

HEALTHCARE PLAN

November 1, 2011

To: Plan Participants

Welcome to the Clallam County Public Utility District Healthcare Plan. This Healthcare Plan was established for the benefit of Clallam County Public Utility District, their eligible employees, retirees, and dependents. The purpose of the Plan is to reimburse covered healthcare expenses, and it is designed to provide comprehensive protection for you and your dependents. We sincerely wish that you and your dependents enjoy good health, but in the event you need to use the Plan, we know that you'll be happy to have the service and security of the Clallam County Public Utility District Healthcare Plan.

Please take time to become familiar with the benefits that the Plan offers. Many terms have specific meanings as used throughout the booklet. Please refer to the definitions section on page 37 for clarification. We suggest you review the booklet carefully. If you have questions regarding coverage or how benefits have been paid, we encourage you to contact our claims administrator, Pacific Underwriters, using the phone numbers given at the end of the booklet.

The District expects to continue the Plan indefinitely. Healthcare coverage is an element of the Collective Bargaining Agreement with IBEW Local 997. The District reserves the right to propose amendments to the Plan at any time. Subject to the Collective Bargaining Agreement, the District also has the right to terminate the Plan. The District's amendment and termination powers may be carried out by the General Manager of the District in accordance with authorization by the District's Board of Commissioners.

Clallam County Public Utility District has full power and authority to control and manage the operation and administration of the Plan and to construe and apply all of its provisions including the specific power and authority to interpret the Plan and to remedy or resolve ambiguities, inconsistencies, or omissions. This specifically includes the power to decide any eligibility and the approval of benefits under the Plan. Any action taken in good faith by the Plan Administrator shall be conclusive and binding upon the participants and the beneficiaries. The District's Health Committee and General Manager will communicate with the claims administrator as to any ambiguities, inconsistencies, or omissions.

Sincerely,

Clallam County Public Utility District

TABLE OF CONTENTS

INTRODUCTION 1

ARTICLE I - ELIGIBILITY 2

 HOW TO ENROLL 3

 WHEN COVERAGE BEGINS 3

 WHEN COVERAGE ENDS 4

ARTICLE II - MEDICAL PLAN BENEFITS 8

 SUMMARY OF MEDICAL PLAN BENEFITS 8

 COVERED MEDICAL PLAN BENEFITS 12

ARTICLE III - PRESCRIPTION DRUG BENEFITS 23

 PHARMACEUTICAL CARE NETWORK 23

 INFORMED RX MAIL ORDER PHARMACY SERVICE 23

ARTICLE IV - VISION BENEFITS 25

 VISION SCHEDULE 25

ARTICLE V - DENTAL BENEFITS 26

 SUMMARY OF DENTAL BENEFITS 26

 COVERED DENTAL BENEFITS 27

ARTICLE VI - GENERAL LIMITATIONS AND EXCLUSIONS 31

ARTICLE VII - CLAIMS ADMINISTRATION 34

ARTICLE VIII - DEFINITIONS 37

ARTICLE IX - SUMMARY PLAN DESCRIPTION 41

 APPEAL OF CLAIM DENIAL 42

 CUSTOMER SERVICE DIRECTORY 42

INTRODUCTION

The following pages contain the Healthcare Plan Description.

This Plan Description replaces any Plan Description, booklet or certificate previously issued by us and makes such document void.

Throughout this Plan Description, the terms “you” and “your” refer to the covered participant. The terms “we,” “us,” and “our” refer to the Clallam County Public Utility District Healthcare Plan. The term “Plan Administrator” refers to Clallam County Public Utility District. The term “Claims Administrator” refers to Pacific Underwriters.

PREFERRED PROVIDER BENEFITS

This Plan includes preferred provider benefits for medical expenses through First Choice Health Network Preferred Provider Organization (PPO). Covered individuals always have the freedom to choose either a First Choice Health Network Preferred Provider (hospitals, facilities and physicians) or a non-preferred provider each time medical care is needed. However, First Choice Health Network Preferred Provider fees will be discounted to you (or your covered dependents) and the Clallam County Public Utility District Healthcare Plan. When seeking medical care, we encourage you to use First Choice Health Network Preferred Providers whenever possible.

You will receive a directory of First Choice Health Network Preferred Providers as part of your enrollment material. The directory will list preferred hospitals and healthcare providers.

NON-PREFERRED PROVIDER BENEFITS

This Plan includes non-preferred provider benefits for medical expenses. If you choose the services of a non-preferred provider, your benefits will be reduced by 20% (in most cases) compared to preferred providers. Your maximum out-of-pocket expenses will also increase from \$400 to \$1,250.

ARTICLE I

ELIGIBILITY

This section will describe who is eligible to enroll under the Plan. Please be aware that the date you or your dependent becomes eligible may be different from the date coverage begins. See the sections entitled "How to Enroll" and "When Coverage Begins."

"Replacement Benefits" Upon the original enrollment of the employer, this Plan will extend benefits as provided in this Plan to all eligible employees and dependents if there has been continuous coverage with the prior carrier up to the enrollment date in the Clallam County Public Utility District Healthcare Plan.

Eligible Individuals

Active employees - You are eligible if you are an active employee of Clallam County Public Utility District No. 1 and have worked long enough to satisfy any required waiting period. A Commissioner of Clallam County Public Utility District No. 1 will also be considered an active employee while serving his/her term as Commissioner.

Retirees - Employees who retire from active employment with the District and are qualified under the Public Employees' Retirement System, Plans I, II, and III, may continue under the District's medical and dental plans, provided that the employee/retiree pays the contributions for the plans. If a retired employee's coverage is terminated for any reason, the retired employee is not eligible for reinstatement of coverage. Coverage for the retired employee must be continuous from his/her active employment to retirement. Subsequent employment by the employee after retirement from the District will terminate the availability of coverage for that employee, provided provisions of the Continuation Omnibus Budget Reconciliation Act of 1985 (COBRA) are met. Spouse employment which provides health coverage for a District retiree will also terminate the availability of coverage under the District's health plans for the retiree, consistent with COBRA.

Eligible Dependents

Dependents include your:

- Spouse, if not legally separated; and
- Child, including a legally adopted child, child legally placed in your home for adoption, or a step child:
 - Who is less than age 26 and is not eligible for employer-based health benefits other than through their parents.
- A developmentally or physically disabled child:
 - Who has reached age 26 and is dependent on you for support and maintenance; and
 - Who is, and continues to be, incapable of self-support due to developmental or physical disability; and
 - Who was disabled prior to reaching age 26; and
 - For whom the Plan Administrator receives proof of disability within 31 days of the effective date of the dependent's coverage.

A dependent does not include any person who is residing outside the United States or who is on active duty in the Armed Forces.

HOW TO ENROLL

The following section explains how to enroll yourself and your eligible dependents.

When You First Become Eligible

You must file an enrollment form with the Human Resources Dept. for yourself and any dependent you want covered within 31 days following the completion of your waiting period.

WHEN COVERAGE BEGINS

Active employees - Coverage becomes effective on the 1st day of the month following or coinciding with your date of hire.

Open Enrollment

If you or your eligible dependents elect not to enroll when originally eligible, you may only enroll during Open Enrollment (the month of December, for coverage effective January 1), or under the Special Enrollment section, if applicable.

Special Enrollment

If you or your dependents decline coverage, there are two situations in which you or your dependents will be allowed to enroll without having to wait until the Plan's next open enrollment period.

- **Individuals Losing Other Coverage**
If you decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. To enroll during this special enrollment period, you and your dependents must otherwise be eligible for coverage under the terms of the Plan. This special enrollment period is available if you or your dependents were covered under another group health plan or had other health insurance coverage at the time you declined coverage under this Plan.

You may enroll during this special enrollment period if you lose the other coverage. Your dependents may enroll during this special enrollment period if your dependents lose the other coverage and you are already enrolled in the Plan. Finally, both you and your dependents may enroll together during this special enrollment period if either of you lose the other coverage.

Special enrollment may be requested only if the other coverage ends because you or your dependents lost eligibility for the other coverage (including a loss of coverage due to legal separation, divorce, death, termination of employment or reduction in hours) or employer contributions for the other coverage terminated. If the other coverage is COBRA continuation coverage, special enrollment may only be requested after you or your dependents have exhausted the continuation coverage. Special enrollment is not available if you or your dependents lost the other coverage because of failure to pay premiums or for cause.

- **Dependent Beneficiaries**
If you are a participant under this Plan (or have met the waiting period applicable to becoming a participant under this Plan and are eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and a person becomes your dependent through marriage, birth, adoption or placement for adoption then the dependent (and if not otherwise enrolled) may be enrolled under this Plan as a covered dependent or employee. In the case of

the birth or adoption of a child, your spouse may be enrolled as a dependent if your spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of marriage, birth, adoption, or placement for adoption.

Coverage under this special enrollment is effective the first day of the month after you request the enrollment for yourself or your dependent. Coverage in the case of a dependent's birth is effective as of the date of birth; or in the case of adoption or placement for adoption, the date of the adoption or placement for adoption.

WHEN COVERAGE ENDS

There are a variety of circumstances in which coverage for you and/or your covered dependents will end. These are described in the following paragraphs.

Plan Termination

The District may at any time terminate this Plan at its discretion. If the Plan is terminated, coverage ends for you and your covered dependents on the date the Plan ends.

Termination Date for an Employee

The coverage of any employee under this Plan will terminate on the earliest occurrence of any of the following dates:

- The date on which termination of the Plan occurs;
- The last day of the month in which you fail to meet the minimum eligibility requirements;
- The last day of the month in which your employment with Clallam County Public Utility District No. 1 is terminated;
- The date you begin active duty in the armed forces;
- The last day of the month for which there is failure to make any required contributions; or
- The last day of the month in which your approved Leave of Absence terminates unless you immediately return to work.

Termination Date for a Dependent

A dependent's coverage will terminate on the earliest occurrence of any of the following dates:

- The date on which termination of the Plan occurs;
- The last day of the month in which the employee's coverage under whom the dependent is covered terminates;
- The date the dependent begins active duty in the armed forces;
- The last day of the month in which the dependent fails to meet this Plan's definition of an eligible dependent;
- The last day of the month for which there is failure to make any required contributions; or
- The last day of the month in which the employee becomes ineligible.

Family Medical Leave Act

If you have worked more than 1,250 hours in the 12-month period immediately preceding the leave, you may be eligible to take up to 12 weeks of unpaid leave for any of the following reasons:

- A child's birth, adoption or foster-care arrival;
- To care for a spouse, parent or child with a "serious health condition";
- The employee's "serious health condition."

“Serious Health Condition” is defined as any illness, injury, impairment or physical or mental condition that involves (i) inpatient care, (ii) continuing treatment by a health care provider, or (iii) substance abuse, all as defined by federal law.

Employees on a qualified leave are allowed to:

- continue group health coverage (medical, dental, vision, prescription drug) during leave the same as if continually employed, including making required contributions; and,
- return to prior job or equivalent one in terms of salary, accrued benefits and other job conditions if returning within the 12-week period. If the employee does not choose to continue coverage, he or she may re-enroll within 31 days of returning to work without penalty if returning within the 12-week period. If on leave more than 12 weeks, he or she will be treated as a re-hire and be subject to normal waiting periods.

An employee not returning to work will be offered COBRA continuation of coverage (see the following section). The date COBRA coverage begins will be the date the employer learns the employee will not be returning, or the date the leave period ends, whichever comes first.

Continuation of Coverage

Under certain circumstances, called Qualifying Events, you and your covered Dependents (Qualified Beneficiaries) have the right to continue coverage beyond the time coverage would ordinarily have ended. The rights and obligations regarding continuation of coverage are explained below.

Qualified Beneficiaries may continue medical, dental, prescription drug and vision coverages provided by this Plan. Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and subsequent amendments, coverage may continue on a self-pay basis when any of the following Qualifying Events occurs:

Qualifying Event	Qualified Beneficiaries (Who May Elect to Continue Coverage)	Maximum Period of Continued Coverage
Employee separated from employment for reasons other than gross misconduct	Employee, spouse and dependent children	18 months*
Reduction in hours of Covered Employee	Employee, spouse and dependent children	18 months*
Death of Covered Employee	Spouse and dependent children	36 months
Divorce or legal separation	Spouse and dependent children	36 months
Employee or Retiree becomes entitled to Medicare	Spouse and dependent children	36 months
Dependent child becomes ineligible	Dependent children	36 months

*NOTE: The maximum period of coverage may be extended from 18 months to 29 months if during the 18-month self-pay period you or your Dependent receives a determination from the Social Security Administration that he or she was disabled at the time of the Qualifying Event or any time within the first 60 days of COBRA continuation coverage. The Qualified Beneficiary must give the Plan Administrator notice of the determination of disability from the Social Security Administration within 60 days of the date of the determination letter and prior to the date the original 18-month continuation would have expired. The Plan is allowed to increase the cost of coverage for the additional 11 months of coverage, up to 150% of the full cost of the coverage. The maximum period of coverage will be extended to 36 months from the date of the termination or reduction in hours if, within the 18-month self-pay period, one of the 36-month Qualifying Events occurs. In addition, if your Medicare entitlement is followed by a termination of employment or reduction in hours, the maximum period of COBRA coverage available to your covered Dependents must not end before 36 months after the date you became entitled to Medicare.

Continued coverage will be at the same level as this coverage under the group Plan when the Qualifying Event occurred. However, any benefit changes that apply to active employees also apply to anyone continuing coverage. All Qualified Beneficiaries covered under this Plan at the time of the Qualifying Event have a separate option to continue coverage.

If you are entitled to COBRA because you are a current or former employee and you give birth or adopt a child while you are on COBRA continuation coverage, you can enroll your new child for COBRA continuation coverage immediately. Also, your newborn and adopted child will obtain qualified beneficiary status. In other words, they will have independent election rights and second qualifying event rights.

If coverage is lost due to termination, reduction in hours, your death, or Title XI Bankruptcy within one year of the filing, Pacific Underwriters will notify Qualified Beneficiaries of their right to continue coverage, including the cost. The Plan is permitted, by law, to charge up to 102% of the full cost of the Plan.

If a Dependent loses coverage for any of the following reasons (divorce, legal separation or Dependent ineligibility), you or your Dependent must notify the Plan Administrator in writing, as soon as possible, but no later than 60 days from the date of this event. Within 14 days after receiving this notice, Pacific Underwriters will notify Qualified Beneficiaries of their right to continue coverage.

A Qualified Beneficiary will have 60 days from receiving that notice or from the date coverage would otherwise be lost, whichever is later, to elect continued coverage. If continued coverage is not requested in writing within 60 days, coverage will end on the last day of the month in which the Qualifying Event occurred. Only one notification will be provided to a family. A Qualified Beneficiary does not have to show proof of insurability to continue coverage.

The Qualified Beneficiary must pay the full contribution for continued coverage. The Plan Administrator must receive the first payment within 45 days after continued coverage is first elected. Monthly payments thereafter are due on the first of each month and must be received on or before the 30th day of each month, unless otherwise determined by the Plan Administrator when circumstances warrant.

Continued coverage under COBRA will end on the last day of the month in which any of the following occurs, whichever is first:

- The Qualified Beneficiary fails to pay the required monthly contribution on time;
- The first day on which the Qualified Beneficiary becomes covered under another group health plan, but only if the new group health plan does not contain any exclusions or limitations for preexisting conditions of that Qualified Beneficiary. If you do become covered under another group health plan and are affected by a preexisting condition limitation, COBRA coverage may

be cut off as soon as that preexisting condition limitation is satisfied due to the new plan's crediting toward the limitation of any prior coverage you had.

- The date the Qualified Beneficiary becomes entitled to Medicare, except when the Qualifying Event is due to a Title XI Bankruptcy;
- The date the Plan discontinues group coverage;
- The date the Qualified Beneficiary's employer no longer participates in this Plan;
- The maximum period of continuation of coverage ends; or
- For disabled Qualified Beneficiaries, the first of the month following the date of the final Social Security determination letter stating that the Qualified Beneficiary is no longer disabled.

If a Qualified Beneficiary is eligible for the other “*continuation of coverage privileges*” required by state law or as provided by this Plan, these extensions will run concurrently with continued coverage under COBRA.

In all cases, the Plan will provide continuation coverage as federally mandated by COBRA, subsequent COBRA amendments, and proposed regulations.

ARTICLE II

MEDICAL PLAN BENEFITS

SUMMARY OF MEDICAL PLAN BENEFITS

This section is only a summary and schedule of the benefits of the Plan. The text of your Healthcare Plan Description spells out the actual benefits and the conditions, limitations and exclusions.

The Clallam County Public Utility District Healthcare Plan has preferred provider arrangements based on agreements that these providers have made with this Plan. It is to your and our financial advantage to obtain services from a preferred provider. Medical expenses are limited to the usual, customary and reasonable charges as determined by the Clallam County Public Utility District Healthcare Plan.

	IN THE PPO	OUT OF THE PPO
LIFETIME MAXIMUM MEDICAL BENEFIT	UNLIMITED	UNLIMITED
ANNUAL MAXIMUM MEDICAL BENEFIT	\$2,000,000	\$2,000,000
DEDUCTIBLES	NONE	NONE
MEDICAL OUT-OF-POCKET MAXIMUM		
After an individual has incurred the maximum amount of eligible out-of-pocket PPO medical expenses or eligible out-of-pocket non-PPO medical expenses in a calendar year, the Plan pays 100% of eligible charges subsequently incurred by that individual in that calendar year. The maximum eligible out-of-pocket medical expenses is \$1,250 (combination of PPO and non-PPO eligible expenses) in a calendar year. Eligible expenses do not include copayments associated with hospital and physician visits, prescription drug copayments, vision, or dental expenses.	\$400	\$1,250
HOSPITAL INPATIENT SERVICES		
Room and Board Semiprivate room Intensive care unit Private room (as medically necessary) Operating and recovery rooms Special unit and treatment rooms	100% after \$100 copayment per day - Maximum \$300 copayment per admission	80% after \$100 copayment per day - Maximum \$300 copayment per admission

Additional Inpatient Services Lab/x-ray professional interpretive fees Drugs, anesthesia, and biologicals Hemodialysis and administration of blood Blood & blood plasma Nursing care All other medically necessary inpatient services	100%	80%
Inpatient Rehabilitation Physical, occupational and speech therapy	100%	80%
HOSPITAL OUTPATIENT SERVICES		
Hospital or Special Facility Charges for Outpatient Surgery	100% after \$50 copayment per visit	80% after \$50 copayment per visit
Hospital Emergency Room Services (\$100 copayment waived for life threatening medical emergencies or within 48 hours of an accidental injury)	100% after \$100 copayment per visit	80% after \$100 copayment per visit
Pre-Admission Testing	100%	80%
Hospital Outpatient Care Including MRI, CT Scans, radium, radioisotope and X-ray therapy, chemotherapy and hemodialysis	100%	80%
PHYSICIAN SERVICES		
Office, Hospital, Facility or Home Visits Specialty care and consultations In-office physician diagnostic, x-ray and laboratory tests In-office minor surgical procedures	100% after \$15 copayment per visit	80% after \$15 copayment per visit
Injections and allergy shots	100%	80%
Second Surgical Opinions	100%	80%
X-ray and Laboratory Services	100%	80%
Surgery	100%	80%
Anesthesiology Services	100%	80%

Maternity Care (Employee and Spouse only) Prenatal care, exams, tests and postnatal care Delivery services	Same as any other medical condition	Same as any other medical condition out of the PPO
Newborn and Well Baby Care In-hospital exam at birth Circumcision of a healthy newborn may be performed on an outpatient basis after release from hospital, or birthing center, if accomplished within initial 21 days of life 5 additional exams in first year of life, including immunizations and vaccinations 2 exams in second year of life, including immunizations and vaccinations	100% 100% 100% after \$15 copayment per visit 100% after \$15 copayment per visit	80% 80% 80% after \$15 copayment per visit 80% after \$15 copayment per visit
Wellness Care Periodic health evaluations Prostate, breast, pelvic exams, PAP smears Immunizations and vaccinations Well child care over age 2	100% after \$15 copayment per visit	80% after \$15 copayment per visit
Mammography Age 25 - 40 (one exam) Over age 40 (one exam per calendar year)	100%	80%
Family Planning (Employee and Spouse only)	100%	80%
OTHER SERVICES AND SUPPLIES		
Outpatient Rehabilitative Care Physical, occupational, speech and audiological therapy	100% after \$15 copayment per visit	80% after \$15 copayment per visit
Chiropractic Care (Limited to 30 visits per calendar year)	100% after \$15 copayment per visit	80% after \$15 copayment per visit
Naturopathic Medicine See PHYSICIAN SERVICES above	100% after \$15 copayment per visit	80% after \$15 copayment per visit
Acupuncture Medically necessary (\$3,000 combined annual limit with Massage Therapy)	100% after \$15 copayment per visit	80% after \$15 copayment per visit

Massage Therapy Medically necessary (\$3,000 combined annual limit with Massage Therapy)	100% after \$15 copayment per visit	80% after \$15 copayment per visit
Neurodevelopmental Therapy (Participants Under Age 7) (Limited to \$2,500 lifetime maximum)	100% after \$15 copayment per visit	80% after \$15 copayment per visit
Skilled Nursing Facility (Limited to 180 days per calendar year)	80%	60%
Home Health Care Benefit	100%	80%
Organ Transplant and Donor Benefit (Subject to specific limitations)	80%	60%
Phenylketonuria (PKU) Formula	100%	80%
Durable Medical Equipment, Supplies and Appliances	80%	60%
Treatment for Mental Health and Psychiatric Services Inpatient care Outpatient care	100% after \$100 copayment per day - Maximum copayment \$300 per admission 100% after \$15 copayment per visit	80% after \$100 copayment per day - Maximum copayment \$300 per admission 80% after \$15 copayment per visit
Treatment for Chemical Dependency (Limited to \$5,000 every 24-month period and \$10,000 lifetime maximum)	100%	80%
Treatment for Obesity (excessive weight) Treatment under this benefit must be preauthorized by the Plan Administrator. Benefits are not subject to an will not apply to the out-of-pocket maximum. (Limited to \$25,000 lifetime maximum)	80%	Not Covered
Diabetic Instruction (Limited to \$250 lifetime maximum)	80%	60%
Cardiac Rehabilitation (Limited to \$2,500 per calendar year)	80%	60%

Special Dental Care (Limited to services incurred within 12 months of an accidental injury)	Same as any other medical condition	Same as any other medical condition out of PPO
Temporomandibular Joint (TMJ) Disorders (Limited to \$2,000 lifetime maximum)	Same as any other medical condition	Same as any other medical condition out of PPO
Hospice Care	100%	80%
Ambulance Transportation	First \$500 at 100%, then 80%	First \$500 at 100%, then 80%

WHEN BENEFITS ARE AVAILABLE

This Plan only pays benefits for covered expenses “incurred” when a person's coverage is in effect. Coverage is in effect when the employee:

- is eligible to be covered according to the eligibility provisions of the Plan, or
- has applied for coverage and been accepted by the Plan.

The expense of a service is incurred on the day the service is rendered and the expense of a supply is incurred on the day the supply is delivered to the patient.

Medical Out-of-Pocket Maximum

After an individual has incurred \$400 of eligible out-of-pocket PPO medical expenses (or \$1,250 of eligible out-of-pocket non-PPO medical expenses) in a calendar year, the Plan pays 100% of eligible charges subsequently incurred by that individual in that calendar year. The maximum eligible out-of-pocket medical expenses is \$1,250 (combination of PPO and non-PPO eligible expenses) in a calendar year. Eligible expenses do not include copayments associated with hospital and physician visits, prescription drug copayments, vision, or dental expenses.

Lifetime Maximum

The maximum lifetime benefit per covered person under this Plan is unlimited.

The maximum annual benefit per covered person under this Plan is \$2,000,000.

Special Alternative Treatment

Payments for charges not covered under this Plan which result from treatment alternatives identified by the Plan or by a medical case management consultant as a cost containment alternative shall be reimbursable if such charges are approved by the Plan Administrator prior to beginning treatment.

COVERED MEDICAL PLAN BENEFITS

The following are “covered expenses” under this Plan when incurred for services and supplies listed in the section below and when medically necessary for diagnosis and/or treatment of an illness or injury, unless otherwise stated:

Hospital Services

Inpatient Care

- Semi-private room-and-board accommodations, nursery and special care units
- Ancillary services including operating, recovery, isolation, cast, and cystoscopic rooms; anesthesia and related supplies; drugs and medications; splints, casts and dressings; blood, blood plasma, blood derivatives and their administration; artificial kidney treatment; oxygen and its administration; x-ray, radium and radioactive isotope, and chemotherapy; x-ray and laboratory exams; electrocardiograms; rehabilitative therapy, physiotherapy and hydrotherapy when consistent with the diagnosis which resulted in your hospitalization.

Outpatient Care

- Emergency room charges for emergency illness or injury
- Radiation therapy (x-ray, radium and radioactive isotope therapy) and chemotherapy
- X-ray, diagnostic test and laboratory charges
- Facility charges for outpatient surgery
- Facility charges for dental surgery only if there is an underlying, specific non-dental physiologic impairment that makes hospitalization medically necessary.

Special Facility Care

We cover care provided in a special facility. A special facility is either an ambulatory surgical facility or a birthing center. Covered expenses consist of:

- procedure room charges, and
- charges for other services and supplies that are medically necessary for treatment.

Preadmission Testing

This includes diagnostic laboratory tests, x-rays, and electrocardiograms (EKG) that you obtain as an outpatient prior to your scheduled admission to the hospital. However, you should make sure your hospital will accept the results of these tests and not simply repeat them.

Physician services

- Services of a physician, surgeon, anesthesiologist, nurse practitioner or radiologist in the office, hospital or other medical facility
- Diagnostic x-rays and laboratory tests

Second Surgical Opinion

If your doctor recommends surgery or other medical treatment, it is often in your best interest to obtain a second opinion with a specialist regarding the necessity of the procedure. In many cases, an alternative method of treatment is available that would save yourself the discomfort of surgery or other medical treatment as well as the time and extra expenses.

Surgery (operative and cutting)

Benefits for the treatment of illnesses and injuries including fractures and dislocations are covered for:

- the surgeon;
- the assistant surgeon;
- the anesthesiologist or certified anesthetist; and,
- surgical supplies such as sutures and sterile set-ups.

Wellness Care

Benefits will be provided for wellness care including, but not limited to, routine physical examinations; gynecological exams, including Pap smear; prostate exams; well child care; necessary diagnostic x-ray and laboratory charges; and routine immunizations and vaccinations.

Mammography Benefit

This Plan will provide benefits for mammography exams limited to the following schedule, unless your physician recommends exams more frequently:

Age 25 - 40 One examination
Over age 40 One examination every calendar year

Medical and Surgical Benefits For Mastectomy

This Plan provides the following medical and surgical benefits for mastectomy, as requested by the patient, in consultation with her physician:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Protheses and physical complications of all stages of the mastectomy, including lymphedemas.

Routine Newborn and Well Baby Care

Benefits will be provided for routine pediatric care of a healthy newborn at birth until discharge. Benefits will also be provided for: circumcision of a healthy newborn may be performed on an outpatient basis after release from hospital, or birthing center, if accomplished within initial twenty-one (21) days of life; five (5) additional physician visits in the first year of life; and two (2) physician visits in the second year of life. These will include routine immunizations and vaccinations.

Hearing Exams and Hearing Aids

Hearing examinations to determine hearing loss are covered, subject to a \$15 copayment for each visit. Hearing aids and rental/repair including fitting and follow-up care are covered to a maximum Plan payment of \$3,000 every 36 months.

Family Planning (Employee and Spouse Only)

Benefits for sterilization, contraceptive devices and injections, and voluntary termination of pregnancy will be provided. Benefits for oral contraceptives will be provided under the prescription drug benefits of your Plan.

Maternity Care

Pregnancy and complications of pregnancy will be covered as any illness condition. For the employee or dependent spouse only, benefits include pre- and post-natal care, prenatal vitamins, obstetrical delivery, caesarean section, miscarriage and complications resulting from pregnancy. No maternity benefits are provided for dependent children, except complications of pregnancy such as toxemia or ectopic pregnancy.

No hospital stay in connection with child birth for the mother or newborn child may be limited to less than 48 hours following a vaginal delivery or less than 96 hours following a Caesarean section, or require that the provider obtain specific authorization for prescribing a length of stay less than the above periods.

Midwife Services

This Plan will provide benefits for Midwife Services performed by a Certified Nurse Midwife (CNM) who is certified/licensed as such and acting within the scope of his/her license. This Plan will not provide benefits for Lay Midwives or other individuals who become “midwives” by virtue of their experience in performing deliveries.

Prenatal Testing for Congenital Disorders

Benefits for prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures will be provided the same as for any other condition during your covered pregnancy. Such services must be medically necessary in accordance with standards set in rule by the Board of Health.

Phenylketonuria (PKU) Formula

Benefits will be provided for formulas medically necessary for the treatment of phenylketonuria (PKU).

Neurodevelopmental Therapy

Benefits will be provided for medically necessary neurodevelopmental therapies for covered dependents under age seven years of age, to a lifetime maximum of \$2,500, when diagnosed by a physician. Treatment must be performed by a physician or, with a written referral from a physician, by a registered physical therapist, a certified speech or audiological therapist, or a certified occupational therapist for maintenance of the patient, in cases where significant deterioration would result without such services.

Outpatient Rehabilitative Care

Rehabilitative care is physical, occupational, speech and audiological therapy services by a professional provider to a patient who is not confined in a hospital.

Chiropractic Treatment

Benefits will be provided for services of a licensed Chiropractor (DC), including any necessary related diagnostic x-rays, limited to 30 visits per calendar year.

Naturopathic Medicine

Benefits will be provided for services of a licensed naturopathic physician (See Physician Services). This benefit does not include homeopathic/naturopathic solutions, vitamins or supplies.

Acupuncture

Acupuncture benefits will be provided for services performed by an Acupuncturist, Physician or a Chiropractor when licensed by the state to practice acupuncture. Treatment must be medically necessary.

Massage Therapy

Massage Therapy benefits are covered when necessary to treat a medical condition when services are performed by a registered, certified or licensed massage therapist. Treatment must be medically necessary and referred by a Physician.

The Acupuncture and Massage Therapy benefits are limited to \$3,000 per calendar year combined.

Cardiac Rehabilitation

Benefits will be provided, subject to your calendar year out-of-pocket maximum, for cardiac rehabilitation when ordered by a physician limited to \$2,500 per calendar year.

Diabetic Instruction

Services and supplies used in diabetes self-management programs are covered under this Plan when they are provided by a health care professional for the treatment of diabetes. For the purposes of this diabetic instruction benefit, "health care professionals" mean physicians, nurses, pharmacists and registered dietitians who are knowledgeable about the disease process of diabetes and treatment of a person with diabetes. Benefits will be provided, subject to your calendar year out-of-pocket maximum, limited to a lifetime maximum of \$250.

Skilled Nursing Facility

Benefits will be provided, subject to your calendar year out-of-pocket maximum, for up to 180 days per calendar year for care in a licensed skilled nursing facility. Covered expenses are limited to the daily service rate up to the amount we would pay if the patient were in a semi-private hospital room. The physician must give us proof of medical necessity, that we find acceptable, showing that the patient would require hospitalization if care in a skilled nursing facility were not possible.

Covered benefits include: semi-private room and board accommodations (room, meals, general nursing care); ancillary services including use of special treatment rooms; drugs and medicines; biologicals (such as blood products and solutions); routine lab exams; physical, occupational or speech therapy treatments; respiratory and other gas therapy and materials used in dressings and casts.

Please note: In addition to the limitations and exclusions listed elsewhere in your booklet, skilled nursing facility benefits are not provided for custodial care, or care primarily for mental retardation or senile deterioration. Also, these benefits do not apply to nervous and mental conditions, chemical dependency or alcohol treatment.

Home Health Care Benefit

This Plan provides home health care benefits for medically necessary covered services rendered, furnished and billed by a state-licensed home health agency. The services must be part of a formal written treatment plan prescribed by a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.) who must certify that it is not medically advisable for the participant to leave home, and that hospital or skilled nursing facility confinement would be required in the absence of home health care. The treatment plan must also describe the services and supplies to be provided to the participant for treatment of an illness or injury. The treatment plan is subject to utilization review performed by the Plan.

Covered services of a state-licensed home health agency are those visits for intermittent care, not to exceed four hours in duration per visit, by a registered nurse or licensed practical nurse; a licensed physical therapist; a certified occupational therapist; an American Speech, Language and Hearing Association-certified speech therapist; a certified respiratory therapist; or a home health aide acting under the direct supervision of one of the above therapists while performing services specifically ordered by a physician.

Also covered are disposable medical supplies, drugs and medicines prescribed by a physician, when provided by the agency.

Please Note: In addition to the limitations and exclusions found elsewhere in this benefit booklet, home health care benefits are not available for homemaker or housekeeping services except by home health aides as ordered in the approved home health treatment plan; supportive environmental materials such as handrails, ramps, air conditioners and telephones; services performed by family members or volunteer workers; social services; dietary assistance; "Meals on Wheels" or nutritional guidance; separate charges for records, reports or transportation; expenses for the normal necessities of living, such as food, clothing and household supplies; custodial care; services in excess of the specified limitations; services rendered or supplies furnished to other than the

participant; any services or supplies not included in the written treatment plan or not specifically set forth as a covered service; services provided during any period of time in which the participant is receiving benefits under this program's "Hospice Care Benefit"; or services furnished by a home health agency that is not state-licensed as such.

Home Infusion Therapy

Benefits will be provided for home infusion therapy.

Transplantation Services

Preauthorization - Transplantations must be preauthorized by the Plan Administrator. Authorization is based upon the patient's medical condition, whether the transplant is medically necessary, the qualifications of the providers, appropriate medical indications for the transplant, whether the procedure is experimental, unproven or investigational, and whether treatment is an appropriate proven medical procedure for the type of condition within the standard of generally accepted medical practice as determined in the sole and absolute discretion of the Plan Administrator.

Medical and surgical treatment or devices related to transplantation that are experimental, investigational or unproven are those not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use, subject to review and approval by any institutional Review Board for the proposed use; or not demonstrated through prevailing peer-reviewed medical literature to be efficacious for the treatment of the disease state at the time of the request. The Plan Administrator reserves the right to make final judgment regarding coverage of experimental, investigational and unproven procedures and treatments.

Medically necessary means those transplant related services which are determined by the Plan Administrator to be medically appropriate for the diagnosis and clinical status of the participants and their dependents; rendered in an appropriate setting; and of demonstrated medical value. The fact that a physician has performed or prescribed a transplant related service, or the fact that it may be the only treatment for a disease, does not mean that it is medically necessary.

Transplant related services are services and supplies related to transplantation when recommended by a physician, provided at or arranged by a transplant hospital and determined to be medically necessary. Such services and supplies include, but are not limited to, hospital charges, physician charges, organ acquisition charges, tissue typing, donor search charges, and ancillary services.

Transplantation Benefits are further limited as follows:

- The recipient must be continuously covered for 12 months under the Plan and satisfy all waiting period requirements or be continuously covered since birth, prior to incurring transplantation-related services.
- The transplant must be included in the following list of Natural Organs, Natural Organ Parts and Artificial Organ Parts:
 - Natural Organs: heart; heart/lung (combined); kidney; kidney/pancreas (combined); lungs (single/bilateral); liver.
 - Natural Organ Parts: cornea; skin, bone and tendons; bone marrow (including self-donated and unrelated donors) but only as follows:
 - With regard to autologous (self-donor) bone marrow transplants, coverage is only available for treatment of non-Hodgkins lymphoma; Hodgkins lymphoma; and acute lymphocytic or nonlymphocytic leukemias. Autologous bone marrow transplants for other conditions will not be covered.
 - With regard to allogeneic (related or unrelated) bone marrow transplants, coverage is only available for treatment of acute lymphocytic leukemia; acute

non-lymphocytic leukemias; chronic myelogenous leukemia; aplastic anemia; Hodgkins lymphoma; non-Hodgkins lymphoma; severe combined immunodeficiency (not AIDS); Wiskott-Aldrich syndrome; infantile malignant osteopetrosis; homozygous beta-thalassemia. Allogeneic bone marrow transplants for conditions other than those listed will not be covered.

- Artificial Organ Parts: joint replacement (but for functional reasons only), skin, heart valves, grafts and patches (vascular) pacemaker, metal plates, and eye lens.

Donor costs. If the recipient is covered under this Plan, the Plan will pay up to \$10,000 for donor costs. Donor costs means the covered expense of removing the tissue from the donor's body and preserving or transporting it to the site where transplantation is performed. If the donor is covered under this Plan and the recipient is not, the Plan will not pay any benefits toward donor costs. Complications and unforeseen effects of the donation will be covered as any other illness.

Transportation, lodging and meal costs. Transportation, lodging and meal costs are covered provided the patient resides more than 25 miles from the transplant facility. Benefits are limited to \$500 per day and \$10,000 per transplant. Benefits include transportation of the recipient and a companion to and from the site of the transplant, lodging and meal costs (excluding alcohol) incurred in the interim by such companion. If the recipient is a minor, transportation, lodging, and meal costs of two persons who travel with the minor are included. Transportation charges are limited to the following:

- Airline travel - coach class only, lowest available airfare;
- Car rental - economy class only. If a car is rented other local transportation charges will not be included;
- Local transportation - taxi service to and from the airport, hotel, and transplant facility when more economical services (hotel vans, shuttles, etc.) are not available.

In addition to the exclusions in the Limitations and Exclusions section, the Plan will not pay for the following:

- Services or supplies provided to an enrolled donor if the recipient is not covered under this Plan and eligible for transplantation benefits, except those for complication or unforeseen effects resulting from the initial operation.
- Services in a non-approved transplant facility.
- Living (non-cadaver) donor transplants of the lung, liver, or other organ (except kidney), including selective islet cell transplants of the pancreas.
- More than one retransplant if the transplant is not successful.
- Xenotransplantation (animal to human transplant)
- Small bowel transplantation
- Islet cell transplantation
- Pancreas transplantation
- Pancreas transplantation after kidney transplantation (sequential)
- Solid organ transplantation in patients with an existing or recent (less than two years from diagnosis) malignancy, excluding hepatomas less than 5 cm. in diameter.

Durable Medical Equipment, Supplies and Appliances

Benefits will be provided, subject to your calendar year out-of-pocket maximum, for the following medically necessary durable medical equipment, supplies and appliances:

- Blood and Blood Plasma.
- Home Medical Equipment rental (or at the election of the Plan, initial purchase in lieu of rental) of medically necessary home medical equipment when prescribed by a physician for therapeutic use. The total rental fee for a piece of home medical equipment will not exceed the full purchase price of that piece of equipment. When medically appropriate, the Plan may

elect to provide benefits for a less costly alternative item. Home medical equipment is equipment that can withstand repeated use, is only for treatment of the medical condition, is not used for convenience only, and is generally not useful to the patient in the absence of the medical condition. No benefits will be provided for items such as, but not limited to, air conditioners, humidifiers, exercise equipment, whirlpool baths, weights, heating pads, lumbro-sacral pillows, adjustable beds, orthopedic chairs or personal hygiene items.

- Supplies and dressings when medically necessary for surgical wounds, cancer, burns, or diabetic ulcers; oxygen; colostomy bags and catheters; surgical and orthopedic braces; orthotics and casting; splints; and trusses.
- Prosthetic Appliances will be provided for functional reasons to replace a missing body part. This benefit also covers the first intraocular lens prescribed to replace the lens. No benefits will be provided for cosmetic prostheses, except for external and internal breast prostheses necessary because of a mastectomy. When medically appropriate, the Plan may elect to provide benefits for a less costly alternative item. Benefits for repair or replacement of a prosthesis due to normal use, adolescent growth or pathological change will be provided.

Treatment for Chemical Dependency, including Alcoholism

This Plan will provide benefits for services of an approved alcoholism treatment or drug treatment facility for medically necessary inpatient and outpatient treatment of alcoholism or chemical dependency, including detoxification and supportive services. Benefits for the treatment of chemical dependency, including alcoholism, are limited to \$5,000 in any 24-month period and a lifetime maximum of \$10,000. No benefits will be provided for information and referral services, Alcoholics Anonymous and similar voluntary mutual support groups, educational programs for drinking drivers, family education or support groups, long-term care or custodial care, emergency service patrol or court ordered services.

Mental Health and Psychiatric Care

This Plan will provide benefits for the treatment of mental health/psychiatric treatment the same as any other medical condition. Services include inpatient and residential facility care in licensed mental health hospital or facility. Out patient care will be provided for services of a psychiatrist, psychologist, clinical social worker (M.A., M.S., M.S.W.), a licensed or registered counselor and a community mental health agency.

Treatment for Obesity

This benefit is subject to a lifetime maximum of \$25,000 and is subject to the overall lifetime maximum. Benefits are payable at 80%. Providers and Facilities must be in the PPO. Benefits are not subject to and will not apply to the out-of-pocket maximum.

Preauthorization – Treatment under this benefit must be preauthorized by the Plan Administrator. All costs of preauthorization are the responsibility of the patient, not of the Healthcare Plan. Authorization is based upon the following requirements:

- Must be continuously enrolled in the group plan for at least 6 months
- Must be medically necessary
- The patient failed conservative treatment and exhibits the willingness to comply with long term medical, surgical, nutritional and behavioral treatment and follow up; this includes documented failure to at least one year of medically supervised weight reduction including diet, exercise and pharmacological therapy, unless contraindicated
- Must be at least 18 years old
- Must be diagnosed by two individual physicians as being morbidly obese

- At least 2 of the following co-morbidities
- Sleep Apnea, diabetes, hypertension, coronary artery disease and hyperlipidemia
- Request is for one of the following procedures
- Vertical Banded Gastroplasty (VBG), Rou-en-Y Gastric Bypass (RYGB) or Adjustable Gastric Banding.
- Surgical Procedure must be requested and performed by a surgeon who is a member of the American Society of Bariatric Surgery (ASBS)

Benefits will be provided for the following:

- Provider office visits, pre-surgical diagnostic tests and procedures, post operative care, follow-up care
- Psychological evaluations
- Anesthesia
- Facility charges
- Complications associated with this service
- Cosmetic or reconstructive surgery and associated facility charges related to the weight loss resulting from these benefits.

In addition to the exclusions in the Limitations and Exclusions section, the Plan will not pay for the following under this benefit:

- Non-surgical treatment of obesity, including but not limited to over the counter dietary control substances, prescription drugs used to treat obesity and any programs or treatment to meet preauthorization requirements.
- Weight control self-help programs (such as Weight Watchers, Jenny Craig or other such programs).

Hospice Care Benefit

This benefit provides hospice care benefits as an alternative to hospitalization for a terminally ill participant. Covered services must be rendered, furnished and billed by a state-licensed hospice agency and included in a written hospice plan of care established and periodically reviewed by a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.).

The physician must certify that the participant is terminally ill and that hospital confinement would be required in the absence of the hospice care. The hospice plan of care shall also describe the services and supplies for the palliative care and medically necessary treatment to be provided to the participant by the hospice. The hospice plan of care is subject to utilization review performed by the Plan. Benefits are provided for:

- Visits by each of the following for intermittent care, not to exceed four hours in duration per visit: a registered or licensed practical nurse; a licensed physical therapist; a certified respiratory therapist; an American Speech, Language and Hearing Association-certified speech therapist; a certified occupational therapist; a master of social work; or a home health aide.

- Medical supplies such as oxygen; catheters; needles; syringes; dressings; and materials used in aseptic techniques, irrigation solutions and intravenous solutions normally used for hospital inpatients.
- Rental of durable medical apparatus and medical equipment such as wheelchairs, hospital beds, respirators, splints, trusses, braces or crutches needed for treatment.

In addition, allowable charges are paid in full for up to 120 hours of respite care each three-month period of hospice care, to relieve all persons caring for and residing with a homebound participant from their duties. The three-month period begins on the initial date of hospice care covered under this program.

Please Note: In addition to the limitations and exclusions found elsewhere in this benefit booklet, hospice care benefits are not available for the following: services rendered or supplies furnished to other than the terminally ill participant, including bereavement counseling; pastoral and spiritual counseling; services performed by family members or volunteer workers; homemaker or housekeeping services, except by home health aides as ordered in the hospice plan of care; supportive environmental materials, such as handrails, ramps, air conditioners and telephones; expenses for the normal necessities of living, such as food, clothing and household supplies; "Meals on Wheels" or similar food services; separate charges for records, reports or transportation; legal and financial counseling services; services and supplies not included in the hospice plan of care, or not specifically set forth as a covered service; services in excess of the specified limitations; services provided during any period of time in which the participant is receiving benefits under this program's "Home Health Care Benefit," or services furnished by a hospice that is not state licensed as such.

Ambulance Transportation

Benefits will be provided for licensed ground, air and sea ambulance services used to transport you from the place where you are injured or stricken by illness to the nearest accredited general hospital where adequate facilities for treatment are available. No other expense for travel will be covered.

Special Dental Care

Treatment of accidental injury to natural teeth or a fractured jaw, if the treatment is given by a physician or dentist while you are covered under this plan *and* within 12 months after the injury. The injury must be one that occurred while the person was covered under this Plan. If dental expenses are covered under either Special Dental Care or the Covered Dental Expenses section of this Plan we will pay benefits under the section which provides the most coverage. We will not pay benefits under both sections for the same service.

Temporomandibular Joint (TMJ) Disorders

Benefits will be provided for medically necessary treatment of temporomandibular joint disorder when provided by a physician, accredited hospital, registered physical therapist, licensed oral surgeon or dentist limited to a lifetime maximum of \$2,000 for all combined TMJ services and supplies, including night guards. No benefits will be provided for restorative techniques to build occlusion or for banding treatment.

Outpatient Prescription Drugs

This Plan will provide benefits for outpatient prescription drugs, insulin or medicines that are not purchased through PCN or the Informed Rx mail order programs. The insulin, drugs and medicines must relate directly to the treatment of an illness or injury and legally cannot be dispensed without a prescription, and must bear the legend "Caution - Federal law prohibits dispensing without a prescription." This benefit is not subject to the stop loss provision of this Plan.

If a participant has primary prescription coverage through another insurance program, this Plan will provide secondary coverage for your out-of-pocket expenses. Please submit a copy of your eligible

prescription receipt along with the explanation of benefit statement or copayments indicating the amount not covered by your primary prescription insurance program directly to this Plan for secondary benefits.

ARTICLE III

PRESCRIPTION DRUG BENEFITS

PHARMACEUTICAL CARE NETWORK

We have contracted with Pharmaceutical Care Network (PCN) to process your claims for prescription drugs. If you go to a PCN pharmacist for covered prescription drugs, follow these steps:

- Tell your pharmacist you're a PCN member. Present your Identification Card every time you pick up a prescription, whether it is new or a refill.
- Advise the pharmacist of the patient's name, date of birth, sex and relationship to you.
- Pay the pharmacist your appropriate copayment.

The copayment listed below is your only cost for covered prescription drugs dispensed by a PCN pharmacist.

Generic and Source* Prescriptions	20% copayment
Name Brand Prescriptions**	20% copayment PLUS the difference in cost between the Name Brand and generic equivalent

* Source prescriptions are prescriptions with no generic equivalent.

** If the prescription indicates "Dispense as written", you do not have to pay the difference in cost from a generic prescription.

INFORMED RX MAIL ORDER PHARMACY SERVICE

This program is available only for "Maintenance Drugs." Maintenance Drugs are those prescriptions required on an ongoing basis for control of chronic medical conditions such as high blood pressure, stomach ulcers, diabetes, asthma/allergies, arthritis and oral contraceptives. You may obtain up to a 90-day supply of your maintenance prescriptions and will be required to pay only a 20% copay for each prescription. To obtain your maintenance prescriptions under this program you must complete a Informed Rx registration form and mail it, along with your copay, to Informed Rx. Your prescription will be mailed to your home address.

PLEASE NOTE:

- If a participant has primary prescription coverage through another insurance program, this Plan will provide secondary coverage for your out-of-pocket expenses. Please submit a copy of your eligible prescription receipt, along with the explanation of benefit statement or copayments indicating the amount not covered by your primary prescription insurance program, directly to this Plan for secondary benefits.
- Prescription drug copayments do not apply toward your calendar year medical stop-loss provision.

COVERED DRUGS

This Plan provides coverage for any legend drug (a drug which requires a prescription by State or Federal law), EXCEPT those items listed below under "exclusions" for this Plan.

DISPENSING PERIOD AND LIMITATIONS

Quantities are limited to a 90-day supply. A separate prescription must be issued per patient.

EXCLUSIONS

Drugs, medications, implements and or health care devices that are **NOT COVERED** under this plan are:

- All over-the-counter medication (OTC)
- Medical devices
- Rogaine
- Fertility drugs
- Vitamins, if OTC, except prenatal vitamins
- Charges covered by any Worker's Compensation law, employer's liability, or occupational disease laws

ARTICLE IV
VISION BENEFITS

Benefits will be provided, based on the Vision Schedule, for each covered participant.

VISION SCHEDULE

Eye Examination 100% PPO and 80% non-PPO after \$15 copayment
(Limited to one examination per calendar year)

Vision supplies must be prescribed by a physician or licensed optometrist. Benefits will be limited to a maximum of \$200 per person every calendar year for all hardware combined.

In addition to the exclusions listed in the GENERAL EXCLUSION section, we will not pay for the following services:

- Plain sunglasses or special vision aids.
- Special procedures such as orthoptics, vision training or subnormal vision aids.
- Any service or supply to the extent that benefits are provided for such under any other provisions of the Plan.
- Procedures that alter the refractive character of the eye, including, but not limited to, radial keratotomy, myotic keratomileusis and other surgical procedures of the refractive keratotomy type, the purpose of which is to cure or reduce myopia or astigmatism. Additionally, reversals or revisions of surgical procedures which alter the refractive character of the eye and complications of all of these procedures are excluded.
- Services or supplies not specifically listed in the VISION SCHEDULE.

ARTICLE V

DENTAL BENEFITS

SUMMARY OF DENTAL BENEFITS

Dental expenses are limited to the usual, customary and reasonable charges as determined by the Healthcare Plan.

	Percentage or Amount Paid
MAXIMUM DENTAL BENEFIT - EVERY CALENDAR YEAR	\$1,500
MAXIMUM LIFETIME ORTHODONTIA BENEFIT	\$1,500
DEDUCTIBLE Applies to Class II and Class III Services only.	\$25 Individual \$75 Family
DENTAL SERVICES	
Class I Services - Diagnostic and Preventive Care Deductible Waived Examination (Limited to no more than once in any five-month period) Prophylaxis (Limited to no more than once in any five-month period) Fluoride treatments for participants under age 16 (Limited to no more than once in any five-month period) Dental X-rays, as required Sealants Space maintainers Emergency palliative treatment Bacteriologic cultures and examination of oral tissue excised for biopsy	100%
Class II - Basic Services subject to deductible Fillings Oral surgery Root canal therapy General anesthesia or local anesthetics with covered dental services Repairs and adjustments to bridges and dentures Basic periodontal services Related oral exams	85%
Class III - Major Services subject to deductible Crowns Inlays and onlays Bridges and dentures Major periodontal services	75%

Class IV - Orthodontia Services Deductible Waived Consultation and treatment plan Cephalometric film and orthodontic x-rays, as required Removable, fixed or cemented orthodontic appliances and adjustments	50%
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COVERED DENTAL BENEFITS

Deductible

There is a \$25 per person / \$75 per Family Deductible for Class II and III services.

Maximum Dental Benefit

The maximum dental benefit in any one calendar year for Class I, II and III dental services is \$1,500 per participant. The lifetime maximum benefit per participant for Class IV services is \$1,500.

Dental Examination

The Plan, at its own expense, will have the right and opportunity to have a dentist of its choice examine any individual for whom claim is pending when and so often as it may reasonably require.

Class I Services - Diagnostic and Preventive

The maximum covered expense is 100% of the usual, customary and reasonable charge for the following services:

- Periodic oral exam - limited to no more than once in any five-month period.
- Prophylaxis (cleaning, scaling and polishing teeth) - limited to no more than once in any five-month period.
- Fluoride treatments for participants under age 16 - limited to no more than once in any five-month period.
- Sealants.
- Dental X-rays.
- Space maintainers designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth). This does not include space maintainers used in orthodontics to create a space between teeth.
- Bacteriologic cultures and examination of oral tissue excised for biopsy.
- Emergency palliative treatment primarily for relief of dental pain, not cure.

Class II Services - Basic Restorative, Endodontics, Basic Periodontics and Oral Surgery

The maximum covered expense is 85% of the usual, customary and reasonable charge for the following services subject to the deductible:

- Fillings (restorations) using amalgam, silicate, acrylic, synthetic porcelain, and composite filling materials to restore teeth broken down by decay or injury.
- Pin retention of fillings.
- Study models, limited to once every three years.
- Crown buildup on non-vital teeth.
- Simple extraction of one or more teeth.
- Oral surgery, including customary postoperative treatment furnished in connection with oral surgery, as follows:
 - Surgical extraction of one or more teeth, including impacted teeth.
 - Extraction of the tooth root.

- Alveolectomy, alveoplasty, and frenectomy.
- Excision of pericoronal gingiva, exostosis, or hyperplastic tissue, and excision of oral tissue for biopsy.
- Reimplantation of a natural tooth or transplantation of a natural tooth.
- Excision of a tumor or cyst and incision and drainage of an abscess or cyst.
- General anesthetics and analgesics, including intravenous sedation, when administered in connection with covered dental procedures.
- Antibiotic injections administered by the treating dentist.
- Endodontic treatment of diseases of the tooth, pulp, root, and surrounding tissue, as follows: root canal therapy, pulpotomy, apicoectomy, and retrograde filling.
- Recementing inlays, onlays, and crowns.
- Recementing bridges.
- Repairs to full and partial dentures and bridges.
- Basic periodontal services
 - Periodontal prophylaxis.
 - Root scaling and root planing.
 - Occlusal adjustment.
- Related oral exams.

Class III Services - Major Restorative, Installation of Bridges and Dentures and Repair, Relining and Adjustments to Dentures and Bridgework.

The maximum covered expense is 75% of the usual, customary and reasonable charge for the following services subject to the deductible:

- Restorative services and supplies as follows:
 - Gold or porcelain inlays, onlays, and crowns, but only when the tooth, as a result of extensive caries or fracture, cannot be restored with an amalgam, silicate, acrylic, synthetic porcelain, or composite filling material.
 - Stainless steel crowns.
 - Post and core.
 - Replacement of an existing inlay, onlay, or crown, but only if it has been at least five years since the restoration was initially placed or last replaced. However, this limitation will not apply if replacement of an existing inlay, onlay, or crown is made necessary by the extraction of one or more functioning natural teeth while your coverage under a group plan through Clallam County Public Utility District No. 1 is in effect.
- Prosthetic services and supplies, as follows:
 - Initial placement of full or partial dentures or fixed bridgework (including acid etch metal bridges).
 - Replacement of full or partial dentures or fixed bridgework which cannot be made serviceable, but only if it has been at least five years since the denture or bridgework was initially placed or last replaced.
 - Addition of one or more teeth to an existing partial denture.
 - Relining or rebasing of existing removable full or partial dentures, but only if it has been at least one year since the denture was placed, and not more often than once in any two-year period.
 - Implants, including surgical placement or removal of implants or attachments to implants.
- Major periodontal treatment of the gums and supporting structures of the teeth, as follows:
 - Gingivectomy, gingival curettage, and mucogingival surgery.
 - Osseous surgery including flap entry and closure.
 - Pedicle or free soft tissue grafts.

- Periodontal appliances (night guards).

Class IV Services - Orthodontic Services

The maximum covered expense is 50% of the usual, customary and reasonable charge for the following services.

- Cephalometric film.
- Removable, fixed or cemented appliance for minor treatment for tooth guidance, including impressions, installation and all adjustments within six months of installation.
- Removable, fixed or cemented appliance for interceptive orthodontic treatment, including impressions, installation and adjustments within six months of installation.
- Comprehensive (full banding) orthodontic treatment of transitional or permanent dentition, including:
 - Initial placement of orthodontic appliance.
 - Subsequent active orthodontic treatment.

Charges for orthodontic treatment for which the first orthodontic appliance was installed before the effective date of your dental coverage under the Plan are not covered. Dental benefits for covered orthodontic expenses are paid as the charges for the orthodontic treatment are incurred, but not before the date the first active orthodontic appliance is placed. No dental benefit will be paid for charges incurred after the date dental coverage ends, even if the orthodontic treatment begins while you are covered.

Extension of Dental Benefits

An expense incurred for a covered dental service that is completed after a person's benefits cease will be deemed to be incurred while he/she is covered if:

- For fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while covered and the device is installed or delivered within 30 days after the coverage ceases.
- For a crown, inlay, or onlay, the tooth is prepared while covered and the crown, inlay or onlay is installed within 30 days after coverage ceases.
- For root canal therapy, the pulp chamber of the tooth is opened while covered and the treatment is completed within 30 days after coverage ceases.

There is no extension for any dental service not shown above.

Prestatement of Benefits

Prestatement of benefits is a process designed to give you and your dentist a better understanding (before services are rendered) of the covered dental services under this Plan.

When charges for a proposed dental service or series of dental services are expected to exceed \$250, your dentist may submit a claim form showing the treatment plan and fees. Pacific Underwriters will then review the treatment plan to determine the estimated benefits payable for each service according to the terms of the Plan, and notify you and your dentist accordingly. The prestatement of benefits provides an estimate of the benefits payable under the Plan and is not a guarantee of coverage. If the prestatement of benefits process is not followed, Pacific Underwriters will determine benefits payable on the basis of the amount of benefits which would have been paid had the prestatement process been followed.

Limitations to Dental Benefits

There are limitations on covered expenses for dental care under this Plan. These limitations are explained in the following paragraphs.

Treatment Options

When there is more than one method of treatment for a dental condition, covered expenses will be limited to the treatment method with the lesser charge.

Care by More Than One Provider

If you or a covered dependent transfers care from one provider to another while receiving treatment, or if more than one provider gives care for a dental condition, covered expenses will be limited to the amount that would have been covered if one provider had performed the service.

DENTAL LIMITATIONS AND EXCLUSIONS

Except as specifically included elsewhere in this Plan, no benefits are payable for:

- Services for which claim was not made within one year of date of service.
- Charges in excess of the usual, customary and reasonable (UCR) fee.
- Charges which, in the absence of this coverage, you or your dependents are not legally required to pay.
- Charges for treatments, materials or supplies which are experimental in nature.
- Appliances or restorations necessary to increase vertical dimensions or restore occlusion.
- Services performed solely for cosmetic reasons.
- Replacement of lost or stolen prostheses.
- Periodontal splints and charges for crowns for the purpose of periodontal splinting.
- Charges for failure to keep a scheduled appointment with a dentist.
- Replacement of teeth missing prior to a person's coverage in a group dental plan through Clallam County Public Utility District No. 1.
- Charges for root canal therapy for which the pulp chamber was opened before the effective date of your dental coverage under a group dental plan through Clallam County Public Utility District No. 1.
- Charges for a gold or porcelain inlay, onlay, or crown for which a tooth was prepared before the effective date of your coverage under a group plan provided through Clallam County Public Utility District No. 1.
- Charges for any prosthetic appliance or modification of any prosthetic appliance for which the impression was made before the effective date of your dental coverage under a group plan through Clallam County Public Utility District No. 1.
- Charges not specifically described as covered benefits under this Plan.

ARTICLE VI

GENERAL LIMITATIONS AND EXCLUSIONS

LIMITATIONS

There are limitations on the medical benefits available under this Plan for the treatment of certain conditions and the use of certain procedures. These limitations are explained in the following paragraphs.

Preexisting Conditions Limitation

In the event that the employee or dependent covered under this Plan has received medical treatment in the six months prior to his or her effective date, coverage for said preexisting condition shall begin when the employee has:

- Completed six continuous months of coverage under the Plan.

Please Note: Preexisting Condition means any condition (except pregnancy) for which the covered employee or dependent:

- has received medical care, consultation, treatment, services or diagnosis; or
- has taken prescribed drugs or medicines.

A condition is diagnosed whenever a physician tells a patient that he or she has that condition or makes an entry to that effect in the person's medical records. This is so even if the physician is examining or treating the person for a different condition.

This limitation does not apply to children under 19.

Specific Procedures/Conditions Limitation

Until you have been enrolled under the provisions of this Plan for a period of 12 consecutive months, no benefits will be provided for services and supplies related to the following procedures or conditions, regardless of whether the condition necessitating the procedure is or is not preexisting:

- Transplants, including organ transplants and stem cell rescue.

Please Note:

- This Plan will also extend to new employees and dependents, credit towards Preexisting Condition Limitations and Specific Procedures/Conditions Limitations for time covered under group or individual coverage, as well as coverage under Medicare, Medicaid and other government plans. Prior coverage will not qualify as "creditable" if there was a break in coverage longer than 63 days prior to the hire date. The waiting period is not considered when determining a break in coverage.
- Preexisting Condition Limitations and Specific Procedures/Conditions Limitations do not apply to newly acquired dependents placed in your home for adoption while you are covered under this Plan or to employees or dependents who lose other group medical coverage as described in the Eligibility Section of this Plan.

General Medicare Limitation

In certain situations, this agreement is primary to Medicare. This means that when you or your covered dependent is enrolled in Medicare and this agreement at the same time, we pay benefits for covered expenses first and Medicare pays second. Those situations are:

- When you or your covered spouse is age 65 or over and by law Medicare is secondary to your employer group health plan;
- When you or your covered dependent incurs covered expenses for kidney transplant or kidney dialysis and by law Medicare is secondary to your employer group health plan; and
- When you or your covered dependent is entitled to benefits under Section 226(b) of the Social Security Act (Medicare disability) and by law Medicare is secondary to your employer group health plan.

In all other instances, we will not pay benefits toward any part of a covered expense to the extent the covered expense is actually paid or would have been paid under Medicare Part A or B had you or your covered dependent properly applied for benefits.

EXCLUSIONS

Unless otherwise specifically included, benefits will not be paid for the following:

- Services for which claim was not made to the Clallam County Public Utility District Healthcare Plan within one year of the date of service.
- Charges in excess of the usual, customary and reasonable (UCR) fee, as determined by the Clallam County Public Utility District Healthcare Plan.
- Benefits that overlap or duplicate benefits for which the participant is eligible under any other group benefit plan, contract, Worker's Compensation or similar employee benefit law.
- Services for a condition resulting from an act of war, declared or undeclared. In the event of any major disaster, epidemic, or similar occurrence, the Plan agrees to render its best efforts to arrange for the provision of the services called for under this Plan but does not undertake to guarantee provision of such services, and assumes no liability if unable to arrange for the provision of such services because of the occurrence of such event.
- Any services or supplies for which no charge is made, or for which a charge is made because this program is in effect, or for services or supplies for which the participant is not legally liable.
- Procedures which are experimental, or have not been proven effective for the participant's condition, or not generally accepted as a standard of good medical practice.
- Charges resulting from any intentionally self-inflicted injury or attempted or successful suicide.
- Illness or injury caused or contributed to while engaging in an illegal occupation or the commission or attempt to commit a felony.
- Services or supplies not: a) medically necessary for treatment of a disease, illness or injury; and b) recommended by a physician, except as specifically defined by the Plan.
- Services provided by a physician who is a spouse, parent, brother, sister or child of the patient.
- Routine foot care procedures such as trimming of nails, corns or callouses; or orthopedic shoes.
- Plastic or reconstructive surgery primarily for cosmetic purposes or treatment required because of complications of cosmetic or reconstructive surgery, except the Plan will provide benefits for the following:
 - Repair of a defect which is the direct result of an accidental injury while covered under the Plan, providing such repair is performed within 12 months of the date of the accident;
 - Repair of a dependent child's congenital anomaly;
 - Reconstruction of the involved breast after a mastectomy required by illness or accidental injury. And, for all stages of one reconstructive breast reduction on the other breast to make it equal in size to the breast reconstructed after mastectomy.

- Expenses due to injury or illness caused by the act or omission of another person (known as the Third Party), where damages are collectable.
- Medical, surgical, appliance treatment or related diagnostic services or restoration for Temporomandibular Joint (TMJ) dysfunction, malocclusion, protrusion or recession of mandible, maxillary hyperplasia or hypoplasia, except as specifically provided under Covered Medical Benefits.
- Marriage, sexual or family counseling; recreational, education or milieu therapy; treatment for dyslexia or learning disabilities; non-medical self-help training.
- Custodial care; hospitalization primarily for rest, diet or convenience, or where no specific treatment is rendered.
- Treatment for obesity (excessive weight) including surgery or complications of surgery except as provided in the Treatment for Obesity benefit.
- Physical exercise programs, even though they may be prescribed by a physician.
- Services and supplies for sexual dysfunctions, inadequacies or sex change operations, including but not limited to infertility, impotence, artificial insemination and genetic testing or counseling.
- Personal or comfort items for registered bed patients in a hospital or long-term care facility. Private duty nursing and private rooms except when determined to be medically necessary and ordered by a physician.
- Court-ordered care for psychiatric, drug or alcohol treatment in any form.
- The fitting, provision or replacement of eyeglasses and vision aids (except as specifically defined under the Vision Care Benefits of this Plan), vision therapy, and/or eye exercises.
- Procedures that alter the refractive character of the eye, including, but not limited to, radial keratotomy, myotic keratomileusis and other surgical procedures of the refractive keratotomy type, the purpose of which is to cure or reduce myopia or astigmatism. Additionally, reversals or revisions of surgical procedures which alter the refractive character of the eye and complications of all of these procedures are excluded.
- Massage or massage therapy unless medically necessary and referred by a Physician.
- Acupuncture unless medically necessary.
- Maternity care for dependent children, except complications of pregnancy.
- Expenses to the extent that they are covered by medical payments insurance, uninsured motorist insurance, under-insurance coverage and personal injury protection benefits.
- Services or supplies not specifically described as benefits under this Plan.
- Work-related conditions: Services or supplies for treatment of illness or injury to an employee, employee's spouse, retiree, or retiree's spouse arising out of or in the course of gainful employment or self employment for wages or profit for which industrial insurance coverage is available from the State of Washington Department of Labor and Industries, whether or not the expense for the service or supply is paid under the industrial insurance coverage.

ARTICLE VII

CLAIMS ADMINISTRATION

Coordination of Benefits

Some individuals may be covered under more than one group healthcare plan. If so, payments of benefits will be coordinated between the plans so as not to pay more than the actual cost of the services you received.

If another plan has primary responsibility for your benefits, this Clallam County Public Utility District Healthcare Plan will pay the difference between any benefits you receive under the primary plan and the benefits to which you are entitled under this plan, not to exceed 100%.

Any group program which does not contain a coordination of benefits provision will always be primary. If you are covered on a retiree program by the Clallam County Public Utility District Healthcare Plan, and become covered also on an active employee program with another group, your coverage on the employee program will be primary. When a program that does contain a coordinating provision covers you as an employee, it is considered primary over any program that covers you as a dependent.

If the benefits covered are in a PPO network, the allowable expense will be the lowest allowable expense of all of the Plans.

If a child is covered under both parents' programs, the primary plan is the plan of the parent whose birthday (excluding year of birth) occurs earlier in the calendar year.

If the parents are separated or divorced, the coverage of the parent with custody of the child is usually considered primary. If the parent with custody of the child has remarried, the program of the parent with custody will be primary over the program of the stepparent. The program of the stepparent will be primary over the program of the parent without custody. However, if there is a court decree which establishes financial responsibility of the health expenses of the child, the program of the parent with such responsibility will be primary over any other program covering the dependent child.

If you have coverage through more than one carrier, first submit your bills to the carrier with primary responsibility. When you receive the explanation of benefits (E.O.B.) back from the primary carrier, attach a copy of the E.O.B. to the bill and submit it to the secondary carrier.

Reimbursement Rights/Subrogation

As a condition to participating in and receiving benefits under this Plan, covered participants agree:

- To reimburse the Plan for any such benefits paid to, or on behalf of, the participants when said benefits are recovered, in any form, regardless of how classified or characterized, from any person, corporation, entity, no-fault carrier, underinsured motorist carrier, uninsured motorist carrier, other insurance policies or funds; and
- To refrain from releasing any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable for or obligated to the participant for the injury or condition without obtaining the Plan Administrator's written approval; and
- Without limiting the preceding, to subrogate the Plan to any and all claims, causes of action or rights that they have or that may arise against any person, corporation and/or other entity and to any coverage, other insurance policies or funds (Coverage) for which the participant claims an entitlement to benefits under this Plan, regardless of how classified or characterized.

In the event a participant settles, recovers or is reimbursed by any third party or Coverage, the participant agrees to hold any such funds received in trust for the benefits of the Plan, and to reimburse the Plan for all benefits paid or that will be paid as a result of said injury or condition. The participant acknowledges that the Plan's subrogation right shall be considered a first priority claim and shall be paid before any other claims for the participant as the result of the illness or injury, regardless of whether the participant is paid, as a result of said injury or condition, out of any recovery or reimbursement received, the participant will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the participant.

If the participant decides to pursue a third party or any Coverage available to he/she as a result of the said injury or condition, the participant agrees to include the Plan's Subrogation claim in that action and if there is a failure to do so the Plan will be legally presumed to be included in such action or recovery. In the event the participant decides not to pursue any third parties or Coverage the participant authorizes the Plan to pursue, sue, compromise or settle any such claims in their name, to execute any and all documents necessary to pursue said claims in their name, and agrees to fully cooperate with the Plan in the prosecution of any such claims.

The participant shall execute and return a Reimbursement Agreement and Assignment of Proceeds to Pacific Underwriters and shall supply other reasonable information and assistance as requested by Pacific Underwriters regarding the claim or potential claim. If the Reimbursement Agreement and Assignment of Proceeds is not executed and returned or if information and assistance is not provided to Pacific Underwriters upon request, no benefits will be payable under the Plan with respect to costs incurred in connection with such illness or injury. The participant agrees to take no prejudicial actions against the subrogation rights of the Plan or to in any way impede the action taken by the Plan to recover its subrogation claim. Such cooperation shall include a duty to provide information, execute and deliver any acknowledgment and other legal instruments documenting the Plan's subrogation rights and take such action as requested by the Plan Administrator to secure the subrogation rights of the Plan.

The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a participant pursuing a claim against any Coverage. The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of this Plan Document. The Plan Administrator may amend the Plan in its sole discretion at any time without notice.

Submission and Payment of Claims

You must submit claims within one year of the time you receive services or supplies for us to pay benefits. We have the sole right to decide whether to pay benefits to you, to the provider of services, or to you and the provider jointly.

Hospital Claims - If you or a covered dependent is hospitalized, all you need to do is present your identification card to the admitting office. In most cases, the hospital will bill us directly for the entire cost of the hospital stay. We'll pay the hospital and send you copies of our payment record. The hospital will then bill you for any of the charges that weren't covered by the Plan.

Sometimes, however, the hospital will ask you at the time of discharge to pay amounts that might not be covered by your benefits. If this happens, you must pay these amounts yourself. We will, of course, reimburse you if any of the charges you pay are covered by this Plan.

Professional Provider Claims - Your professional provider may bill charges directly to us. If not, you may send professional provider bills to us yourself. Be sure the professional provider uses his or her billing form and includes on the bill -

- the patient's name, Social Security number and Plan name;
- the date treatment was given;
- the diagnosis; and
- an itemized description of the services given and the charges for them.

IF THE TREATMENT IS FOR AN ACCIDENTAL INJURY, INCLUDE A STATEMENT EXPLAINING THE DATE, TIME, PLACE, AND CIRCUMSTANCES OF THE ACCIDENT WHEN YOU SEND US THE PROFESSIONAL PROVIDER'S BILL.

Ambulance Claims - Bills for ambulance service must show where the patient was picked up and where he or she was taken. They should also show the date of service, the patient's name and Plan and identification numbers.

Claims Processing Reports - Soon after you make a claim, we will report to you on the action we have taken on it. This will be done on a form called an Explanation of Benefits Sheet. We may pay claims or deny them.

If we deny all or part of a claim, the reason for our action will be stated on the Explanation of Benefits Sheet.

Right to Recover Benefits Paid by Mistake

If Pacific Underwriters mistakenly makes a payment to you or to a provider on your behalf, and you are not eligible for all or a part of that payment, then Pacific Underwriters has the right to recover the payment from you or the provider who received the payment. Pacific Underwriters' right to recover a mistaken payment includes the right to deduct the amount paid by mistake from future benefits.

Release of Medical Information

As a condition of receiving benefits under this Plan, you and your dependents authorize any physician, hospital or other provider of service to disclose to Pacific Underwriters any medical information necessary to administer claims. Pacific Underwriters will keep such information confidential to the extent possible.

Right to Review

The Plan at its own expense shall have the right and opportunity to have any Plan member examined by the appropriate health professional when there is a question of fraud or abuse of Plan benefits.

Termination of the Plan

The District has established the Plan with the intention and expectation that it will continue indefinitely, but will have no obligation to maintain the Plan for any length of time. The District reserves the right to amend or terminate, in whole or in part, this Plan at any time without liability. Termination and Plan amendments affecting employees will be communicated to them. Upon termination of the Plan, as to any individual or group, the rights of enrollees to benefits are limited to claims incurred up to the date of termination.

ARTICLE VIII

DEFINITIONS

Ambulatory Surgical Center. A private or public facility with an organized staff of physicians, permanent facilities that are primarily for surgery, continuous physician and nursing services, and which does not provide overnight accommodations.

Approved Alcoholism or Drug Treatment Facility. A facility licensed by the state in which it is located to treat alcoholism or drug addiction.

Children. Includes any unmarried natural, adopted, or stepchild who is primarily dependent on the employee for support and is claimed as an exemption on the employee's Federal Income Tax return.

Close Relative. The covered person's spouse, brother, sister, parent or child.

Complications of Pregnancy. Conditions requiring hospital confinement (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy or are caused by pregnancy, such as (a) acute nephritis, (b) nephrosis, (c) cardiac decompensation, (d) missed abortion, and (e) similar medical and surgical conditions of comparable severity.

Complications of pregnancy also include (a) non-elective Caesarean section, (b) ectopic pregnancy which is terminated, and (c) spontaneous termination of pregnancy, which occurs during a period of gestation in which a viable birth is not possible.

Complications of pregnancy do not include (a) false labor, (b) occasional spotting, (c) physician prescribed rest during the period of pregnancy, (d) morning sickness, (e) hyperemesis gravidarum, and (f) similar conditions associated with the management of a difficult pregnancy not constituting a medically distinct complication of pregnancy.

Confined. When the person is confined for an injury or sickness in a hospital, at home or elsewhere, and is unable to carry on any substantial part of normal daily activity.

Confinement in a Hospital is when a person is confined for at least 18 consecutive hours, or when room and board charges are made. Confinement of a lesser duration when surgery or emergency care beginning no later than 24 hours after a non-occupational injury.

Convalescent Hospital. A lawfully operated institution that provides room and board; has daily 24-hour nursing services through one or more professional nurses for persons convalescing from sickness or injury; and is supervised by a proprietor or employee who is a physician or a registered graduate nurse. It must maintain adequate medical records.

This does not include a rest or nursing facility; a place of custodial care; a place operated by the state, county, city for care of the mentally ill; or any agency of the U.S. Government.

Copayment. A specified dollar amount of covered expenses or share of the charges for services which is the responsibility of the covered participant to pay.

Dental Services. Includes treatment of the mouth, gums, teeth, mouth tissues, maxillae or mandible bones or attached muscle, any orthognathic procedures, orthodontic appliances, dentures and any service generally recognized as dental work.

District. Refers to Clallam County Public Utility District No. 1.

Durable Medical Equipment includes the following: kidney dialysis machines; iron lungs; oxygen tents; hospital beds; wheelchairs and similar medical equipment designed mainly for use in hospital for therapeutic purposes.

Eligible Dependent includes those dependents as described in Article I, Eligibility.

Emergency Care. The care required in connection with a sudden and unexpected onset of a condition requiring medical or surgical care, such as, but not limited to, heart attack, severe bleeding, broken bones, loss of consciousness, convulsions, acute asthmatic attacks, poisoning, or other acute medical problem considered life threatening.

Experimental or Investigational. A drug, device, medical/dental treatment is experimental or investigational:

- if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- if the drug, device, medical/dental treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- if Reliable Evidence shows that the drug, device, medical/dental treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of an on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical/dental treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

Home Health Care Agency. A private or public agency or organization that administers and provides Home Health Care. It must be certified by either Medicare or by the local Department of Social and Health Services as a Home Health Care Agency.

Hospice. A private or public agency or organization that administers and provides hospice care. Must be certified by Medicare to the local Department of Social and Health Services as a Hospice Care Agency.

Hospital. An institution which is licensed by the state in which it operates and which provides diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured or ill persons under the supervision of and by a staff of physicians and other medical personnel.

Hospital does not include a rest home, place for custodial care, home for the aged, a place used primarily for the confinement or treatment of drug addicts, or an institution for the care of the mentally ill operated by any governmental agency.

Illness. A disorder of the body or mind, a disease or pregnancy. All illnesses which are due to the same cause or to a related cause will be deemed to be one illness.

Incurred means the date the covered person receives or is furnished the confinement, service or supply for which the charge is made.

Injury. A bodily injury sustained suddenly and accidentally during the period of coverage.

Inpatient. Confined as a registered bed patient in a Hospital, Skilled Nursing Facility, Hospice, or Free-Standing Chemical Dependency Treatment Center.

Leave of Absence. A period of time off work granted at the request of the employee during which he or she is still considered to be employed and is carried on the employment records of the group. A leave can be granted for any reason acceptable to the employer, including disability and pregnancy.

Medically Necessary. A service or supply meeting all of the following criteria, as determined by the Clallam County Public Utility District Healthcare Plan:

- It is required to diagnose or treat the patient's condition and the condition could not have been diagnosed or treated without it.
- It is consistent with the symptom or diagnosis and treatment of the condition.
- It is the most appropriate supply or level of service that is essential to the patient's needs.
- When applied to an inpatient, it cannot be safely provided to the patient as an outpatient.
- It is appropriate with regard to good medical practice.
- It is not primarily for the convenience of the patient or provider.

Mental Health Services. Any professional care by a psychiatrist, psychologist, clinical social worker (M.S.W., M.S, M.A.), a licensed counselor, a community mental health agency, or admission to a hospital by these professionals.

Outpatient. The term "Outpatient" refers to the classification of a covered person receiving medical care, treatment, services or supplies at a clinic, a physician's office, or at a hospital if not a registered bed patient at that hospital, an outpatient psychiatric facility or an outpatient alcoholism treatment facility.

Plan Benefits. Covered medical services, hospital services, dental services, and other services provided under the Plan.

Physical Therapy. A modality which purpose is to strengthen and improve the gross motor function. For purposes of this plan physical therapy also includes occupational therapy, which is therapy that works toward strengthening the upper body and improving fine motor movement, the goal of both modalities being to return a person to independence.

Physician. Licensed physician means a licensed Doctor of Medicine or Osteopathy, a duly licensed dentist, midwife, chiropractor, naturopath, psychologist, podiatrist or nurse practitioner practicing within the scope of his/her profession, other than you or your relative. The definition may also include a clinical social worker or counselor.

Preexisting Condition. Preexisting Condition means any condition (except pregnancy) for which the covered employee or dependent in the six-month period prior to his or her effective date of coverage:

- has received medical care, consultation, treatment, services or diagnosis; or
- has taken prescribed drugs or medicines.

Prosthesis. An artificial substitute to replace a missing natural body part.

Pregnancy. The condition of being pregnant and all conditions and/or complications resulting therefrom. Pregnancy is covered the same as any other illness for the covered employee or spouse only.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical/dental treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical/dental treatment or procedure.

Room and Board Charges. The institution's charges for necessary institutional services and supplies, made regularly at a daily or weekly rate as a condition of occupancy of the type of accommodations occupied.

Semi-Private Rate. The daily room and board charge which an institution applies to the greatest number of beds in its semi-private room containing two or more beds. If the institution has no semi-private rooms, the semi-private room rate will be the daily room and board rate most commonly charged for semi-private rooms with two or more beds by similar institutions in the area. The term "area" means a city, a county or any greater area necessary to obtain a representative cross section of similar institutions.

Sickness. A sickness causing loss commencing while this Plan is in force as to the covered person whose sickness is the basis of the claim. Sickness shall all be deemed to include disability caused or contributed by pregnancy, miscarriage, childbirth and recovery therefrom. It shall only mean sickness or disease which requires treatment by a physician.

Skilled Nursing Facility. A nursing facility that furnishes room and board and skilled nursing care 24 hours a day and is accredited as an extended care facility or is recognized under the Health Insurance for the Aged Act and is not, other than incidentally, a place for rest, a place for domiciliary care, a place for the aged, a hotel or motel. It is not a place operated by the state, county, or city for the care of the mentally ill; or operated by the U.S. Government and its agencies.

Surgery. The following are surgical classes: a cutting operation; suturing of a wound; treatment of a fracture; reduction of a dislocation; radiotherapy, if used in lieu of a cutting operation; electrocauterization; diagnostic and therapeutic endoscopic procedures; injection treatment of hemorrhoids and varicose veins.

Terminally Ill. A person who has a medical prognosis of a life expectancy of six months or less.

Total Disability. Disability due to injury or disease which commences while covered under this Plan and which totally and continuously prevents Plan member from engaging in normal occupation with the employer. Total disability of a dependent means disability due to injury or disease which prevents the covered dependent from engaging in substantially all of the normal activities of a person of like age and sex in good health. The employee or dependent must be under the care of a physician.

Treatment. The consultations, tests and procedures customarily applied in the care of persons with similar complaints and findings by similarly trained practitioners, and generally accepted as the effective elements of care.

Usual, Customary, and Reasonable (UCR). As determined by the Clallam County Public Utility District Healthcare Plan, the lowest of the following:

- The provider's actual charge to the patient after any discounts or other reductions.
- The charge most frequently made by the provider to all other patients for comparable services or supplies.
- The charge most frequently made by providers with similar professional qualifications for comparable services and supplies within the same geographic area.

Waiting Period. The time between the date of employment and the first day of coverage under the Plan, which is the first day of the month following or coinciding with your date of hire. The waiting period is counted toward satisfaction of the time period for preexisting condition and specific/condition limitations.

Well-Baby Care. Medical treatment, services or supplies rendered to a child or newborn solely for the purpose of health maintenance and not for the treatment of an illness or injury.

ARTICLE IX

SUMMARY PLAN DESCRIPTION

Name of Plan

Clallam County Public Utility District Healthcare Plan

Employer Identification Number

91-6001041

Plan Number

PURMS09

Benefits

Medical, Vision, Dental and Prescription Drugs.

Type of Administration

Benefits are provided under the terms and conditions of a group healthcare plan provided by Clallam County Public Utility District No. 1. The District expects to continue the Plan indefinitely. Future conditions, however, cannot be foreseen and the District reserves the right to modify, alter, amend or terminate the Plan at any time.

Plan Administrator

Clallam County Public Utility District No. 1
2431 E. Highway 101
P.O. Box 1090
Port Angeles, WA 98362

Agent for Service of Legal Process

Clallam County Public Utility District No. 1
2431 E. Highway 101
P.O. Box 1090
Port Angeles, WA 98362

Cost

The employer and employee share in the cost of this program.

Plan Year

The Plan year for this Plan begins on January 1 and ends on December 31 of each year.

APPEAL OF CLAIM DENIAL

If there are any questions about a claim payment, Pacific Underwriters should be contacted.

If you wish to initiate an appeal because there is a disagreement with the reasons why the claim was denied, the Plan Administrator should be notified in writing within 60 days after the date notice of denial was received, unless special circumstances warrant an extension. A request for review of the claim and examination of any pertinent documents may be made by you or anyone authorized to act on your behalf. The reasons why you believe the claim should not have been denied, as well as any data, questions, or comments, should be submitted in writing. The Plan Administrator's decision on the review will be in writing and made within 60 days of receipt of the request for review unless special circumstances warrant an extension.

You may also appeal claim denials to Pacific Underwriters. Contact Pacific Underwriters for appeal procedures. The responsibility for final determinations of appeals of claims denied in whole or in part rests with the Public Utility Risk Management Services (PURMS) Self-Insurance Fund.

CUSTOMER SERVICE DIRECTORY

Claims Administrator:

Pacific Underwriters

Richard (Dick) Rodruck - 1.800.562.5226

Claims Consultant:

Diane Christensen - 1.800.562.5226

Bambi Harrison - 1.800.562.5226

Coverage Questions:

Diane Christensen - 1.800.562.5226

Bambi Harrison - 1.800.562.5226

Ryan VanAckeren - 1.800.562.5226

Eligibility:

Patty Iwamoto - 1.800.562.5226

Ryan VanAckeren - 1.800.562.5226

Bambi Harrison - 1.800.562.5226

Diane Christensen - 1.800.562.5226

Correspondence and Claim Filing Address:

Pacific Underwriters

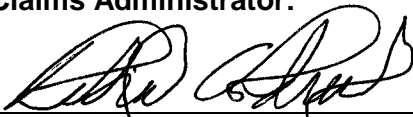
P.O. Box 66040

Seattle, WA 98166

Telephone for all questions regarding coverage and claims:

1.800.562.5226

Claims Administrator:



Signature

6/1/2009

Date