



Health and Welfare Benefit Booklet

CONTENTS

| | |
|--|----|
| GROUP COVERAGE AT A GLANCE..... | 1 |
| PLAN EFFECTIVE DATE | 1 |
| SOME TERMS YOU SHOULD KNOW | 1 |
| PAYMENT SUMMARY | 1 |
| MAXIMUM PLAN PAYMENT | 4 |
| ANNUAL OUT-OF-POCKET LIMIT | 4 |
| EMERGENCY CARE..... | 4 |
| COVERAGE OUTSIDE THE SERVICE AREA | 4 |
| COVERED SERVICES AND SUPPLIES | 4 |
| AMBULANCE SERVICES | 4 |
| CHEMICAL DEPENDENCY SERVICES | 5 |
| DIAGNOSTIC TESTING | 5 |
| DURABLE MEDICAL EQUIPMENT, SUPPLIES AND PROSTHESES | 5 |
| EMERGENCY ROOM SERVICES..... | 6 |
| HEARING CARE..... | 6 |
| HOME HEALTH CARE | 6 |
| HOSPICE CARE (INCLUDING RESPITE CARE) | 6 |
| HOSPITAL INPATIENT SERVICES | 6 |
| MENTAL HEALTH CARE | 6 |
| MENTAL HEALTH SERVICES AND YOUR RIGHTS | 7 |
| MISCELLANEOUS SERVICES | 7 |
| OBSTETRIC AND NEWBORN CARE | 8 |
| OFFICE, CLINIC AND HOSPITAL VISITS | 8 |
| ORGAN TRANSPLANTS | 9 |
| OUTPATIENT/DAY SURGERY, AMBULATORY SURGERY CENTER | 9 |
| PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY | 9 |
| PRESCRIPTION DRUGS, INSULIN AND DIABETIC SUPPLIES | 10 |
| PREVENTIVE CARE | 11 |
| RADIATION AND CHEMOTHERAPY SERVICES | 11 |
| SKILLED NURSING FACILITY CARE | 11 |
| TOBACCO CESSATION SERVICES..... | 11 |
| Vision Care (routine) | 11 |
| EXCLUSIONS | 12 |
| DEFINITIONS | 13 |
| DENTAL COVERAGE | 15 |
| DEDUCTIBLE | 15 |
| MAXIMUM ANNUAL PLAN PAYMENT | 15 |
| LIFETIME BENEFIT MAXIMUMS | 15 |

| | |
|---|----|
| SPECIALITY TREATMENT | 15 |
| EMERGENCY CARE..... | 15 |
| PREDETERMINATION OF BENEFITS | 15 |
| COVERED DENTAL BENEFITS, LIMITATIONS AND EXCLUSIONS | 16 |
| CLASS I BENEFITS..... | 16 |
| DIAGNOSTIC SERVICES | 16 |
| PREVENTIVE SERVICES..... | 16 |
| CLASS II BENEFITS | 16 |
| RESTORATIVE SERVICES: | 16 |
| ORAL SURGERY..... | 17 |
| PERIODONTIC SERVICES..... | 17 |
| ENDODONTICS..... | 17 |
| CLASS III BENEFITS..... | 18 |
| PERIODONTIC SERVICES..... | 18 |
| RESTORATIVE SERVICES | 18 |
| PROSTHODONTIC SERVICES | 18 |
| ORTHODONTIA BENEFITS | 19 |
| TEMPOROMANDIBULAR JOINT TREATMENT | 19 |
| ORTHOGNATHIC SURGERY..... | 20 |
| GENERAL EXCLUSIONS..... | 21 |
| ELIGIBILITY | 23 |
| ELIGIBLE EMPLOYEES | 23 |
| ELIGIBLE DEPENDENTS..... | 23 |
| MEDICARE ELIGIBILITY..... | 24 |
| ENROLLMENT | 24 |
| WAIVER OF COVERAGE..... | 24 |
| WHEN COVERAGE BEGINS | 25 |
| FOR EMPLOYEES:..... | 25 |
| FOR DEPENDENTS:..... | 25 |
| WHEN COVERAGE ENDS | 26 |
| OPTIONS FOR CONTINUING BENEFITS | 26 |
| FAMILY AND MEDICAL LEAVE ACT OF 1992 | 27 |
| CONTINUING COVERAGE UNDER THE FEDERAL COBRA LAW | 27 |
| THIRD PARTY LIABILITY (SUBROGATION/REIMBURSEMENT) | 28 |
| COORDINATION OF BENEFITS (COB) | 28 |
| APPEAL OF A CLAIM DENIAL – ALL CLAIMS..... | 30 |
| CUSTOMER SERVICE DIRECTORY | 30 |

GROUP COVERAGE AT A GLANCE

This “coverage at a glance” is a general overview. Pacific County PUD, through the Public Utility Risk Management Services (PURMS) Self-Insurance Fund, provides the Plan described in this booklet. The Plan is administered by Pacific Underwriters. The coverages, benefits and amounts described may be changed at a later date. Any change in you and your dependent’s benefits, class or status will take effect only when all of the Plan terms have been met.

The Plan allows you a wide choice of network providers through the First Choice Health Network and Providence Preferred Network who have agreed to accept the “reasonable amount” as payment for services to employees. The PURMS Self-Insurance Agreement has several terms and conditions which may affect the procedures outlined in this booklet. A copy of the agreement is available at the Company or Administrator’s office.

PLAN EFFECTIVE DATE

The Plan Effective Date is January 1, 2001, revised January 1, 2010.

SOME TERMS YOU SHOULD KNOW

You and your means you, the employee.

We, us, our and ours mean Pacific County PUD.

Administrator means Pacific Underwriters.

Fund means the PURMS Self-Insurance Fund.

A year is a calendar year running from January 1 through December 31.

Medicare means the benefits of the XVIII of the Social Security Act of 1965, and all amendments to it.

PAYMENT SUMMARY

Benefits will be provided at the payment levels specified below and in the benefits section of this booklet up to the benefit maximum limits. Please read the “Covered Services and Supplies” sections for details on specific benefit limitations, maximums and exclusions.

| DESCRIPTION | In Network | Out of Network |
|-------------------------------------|---|---|
| Alternative Health Care | 100% after \$15 copay | 90% after \$30 copay |
| Annual Deductible | None | None |
| Annual Out of Pocket | \$750/person/year \$1,500/family/year | \$750/person/year \$1,500/family/year |
| Ambulance Services | | |
| Air Ambulance | 100% after \$100 copay | 100% after \$100 copay |
| Ground Ambulance | 100% after \$50 copay | 100% after \$50 copay |
| Ambulatory Surgical center | 100% after \$15 copay | 100% after \$30 copay |
| Chemical Dependency Services | \$10,326 per 24 consecutive calendar month period | \$10,000 per 24 consecutive calendar month period |
| Inpatient | 100% subject to hospital copay | 90% subject to hospital copay |
| Outpatient | 100% after \$15 copay per visit | 90% after \$30 copay per visit |
| Diabetic Education | 100% after \$15 copay per visit | 100% after \$15 copay per visit |

| | | |
|---|---|---|
| Diagnostic Testing, Laboratory and X-ray | 100% | 100% |
| Durable Medical Equipment, Supplies And Prostheses | 90% | 60% |
| Emergency Room Services including hospital staff professional services (Copay waived if admitted directly from emergency room) | 100% after \$50 copay per visit | 90% after \$50 copay per visit |
| Hearing Care | | |
| Routine Exam | 100% after \$15 copay per exam | 90% after \$30 copay per exam |
| Hardware | 100%; maximum of \$300 every 36 months | 100%; maximum of \$300 every 36 months |
| Home Health and Hospice Care | 100% | 90% |
| Hospital Inpatient Services | | |
| Inpatient Facility services | 100% after \$100 copay per day; maximum \$300 per person per year | 100% after \$100 copay per day; maximum \$300 per person per year |
| Inpatient professional services | 100% | 100% |
| Mammograms | 100% | 100% |
| Mental Health Care | | |
| Inpatient | 80% to 10 days per year | 50% to 10 days per year |
| Outpatient | 50% to 20 visits per year | 50% to 20 visits per year |
| Neurodevelopmental Therapy For Children Age 6 and Under | | |
| Inpatient – 60 days per year | 100% subject to hospital copay | 100% subject to hospital copay |
| Outpatient – 60 visits per year | 100% after \$15 copay per visit | 90% after \$30 copay per visit |
| Obstetrical Care | | |
| Inpatient facility services | 100% subject to hospital copay | 100% subject to hospital copay |
| Professional inpatient and outpatient services | 100% after \$15 copay per visit | 100% after \$30 copay per visit |
| Office and Clinic visits | 100% after \$15 copay per visit | 100% after \$30 copay per visit |
| Organ Transplants | | |
| Inpatient facility services | 100% subject to hospital copay | 90% subject to hospital copay |

| | | |
|--|--|--|
| Inpatient professional services | 100% | 90% |
| Outpatient / Day surgery | 100% after \$15 copay per visit | 100% after \$30 copay per visit |
| Physical, Occupational and speech Therapies | | |
| Inpatient – 60 days per year | 100% subject to hospital copay | 90% subject to hospital copay |
| Outpatient – 60 visits per year for all therapies combined | 100% after \$15 copay per visit | 90% after \$30 copay per visit |
| Prescription Drugs, Insulin and Diabetic Supplies | | |
| Retail – Up to a 30-day supply | | |
| All generic drugs, insulin and Diabetic supplies | 100% after \$10 copay per prescription or refill | 100% after \$10 copay per prescription or refill |
| Name-brand | 100% after \$20 copay per prescription or refill | 100% after \$20 copay per prescription or refill |
| Generic and name-brand drugs Mail-order – up to 90-day supply | 100% after \$30 copay per prescription or Refill | 100% after \$30 copay per prescription or Refill |
| Preventive Care | 100% | 100% |
| Radiation-Chemotherapy | 100% | 100% |
| Skilled Nursing Facility; 150 days per Year | 100% subject to hospital copay | 90% subject to hospital copay |
| Spinal Manipulations; Maximum 12 visits per year | 100% after \$15 copay per visit | 90% after \$30 copay per visit |
| Tobacco Cessation Services | | |
| Tobacco cessation program | Up to \$350 per insured per calendar year | Up to \$250 per insured per calendar year |
| Tobacco cessation prescription drugs | Up to \$350 per insured per calendar year | Up to \$250 per insured per calendar year |
| Temporomandibular Joint Dysfunction (TMJ) Surgical Treatment Only | 50% to \$1,000 per year | 50% to \$1,000 per year |
| Vision Care (routine) | | |
| Routine Eye Exams: one exam Each 12 months | 100% after \$15 copay per exam | 100% after \$30 copay per exam |
| Hardware each 24 months | 100% to \$400 maximum | 100% to \$400 maximum |

| ADDITIONAL FEATURES | | |
|----------------------------|---|---|
| Human Growth Hormone | 80% | 80% |
| Norplant Every five years. | \$100 copay for one implant and removal | \$100 copay for one implant and removal |
| Orthotics | Covered under Durable Medical Equipment | Covered under Durable Medical Equipment |
| Urgent Care Centers | 100% after \$15 copay per visit | 100% after \$15 copay per visit |

MAXIMUM PLAN PAYMENT

The total amount paid out by the Fund on behalf of each insured for all benefits is limited to a lifetime maximum Plan payment of \$1,000,000. Up to \$10,000 of the lifetime maximum is restored automatically each January 1 for benefits paid by the Fund during the prior calendar year. Some services are also subject to specific calendar year lifetime benefit limitations as detailed in the “Covered Services and Supplies” section.

ANNUAL OUT-OF-POCKET LIMIT

Copayments and coinsurance paid by you for covered services throughout the calendar year shall not be more than \$750 per person or \$1,500 per family. This maximum applies to combined expenses for all inpatient hospital admissions; ambulance services; outpatient/day surgery or ambulatory surgery centers; physical, occupational and speech therapy; organ transplants; and all skilled nursing facility benefits covered under the Plan. Charges for other benefits, charges beyond the benefit maximums and charges for non-covered services will not accumulate toward the annual out-of-pocket limit.

EMERGENCY CARE

In cases of accidental injury or medical emergency, an insured may obtain services from the most conveniently available licensed health care provider.

COVERAGE OUTSIDE THE SERVICE AREA

Outside the Network area, benefits will be provided for care received from a provider based on the allowed amount at the level specified in the Payment Schedule for Network benefits.

No benefits will be provided when an insured leaves the Network area to obtain care for any condition. The only exception is if this care is medically necessary and approved in advance, in writing, by the Fund.

Remember to present your identification card when consulting a provider or receiving treatment at a hospital.

Retirees refer to exclusion #2 on page 13.

COVERED SERVICES AND SUPPLIES

All benefits are subject to the exclusions, limitations, and eligible provisions contained in this booklet. The Fund pays for services through all types of health care providers licensed under state law. Benefits are payable for preventive care and medically necessary services or supplies. ***The limits and copays for the following services are for network services only, please refer to the Non-Network schedule for the appropriate limits and copays.***

AMBULANCE SERVICES

Emergency ground ambulance services are subject to a \$50 copayment per trip to the nearest facility where care is available. If ground ambulance services are not appropriate for transporting an insured to

the nearest facility, the Plan covers emergency air ambulance subject to a \$100 copayment per trip. The services must meet the definition of an emergency and be considered the only appropriate method of transportation, based solely on medical necessity.

CHEMICAL DEPENDENCY SERVICES

Medically necessary inpatient and outpatient chemical dependency treatment and supporting services are covered on the same basis as other chronic illness or disease, subject to the inpatient hospital or office visit copayment. Court ordered treatment would be covered if determined medically necessary. Insureds are eligible to receive a maximum benefit of \$10,326 for covered chemical dependency treatment during any 24-month period.

When an insured is not yet enrolled in other chemical dependency treatment, medically necessary detoxification is covered as a medical emergency. Medical emergency treatment for detoxification is not included in the calculation of the \$10,326 maximum.

For purposes of this chemical dependency treatment provision, “medically necessary” means indicated in the “Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders II” as published in 1996 by the American Society of Addiction Medicine.

DIAGNOSTIC TESTING

Laboratory or diagnostic imaging including, but not limited to x-rays, ultrasound, mammography, nuclear medicine and allergy testing are covered in full.

DURABLE MEDICAL EQUIPMENT, SUPPLIES AND PROSTHESES

The Plan covers the rental or purchase of durable medical equipment, medical supplies and prostheses of 90% of allowed charges. Supplies used for treatment of diabetes are covered under the “Prescription Drugs, Insulin, and Diabetic Supplies” benefit.

Durable medical equipment is equipment that:

- a. is prescribed for an insured;
- b. is medically necessary;
- c. is primarily and customarily used only for a medical purpose;
- d. is designed for prolonged use; and;
- e. services a specific therapeutic purpose in the treatment of an insured’s illness or injury.

Covered services include:

- a. the rental or purchase of durable medical equipment such as wheelchairs, hospital beds, and respiratory equipment (combined rental fees shall not exceed full purchase price);
- b. diabetic equipment not covered in the pharmacy benefit including blood glucose monitors, insulin injection aids, and insulin pumps and accessories;
- c. casts, splints, crutches, trusses or braces;
- d. oxygen and rental equipment for its administration;
- e. ostomy supplies;
- f. artificial limbs or eyes (including implant lenses prescribed and required as a result of cataract surgery or to replace a missing portion of the eye);
- g. the initial external prosthesis and bra necessitated by surgery of the breast, and replacement of these items when necessitated by normal wear, a change in medical condition or when additional surgery is performed that warrants a new prosthesis and/or bra;

- h. penile prosthesis when impotence is caused by a covered medical condition (not psychological), is a complication which is a direct result of a covered surgery or is a result of an injury to the genitalia or spinal cord and other accepted treatment has been unsuccessful; and
- i. a wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition, up to a lifetime maximum payment of \$100 per person;
- j. orthotics.

EMERGENCY ROOM SERVICES

Emergency visits at an emergency room facility are covered after a \$50 copayment per visit. If an insured is admitted as a registered bed patient from the emergency room, the copayment will be waived and the hospital copayment may be applied. Use of a hospital emergency room for a non- medical emergency is not covered.

HEARING CARE

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 \$300 every 36 months.

HOME HEALTH CARE

The following home health services are covered in full; part-time or intermittent skilled nursing care, physical therapy and speech therapy; home infusion therapy; ancillary services, including occupational therapy, clinical social services, and intermittent home health aid services, when provided in conjunction with the above skilled services.

HOSPICE CARE (INCLUDING RESPITE CARE)

Medically necessary or palliative hospice care for terminally ill insureds is covered in full for up to six months. The provider must be licensed by the state as a hospice or, if state licensure is not required, approved by Medicare as a hospice.

HOSPITAL INPATIENT SERVICES

The Plan covers medically necessary hospital accommodation and inpatient services, supplies, equipment, and drugs prescribed by a Plan-designated provider for treatment of covered conditions (including, but not limited to, general nursing care, surgery, diagnostic tests and exams, radiation and x-ray therapy, blood and blood derivatives, bone and eye bank services, and take-home medications dispensed by the hospital at the time of discharge). Inpatient hospital services are subject to a \$100 copayment per day to a maximum of \$300, per person, per calendar year. Convalescent, custodial or domiciliary care is not covered.

MENTAL HEALTH CARE

Mental health services are covered when (1) determined to be medically necessary, (2) provided by a psychiatrist (M.D.), psychologist (Ph.D.), community mental health agency licensed by the Department of Health, state hospital, or other Plan-designated provider. Services must be consistent with generally recognized standards within a relevant health profession.

Inpatient: Professional and facility services for diagnosed and treatment of a mental illness is covered at 80% to 10 days per calendar year. This includes medically necessary diagnosis and treatment of eating disorders (bulimia and anorexia nervosa). As an alternative to inpatient care, your Plan covers “partial hospital days.” Two partial hospital days will count as one inpatient day.

Outpatient: Services for diagnosis and treatment of mental illness are covered at 50% to 20 visits per calendar year. This includes medically necessary diagnosis and treatment of eating disorders (bulimia and anorexia nervosa).

“Outpatient Visit” means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards as defined in the “Physicians Current Procedural Terminology, published by the American Medical Association.

Preauthorization is not required for emergency admissions, including involuntary commitment to a state hospital. The Plan will cover court-ordered treatment only if determined medically necessary.

MENTAL HEALTH SERVICES AND YOUR RIGHTS

There are established standards to assure the competency and professional conduct of mental health service providers, to guarantee your right to informed consent to treatment, to assure the privacy of your medical information, to enable you to know which services are covered under this Plan and to know the limitations on your coverage.

If you would like to know more about your rights under the law, you may contact the Office of Insurance Commissioner at 800-562-6900. If you have a concern about the qualifications or professional conduct of your mental health service provider, please call the State Health Department at (360) 236-4010.

MISCELLANEOUS SERVICES

Accidental Injury to teeth: The services of a licensed dentist, or denturist when providing services within the scope of his/her license, will be covered subject to an office visit copayment for repair of accidental injury to natural teeth. Evaluation of the injury and development of a treatment Plan must be completed within 30 days of the injury. The insured must be continuously covered by the Fund medical Plan from the date of injury through the date services are provided. Injuries caused by biting or chewing; malocclusion resulting from an accidental injury; orthodontic treatment, and dental implants are not covered.

Alternative Health Care Benefits: This plan provides alternative medical care benefits for services rendered by a licensed acupuncturist, massage therapist or a naturopath at 100% after a \$15 co-payment for Network Providers or 90% after a \$30 co-payment for Non-network Providers.

Biofeedback: For both medical and/or mental conditions are paid after a \$15 copayment up to 10 visits per year.

Blood and Blood Derivatives: Blood and blood derivatives, including but not limited to, synthetic factors, plasma expanders, and their administration, are covered in full when medically necessary.

Diabetic Education: Medically necessary diabetic education is covered subject to the office visit copayment for each visit.

Human Growth Hormone: Benefits are available for human growth hormone drug therapy payable at 80% of the allowable charge.

Neurodevelopmental Therapies: Subject to inpatient hospital copayments, the Plan will pay up to 60 days of inpatient hospital care per calendar year for medically necessary neurodevelopmental therapies for covered dependent children age six and under. Outpatient services for neurodevelopmental therapies for covered dependent children age six and under are provided in full after the office visit copayment for each visit, up to a maximum of 60 visits per calendar year for all therapies combines. Benefits include only the services of providers authorized to deliver occupational therapy, speech therapy and physical therapy. Benefits are payable only for medically necessary care where significant deterioration in the child’s condition would result without such services, or to restore and improve function of the child. Benefits are provided for neurological and psychological testing and evaluations for children age six and under, up to a maximum benefit of \$500 per insured per calendar year. This benefit includes an initial evaluation necessary to determine if the treatment is achieving the desired medical results.

PKU: Phenylketonuria (PKU) supplements are covered in full for treatment of this disorder.

Reconstructive Breast Surgery: An insured who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, will be covered for.

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses; and
- Physical complications of all stages of mastectomy, including lymphedemas.

TMJ: Surgical services for medically necessary treatment of temporomandibular joint dysfunction (TMJ), except for upper and lower jaw augmentation or reduction services and/or orthognathic surgery, are covered at 50% to a calendar year maximum Plan payment of \$1,000 combined for inpatient and outpatient services.

OBSTETRIC AND NEWBORN CARE

The Plan covers services for pregnancy and its complications. Professional services covered in full include prenatal and postpartum care, prenatal testing, normal or cesarean delivery, and complications resulting from pregnancy. Medically necessary hospital services are covered for obstetrical care, subject to the inpatient hospital copayment. Use of a birthing center will also be covered.

Routine newborn nursery care will be covered during hospitalization of the mother receiving maternity benefits under this Plan, and will not be subject to a copayment.

Hospitalization for newborn children for other than routine newborn care will be covered subject to the hospital copayment for the first 21 days from the date of birth provided the mother is covered by this contract.

Benefits for professional and other services for necessary follow-up care for newborns are provided subject to any applicable copayment or coinsurance amounts for the first 21 days from the date of birth provided the mother is covered by this contract.

Benefits for services received by the newborn beyond the initial 21 days are subject to the eligibility requirements of the contract, including submission of any the Fund application for coverage, and payment of any required premium.

If the newborn is hospitalized on the date coverage would otherwise terminate, the newborn will continue to be eligible for covered services for the condition for which the newborn was hospitalized until discharged, or until benefits are exhausted, whichever occurs first.

Services related to voluntary and involuntary termination of pregnancy on an outpatient basis are covered, subject to the office visit or outpatient surgery copayment. Inpatient services related to voluntary and involuntary termination of pregnancy are covered, subject to the inpatient hospital copayment.

OFFICE, CLINIC AND HOSPITAL VISITS

Services provided by a specialist are covered in full after a \$15 copayment for each home, office or clinic visit.

Manipulations of the spine and extremities are covered to a maximum of 12 visits per calendar year at 100% after a \$15 co-payment for Network Providers and at 90% after a \$30 co-payment for Non-network Providers.

Family Planning services are covered. Contraceptive supplies and devices (such as, but not limited to, IUDs, diaphragms, cervical caps and long-acting progestational agents) are also covered. Norplant is subject to \$100 copay. Elective sterilization is covered.

Hospital or skilled nursing facility visits are covered in full. Covered services under this benefit include those provided by the surgeon assistant surgeon (when deemed medically necessary) and anesthesiologist.

ORGAN TRANSPLANTS

The Plan cover services related to organ transplants, including professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery and follow up care, subject to hospital inpatient or office visit copayments and preauthorization requirements. This benefit includes covered donor expenses. See other benefits of this Plan for related services, such as prescription drugs and outpatient laboratory and x-ray.

Organ transplants are covered when they meet all the following criteria:

1. The service is required because of disease, illness or injury and is performed for the primary purpose of preventing, improving, or stabilizing the disease illness or injury.
2. There is sufficient evidence to indicate that the service will directly improve the length or quality of an insured's life. Evidence is considered to be sufficient to draw conclusions if it is peer-reviewed (as defined by the National Association of Insurance Commissioners), is well controlled, directly or indirectly relates the service to the length or quality of life, and is reproducible both within and outside of research settings.
3. The service's expected beneficial effects on the length or quality of life outweigh is expected harmful effects.
4. The service is a cost-effective method available to address the disease, illness or injury. "Cost-effective" means there is no other equally effective intervention available and suitable for you, which is more conservative or substantially less costly.

Organ Transplant Recipient: All services and supplies related to the organ transplant for you receiving the organ, including transportation to and from Plan-designated facilities (beyond that distance you would normally be required to travel for most hospital services), are covered in accordance with the transplant benefit language, provided you has been accepted into the treating facility's transplant program and continues to follow that program's prescribed protocol.

Organ Transplant Donor: The costs related to organ removal, as well as the costs of treatment complications directly resulting from the surgery, are covered, provided the organ recipient is you of a the Fund, and provided the donor is not eligible for coverage under any other health care Plan or government-funded program

Benefit Limitations: Transplants that are not preauthorized are not covered. No benefits are provided for charges related to locating a donor, such as tissue typing of family members.

OUTPATIENT/DAY SURGERY, AMBULATORY SURGERY CENTER

Services for outpatient surgery, day surgery, services at an ambulatory surgery center or short-stay obstetrical services (discharged within 24 hours of admission) are covered after the insured satisfies a \$15 facility copayment per surgery or procedure for Network Facilities and \$30 facility copayment per surgery or procedure for Non-network Facilities.

PHYSICAL, OCCUPATIONAL AND SPEECH THERAPY

Coverage is provided for inpatient and outpatient therapy services to restore or improve physical functioning due to a covered illness or injury. Inpatient rehabilitation therapy services are covered in full to a maximum of 60 days per calendar year, subject to the hospital inpatient copayment. Outpatient therapy services are covered in full to a maximum of 60 visits for all therapies combined per calendar year, subject to the office visit copayment. Outpatient services must be furnished by a physician, licensed or registered physical or occupational therapist, or certified speech therapist.

In addition, benefits are provided for neurological and psychological testing and evaluations up to a maximum benefit of \$500 per insured per calendar year. This benefit includes an initial evaluation necessary

to prescribe a rehabilitation treatment Plan, plus any later re-evaluations necessary to determine if the treatment is achieving the desired medical results.

PRESCRIPTION DRUGS, INSULIN AND DIABETIC SUPPLIES

Retail:

Up to 30-day supply or refill of outpatient prescription drugs, is covered subject to the copayments explained below, or the actual cost of the prescription if less than the copayment. You may obtain up to a three-month supply for an individual prescription at one filling, with the payment of three single-month copayments. In order to receive a quantity sufficient for a three-month supply, the prescription should specify that each fill be for three months or longer. Prescriptions written for a quantity sufficient for only a one-month supply with the ability to refill for an additional 30 days or longer may be limited to a one-month supply per fill. Single-dose, long acting drugs, and drugs packaged or dispensed in a single unit (such as inhalers) are subject to single copay.

Benefits are also provided for diabetic supplies, including but not limited to: insulin, associated needles and syringes, prescription agents for the controlling of blood sugar, glucagons emergency kits, and disposable diabetic testing supplies including test strips for blood glucose monitors.

Generic drugs will be dispensed unless a suitable generic is not available. Generic drugs are prescription drugs that are sufficiently similar to brand-name products to have achieve and AB rating from a Food and Drug Administration. Approved drugs include federal legend drugs and insulin.

If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug.

Copayments:

\$10 Diabetic supplies, all insulin, and all generic drugs.

\$20 Formulary and nonformulary brand name drugs.

Mail Order Benefit:

You can also order your prescription by mail. Insureds must submit prescriptions and refills on the appropriate mail-order form along with the required copayment directly to the participating mail-order pharmacy. A supply of mail order forms may be obtained by contacting:

The Administrator 1-800-562-5226

- Up to a 90 day supply (a single copay applies for each prescription or refill)
- \$30 copayment

Off-Label Drugs: FDA-approved drugs used for off-label indications will be provided only if recognized as effective for treatment 1) in one of the standard reference compendia; 2) in the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or 3) by the federal Secretary of Health and Human Services. No benefits will be provided for any drug when the FDA has determined its use to be contra-indicated.

- a. “Off-label” means the prescribed use of a drug which is other than that stated in its FDA-approved labeling
- b. “Standard Reference Compendia” means:
 - 1) The American Hospital Formulary Service Drug Information;
 - 2) The American Medical Association Drug Evaluation
 - 3) The United States Pharmacopoeia-Drug Information; or

- 4) Other authoritative compendia as identified from time to time by the federal Secretary of Health and Human Services or in the insurance commissioner.
- c. "Peer-reviewed Medical Literature" means scientific studies printed in journals or other publications in which original manuscripts are published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts. Peer-reviewed medical literature does not include in-house publications of pharmaceutical manufacturing companies.

PREVENTIVE CARE

Preventive care services, including medical exams required for a CDL license, are covered at 100% for Network Providers and 100% for Non-network Providers subject to the following schedules.

- Routine newborn care, plus six office exams for healthy babies during the first year of life.
- Age 1 - 2, two exams per year
- Age 2 - 6, yearly exams
- Age 7 - 59, exams every two years
- Age 60 and over, yearly exams.

Preventive care services include but are not limited to:

- routine physical examinations
- breast and pelvic examinations (annual)
- well-baby and well-child health care
- mammography (annual)
- standard immunizations and vaccines
- birth control devices, pills or drugs

RADIATION AND CHEMOTHERAPY SERVICES

Radiation and chemotherapy services are covered in full when provided or referred by a Plan-designated provider.

SKILLED NURSING FACILITY CARE

Medically necessary care in a Plan-designated skilled nursing facility is covered in full to 150 days per calendar year, subject to hospital inpatient copayments.

TOBACCO CESSATION SERVICES

Tobacco cessation treatment is provided as follows:

- Up to \$350 per insured per calendar year for a participating tobacco-cessation program.
- Up to \$350 per insured per calendar year for drugs and medication, including nicotine patches. (Prescription drugs subject to appropriate copay under the Prescription Drug benefit).

Vision Care (routine)

Routine eye examinations, including refractions are covered once every 12 months, subject to the \$15 office visit copayment.

An allowance of \$400 toward prescription eyeglass lenses and frames, or contact lenses, including expenses associated with their fitting, is provided once every 24 months when obtained through a Plan-designated provider.

EXCLUSIONS

In addition to any exclusion listed in the previous pages, the Plan does not cover the following:

1. Services not provided by a Plan-designated provider or obtained in accordance with the Fund' standard referral and authorization requirement, except for emergency care or as covered under coordination of benefits provisions.
2. Services rendered outside the Network area when the need for care could have been reasonably foreseen by you before leaving the Network area, unless preauthorized by the Fund. This exclusion does not apply to insureds living outside the Network area.
3. Experimental or investigational services, supplies and drugs. If we determine that a service is experimental or investigative, and therefore not covered, you may appeal our decision. We will respond in writing within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with your informed written consent.
4. Services or supplies for which no charge is made, or for which a charge wouldn't have been made if you had no healthcare coverage or for which you are not liable; services provided by a family member.
5. Cosmetic services or supplies except: to restore function, for reconstructive surgery of a congenital anomaly, or reconstructive breast surgery following a mastectomy necessitated by disease, illness or injury.
6. Convalescent or custodial care, or residential mental health treatment programs.
7. Conditions caused by or arising from acts of war.
8. Dental care including orthognathic surgery, nonsurgical treatment of temporomandibular joint dysfunction (TMJ) and myofascial pain dysfunction (MPD), and dental implants.
9. Sexual reassignment surgery services and supplies.
10. Reversal of voluntary sterilization.
11. Testing and treatment of infertility and sterility, including but not limited to artificial insemination and invitro fertilization.
12. Services and supplies provided solely for the comfort of you, except palliative care provided under the "Hospice Care" benefit.
13. Coverage for an organ donor, unless the recipient is an insured under this Plan.
14. Medical services, drugs, supplies or surgery (such as but not limited to gastroplasty, gastric stapling or intestinal bypass) directly related to the treatment of obesity.
15. Evaluation and treatment of learning disabilities, including dyslexia, except as provided for neurodevelopmental therapies.
16. Orthoptic therapy (eye training): vision services, except as specified for vision care. Surgery to improve the refractive character of the cornea including any direct or indirect complications.
17. Routine foot care.
18. Services for which you have a contractual right to recover cost under homeowner's or other no-fault coverage, to the extent that it can be determined that you received double recovery for such services.
19. Charges for missed appointments or for failure to provide timely notice for cancellation of appointment; charges for completing or copying forms or records.
20. Any medical services or supplies not specifically listed as covered.
21. Direct complications arising from excluded services.

22. Pharmaceutical treatment of impotence.

DEFINITIONS

Coinsurance: The percentage insureds pay on claims when the Plan provides benefits at less than 100%.

Copayment: A dollar amount insureds pay when receiving specific services.

Custodial/Convalescent Care: Care that is designed primarily to assist you in activities of daily living, including institutional care that serves primarily to support self-care and provide room and board. Custodial care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparing special diets, and supervision of medications that are ordinarily self-administered.

Insured: You or a covered dependent enrolled in this Plan.

Experimental or Investigational Services: Experimental or Investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply which meet one or more of the following criteria:

1. A drug or device, which cannot be lawfully marketed without the approval of the FDA, and has not been granted such approval on the date the service, is provided.
2. The service is subject to oversight by an Institutional Review Board.
3. Reliable evidence does not demonstrate efficacy of the service, nor does it define a specific role for the service in clinical evaluation, management or treatment.
4. The service is subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy.
5. Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence includes, but is not limited to, reports and articles published in an authoritative medical and scientific literature.

Medical Emergency: A “medical emergency condition” means the emergent and acute onset of a symptom or symptoms, including sever pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy. (A “prudent layperson” is someone who has an average knowledge of health and medicine.)

Examples of medical emergencies are severe pain, suspected heart attacks, and fractures. Examples of non-emergencies are minor cuts and scrapes.

Medically Necessary: A service or supply required for diagnosis and treatment of an insured’s condition.

1. It is consistent with the symptoms, diagnosis and treatment of an insured’s condition.
2. It is not solely for the convenience of you or the provider.
3. It is the least costly of the alternative levels of service or supplies that are adequate and available.
4. When you are an inpatient, it further means that the services and supplies cannot be safely provided on an outpatient basis without adversely affecting an insured’s condition or the quality of medical care rendered.
5. It is generally performed or accepted by the medical or dental profession.
6. It is the most appropriate level of service or type of supply needed for such diagnosis of treatment.

The Fund reserves the right to determine whether a service, supply or setting is medically necessary.

Network: First Choice Health Network and Providence Preferred Network.

Network Benefits: The level of benefits available when care is given by a Network Provider. See the Benefits section for more information.

Network Providers: The Fund has made special arrangements through the Network to provide services to employees and their dependents. Network Providers agree to help control costs and to provide quality health care at a reduced cost to those covered by this Plan. If you choose to obtain services from a non-network provider, the Fund will pay a percentage of the amount that would have been paid had the services been provided by a Network Provider.

It is the patient's responsibility to ascertain that the provider of service is a Network Provider. The list of Network Providers is subject to change, and an up-to-date list is available at the Administrator's office.

Non-network Benefits: The level of benefits available for providers other than Network Providers, unless specifically stated otherwise.

Plan: The Pacific County PUD benefit Plan of coverage.

Women's Health Care Practitioner: A health care practitioner that, consistent with their lawful scope of practice, provides Women's Health Care Services. Women's Health Care Practitioners include general practitioners, family practitioners, obstetricians and gynecologists, physician and osteopathic assistants, advanced registered nurse practitioners, and licensed or certified midwives.

Women's Health Care Services: Maternity care, reproductive health services, gynecological care, general examination and preventive care as medically appropriate, and medically appropriate follow-up visits for such services. Women's Health Care Services does not include any services otherwise excluded or limited under this Plan.

DENTAL COVERAGE

DEDUCTIBLE

This Plan has a \$50 deductible per person (\$150 deductible per family) per calendar year. Diagnostic/preventive services are not subject to the deductible.

MAXIMUM ANNUAL PLAN PAYMENT

The maximum amount of benefits payable for each insured in any one calendar year is \$2,000.

LIFETIME BENEFIT MAXIMUMS

The lifetime maximum amounts payable per insured for covered dental benefits are:

1. Orthodontia: \$1,500
2. Temporomandibular joint (TMJ) treatment: \$1,000
3. Orthognathic surgery: \$5,000

BENEFIT LEVELS

| SERVICES | |
|---|------|
| Diagnostic/preventive | 100% |
| Restorative fillings | 80% |
| Oral surgery | 80% |
| Periodontic services | 80% |
| Endodontic services | 80% |
| Restorative crowns | 60% |
| Prosthodontic (dentures and bridges) | 60% |
| Orthodontic (to lifetime Maximum Plan payment of \$1,500) | 70% |
| Nonsurgical TMJ (to lifetime maximum Plan payment of \$1,000) | 70% |
| Orthognathic (to lifetime maximum Plan payment of \$5,000) | 70% |

SPECIALITY TREATMENT

Specialty treatment is a covered benefit under the Plan.

EMERGENCY CARE

Emergency care is defined as treatment for relief of pain resulting from an unexpected condition that requires immediate dental treatment.

PREDETERMINATION OF BENEFITS

If your dental care will be extensive, you may wish to know in advance exactly what procedures are covered, the amount that will be paid toward the treatment, and your financial responsibility. A predetermination is recommended for major procedures, such as periodontal surgery, crowns, inlays, onlays, occlusal guards, complete occlusal equilibration and prosthetics. To obtain a predetermination, ask your dentist to submit a standard Plan claim form to the Fund. A predetermination is not a guarantee of benefits avail-

able. The actual benefits available are determined at the time of claims submission and are based on the specific service rendered and eligibility status at the time of service. **A predetermination is not required to receive benefits.**

COVERED DENTAL BENEFITS, LIMITATIONS AND EXCLUSIONS

The following covered dental benefits are subject to limitations and exclusions contained in this booklet. Such benefits (as defined) are available only when rendered by a licensed dentist when appropriate and necessary as determined by the standards of generally accepted dental practice. The amounts payable for covered dental benefits are as stated above. Claims for services must be submitted within 12 months of the completion of treatment.

CLASS I BENEFITS

DIAGNOSTIC SERVICES

Covered Dental Benefits: Routine examinations, x-rays, emergency examination and examination by a specialist in an American Dental Association recognized specialty.

Limitations: Examination is covered twice in a calendar year. Complete series (four bitewing x-rays and up to ten periapical x-rays) or panorex x-rays are covered once every five years. Supplementary bitewing x-rays are covered once every 12-months.

Exclusions: Consultations or elective second opinions. Study models and charges for the review of a proposed treatment Plan. Refer also to the General Exclusions section.

PREVENTIVE SERVICES

Covered Dental Benefits: Prophylaxis (cleaning), fissure sealants and topical application of fluoride; space maintainers when used to maintain space for eruption of permanent teeth.

Limitations: Any type of prophylaxis (cleaning) is covered twice in a calendar year (refer to Class II, Periodontics Services; Limitations, for additional limitation information). Topical application of fluoride is covered twice in a calendar year through age eighteen (18) when performed in conjunction with a prophylaxis. Preventive therapies (e.g., fluoridated varnishes) are a covered benefit under certain conditions of oral health when performed at the suggested regimen for that therapy. Children through age 18 are eligible for either topical application of fluoride or preventive therapies, but not both, as described above. Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered. Fissure sealant application is payable for children once every three years per applicable tooth, through age fourteen (14). Payment for sealants will be made only for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface. If eruption of permanent molars is delayed, sealants will be allowed if applied with 12 months of eruption. The attending dentist must provide documentation.

Exclusions: Plaque control program, oral hygiene instruction, dietary instruction and home fluoride kits, cleaning of a prosthetic appliance, and replacement of a space maintainer previously paid for by the Plan. Refer also to the General exclusions section.

CLASS II BENEFITS

RESTORATIVE SERVICES:

Covered Dental Benefits: Amalgam, composite or filled resin restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp). Stainless steel crowns.

Limitations: Restorations on the same surface(s) of the same tooth are covered once in a two (2) year period. Stainless steel crowns are covered once in a two (2) year period. Refer to Class III Limitations if teeth are restored with crowns, inlays or onlays.

Exclusions: Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion; overhang removal, recontouring or polishing of restoration. Refer also to the General exclusions section.

ORAL SURGERY

Covered Dental Benefits: Major and minor oral surgeries that include the following general categories: removal of teeth, preprosthetic surgery, treatment of pathological conditions, traumatic facial injuries, ridge extension for insertion of denture (vestibuloplasty), and general anesthesia/intravenous sedation.

Limitations: General anesthesia/intravenous sedation is covered only when administered by a licensed dentist, or approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington in conjunction with certain covered oral surgery procedures.

Exclusions: Iliac crest or rib grafts to alveolar ridges. Tooth transplants. Refer also to the General Exclusions section.

PERIODONTIC SERVICES

Covered Dental Benefits: Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth including examinations, periodontal maintenance, periodontal scaling/root Planning, periodontal surgery, and general anesthesia/intravenous sedation. Refer to Class III Periodontics for benefits and limitations on complete occlusal equilibration and occlusal guards (night guards).

Limitations: Examinations are covered twice in a calendar year. Under certain conditions of oral health, periodontal maintenance and/or prophylaxis may be covered up to a total of four (4) times in a calendar year. Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered. Periodontal scaling/root planing is covered once in a three (3) year period. Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that your dentist submit a predetermination of benefits to determine if the treatment will be covered. Osseous surgery (per site), gingival flap surgery (per site), soft tissue grafts (per site) are covered once in a three (3) year period. Osseous surgery and site specific therapy must be preceded by scaling and root planing a minimum of six (6) weeks and a maximum of six (6) months, or the patient must have been in active supportive periodontal therapy, prior to such treatment. General anesthesia/intravenous sedation is covered only when administered by a licensed dentist or approved licensed professional who meets the education, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington in conjunction with certain covered periodontal surgery procedures.

Exclusions: Periodontal splinting and/or crown and bridgework in conjunction with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances. Gingival curettage. Site-specific therapy is not covered when used for the purpose of maintaining non-covered dental procedures or implants. Refer also to the General Exclusions section.

ENDODONTICS

Covered Dental Benefits: Procedures for pulpal and root canal treatment, including pulp exposure treatment, pulpotomy and apicoectomy.

Limitations: Root canal treatment on the same tooth is covered only once in a two (2) year period. General anesthesia/intravenous sedation is covered only when administered by a licensed dentist or licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington in conjunction with certain covered endodon-

tic surgery procedures. Refer to Class III Limitations if the root canals are placed in conjunction with a prosthetic appliance.

Exclusions: Bleaching of teeth. Refer also to the General Exclusions section.

CLASS III BENEFITS

PERIODONTIC SERVICES

Covered Dental Benefits: Under certain conditions of oral health, services covered are: occlusal guards (night guards) and complete occlusal equilibration. Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a pre-determination of benefits to determine if the treatment will be covered.

Limitations: Occlusal guards, including repairs, are covered once in a three (3) year period. Occlusal equilibration is covered once in a lifetime.

Exclusions: Periodontal splinting, crown and bridgework in conjunction with periodontal splinting, crowns as part of periodontal therapy and periodontal appliances.

RESTORATIVE SERVICES

Covered Dental Benefits: Crowns, inlays (only when used as an abutment for a fixed bridge), onlays (whether they are gold, porcelain, approved gold substitute castings (except processed resin) or combinations thereof), build-ups for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp), when teeth cannot reasonably be restored with filling materials such as amalgam or filled resins.

Limitations: Crowns or onlays on the same teeth are covered once in five (5) year period. Inlays are a covered benefit on the same teeth once in a five (5) year period only when used as an abutment for a fixed bridge. Build-ups are covered once in a two (2) year period. If a tooth can be restored with a filling material such as amalgam or filled resin, an allowance will be made for such a procedure toward the cost of any other type of restorations that may be provided.

Exclusions: A crown used as an abutment to a partial denture for purposes of recontouring, repositioning or to provide additional retention is not covered unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a partial denture is required. Crowns used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or existing restorations with defective margins when no pathology exists. Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology. Refer also to the General Exclusions section.

PROSTHODONTIC SERVICES

Covered Dental Benefits: Dentures, fixed bridges, removable partial dentures and the adjustment or repair of an existing prosthetic device. Surgical placement or removal of implants or attachments to implants.

Limitations: Replacement of an existing prosthetic device is covered only once every five years and only then if it is unserviceable and cannot be made serviceable. Replacement of implants and superstructures is covered only after five years have elapsed from any prior provision of the implant.

1. Full, immediate and overdentures. The Plan will allow the appropriate amount for a full, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment. Root canal treatment performed in conjunction with overdentures is limited to two teeth per arch and is paid at the Class III Payment Level.
2. Temporary/interim dentures. The Plan will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after twelve (12) months.

3. Partial dentures. If a more elaborate or precision device is used to restore the case, the Plan will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided.
4. Denture adjustment and relines. Denture adjustments and relines done more than six months after the initial placement are covered, except as noted under Temporary/interim dentures. Subsequent relines or jump rebases (but not both) will be covered once in a twelve (12) months period.

Exclusions: Duplicate dentures, personalized dentures, cleaning of prosthetic appliances, crowns and copings in conjunction with overdentures. Refer also to the general exclusions.

ORTHODONTIA BENEFITS

All orthodontic treatment must be submitted to and authorized by the Fund before treatment begins. Failure to have treatment preauthorized could result in a reduction or denial of benefits under this Plan.

Orthodontic treatment is defined as the necessary procedures of treatment, performed by a licensed dentist, involving surgical or appliance therapy for movement of teeth and post-treatment retention.

The lifetime maximum amount payable for orthodontic benefits rendered to an insured is \$1,500. Not more than \$750 of the maximum, or one-half of the Plan's total responsibility, shall be payable for treatment during the "construction phase." The final payment shall be made during the seventh month following the construction phase, providing the employee is eligible and the dependent is in compliance with the age limitations. The Plan will not pay for treatment if claim forms are submitted more than 12 months after banding date.

The amount payable for orthodontic treatment shall be 70% of the lesser of the usual, customary and reasonable fees of the fees actually charged.

Covered Dental Benefits: Treatment of malalignment of teeth and/or jaws. Orthodontic work that began prior to the insured's effective date but was completed after the effective date will be considered for payment on a prorated basis.

In addition to the limitations and exclusions contained in this booklet, the following also apply to orthodontic treatment:

Limitations: Payment of monthly or other periodic charges is limited to:

1. Completion, or through age 22 for eligible dependent children, if full-time students, whichever occurs first
2. Termination of the treatment Plan prior to completion of the case.
3. Termination of this Plan. If coverage ends (because of age or termination of the Plan) while treatment is still in progress, only services completed up to the date coverage ends will be covered.

Exclusions:

1. Charges for replacement or repair of an appliance.
2. No benefits will be provided for services considered inappropriate and unnecessary, as determined by the Plan.
3. Refer also to the General Exclusions section.

TEMPOROMANDIBULAR JOINT TREATMENT

All temporomandibular joint (TMJ) benefits must be preauthorized by the Plan before treatment begins. Benefits will be denied if treatment is not preauthorized.

TMJ treatment is defined a nonsurgical intra-oral services provided by a licensed dentist or physician, when necessary and customary according to the standards of generally accepted dental practice, for the treatment of dental symptoms associated with the malfunction of the temporomandibular joint, including myofascial pain dysfunction. These procedures include:

- TMJ examination
- X-rays (TMJ film and arthrogram)
- Temporary repositioning splint
- Occlusal guard (nightguard)
- Removable metal overlay stabilizing appliance
- Stabilizing appliance
- Full mouth occlusal equilibration
- Arthrocentesis
- Manipulation under local anesthesia

The amount payable for TMJ benefits shall be 70% of the lesser of the usual, customary and reasonable fees or the fees actually charged. The lifetime maximum amount payable for TMJ benefits rendered to an insured is \$1,000.

To obtain authorization, dentists must submit documentation for necessity or treatment to the Plan with a proposed treatment Plan.

In addition to the limitations and exclusions set forth in this booklet, the following also apply to TMJ benefits:

1. The Plan shall not pay for the repair or replacement of any appliance furnished in whole or in part for temporomandibular joints.
2. The Plan shall not cover services that would normally be provided under medical care, including, but not limited to, psychotherapy, special joint exams and x-rays, joint surgery and medications.
3. Fixed appliances and restorations are not covered.
4. With the exception of TMJ examinations, TMJ film and arthrogram, diagnostic procedures not otherwise covered under the Plan are not covered herein.
5. Any procedures that are performed in conjunction with TMJ services, and are covered benefits under another portion of the dental Plan, are not covered under this portion.

ORTHOGNATHIC SURGERY

All orthognathic treatment must be submitted to the Fund before treatment begins. Benefits will be denied if treatment is not preauthorized.

Orthognathic treatment is defined as the necessary surgical procedures of treatment, performed by a licensed dentist or physician, to correct the malposition of the maxilla (upper jaw bone) and/or the mandible (lower jaw bone).

The amount payable for orthognathic treatment shall be 70% of the lesser of the usual, customary and reasonable fees or the fees actually charged. The lifetime maximum amount payable for orthognathic benefits rendered to an insured is \$5,000.

In addition to the limitations and exclusions set forth in this booklet, the following also apply to orthognathic treatment.

Limitations: Complications will be covered only if treatment is sought within 30 days from the original treatment.

Exclusions: The Plan shall not cover:

1. Services that would be provided under medical care including, but not limited to, hospital and professional services.
2. Diagnostic procedures not otherwise covered under this Plan.
3. Any procedures that are performed in conjunction with orthognathic surgery services, and are covered benefits under another portion of the dental Plan.
4. Refer also to the General Exclusions section.

GENERAL EXCLUSIONS

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

1. Dentistry for cosmetic reasons. Cosmetic services include, but are not limited to, laminates, veneers or tooth bleaching.
2. Restorations or appliances necessary to increase or alter the vertical dimension or to restore the occlusion. Excluded procedures include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth.
3. Application of desensitizing medicaments.
4. Services or supplies that the Fund determines are experimental or investigative. Determination is made according to the following criteria. If any of these situations are met, the service or supply is considered experimental and/or investigative, and benefits will not be provided.
 - a. It cannot be lawfully marketed without the approval of the U.S. Food and Drug Administration (FDA), and such approval has not been granted on the date it is furnished.
 - b. The provider has not demonstrated proficiency in the service, based on experience, outcome or volume of cases.
 - c. Reliable evidence shows the service is the subject of ongoing clinical trials to determine its safety or effectiveness.
 - d. Reliable evidence has shown the service is not as safe or effective for a particular dental condition compared to other generally available services and that it poses a significant risk to an insured's health or safety.

Reliable evidence means only published reports and articles in authoritative dental and scientific literature, scientific results of the provider's written protocols or scientific data from another provider studying the same services.

The documentation used to establish the Fund's criteria will be made available for your examination at the office of the Fund if you send a written request. If the Fund determines that a service is experimental or investigative, and therefore not covered, you may appeal the decision.
5. General anesthesia, including intravenous sedation, except when in conjunction with covered oral surgery, endodontic and periodontal surgical procedures.
6. Hospital or other facility care for dental procedures, including physician services and additional fees charged by the dentist for hospital treatment. However, this exclusion will not apply and benefits will be provided for services rendered during such hospital care, including outpatient charges, if all these requirement are met:

- a. A hospital setting for the dental care must be medically necessary.
 - b. Expenses for such care are not covered under an insured's employer-sponsored medical plan.
 - c. Prior to hospitalization, a request for preauthorization of dental treatment performed at a hospital is submitted to and approved by the Fund. Such request for preauthorization must be accompanied by a physician's statement of medical necessity.
7. Dental services started prior to the date the person became eligible for services under this Plan, except as provided for orthodontic benefits.
8. Services for accidental injury to natural teeth when evaluation of treatment and development of treatment plan is performed more than 30 days from the date of the injury.
9. Expenses incurred after termination of coverage, except expenses for:
 - a. Prosthetic devices that are fitted and ordered prior to termination and delivered within 30 days after termination.
 - b. Crowns, if the tooth is prepared prior to termination and the crown is seated on the tooth within 30 days after termination.
 - c. Root canal treatment, if the tooth canal is opened prior to termination and treatment is completed within 30 days after termination.
10. Missed appointments.
11. Completing insurance forms or reports, or for providing records.
12. Habit-breaking appliances, except as specified under the orthodontia benefit.
13. Full-mouth reconstruction.
14. Charges for dental services performed by anyone who is not a licensed dentist or physician, as specified.
15. Services or supplies that are not listed as covered.
16. Treatment of congenital deformity or malformations.
17. Orthodontic treatment, orthognathic treatment, and treatment of TMJ disorders that are not authorized in advance by the Fund.
18. Replacement of lost or broken dentures or other appliances.
19. Services for which you have contractual right to recover cost, whether a claim is asserted or not, under automobile, medical, personal injury protection, homeowners or other no-fault insurance.
20. In the event an Insured fails to obtain a required examination from a Fund-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.
21. The Fund shall have the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions shown in the Contract, but it shall not exercise this authority, arbitrarily or capriciously or in violation of the provisions of the contract.

ELIGIBILITY

(ALL PLANS)

(See “When Coverage Begins” To Determine
When Coverage for Eligible Insureds Begins)

ELIGIBLE EMPLOYEES

The following employees are eligible to apply for coverage:

1. **PERMANENT EMPLOYEES:** Employees who work at least an average of 20 hours per week over a six month period and are expected to be employed for more than six months are eligible to apply for coverage on the first day of employment.
2. **NONPERMANENT EMPLOYEES:** Employees who work at least half time and are expected to be employed for no more than six months. If employment continues beyond the initial six-month period, employees are eligible to apply for coverage on the first day of the seventh month of employment.
3. **SEASONAL EMPLOYEES:** Employees who work at least half-time per month during a designated season for a minimum of three months but less than nine months per year and who have an understanding of continued employment with state government season after season. Employees are eligible to apply for coverage on the first day of employment. Employees are not eligible for the employer contribution during the break between seasons of employment, but may be eligible to continue coverage by self-paying premiums as calculated by PURMS.
4. **COMMISSIONERS:** Commissioners are eligible to apply for coverage on the date their term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible to apply for coverage on the date their term begins or when they take the oath of office, whichever occurs first.

ELIGIBLE DEPENDENTS

The following are eligible as your dependents under the Plan:

1. Your lawful spouse.
2. Your dependent children through age 19. The term “children” includes your natural children, stepchildren, legally adopted children, children for whom you have assumed a legal obligation for total or partial support of a child in anticipation of adoption of the child, or children specified in a court order or divorce decree. Married children who qualify as dependents of yours under the Internal Revenue Code, and additional legal dependents approved by us are included. Dependent children who are fulltime students who are developmentally or physically disabled are eligible beyond the age of 19 under the following conditions:
 - a. Students age 20 through age 23 are eligible if they are: (i) dependent on you for maintenance and support, and (ii) are registered and attend full-time an accredited secondary school, college, university, vocational school or school of nursing. Coverage of dependent students continues year-round for those who attend three of the four school quarters, and for three full calendar months following graduation as long as you are covered at the same time.
 - b. Dependent children of any age are eligible if they are incapable of self-support due to developmental disability or physical handicap, provided that their condition occurred before age 20, or during the time they were covered under a the Fund as a full-time student. Proof of such disability and dependency must be furnished to us upon application and as periodically requested thereafter.

MEDICARE ELIGIBILITY

If you become eligible for Medicare, you should contact the nearest Social Security Office to inquire about the advantages of immediate or deferred Medicare enrollment.

For active employees and their spouses age 65 and older, the Plan will provide primary coverage and Medicare coverage will be secondary. However, active employees 65 or older are entitled to accept or reject coverage under the Fund medical Plan. If an active employee rejects the Plan, Medicare will be the primary payor for Medicare-covered health services that the active employee receives. If an employee rejects the employer Plan, the employer cannot provide the employee with a Plan that pays supplemental benefits for Medicare-covered services or subsidize such coverage. An employer may, however, offer a Plan that pays for health care services not covered by Medicare, such as hearing aids, routine dental care, and physical checkups. Before selecting Medicare as primary coverage, please contact an HCA benefits specialist for more information.

Medicare regulations allow deferral of enrollment in Medicare Part B in most situations for active employees and their spouses; such deferral is allowed without penalty up to the date the employee terminates employment or retires. Upon retirement, the employee must enroll in both Parts A and B of Medicare. Medicare will become the primary coverage in most cases, and the Fund-sponsored medical Plan becomes secondary. Employees retiring July 1, 1991, and after must be enrolled in Medicare Parts A and B, if eligible.

Please contact us for information about retiree eligibility and benefit information.

ENROLLMENT

(See “When Coverage Begins” To Determine When Coverage For Eligible Insured Begins)

Employees and their eligible dependents may enroll in this Plan within 31 days of the date the employee first becomes eligible to apply for the Fund coverage as described in the section titled “Eligibility”. Enrollment forms are furnished by the employee’s payroll, personnel or insurance office and should be returned to that office within 31 days of the termination of the other coverage. Dependents will be required to provide proof of continuous coverage to us in order to establish eligibility to enroll.

Eligible employees and dependents may be added to coverage during any open enrollment period determined by us or, in most cases, if the employee acquires a new dependent as a result of marriage, birth, adoption or placement for adoption. Eligible employees and dependents may be added in these situations without proof of continuous coverage.

Verification of the dependency status of anyone enrolled under the employee’s the Fund coverage may be requested at any time by the Fund or us.

WAIVER OF COVERAGE

Employees eligible for the Fund medical care coverage has the option of waiving medical coverage for themselves and any or all dependents if they are covered by another medical Plan. In order to waive coverage, the employee must complete an enrollment form that identifies the individuals for whom coverage is being waived. If an employee waives coverage for him/herself, coverage is automatically waived for all eligible dependents. An employee may choose to enroll only him/herself, and waive coverage for any or all dependents.

Employees and dependents whose medical coverage is waived will remain enrolled in their dental Plan. Employees will also remain enrolled in life and long-term disability coverage.

If the medical coverage is waived, an otherwise insured may not enroll in the Plan within 31 days of loss of other medical coverage. Proof of other medical coverage is required to demonstrate that: 1) coverage was continuous from the date the coverage was waived; and 2) the period between loss of coverage and application for the coverage is 31 days or less.

The employee and dependents may have an additional opportunity to enroll in the event of acquisition of a new dependent as a result of marriage, birth, adoption, or placement for adoption, provided that enrollment is requested within 31 days of marriage, or within 60 days of birth, adoption or placement for adoption.

ENROLLING A DEPENDENT ACQUIRED AFTER YOUR EFFECTIVE DATE OF COVERAGE

You may enroll dependents who become eligible after your effective date. Newly eligible dependents must be enrolled within 31 days of eligibility, except that:

1. Newborn or adoptive children must be enrolled within 60 days of eligibility.
2. When a newborn or adoptive child becomes eligible before the 16th day of the month and the addition of the child increases the premium, the new full month's premium is charged; otherwise, the new premium will begin with the next full calendar month.
3. Dependents who lose other medical coverage must enroll within 31 days of the date their other coverage ends. Dependents will be required to provide proof of continuous medical coverage. If the dependent meets enrollment criteria and premiums are paid, coverage will begin the first day of the month following the date other coverage is terminated.

You should contact our personnel, payroll or insurance office, or us for an enrollment form.

DISENROLLING A DEPENDENT

Employees should contact their payroll, personnel or insurance office for forms and information on how to update their records. A dependent may be deleted from coverage by submitting an enrollment/change form to the employee's personnel, payroll or insurance office. Failure to delete a dependent in a timely manner may result in loss of continuation privileges for the dependent and retroactive denial of claims. Please refer to the section titled "Options for Continuing Benefits" for more information.

Enrollment changes should be made as soon as possible.

WHEN COVERAGE BEGINS

Coverage will begin for employees and their dependents as follows:

FOR EMPLOYEES:

1. **PERMANENT EMPLOYEES:** Coverage begins on the date of employment.
2. **NONPERMANENT EMPLOYEES:** Coverage for nonpermanent employees begins on the first day of the seventh calendar month following the date of employment.
3. **COMMISSIONERS:** Coverage for Commissioners begins on the first day of their elected term.

FOR DEPENDENTS:

Coverage for eligible dependents begins on the day your coverage begins if you list the dependents on the application for coverage.

For newly acquired dependents (except newborn or adoptive children) who are enrolled in accordance with the Fund rules, coverage begins on the first day of the month following the date of eligibility.

Coverage for a newborn child begins at birth. Coverage for an adoptive child begins on the date that you assume a legal obligation for total or partial support in anticipation of adoption of the child.

Coverage for other eligible dependents begins on the date the condition of dependency is established and approved by us.

SPECIAL ENROLLMENT FOR EMPLOYEES AND THEIR DEPENDENTS WHO PREVIOUSLY WAIVED COVERAGE

Coverage for eligible employees and their dependents whose medical coverage was previously waived will be effective as described below. The employee must enroll in order to enroll dependents.

1. Coverage for eligible employees and dependents enrolling because of loss of other medical coverage will begin on the date the prior coverage terminated. The application must be received by the employee's payroll, personnel or insurance office within 31 days of termination of other medical coverage, and proof of other continuous coverage must be provided.
2. Coverage for eligible employees and dependents enrolling following a marriage will begin on the date of marriage. The application for coverage must be received by the employee's payroll, personnel or insurance office within 31 days of the date of marriage.
3. Coverage for eligible employees and dependents enrolling following a birth or placement of a child for adoption will begin on the date on which the birth or placement occurred. Coverage for a newborn child will begin at birth. Coverage for a child placed for adoption will begin on the date that the employee assumes a legal obligation for total or partial support in anticipation of adoption of the child. The application for coverage must be received by the employee's payroll, personnel or insurance office within 60 days of the birth or date of placement.

WHEN COVERAGE ENDS

Coverage ends on the earliest of the following dates:

1. For any person enrolled in the Plan, coverage ends on the date the Plan terminates, if that should occur.
2. For a dependent who declines the opportunity or is ineligible to continue coverage on a self-pay basis, coverage ends at the end of the month in which he or she ceases to qualify as a dependent (such as a non-student child reaching age 20 or a spouse when a final decree of divorce is entered).
3. For an employee who has chosen to continue coverage on a self-pay basis, such coverage ends: (a) on the date you are otherwise enrolled in other group medical coverage; or (b) at the end of the last month in which you are eligible to continue coverage or for which the premium has been paid.
4. For a terminated employee who has chosen to continue coverage on a self-pay basis, the employer/employee-paid premium will cover the employee through the end of the month in which the termination of employment occurs, and the self-pay premium will cover the employee beginning the first of the following month.
5. For an eligible retired employee, at the end of the last month in which you are eligible to continue coverage subject to the Collective Bargaining Agreement.

If you are confined in a hospital or other inpatient facility for which benefits are provided when coverage ends, benefits will be extended until you are discharged from that facility or until benefits are exhausted, whichever occurs first. When coverage ends, you may be eligible for continuation of coverage or conversion to other medical coverage if application is made within 31 days after coverage would normally end.

OPTIONS FOR CONTINUING BENEFITS

Employees covered by this Plan have options for providing continued coverage for themselves and their dependents during temporary or permanent loss of eligibility: (1) the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives insureds the right to continue group coverage for a period of 18 to 36 months, (2) the Family and Medical Leave Act of 1993 gives you the opportunity to extend eligibility with employer contribution toward premium for up to 12 weeks. The dependents of employees also have options for continuing coverage for themselves following loss of eligibility.

When an employee returns to work:

1. Employees electing to self-pay during an approved leave without pay will be eligible for employer-sponsored benefits the first day they return to work.
2. When employees elect not to self-pay during an approved leave without pay, and they return to work in an eligible position, insurance benefits will begin on the first day of their return to work.

FAMILY AND MEDICAL LEAVE ACT OF 1992

Employer contributions toward the Fund coverage will continue up to the first 12 weeks of approved family leave in accordance with the Family and Medical Leave Act of 1993. Employees must also continue to pay the employee premium contribution during this period to maintain eligibility. After that, coverage may be continued as explained in the section titled “Continuing Coverage under the Federal COBRA Law”.

CONTINUING COVERAGE UNDER THE FEDERAL COBRA LAW

Under the Federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments, employers are required (in most situations) to offer continuation of group coverage to insureds losing eligibility for such coverage. When a “qualifying event” ends eligibility for coverage, you must contact the employee’s payroll, personnel, insurance office, or the Administrator at 1-(800) 562-5226 within 60 days of the qualifying event for information about the right to COBRA continuation and self-pay premium rates. If insureds have the right to continue group coverage, they must enroll within 60 days of the qualifying event, and will be required to pay their own premiums. Failure to notify the payroll, personnel, insurance office or us may result in loss of COBRA continuation privileges and retroactive denial of claims. Qualifying events:

1. The employee and his or her covered dependents may continue the Fund-sponsored group coverage for up to 18 consecutive months if the qualifying event is: (a) reduction of the employee’s work hours, or (b) termination of employment, except for discharge due to actions defined by the employer as gross misconduct. A second qualifying event during this 18-month period may extend the continuation period for dependents. If the employee is disabled under Title II of the Social Security act at any time during the first 60 days of COBRA coverage, the employee and dependents may continue coverage for 11 additional months.
2. The covered spouse or children may continue coverage for up to 36 consecutive months if the qualifying event is: (a) the employee’s death, (b) divorce, (c) election of Medicare as the employee’s primary medical coverage, or (d) a child’s loss of eligibility for dependent coverage.

COBRA insureds may add eligible dependents in accordance with the Plan’s rules after their continuation period begins. However, those added dependents are not eligible for further coverage if a second qualifying event should occur.

Continued coverage will end on the last day of the monthly period of which premiums, as calculated by PURMS, have been paid in which the first of the following occurs:

1. the applicable continuation period expires.
2. the next required premium payment is not made when due;
3. the insured becomes covered under another group medical Plan, unless the new Plan covering the insured contains a preexisting condition exclusion or limitation that applies to the insured in which case COBRA coverage will cease on the earlier of (a) the end of the COBRA continuation period, or (b) the cessation of the application of the preexisting condition exclusion; or
4. the former employer ceases to offer group medical coverage.

Employees continuing their coverage under the COBRA law after termination of employment or reduction in hours, and who are disabled under Title II of the Social Security Act at any time during the first 60 days of COBRA coverage, can extend the continuation period an additional 11 months for all covered

individuals. To qualify to the extended coverage, we must be notified before the end of the initial 18 months of COBRA coverage and within 60 days of the disability determination.

Each of the employee's enrolled dependents is entitled to make a separate decision to exercise their COBRA continuation option.

THIRD PARTY LIABILITY (SUBROGATION/REIMBURSEMENT)

Based on the following legal criteria, subrogation means that if you receive this program's benefits for an injury or condition possibly caused by another person, you must include in your insurance claim or liability claim the amount of those benefits. After you have been fully compensated for your loss any money recovered in excess of full compensation must be used to reimburse the Fund. The Fund will prorate any attorney's fees against the amount owed.

To the extent of any amounts paid by the Fund for an insured on account of services made necessary by an injury to or condition of his or her person, the Fund shall be subrogated to his or her rights against any third party liable for the injury or condition. The Fund shall, however, not be obligated to pay for such services unless and until the insured, or someone legally qualified and authorized to act for him or her, agrees to:

- Include those amounts in any insurance claim or in any liability claim made against the third party for the injury or conditions.
- Repay the Fund those amounts included in the claim from the excess received by the injured party, after full compensation for the loss is received.
- Cooperate fully with the Fund in asserting its rights under the Contract, to supply the Fund with any and all information and execute any and all instruments the Fund reasonably needs for that purpose.

Provided the injured party is in compliance with the above, the Fund will prorate any attorney's fees incurred in the recovery.

COORDINATION OF BENEFITS (COB)

(Coverage under another group or individual Plan)

Many people subscribe to more than one group or individual health care Plan in order to protect themselves against the high costs of medical care. To keep the cost of your health care benefits as low as possible, the Fund will coordinate benefit payment with your other group or individual health care Plans so that you will receive up to, but not more than actual expenses for covered benefits. This prevents people from collecting more than the actual costs of services, which can substantially increase rates.

If you or your dependents are covered under another group or individual Plan, it is your responsibility to make sure that identical, itemized bills are submitted to both carriers at the same time. The Fund and your other carrier will determine payment.

If the other Plan does not contain a coordination of benefits provision, that Plan will pay first. This Plan will then pay the remainder of covered expenses. If the other Plan contains a coordination of benefits provision, the following rules will determine payment.

1. The Plan covering you as a Insured will pay first.
2. The Plan covering you as the dependent of a Insured whose day and month of birth occur earlier in the calendar year will pay before the Plan covering you as the dependent of a Insured whose day and month of birth occur later in the calendar year; except that, if the other Plan does not contain this rule, resulting in conflicting order of benefit determination, the other Plan's provisions will apply. However, if a dependent child's parents are separated or divorced, the following will apply:

- a. If the parent with custody has not remarried, the Plan of the parent with custody will pay before the Plan of the parent without custody.
 - b. If the parent with custody has remarried, the benefits of the Plans that cover the child will be determined in the following order: Plan of the parent with custody; Plan of the spouse of the parent with custody; Plan of the parent without custody; Plan of the spouse of the parent without custody.
 - c. However, if the court decree establishes financial responsibility for the health care of the child, the benefits of the Plan that covers the child as the dependent of the parent with such financial responsibility will be determined first.
3. If none of the above rules established which Plan pays first, the benefits of the Plan that has covered you for the longer period of time will be determined first. However, for a retired or laid-off Insured and his or her dependents, the Plan covering such person as an active employee or dependent except that, if the other Plan does not have a provision regarding retired or laid-off Insureds will not apply.
4. If none of the above rules establish which Plan pays first, the benefits of the Plan that has covered the Insured for the longer period of time will be determined first.

APPEAL OF A CLAIM DENIAL – ALL CLAIMS

The complete Appeal Procedures are in the Self-Insurance Agreement available at the Fund office.

If there are any questions about a claim payment, the Administrator should be contacted. If it is desired to initiate an Appeal Procedure because there is a disagreement with the reasons why the claim was denied, the Administrator should be notified in writing. A request for a review of the claim and examination of any pertinent documents may be made by the claimant or anyone authorized to act on his or her behalf. The reasons why it is believed that the claim should not have been denied, as well as any data, questions or appropriate comments, should be submitted in writing.

The responsibility for full or final determinations of eligibility for benefits; interpretation of terms; determinations of claim; and appeals of claim denied in whole or in part under the Plan rests exclusively with the Administrator.

CUSTOMER SERVICE DIRECTORY

Administrator:

Richard (Dick) Rodruck - 1.800.562.5226

Claims Consultant:

Diane Christensen - 1.800.562.5226

Coverage Questions:

Diane Christensen - 1.800.562.5226

Ryan VanAckeren - 1.800.562.5226

Eligibility:

Sue Rhoads - 1.800.562.5226

Ryan VanAckeren - 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

Administrator

A handwritten signature in black ink, appearing to read "Richard Rodruck", is written over a solid horizontal line.