R.N.**

Companion
This is a person whose presence as a **Companion** or caregiver is necessary to enable an **NME Patient**:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

Convalescent Facility
This is an institution that:

- Is licensed to provide, and does provide, the following on an inpatient basis for persons convalescing from disease or injury:
  - professional nursing care by an **R.N.**, or by a **L.P.N.** directed by a full-time **R.N.**; and
  - physical restoration services to help patients to meet a goal of self-care in daily living activities.

- Provides 24 hour a day nursing care by licensed nurses directed by a full-time **R.N.**
- Is supervised full-time by a **physician** or **R.N.**
- Keeps a complete medical record on each patient.
- Has a utilization review plan.
- Is not mainly a place for rest, for the aged, for chemical dependency services, for custodial or educational care, or for care of mental disorders.
- Makes charges.

Copay(ment)
This is a fee, charged to a person, which represents a portion of the applicable expense.

As to a **prescription drug** dispensed by an In-network **pharmacy**, this is the fee charged to a person at the time the **prescription drug** is dispensed payable directly to the **pharmacy** for each **prescription** or refill at the time the **prescription** or refill is dispensed. For drugs dispensed as packaged kits, the fee applies to each kit at the time it is dispensed. In no event will the copay be greater than the **prescription**, kit, or refill.
It is specified in the Summary of Coverage.

Custodial Care
This means services and supplies furnished to a person mainly to help him or her in the activities of daily life. This includes board and room and other institutional care. The person does not have to be disabled. Such services and supplies are custodial care without regard to:

- by whom they are prescribed; or
- by whom they are recommended; or
- by whom or by which they are performed.

Dentist
This means a legally qualified dentist. Also, a **physician** who is licensed to do the dental work he or she performs.

Directory
This is a listing of all **In-network Providers** for the class of employees of which you are a member. A current list of participating providers is available through Aetna's on-line provider directory, DocFind, at www.aetna.com/docfind/custom/cityofseattle.

Durable Medical and Surgical Equipment
This means no more than one item of equipment for the same or similar purpose, and the accessories needed to operate it, that is:

- made to withstand prolonged use;

- made for and mainly used in the treatment of a disease or injury;
- suited for use in the home;
- not normally of use to persons who do not have a disease or injury;
- not for use in altering air quality or temperature;
- not for exercise or training.

Not included is equipment such as: whirlpools; portable whirlpool pumps; sauna baths; massage devices; overbed tables; elevators; communication aids; vision aids; corrective shoes; enuresis equipment; hearing aids; heating pads; weights; over-the-counter arch supports; orthotics; personal hygiene items; and telephone alert systems.

Emergency Admission
One where the **physician** admits the person to the **hospital** or **treatment facility** right after the sudden and, at that time, unexpected onset of a change in the person's physical or mental condition:

- which requires confinement right away as a full-time inpatient; and
- for which if immediate inpatient care was not given could, as determined by Aetna, reasonably be expected to result in:
  - placing the person's health in serious jeopardy; or
  - serious impairment to bodily function; or
  - serious dysfunction of a body part or organ; or
  - in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Care
This means the treatment given in a **hospital's** emergency room to evaluate and treat medical conditions of a recent onset and severity, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or
- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Condition
This means a recent and severe medical condition, including, but not limited to, severe pain, which would lead a prudent layperson possessing an average knowledge of medicine and health, to believe that his or her condition, sickness, or injury is of such a nature that failure to get immediate medical care could result in:

- placing the person's health in serious jeopardy; or

- serious impairment to bodily function; or
- serious dysfunction of a body part or organ; or
- in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Generic Drug
A **prescription drug** which is not protected by trademark registration, but is produced and sold under the chemical formulation name.

Home Health Care Agency
This is an agency that:

- mainly provides skilled nursing and other therapeutic services; and
- is associated with a professional group which makes policy; this group must have at least one **physician** and one **R.N.**; and
- has full-time supervision by a **physician** or an **R.N**.; and
- keeps complete medical records on each person; and
- has a full-time administrator; and
- meets licensing standards.

Home Health Care Plan
This is a plan that provides for care and treatment of a disease or injury. The care and treatment must be:

- prescribed in writing by the attending **physician**; and
- an alternative to confinement in a **hospital** or **convalescent facility**.

Hospice Care
This is care given to a **terminally ill** person by or under arrangements with a **Hospice Care Agency**. The care must be part of a **Hospice Care Program**.

Hospice Care Agency
This is an agency or organization which:

- Has **Hospice Care** available 24 hours a day.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Provides:
  - skilled nursing services; and
  - medical social services; and
  - psychological and dietary counseling.

- Provides or arranges for other services which will include:
  - services of a **physician**; and
  - physical and occupational therapy; and
  - part-time home health aide services which mainly consist of caring for **terminally ill** persons; and

- inpatient care in a facility when needed for pain control and acute and chronic symptom management.
- Has personnel which include at least:
  - one **physician**; and
  - one **R.N.**; and
  - one licensed or certified social worker employed by the Agency.

- Establishes policies governing the provision of **Hospice Care**.
- Assesses the patient's medical and social needs.
- Develops a **Hospice Care Program** to meet those needs.
- Provides an ongoing quality assurance program. This includes reviews by **physicians**, other than those who own or direct the Agency.
- Permits all area medical personnel to utilize its services for their patients.
- Keeps a medical record on each patient.
- Has a full-time administrator.

Hospice Care Program
This is a written plan of **Hospice Care**, which:

- Is established by and reviewed from time to time by:
  - a **physician** attending the person; and
  - appropriate personnel of a **Hospice Care Agency**.

- Is designed to provide:
  - palliative and supportive care to **terminally ill** persons; and
  - supportive care to their families.

- Includes:
  - an assessment of the person's medical and social needs; and
  - a description of the care to be given to meet those needs.

Hospice Facility
This is a facility, or distinct part of one, which:

- Mainly provides inpatient **Hospice Care** to **terminally ill** persons.
- Charges its patients.
- Meets any licensing or certification standards set forth by the jurisdiction where it is.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program; this includes reviews by **physicians** other than those who own or direct the facility.
- Is run by a staff of **physicians**; at least one such **physician** must be on call at all times.
- Provides, 24 hours a day, nursing services under the direction of an

R.N.
- Has a full-time administrator.

Hospital
This is a place that:

- Mainly provides inpatient facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons.
- Is supervised by a staff of **physicians**.
- Provides 24 hour a day **R.N.** service.
- Is not mainly a place for rest, for the aged, for chemical dependency services, or a nursing home.
- Makes charges.

In-network Care
This is a health care service or supply furnished by:

- an **In-network Provider**; or
- a health care provider that is not an **In-network Provider** for an **emergency condition** when travel to an **In-network Provider** is not feasible.

In-network Provider
This is a health care provider that has contracted to furnish services or supplies for a **Negotiated Charge**; but only if the provider is, with Aetna's consent, included in the **Directory** as a In-network Provider for:

- the service or supply involved; and
- the class of employees of which you are member.

In-network Pharmacy
A **pharmacy,** including a **mail order pharmacy**, which is party to a contract with Aetna to dispense drugs to persons covered under this Plan, but only:

- while the contract remains in effect; and
- while such a **pharmacy** dispenses a **prescription drug** under the terms of its contract with Aetna.

L.P.N.
This means a licensed practical nurse.

Mail Order Pharmacy
An establishment where **prescription drugs** are legally dispensed by mail.

Medication Formulary
A listing of **prescription drugs** which have been evaluated and selected by Aetna clinical pharmacists for their therapeutic equivalency and efficacy. This listing includes both **brand name drugs** and **generic**

drugs and is subject to periodic review and modification by Aetna. See your Employer for a current listing.

Mental Disorder
This is a disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a mental health professional such as a psychiatrist, a psychologist or a psychiatric social worker. A mental disorder includes; but is not limited to:

- Chemical dependency
- Schizophrenia
- Bipolar disorder
- Pervasive Mental Developmental Disorder (Autism)
- Panic disorder
- Major depressive disorder
- Psychotic depression
- Obsessive compulsive disorder

For the purposes of benefits under this Plan, mental disorder will include chemical dependency only if any separate benefit for a particular type of treatment does not apply to chemical dependency.

Mental Disorder Treatment Facility
This is an institution that:

- Mainly provides a program for the diagnosis, evaluation, and effective treatment of **mental disorders**.
- Is not mainly a school or a custodial, recreational or training institution.
- Provides infirmary-level medical services. Also, it provides, or arranges with a **hospital** in the area for, any other medical service that may be required.
- Is supervised full-time by a psychiatrist who is responsible for patient care and is there regularly.
- Is staffed by **psychiatric physicians** involved in care and treatment.
- Has a psychiatric physician present during the whole treatment day.
- Provides, at all times, psychiatric social work and nursing services.
- Provides, at all times, skilled nursing care by licensed nurses who are supervised by a full-time R.N.
- Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs. The plan must be supervised by a psychiatric physician.
- Makes charges.
- Meets licensing standards.

Morbid Obesity
This means a Body Mass Index that is: greater than 40 kilograms per meter squared; or equal to or greater than 35 kilograms per meter squared with a comorbid medical condition, including: hypertension; a cardiopulmonary condition; sleep apnea; or diabetes.

NME Patient
This is a person who:

- requires any of the NME procedure and treatment types for which the charges are a Covered Medical Expense; and
- contacts Aetna and is approved by Aetna as an **NME Patient**; and
- agrees to have the procedure or treatment performed in a **hospital** designated by Aetna as the most appropriate facility.

Necessary
A service or supply furnished by a particular provider is necessary if Aetna determines that it is appropriate for the diagnosis, the care or the treatment of the disease or injury involved.

To be appropriate, the service or supply must:

- be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition;
- be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or injury involved and the person's overall health condition; and
- as to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, Aetna will take into consideration:

- information provided on the affected person's health status;
- reports in peer reviewed medical literature;
- reports and guidelines published by nationally recognized healthcare organizations that include supporting scientific data;
- generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;
- the opinion of health professionals in the generally recognized health specialty involved; and
- any other relevant information brought to Aetna's attention.

In no event will the following services or supplies be considered to be necessary:

- those that do not require the technical skills of a medical, a mental health or a dental professional; or
- those furnished mainly for the personal comfort or convenience of the person, any person who is part of his or her family; or
- those furnished solely because the person is an inpatient on any day on which the person's disease or injury could safely and adequately be diagnosed or treated while not confined; or
- those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a physician's or a dentist's office or other less costly setting.

Negotiated Charge
This is the maximum charge an **In-network Provider** has agreed to make as to any service or supply for the purpose of the benefits under this Plan.

Non-Designated In-Network Specialists
These are In-Network Providers in one of the following specialty areas, who have not been designated as Aexcel Designated In-Network Specialists by Aetna: Cardiology, Cardiothoracic Surgery, Gastroenterology, General Surgery, Neurology, Neurosurgery, Obstetrics/Gynecology, Orthopedics, Otolaryngology, Plastic Surgery, Urology, and Vascular Surgery.

Non-Occupational Disease
A non-occupational disease is a disease that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from a disease that does.

A disease will be deemed to be non-occupational regardless of cause if proof is furnished that the person:

- is covered under any type of workers' compensation law; and
- is not covered for that disease under such law.

Non-Occupational Injury
A non-occupational injury is an accidental bodily injury that does not:

- arise out of (or in the course of) any work for pay or profit; or
- result in any way from an injury which does.

Non-urgent Admission
One which is not an **emergency admission** or an **urgent admission**.

Orthodontic Treatment
This is any:

- medical service or supply; or
- dental service or supply;

furnished to prevent or to diagnose or to correct a misalignment due to an accident:

- of the teeth; or
- of the bite; or
- of the jaws or jaw joint relationship;

whether or not for the purpose of relieving pain.

Not included is:

- the installation of a space maintainer; or
- a surgical procedure to correct malocclusion.

Other Health Care
This is a health care service or supply that is neither **In-network** or **Out-of-network** and is paid at the In-network Payment Percentage due to geographical limitations or provider availability. Any amount over the In-Network Recognized Charge for services or supplies is the responsibility of the member.

Out-of-network Care
This is a health care service or supply furnished by a health care provider that is not an **In-network Provider**; if, as determined by Aetna:

- the service or supply could have been provided by an **In-network Provider**; and
- the provider is of a type that falls into one or more of the categories of providers listed in the **Directory**.

Out-of-network Provider
This is a health care provider that has not contracted to furnish services or supplies at a **Negotiated Charge.**

Out-of-network Pharmacy
A **pharmacy** which is not party to a contract with Aetna, or a **pharmacy** which is party to such a contract but does not dispense **prescription drugs** in accordance with its terms.

Pharmacy
An establishment where **prescription drugs** are legally dispensed.

Physician
This means a legally qualified physician.

Prescriber
Any person, while acting within the scope of his or her license, who has the legal authority to write an order for a **prescription drug**.

Prescription
An order of a **prescriber** for a **prescription drug**. If it is an oral order, it must promptly be put in writing by the **pharmacy**.

Prescription Drugs
Any of the following:

- A drug, biological, or compounded **prescription** which, by Federal Law, may be dispensed only by **prescription** and which is required to be labeled "Caution: Federal Law prohibits dispensing without prescription".
- An injectable drug prescribed to be self-administered or administered by any other person except one who is acting within his or her capacity as a paid healthcare professional. Covered injectable drugs include insulin.
- Disposable needles and syringes which are purchased to administer a covered injectable **prescription drug**.
- Disposable diabetic supplies.

R.N.
This means a registered nurse.

Recognized Charge
Only that part of a charge which is recognized is covered. The recognized charge for a service or supply is the lowest of:

- the provider's usual charge for furnishing it; and
- the charge Aetna determines to be appropriate, based on factors such as the cost of providing the same or a similar service or supply and the manner in which charges for the service or supply are made; and
- the charge Aetna determines to be the Recognized Charge Percentage made for that service or supply. The Recognized Charge Percentage is the charge determined by Aetna on a semiannual basis to be in the 70th percentile of the charges made for a service or supply by providers in the geographic area where it is furnished.

In determining the Recognized Charge for a service or supply that is:

- unusual; or
- not often provided in the area; or
- provided by only a small number of providers in the area;

Aetna may take into account factors, such as:

- the complexity;
- the degree of skill needed;
- the type of specialty of the provider;
- the range of services or supplies provided by a facility; and
- the recognized charge in other areas.

In some circumstances, Aetna may have an agreement with a provider (either directly, or indirectly through a third party) which sets the rate that Aetna will pay for a service or supply. In these instances, in spite of the methodology described above, the Recognized Charge is the rate established in such agreement.

Semiprivate Rate
This is the **charge** for **board and room** which an institution applies to the most beds in its semiprivate rooms with 2 or more beds. If there are no such rooms, Aetna will figure the rate. It will be the rate most commonly charged by similar institutions in the same geographic area.

Terminally Ill
This is a medical prognosis of 6 months or less to live.

Urgent Admission
One where the **physician** admits the person to the **hospital** due to:

- the onset of or change in a disease; or
- the diagnosis of a disease; or
- an injury caused by an accident;

which, while not needing an **emergency admission**, is severe enough to require confinement as an inpatient in a **hospital** within 2 weeks from the date the need for the confinement becomes apparent.

Continuation of Coverage under Federal Law

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 the retiree's 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 the retiree's family members, and what they 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. Under this Plan, q***ualified beneficiaries are 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. 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 by the City of Seattle and not to any other benefits offered under the Plan or by the City of Seattle (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 5th 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 5th 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 COBRA Administrator, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." 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 the spouse/domestic partner of a retiree, 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 happen:

- your spouse/domestic dies and pension payments cease;
- you become divorced or legally separated from your spouse, or you terminate your domestic partnership. Also, if your spouse (the retiree) 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 a retiree, 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-retiree dies and pension payments cease;

- you stop being eligible for coverage under the Plan as a "dependent child."

WHEN IS COBRA COVERAGE AVAILABLE?

When the qualifying event is the death of the retiree, the Plan will offer COBRA coverage to qualified beneficiaries. For the other qualifying events (divorce or legal separation of the retiree 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 the COBRA Administrator.)

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:

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

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 retiree's spouse may elect COBRA even if the retiree's child does not. COBRA coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. Covered 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 Plan on the day before a qualifying

event, he or she may elect COBRA under the Dental Plan only, the Medical Plan only, or under both the Medical Plan and the Dental 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 31 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.

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; or
- the employer ceases to provide any group health plan for its employees.

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.

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 retiree 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. 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 5th 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 individual during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered individual is a qualified beneficiary, the covered individual 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 covered individual. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

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

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 5th 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

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 the COBRA Administrator no later than the deadline described above.

You must use the Plan's form entitled *Health Care Benefits Change Form* to notify the COBRA Administrator 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 Preventive Plan);
- the name and address of the retiree
- 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 the COBRA Administrator.)

If your coverage is reduced or eliminated and a divorce or legal separation occurs within three months of the reduction of 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 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 retiree, 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 OTHER COVERAGE, OR MEDICARE ENTITLEMENT

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).

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 Preventive Plan);
- the name and address of the retiree;
- 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.

The retiree, 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.

Health Insurance Portability and Accountability Act of 1996

Use and Disclosure of Protected Health Information

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules, the Plan Sponsor (Employer) must establish the permitted and required uses of Protected Health Information (PHI). The privacy rules take effect, and require compliance on April 14, 2003.

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 HIPAA Section.

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 permitted by law.

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 that apply to the Employer (Plan Sponsor) with respect to such 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.

- 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 received from the Plan to the U.S. Department of Health and Human Services to determine the Plan's compliance with 45 Code of Federal Regulations Parts 160-64.

- If feasible, return or destroy all Plan Enrollee Protected Health Information received from the Plan that the Employer (Plan Sponsor) maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or disclosure is not feasible, limit further uses and disclosures 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 employees, classes of employees, or other persons under the control of the Employer (Plan Sponsor) may be given access to Plan Enrollees' Protected Health Information:

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

- ***Departmental Benefits Representative/Coordinator and/or designee***

This list includes the employee, class of employees or other persons 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 employee, classes of employees or other persons 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 employee, classes of employees or other persons 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 HIPAA Section. 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 persons 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.