



# HEALTH BENEFITS PLAN



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## I. INTRODUCTION

This brochure is a description of the benefits available under your plan with Skagit County PUD arranged through the Public Utility Risk Management Services (PURMS) Self-Insurance Fund and Administered by Pacific Underwriters.

Skagit County PUD offers an excellent benefit package covering a broad range of services for injury and illness. This plan provides coverage for employees and dependents enrolled with Skagit County PUD. The plan allows you a wide choice of network providers through the First Choice Health Network who have agreed to accept the "reasonable amount" as payment for services to employees.

In this brochure, Skagit County PUD is referred to as the "Company", First Choice Health Network is referred to as the "Network", Pacific Underwriters is referred to as the "Administrator" and the PURMS Self-Insurance Fund is referred to as the "Fund". 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.

## II. PROVIDERS OF SERVICES

### **Covered Providers:**

- A. 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 on the First Choice Health website at [www.fchn.com](http://www.fchn.com). The patient must also comply with certain cost containment provisions that are explained under "How Your Coverage Works " beginning on Page 7 of this booklet.
- B. Acupuncturist. For necessary care and treatment by a licensed acupuncturist.
- C. Chiropractor. For necessary care and treatment by a licensed chiropractor.
- D. Naturopath. For necessary care and treatment by a licensed naturopath.
- E. Massage Therapist. For necessary care and treatment by a licensed massage therapist. Massage therapy services must be ordered by a physician.

### **Emergency Care or Referred Care within the State of Washington**

Coverage will be provided for emergency care or referred care to the extent such services and supplies would have been provided under this contract if such service had been received from a Network Provider.

### **Emergency Care World-Wide**

If a medical emergency or accidental injury occurs to an Employee while traveling, coverage shall be provided to the extent such services and supplies would have been provided under this contract if such services had been received from or referred by a Network Physician. See Page 7—How Your Coverage Works—for an explanation of how your claim from Network Provider will be processed.

### **Services of Registered Nurses or Community Mental Health Agency**

When services are provided by a registered nurse which are within the lawful scope of such nurse's license or from a community mental health agency and such services would have been covered if rendered by a Network Physician, the Administrator will reimburse you for the cost of services but not to exceed the amount which would have been paid to a Network Provider.

## **III. ELIGIBILITY AND ENROLLMENT**

### **ELIGIBILITY**

This coverage is available to employees of the PUD who are employed full-time or on a regular schedule totaling not less than 30 hours per week, and their "dependents".

A "dependent" is defined as:

- a. The spouse of the Insured.
- b. A child of the Insured under the age of 26 and is not eligible for employer-based health benefits other than through their parents.
- c. "Child" means a natural child of the Insured, an adopted child of the Insured or a stepchild of the Insured (during the marriage of the Insured and the natural parent), but does not include foster children, wards, or children who are the subject of an Assignment of Parental Rights, even if decreed by a court. "Child" also does not include children of Dependents unless the Insured is a court-appointed guardian. Provided, however, that a child who is placed with an Insured for the purposes of adoption shall be considered a Dependent of the Insured. Coverage of any Dependent child of an Insured shall not be terminated by the child's attaining the relevant limiting age (26) if the child is and continues to be Disabled and is not eligible to be covered under any government program except Medicaid. Proof of disability must be furnished annually.

### **ENROLLMENT**

Enrollment (except for newborns and adoptive children) is contingent upon receipt by the Administrator of a fully completed and signed application for coverage on

the Administrator's regular forms, and acceptance by the Administrator by delivery to you of identification cards.

New employees and their eligible dependents may enroll to be effective:

- a. On the first day of the month following the date of employment, however,
- b. If the date of employment is the first working day of the calendar month, enrollment will be effective on the date of employment.

Application must be made to the Administrator within 30 days following the date such enrollment is effective.

Newly acquired dependents (except a newborn or an adoptive child) may be enrolled to be effective on the first day of the month following the date of the dependent's acquisition provided application is made within 60 days of acquisition. A spouse who loses his or her own medical coverage because of termination of employment, loss of eligibility, or termination of another group medical plan may be enrolled to be effective on the first day of the month following the date of loss of coverage provided application is made within 60 days of the termination of such other coverage, together with confirmation of the reason for loss of coverage. A newborn child shall become eligible commencing with the day of birth, provided application is made for coverage within 60 days of the child's birth.

A child placed for adoption with the Insured or for whom the Insured has assumed a total or partial legal obligation for support in anticipation of adoption will be eligible on the date the legal obligation is assumed, provided application is made within 60 days of such assumption of the legal obligation. Those employees who fail to enroll at the time of eligibility or open enrollment 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.

#### **POSTPONEMENT OF COVERAGE**

If a covered employee is hospitalized at the time coverage would otherwise have been effective, the employee's coverage will become effective on the day following discharge from the hospital (this provision does not apply to newborns who are enrolled within 60 days of birth or to children placed for adoption within 60 days of placement).

#### **IV. SELF PAY OPTIONS**

##### **SELF PAY DURING LABOR DISPUTE OR LEAVE OF ABSENCE**

In the case of a strike, lockout or other labor dispute or an authorized leave of absence where the employer discontinues payment for coverage under this contract, you may pay the monthly payments as they become due for a period not to exceed six months.

## **COBRA CONTINUED COVERAGE RIGHTS**

If you and/or your covered dependents lose coverage under a group health plan due to termination of employment (for reasons other than gross misconduct), or a reduction of hours, you may purchase continued coverage under the group plan for you, your enrolled spouse and/or dependent children for up to 18 months. If you elect continuation of coverage, you must pay the full cost of coverage each month. Individuals who are entitled to Medicare may or may not be eligible for continuation coverage. If an Employee at any time during the first 60 days of COBRA coverage is determined to be disabled by Social Security, the continuation period for you and eligible dependents is extended to 29 months. The person designated as disabled must notify his/her employer within 60 days of the date of determination by Social Security, and within 30 days of any loss of disability status as described in "Your Responsibilities" below.

If your spouse or dependent children (if any) are enrolled in the plan and lose coverage due to one of the following events, they may purchase continued coverage under the group plan for up to 36 months:

- Death of employee;
- Divorce or legal separation of the employee and spouse;
- The employee becomes entitled to Medicare; or
- A dependent child is no longer a dependent child as defined by the plan.

Again, your spouse or dependent must pay the full cost of coverage each month. A higher amount may be charged during the period of extended coverage while disabled. Proof of insurability is not required for you or your family to continue coverage in these circumstances. The right to continue purchasing group coverage may terminate before 18, 29, or 36 months (whichever applies) if:

- You fail to pay the required premium on time;
- Your employer terminates all group health plans for all employees;
- The person continuing coverage becomes entitled for Medicare;
- The person continuing coverage is covered under another group health plan not maintained by the employer. Other coverage will not terminate your continued coverage so long as you have a pre-existing condition which is not covered under the other employer's plan due to a plan exclusion or limitation; or
- The person continuing coverage due to disability under the Social Security Act is determined to have recovered.

### **Your Responsibilities**

If you want continuation coverage when you become divorced or legally separated, or when your dependent child is no longer a dependent child under the terms of the plan, you must immediately notify your employer in writing, within 60 days of the date of the qualifying event, or the date coverage ceased under the plan (whichever is later). If, while self-paying as a result of termination of employment or reduction of hours, you or your dependent receive a determination from the Social Security Administration of disability, the disabled individual must notify his/her employer within the initial 18-month coverage period and within 60 days of Social Security's disability determination. Verbal notice is not binding until confirmed in

writing. The employee designated as disabled must notify the contract holder within 30 days of any loss of disability status.

In the other qualifying circumstances, you will be notified that continuation coverage is available and you must then make an election. If you do not receive notice of your opportunity to elect continuation coverage, contact your employer for an election form.

### **Election Period**

You must decide whether or not you want to purchase continued coverage within 60 days after the date you are notified of your eligibility for continuation coverage, or the date coverage would otherwise terminate (whichever is later).

### **Multiple Events**

If you become entitled to Medicare or if your dependent(s) suffer more than one qualifying event, your spouse and/or your dependent children may be eligible for an additional period of continuation coverage not to exceed a total of 36 months. Your COBRA rights are subject to change. Coverage will be provided only as required by law. If the law changes, your rights will change accordingly.

### **RETIREE COVERAGE**

Plan benefits may be continued as retiree coverage for employees and commissioners meeting the eligibility criteria outlined in the District's Retired Employees' Health and Welfare Plan Policy #1011. The cost of retiree coverage premiums are the responsibility of the retiree. Plan benefits for retirees are reduced upon eligibility for Medicare, regardless of whether or not Medicare enrollment occurs.

## **V. TERMINATION OF BENEFITS**

Except as provided under "Self Pay During Labor Disputes Or Leave Of Absence", "Leaves Under The Family And Medical leave Act (FMLA)", and "Cobra Continued Coverage Rights", coverage under this plan will terminate on the last day of the month in which the person ceases to be eligible or when the required monthly premium is not paid when due; OR if a employee or dependent is a registered inpatient in an accredited hospital at the time his coverage would otherwise terminate, and remains continuously hospitalized for the same injury or illness which necessitated the hospitalization, the Fund shall continue to provide the benefits of the contract until you or dependent is discharged form the hospital or until the maximum benefits of the contract have been paid, whichever occurs first.

## **VI. HOW YOUR COVERAGE WORKS**

### **SERVICES PROVIDED BY NETWORK PROVIDERS**

In general, by presenting your identification card to your Network Physician or hospital, their charges will be billed directly to the Administrator. Except for co-payment requirements for office services, hospital admissions, emergency room services, psychiatric care and prescription drugs, Network Providers agree to

accept the Fund's payment as payment in full for most covered services. Other services to include durable medical equipment will be paid at a coinsurance percentage for the first \$500 of expenses per calendar year and at 100% thereafter. Specified services of Designated Referral Centers are paid in full.

### **SERVICES MUST BE OBTAINED FROM NETWORK PROVIDERS**

Except as specified on page 3, and Other Benefits on page 19, care must be obtained from a Network Provider in order to receive the full benefits of this contract. If you choose to obtain services from a Provider who is not a Network Provider, benefits will be limited to 70 percent of the usual amount paid a Participating Provider as determined by The Fund, however, Anesthesiologists will be paid at the Network Provider percentage.

### **MANDATORY OUTPATIENT SURGERY**

Many routine surgical procedures can be safely performed on an outpatient basis and at less cost than an inpatient stay. Your Network Physician will perform certain surgical procedures only on an outpatient basis, unless you have a medical condition that make hospitalization necessary. If you choose not to have the procedure performed on an outpatient basis, full contract benefits will be provided except that you will be responsible for all room and board charges for the following procedures:

- a. Breast biopsy (needle or incisional)
- b. Carpal tunnel
- c. Cataract extraction
- d. Cystoscopy
- e. Dilation and curettage
- f. Excision of Bartholin's gland and cyst
- g. Ganglionectomy
- h. Gasrointestinal endoscopy
  1. Esophagoscopy
  2. Gastroscopy (flexible Fiberoptic)
  3. Colonoscopy (flexible Fiberoptic)
  4. Duodenoscopy (flexible fiberoptic)
- i. Hemorrhoidectomy
- j. Inguinal hernia repair
- k. Laparoscopy with tubal ligation
- l. Oral surgery
- m. Strabismus surgery
- n. Tonsillectomy and adenoidectomy
- o. Umbilical hernia repair
- p. Varicose vein, ligation and injection
- q. Femoral hernia repair
- r. Cardiac catheterization
- s. Arthroscopy
- t. Bronchoscopy
- u. Tubal ligation
- v. Lymph node biopsy
- w. Excision of bunion

- x. Septoplasty
- y. Pilonidal cystectomy

### **WHEN YOU NEED TO SUBMIT A CLAIM**

When you have obtained care from a non-participating physician, obtain an itemized statement showing date of service, description of services rendered, and charges together with a description of the condition treated. A copy of itemized charges must be presented to the Administrator so that the appropriate reimbursement can be made to you.

For prescriptions purchased from a Network Pharmacy, present your ID card to the pharmacy and pay the co-pay. A current list of Network Pharmacies can be obtained from the Administrator.

For prescriptions not purchased from a Network Pharmacy, pay for your prescription, and mail your receipt and prescription "stub" to the Administrator for a reimbursement.

*Proof of expense must be submitted to the administrator within twelve months of the date the service was provided.*

### **BENEFITS WHICH ARE MEDICALLY NECESSARY**

Except for the sterilization and well-care benefits, contract benefits are limited to those medically necessary services or supplies provided by a hospital, physician, or other provider to identify or treat an illness or injury without which the life or health of a employee would be endangered and which determined by the plan are:

1. Consistent with the symptom or diagnosis and treatment of the condition, disease, ailment, or injury;
2. Appropriate with regard to standards of good medical practice;
3. Not primarily for the convenience of the employee, his physician, or other provider; and
4. The most appropriate supply or level of service that can safely be provided to the employee.

When applied to an inpatient, it further means that the employee's medical symptoms or condition require that the services or supplies cannot be safely provided to the employee as an outpatient. Hospital admissions the day or night before surgery are generally not considered to be medically necessary.

### **CASE MANAGEMENT**

The Administrator may elect to provide alternative benefits that are not listed as covered services in this contract. The alternative covered benefits shall be determined on a case-by-case basis by the Administrator for services that it deems are medically necessary, cost-effective, and agreeable to you or your dependent, and provider. The Administrator shall not be committed to provide these same or similar alternative benefits for another employee or dependent, nor shall the

Administrator lose the right to strictly apply the express provisions of this contract for future services or benefits.

### **ALTERNATIVE CARE**

As an alternative to hospitalization or institutionalization of a covered employee and with the intent to cover placement of the covered employee in the most appropriate and cost-effective setting, this Contract shall include substitution of home health care, provided in lieu of hospitalization or other institutional care, furnished by home health, hospice and home care agencies licensed under RCW 70.127, and as hereafter amended, at equal or lesser cost. Such expenses may include coverage for durable medical equipment which permits the covered employee to stay at home, care provided in Alzheimer's centers, adult family homes, assisted living facilities, congregate care facilities, adult day health care, home health, hospice and home care, or similar alternative care arrangements which provide necessary care in less restrictive or less expensive environments.

Substitution of less expensive or less intensive services shall be made only with the consent of the covered employee and upon the recommendation of the covered employee's attending physician or licensed health care provider that such services will adequately meet the covered employee's needs. The decision to substitute less expensive or less intensive services shall be determined based on the medical needs of the covered employee.

The Administrator may require that home health agencies or similar alternative care providers have written treatment plans approved by the covered employee's attending physician or other licensed health care provider. Alternative care benefits will be limited to no less than the maximum benefits which would be payable for hospital or other institutional expenses under the contract, and will include all deductible and coinsurances which would be payable by the covered employee under the hospital or other institutional expense coverage under this Contract.

Nothing contained in this provision shall be construed to provide coverage for custodial care.

## **VII. BENEFITS**

Subject to the requirements outlined under "How Your Coverage Works", the Company will provide the covered individual with the benefits hereafter stated for medical, surgical, and hospital expenses actually incurred which are reasonable and necessary for the treatment of an illness, injury, pregnancy, or physical disability of such person, plus the specified well-care, subject to the maximum lifetime limit and other terms, limitations and exclusions herein stated.

### **STOP-LOSS**

When the covered individual has incurred \$500 in coinsurance in any one calendar year, payment will increase to 100% of the reasonable charge for further covered services incurred during the same calendar year by that covered employee. The stop-loss does not apply to outpatient rehabilitative treatment.

Except as provided under "Other Benefits", the stop-loss provision does not apply to services provided by non-Network Providers except in the cases of emergency or referred care or when the care is provided by a registered nurse; nor does stop-loss apply to outpatient rehabilitative treatment.

### **SERVICES OF NETWORK PHYSICIANS**

The Network Physicians agree to furnish to the covered individual the following services and to accept The Fund's fee schedule as payment in full.

1. The Administrator will pay the Network Physician's charge up to the fee schedule allowance less any required co-payment for each of the following services necessary for treatment or diagnosis of illness, injury or physical disability.
  - a. Office and home calls less a \$10 co-payment for each call.
  - b. Diagnostic x-ray and laboratory tests.
  - c. Hospital visits and consultation.
  - d. Surgical operations and aftercare.
  - e. Administration of anesthesia.
  - f. Radium and deep x-ray therapy.
  - g. Treatment of fractures and accidental bodily injuries.
  - h. A bone density test (x-ray) for the employee or spouse annually or as recommended by the attending physician. The covered individual is subject to a \$10 co-payment for each test.

The Administrator will pay the Network Physician's charge up to the fee schedule allowance less any required co-payment for each of the well-care benefits.

1. Routine Physical Examinations 100%. Services will be provided for the covered employee and spouse for one routine physical examination per calendar year. Included in the routine physical examination are services for Mammogram and lab tests (i.e., Hematology, Auto Diff, Comprehensive Metabolic Profile, Lipid Profile, Cholesterol, Triglycerides, HDL, LDL, HDL Risk Factor and Thyroids). The covered individual is subject to a \$10 co-payment for each routine physical examination.
2. Pediatric and adult immunizations for diphtheria, pertussis, tetanus, measles, mumps, rubella, oral poliovirus, meningococcal, haemophilus influenza B and hepatitis B will be covered 100%.
3. Immunizations for Hepatitis A & B Combined, Flu, Shingles, and Cervical Cancer will be covered 100%.
4. Well-child examinations for the covered child to a maximum of six within the first year of child's birth, two during the child's second year, annually from the third through sixth years, and once each 12-month period thereafter. The covered individual is subject to a \$10 co-payment for each examination.
5. Laboratory charges for a pap smear once each 12-month period for the female employee or female dependent.
6. A prostate-specific antigen test for the male employee or male spouse, age 50 or over, once each 12-month period.
7. Fecal occult blood tests for the employee or spouse age 50 and over once each 12-month period.

8. A sigmoidoscopy for the employee or spouse age 50 or over once each 12-month period. The covered individual is subject to a \$10 co-payment for each examination.
9. One eye refraction each 24-month period. The Covered individual is subject to a \$10 co-payment for this service.
10. A Colonoscopy for the employee or spouse age 50 or over once each 60 month period or as recommended by the attending physician. The covered individual is subject to a \$10 co-payment for each examination. The sections "Services Must Be Obtained from Network Providers" and "Mandatory Outpatient Surgery" will apply.
11. Hearing Aid Benefits for examination, hearing aid, ear molds(s), and repairs are provided at 85% to \$1,000 every three calendar years. Hearing aid expenses that exceed the \$1,000 limit are not covered under this plan. The following expenses are not covered:
  - ⌘ Charges for hearing aids that do not meet professionally accepted standards of practice, including charges for any services or supplies that are experimental in nature.
  - ⌘ Replacement of hearing aids that are lost, broken or stolen unless the replacement occurs after the three-year period described above.

## **Transplants**

The benefits of this plan will be provided for all medically necessary services or supplies relating to all transplants as follows, as determined by the Administrator: A transplant recipient who is covered under this plan will be eligible for the following transplants, subject to the conditions and limits described in the Benefit.

1. Heart
2. Heart/Lung (combined)
3. Kidney
4. Kidney/Pancreas (combined)
5. Lungs - single/bilateral
6. Liver
7. Bone marrow (including self-donated and unrelated donors) or other forms of stem cell rescue only as specified below.
8. Lungs—lobar
9. Cornea
10. Other forms of stem cell rescue (only covered for certain conditions-see contract)
11. Small Bowel
12. Small Bowel/Liver

### **Donor Organ Benefits:**

Donor organ procurement costs will be covered to a maximum of \$25,000 per transplant provided the recipient is covered for the transplant under this contract. Donor organ procurement benefits are limited to selection, removal of the organ, storage, transportation of the surgical harvesting team and the organ, and such other medically necessary procurement costs as determined by the Administrator. Donor benefits will be charged against the recipient's benefit limits.

## Limitations

The benefits of this section will be limited as follows:

With regard to autologous (self-donor) bone marrow transplants or associated high-dose chemotherapy, coverage is available for treatment only for the following malignancies/conditions:

1. Non-Hodgkins lymphoma
2. Hodgkins lymphoma
3. Neuroblastoma
4. Acute lymphocytic or non-lymphocytic leukemias
5. Germ cell
6. Multiple myeloma which is newly diagnosed or is in remission.

Autologous bone marrow transplants or associated high-dose chemotherapy for other conditions will not be covered.

With regard to allogeneic (related or unrelated) bone marrow transplants or associated high-dose chemotherapy, coverage is available for treatment only for the following malignancies/conditions:

1. Acute lymphocytic leukemia
2. Acute non-lymphocytic leukemias
3. Chronic myelogenous leukemia
4. Aplastic anemia
5. Hodgkins lymphoma
6. Non-Hodgkins lymphoma
7. Severe combined immunodeficiency (not AIDS)
8. Wiskott-Aldrich syndrome
9. Infantile malignant osteopetrosis
10. Neuroblastoma stage III and IV in children over one year of age
11. Homozygous beta-thalassemia

Allogeneic bone marrow transplants or associated high-dose chemotherapy for conditions other than those listed above will not be covered.

No benefits will be provided for the following:

1. Nonhuman, artificial, or mechanical transplants.
2. Investigational procedures.
3. When donor benefits are available through other group coverage.
4. When government funding of any kind is provided.
5. When the recipient is not covered under this plan.
6. Lodging, food, or transportation costs, unless otherwise specifically provided under this contract.
7. Donor and procurement services and costs incurred outside the United States, unless specifically approved by the Administrator.
8. Living (non-cadaver) donor transplants of the lung, liver, or other organ (except kidney), including selective islet cell transplants of the pancreas.

## Services of Network Hospitals

Services provided to an Employee while confined as an inpatient will be paid in full less a \$200 co-payment for each admission. Room and board charges will be

limited to the semi-private rate (private room if medically necessary, or if semi-private rooms do not exist in the facility).

The following services provided to an Employee for outpatient care will be paid as follows:

- ☞ Outpatient treatment will be limited to surgery; radiation therapy; chemotherapy, and diagnostic procedures such as scans will be paid in full.

Emergency room services will be paid in full less a \$50 co-payment for each visit (waived if directly admitted to the hospital as an inpatient).

NOTE: Benefits for rehabilitative treatment, psychiatric treatment, temporomandibular joint dysfunction, organ transplants, PTCA or open-heart surgical procedures and sterilization are limited and specified elsewhere.

### **Home Health Benefit**

Covered Services:

Benefits are limited to the following services in the patient's home and must be provided by employees of the Home Health Care Agency:

1. Physician services.
2. Nursing services by a registered nurse (R.N.) or licensed practical nurse (L.P.N.).
3. Physical therapy services by a licensed physical therapist.
  - Massage Therapy is covered under the Physical Therapy Benefit and must be ordered by a physician.
4. Speech therapy by an ASHA certified speech therapist.
5. Occupational therapy services by an occupational therapist certified by the American Occupational Therapy Association.
6. Medical social services by a person with a master's degree in social work.
7. Home health aide services by an aide who is under the supervision of a registered nurse or a licensed physical or certified speech therapist, limited to the following: part-time or intermittent care, including ambulation and exercise, personal care or household services essential to achieve the medically desired results, assistance with medications, reporting changes in the patient's condition and needs, and completion of appropriate records.
8. Respiratory therapy services of an inhalation therapist certified by the National Board of Respiratory Therapists.
9. Medical supplies dispensed by the home health agency that would have been provided on an inpatient basis.
10. Nutritional guidance by a registered dietitian.
11. Nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation.

NOTE: For medical equipment or prescription drugs see "Other Benefits" of this plan.

Exclusions of Home Health Benefit:

1. Services normally provided under a hospice program.
2. Services to other family employees

3. Services of volunteers, household employees, family or friends.
4. Food, clothing, housing or transportation. (See ambulance benefit of this plan.)
5. Supportive environmental materials such as, but not limited to ramps, handrails, or air conditioners.

### **Hospice Services**

Hospice services provided by a Network Hospice for medically necessary treatment or palliative care (medical relief of pain and other symptoms) to the terminally ill patient for a maximum limit of six (6) months.

Conditions for Coverage:

The patient's Network Physician must establish or approve and periodically review, at least every 60 days, a written treatment plan.

Covered Inpatient Services:

When the patient is confined as an inpatient in a Network Hospice that is not an approved hospital, the same benefits that are available in the home will be available to the patient as an inpatient. In addition a semi-private room benefit will be provided. This inpatient hospice benefit will be limited to 14 days during the six-month period.

Limitations

- ⌘ Visits of four or more hours in which skilled care is required by a registered nurse, licensed practical nurse, or home health aide, shall be limited to a combined total of 120 hours or six months, whichever is greater.
- ⌘ Respite care of four or more hours per day in which no skilled care is required will be limited to a combined total of 120 hours per three-month period.

Exclusions of Hospice Benefit:

Benefits will not be provided for the following:

1. Services for spiritual counseling or bereavement counseling.
2. Services to other family employees.
3. Services of volunteers, household employees, family or friends.
4. Food, clothing, housing or transportation. (See the ambulance benefit of his plan.)
5. Supportive environmental materials such as, but not limited to, ramps, handrails, or air conditioners.
6. Homemaker or housekeeping services, except a specifically provided above under the home health aide benefit.
7. Financial or legal counseling services.
8. Custodial or maintenance care, except the benefits will be provided for palliative care to a terminally ill patient, subject to the limits stated.
9. Services or supplies not included in the written treatment plan, not specifically set forth as a covered benefit, or limited or excluded under the regular limitations and exclusions of this plan.

## **Maternity/Newborn Care**

For maternity and newborn care, the attending provider in consultation with the patient makes the following decisions regarding the following:

- ☒ Length of inpatient stay;
- ☒ Inpatient post-delivery care;
- ☒ Follow-up care to include type and location that may include home health care agencies and registered nurses.

Benefits for maternity care will be provided to a female employee or spouse of a male employee, and will include care required for a vaginal delivery, cesarean section, ectopic pregnancy, and abortion.

Professional and hospital services for maternity care will be paid the same as for any other medical condition. Circumcision of a newborn, and screening and diagnostic procedures which are medically necessary for prenatal diagnosis of congenital disorders of the fetus will also be provided a person eligible for maternity care under this contract. No benefit will be provided for elective sex typing or paternal typing.

Contract benefits relating to complications of pregnancy will be provided any Employee limited to the following:

1. Ectopic pregnancy that is terminated.
2. Conditions requiring intra-abdominal surgery after the end of pregnancy.
3. Toxemia with convulsions (eclampsia of pregnancy).
4. Non-elective abortion when a viable birth is impossible.
5. Non-elective emergency cesarean section.
6. When pregnancy is not terminated, conditions that are adversely affected or are caused by pregnancy and require hospital confinement, such as acute nephritis, hephtosis, cardiac decompensation, or missed abortion.

Complications of pregnancy do not include false labor, occasional spotting, prescribed or recommended rest, morning sickness, pre-eclampsia, or any similar condition associated with the management of a difficult pregnancy that does not constitute, in the judgment of the Administrator, a medically distinct complication of pregnancy.

The benefits are not subject to the waiting period provisions.

Benefits for well newborn care will be equivalent to the coverage of the child's mother for up to three weeks, even if there are separate hospital admissions, and include hospital nursery charges, professional services, and follow-up care.

Coverage for an ill newborn or a well newborn whose mother is not covered under the contract will be provided to the same extent as any other dependents.

Benefits for a newborn are not subject to any waiting period provisions.

## **Chemical Dependency Treatment**

Benefits will be provided for services of a Network Treatment Facility for medically necessary inpatient and outpatient treatment of chemical dependency, including detoxification and supportive services. Benefits provided for treatment will be the same as benefits provided for treatment of other illness conditions under this plan.

Benefits will be limited to a maximum of \$10,000 during any consecutive 24-month period. In situations where a covered employee is under court order to undergo a chemical dependency assessment or treatment, or in situations related to deferral of prosecution, deferral of sentencing or suspended sentencing, or in situations pertaining to motor vehicle driving rights and the Washington State Department of Licensing, the covered employee must furnish at his or her expense not less than ten (10) and no more than thirty (30) working days before treatment is to begin, an initial assessment of the need for chemical dependency treatment and a treatment plan, made by an individual of the patient's choice who is a physician or a qualified counselor employed by an approved treatment facility to enable the Administrator to make its own evaluation of medical necessity prior to scheduled treatment.

In addition, medically necessary detoxification, which occurs while an individual is not yet enrolled in chemical dependency treatment, is covered under the Emergency Room benefit of this plan.

## **Benefits for Rehabilitative Treatment**

Benefits for rehabilitative treatment which are necessary to restore and improve function that was previously normal but lost following an accidental injury or illness, for treatment of neurodevelopmental disabilities, or treatment of congenital anomalies of a newborn covered from birth will be provided as follows:

### **Outpatient Services**

Physical, speech, and occupational therapy will be provided at 80 percent of the Network Provider's reasonable charge to a maximum of \$750 per calendar year. The benefit maximum may be extended upon submission by the treatment physician of a treatment plan meeting the approval of the Administrator up to an additional \$2,000 per calendar year. The stop-loss provision of the contract does not apply to this benefit.

### **Inpatient Services**

Subject to prior approval by the Administrator of a written plan of treatment; benefits for rehabilitative treatment at a Medicare certified facility will be provided at 80 percent of the reasonable charge subject to the stop-loss limit and the following.

### **Limitations**

1. The covered employee must have been covered by a contract with the Company when the illness or injury occurred and continually since that time.

2. Treatment must begin within 12 months of the injury or illness and will be provided to a maximum of 12 months from the date treatment begins; however, benefits will terminate at such time that further significant restoration and improvement of function cannot be documented.
3. Spinal Manipulations are limited to 12 per calendar year.
4. Acupuncture treatments are limited to 12 per calendar year.

**Maximum Benefits**

Benefits under this section shall not exceed \$1,000 per day to a maximum of \$10,000 per condition, except that up to \$30,000 will be provided for cerebral vascular accident, brain injury, or spinal cord injury.

**Neurodevelopmental Therapies**

The above benefits will be provided for neurodevelopmental therapies for covered employee's dependent age six and under where the services are necessary to restore and improve function or to maintain a condition where significant deterioration in the covered employee's condition will result to a maximum of \$2,000 per calendar year. Benefits provided for treatment of neurodevelopmental therapies will apply to the overall benefit maximum for outpatient and/or inpatient care.

No benefits will be provided for:

- a. Custodial care.
- b. Maintenance; non-medical self help; recreational; vocation, or education therapy.
- c. Learning disabilities.
- d. Psychiatric care.
- e. Alcohol, drug or chemical substance abuse rehabilitation.
- f. Gym or swim therapy.

**Temporomandibular Joint Disorders (TMJ)**

Benefits of this contract will be provided on the same basis as for other injuries or musculoskeletal disorders for treatment of temporomandibular joint disorders to a maximum of \$1,000 per calendar year and limited to a combined lifetime maximum of \$5,000 as to any one covered employee.

"Temporomandibular Joint Disorders" shall include those disorders which have one or more of the following characteristics: Pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

Covered services are limited to those which are:

- a. Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and
- b. Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection,

- disease, difficulty in speaking, or difficulty in chewing or swallowing food;  
and
- c. Recognized as effective, according to the professional standards of good medical practice; and
  - d. Not experimental or primarily for cosmetic purposes.

### **Benefits for Mental Health Treatment**

The Company will provide the following services of a Network Mental Health Provider, hospital, or other Plan Designated Provider when such services are referred by a Network Provider:

1. Inpatient services to a maximum of 10 days per calendar year, subject to a \$200 co-payment per admission,
2. Outpatient services, including individual and family counseling, to a maximum of 20 visits per calendar year, subject to a \$10 co-payment per visit.

### **Services of a Network Pharmacy**

Subject to the required co-payment, benefits for services of a Network Pharmacy will be paid in full for drugs and medicines directly related to the treatment of illness or injury and prescribed by a Provider, subject to the following conditions:

1. Prescriptions are limited to a 30-day supply.
2. Co-payment: The employee is subject to a \$10 co-payment for each brand name prescription and to a \$5 co-payment for each generic drug prescription.
3. Cosmetic and other drugs not contained in the Administrator's formulary are specifically excluded unless pre-authorized by the Administrator.
4. The pharmacy co-payments do not apply to out-of-pocket maximums.
5. Prescription smoking deterrents are covered, and are limited to three months per year.

### **Mail order Pharmacy Benefit**

Subject to the required co-payment, benefits for services of a participating mail order pharmacy will be paid in full for drugs and medicines directly related to the treatment of illness or injury and prescribed by a Provider, subject to the following conditions.

1. Prescriptions are limited to a 90-day supply.
2. Co-payment: The employee is subject to a \$20 co-payment for each brand name prescription and to a \$10 co-payment for each generic drug prescription.
3. Cosmetic and other drugs not contained in the Administrator's formulary are specifically excluded unless pre-authorized by the Administrator.
4. The pharmacy co-payments do not apply to out-of-pocket maximums.

Notwithstanding any provisions of this contract to the contrary, coverage shall not be excluded for a drug prescribed by a physician for off-label use, meaning that the prescribed use is other than that stated in its Federal Food and Drug Administration (FDA) approved labeling, if such drug is recognized as effective in

one of the Standard Reference Compensia, or if not in the majority of relevant peer-reviewed medical literature, or by the Federal Secretary of Health and Human Services.

Medically necessary services associated with the administration of any such drug will be covered in accordance with other benefit provisions of this contract.

### **Other Benefits**

Benefits for the following services are provided at 80 percent of the provider's reasonable charge subject to the stop-loss limit.

- ☒ 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 Equipment—Special equipment and supplies for which the covered employee has an immediate need: casts; splints; braces; surgical and orthopedic appliances; colostomy bags and supplies required for their use; catheters; syringes and needles medically necessary for diabetes or allergies; dressings medically necessary for wounds, cancer, burns, or ulcers; oxygen.
- ☒ Prostheses—Purchases of a prosthesis provided for functional reasons when replacing a missing body part. No benefits will be provided for cosmetic prostheses except for external and internal breast prosthesis necessary because of a mastectomy. Replacement of external breast prosthesis is limited to once every three calendar years.
- ☒ Durable Medical Equipment—Rental (or, at the election of the Administrator, purchase in lieu of rental) of necessary durable medical equipment when prescribed by a physician for therapeutic use, including the following: crutches, iron lung, wheelchair, kidney dialysis equipment, hospital beds, traction equipment, and equipment for administration of oxygen. No benefits will be provided for such items as air conditioners, dehumidifiers, purifiers, arch supports, corrective shoes, heating pads, deluxe equipment such as motorized wheelchairs, or beds, enuresis training equipment, exercise cycles, or whirlpool baths.
- ☒ Blood Bank Charges—Administration of blood and its derivatives and cross-matching.
- ☒ Dental Services for Injury - Dental repair as a result of injury will be paid up to a limit of \$750 for each separate injury occurring while covered hereunder. Replacement of dental fillings, repair of deciduous teeth, repair or replacement of plates or bridgework is excluded.
- ☒ Sterilization - Services relating to surgical sterilization to a maximum of \$1,000.
- ☒ PKU - Formulas necessary for treatment of phenylketonuria (PKU). Waiting period provisions of this contract do not apply to this benefit.
- ☒ Diabetic Training - Diabetic training programs will be provided to a maximum of \$ 150 per calendar year.

## **MAXIMUM LIMIT OF MAJOR MEDICAL BENEFITS**

1. Services, benefits, and reimbursements to be provided anyone patient under this exhibit shall not exceed a total cost to the Company of \$2,000,000 annually for all injuries, illnesses, or conditions combined and are unlimited during the patient's lifetime.

## **VIII. EXCLUSIONS AND WAITING PERIODS**

### **EXCLUSIONS**

Benefits are not provided for:

1. Impotency, infertility, sterility; treatment or surgery for trans-sexualism; reversal of sterilization; artificial insemination; in vitro fertilization.
2. Military or war-related injury or illness.
3. Any injury sustained while practicing for or competing in professional or semiprofessional competition.
4. Services provided by a federal or state governmental hospital, except as required by law.
5. Hospitalization solely for diagnostic purposes or for custodial or convalescent care.
6. Treatment for dental conditions; services performed by dentists and/or oral surgeons and hospitalization for these services. This exclusion does not apply to treatment of a fractured jaw or to the specific benefit for injury to teeth or treatment of temporomandibular joint dysfunction, nor to any dental coverage exhibits to which the group has elected coverage.
7. Treatment for obesity including surgery and complications thereof; however, office visits for the treatment of obesity is covered.
8. Services, supplies and procedures for cosmetic, plastic and reconstructive purposes, except that the following will be provided:
  - a. Care related to an injury occurring while covered under the contract.
  - b. Repair of a congenital anomaly of a newborn covered at birth under the contract.
  - c. Post mastectomy reconstructive surgery.
9. Treatment which is experimental or investigative in nature, meaning any service, prescription, treatment, procedure, facility, equipment, drug, drug usage, medical device or supply that:
  - a. Final governmental approval from the appropriate government regulatory bodies;
  - b. Conclusive scientific evidence proves the service or supply to be efficacious;
  - c. The service shows a demonstrable benefit for a particular condition, illness or disease and that the benefits(s) outweigh the risk(s);
  - d. The service results in greater benefits for a particular condition, illness or disease than other generally available services;
  - e. Evidence supports that the resulting improvements are attainable outside of the research or investigational setting; or
10. Has been determined by the Administrator as not being in general use in the medical community in the state of Washington, or not meeting the criteria listed under this exclusion.

11. Milieu therapy (treatment in an institution intended primarily to provide a change in environment or a controlled environment).
12. Any service to the extent it is payable under Title XVIII of the Social Security Act of 1965 (Medicare) as amended or to the extent it would have been payable if you or dependent had made proper application for coverage or had obtained service from a provider recognized by the Medicare Program.
13. Any care to dependent children for pregnancy, except as provided for complications of pregnancy.
14. Intentionally self-inflicted injuries and attempted suicide.
15. Services and benefits to the extent for which the covered employee may be eligible as a result of automobile medical, automobile no-fault insurance, personal injury protection ("PIP") or similar contract of insurance.
16. Biofeedback.
17. Routine foot care; orthotics; except as required by the Diabetic Cost Reduction Act.
18. Treatment resulting from drug or chemical abuse except as provided for rehabilitation.
19. Chiropractic coverage (see Limitations).

### **WAITING PERIODS**

Organ Transplants: No benefits will be provided for services related to an organ transplant until the covered employee has been covered under this contract (or another contract with the Administrator that also covers the transplant) for a period of 12 consecutive months, whether or not the condition is preexisting or an emergency. This provision does not apply to newborns or adoptive children.

Preexisting Conditions: No benefits will be provided for services related to preexisting conditions until the covered employee has been covered under this contract for a period of three consecutive months. Covered employees who were previously covered by another similar health insurance plan (including an employer provided self-funded health plan) within the 3-month period immediately preceding the date of application for coverage under this plan will receive credit for the months continuously covered under the prior plan toward these waiting periods. These waiting periods do not apply to newborns or adoptive children or do they apply to covered benefits for maternity care. A preexisting condition is a condition for which medical advice was given, or for which a health care provider recommended or provided treatment within three months prior to the effective date of coverage. This provision does not apply to children under age 19.

### **IX. VISION BENEFITS**

**EXAMS:** One eye refraction each 24-month period. The Covered individual is subject to a \$10 co-payment for this service.

**HARDWARE:** An allowance of \$250 per family toward prescription eyeglass lenses and frames, or contact lenses, including expenses associated with their fitting, is provided once every calendar year.

## **X. COORDINATION OF BENEFITS**

You may be covered under more than one health care plan. If so, payment of benefits will be coordinated between the plans so as not to pay more than the actual cost of the services you received.

The plan that pays first pays all the expenses allowed under its coverage. Then the other plan pays the remaining allowed expenses. Co-pays, coinsurance, and other cost-sharing arrangements are not included in the coordination of benefit payments, and will be your responsibility to pay.

Some plans do not have a Coordination of Benefits provisions. If your other plan does not have one, that plan will pay its benefits first. Your plan will pay the rest of your covered expenses but not more than would have been paid if you had not had another health care plan.

If your other plan(s) have a Coordination of Benefits provision, benefits will be paid by the plans in the following order:

1. The plan that covers the patient other than as a dependent shall be exhausted first. However, the other plans shall pay first if the patient is a laid-off or retired employee under this plan, or a dependent thereof.
2. The Plan that covers the patient as a dependent of a person whose day and month of birth occurs earlier in the calendar year shall be exhausted before the benefits of a plan that covers the patient as a dependent of a person whose day and month of birth occurs later in a calendar year, except that if the other plan does not contain this rule, resulting in conflicting orders of benefits determination, the other plan's provisions shall govern. However, if the patient is a dependent child whose parents are separated or divorced, the following rules shall apply:
  - a. If a parent with custody has not remarried, the benefits of the plan of the parent with custody will be exhausted before the plan of the parent without custody.
  - b. If a parent with custody has remarried the benefits of the plans that cover the child will be exhausted in the following order:
    - i. The plan of the parent with custody.
    - ii. The plan of the spouse of the parent with custody.
    - iii. The plan of the parent without custody.
    - iv. The plan of the spouse of the parent without custody.

Notwithstanding paragraphs a. and b. above, if there is a court decree that established financial responsibility for the health care of the child, the benefits of the plan that covers the child as a dependent of the parent with such financial responsibility shall be exhausted first.

When the above rules do not establish an order of benefit determination, the benefits of a plan that has covered the patient for the longer period of time shall be

determined before the benefits of a plan that has covered such patient the shorter period of time. However, for a retired or laid-off employee and his or her dependents covered by this plan, the benefits of this plan will be determined after the benefits of any other plan covering such a person as an active employee or dependent thereof except; if the other plan does not have a provision regarding retired or laid-off employees, resulting in each plan determining its benefits after the other, this plan's provision for retired or laid-off employees shall not apply.

If none of the above rules establishes an order of benefits determination, the benefits of the plan that has covered an employee for the longer period of time shall be determined before the benefits of the plan that has covered an employee for the shorter period of time.

## **XI. SUBROGATION**

If you or a covered dependent is injured due to the act or omission of another party who is legally liable, the benefits of this contract will be available, provided you agree to cooperate with the Fund in its subrogation rights and you agree to reimburse the Fund for the amount it has paid if you recover from the party who is liable. Such reimbursement will be limited to the amount collected which is in excess of that necessary to fully compensate you for the total loss sustained.

The subrogation and indemnity rights of the Fund shall extend to any recovery by a dependent or by a covered employee or personal representative of a patient, if the patient dies.

When reasonable collection costs and reasonable legal expenses have been incurred in recovering payments which benefit both the covered employee and the Fund, whether incurred in an action for damages or otherwise, there shall be an equitable apportionment of such collection costs and legal expenses.

## **XII. HIPAA PRIVACY RULES**

### **I. Introduction**

Individually identifiable health information ("Health Information") regarding all Covered Employees and dependents participating in the Health Plan ("Plan Participants") is currently and will continue to be provided by the Administrator for the Health Plan to the Plan Sponsor, and to specified employees or classes of employees in the Plan Sponsor's workforce, to the minimum extent necessary for the Plan Sponsor to perform certain Plan Administrative Functions on behalf of the Health Plan. When Health Information is provided from the Plan, through the Administrator, to the Plan Sponsor, it is Health Information that is protected ("Protected Health Information" or "PHI") by the privacy requirements contained in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), and its implementing regulations contained in 45 CFR Part 160 and Part 164, Subparts A and E (the "Privacy Rules").

HIPAA and the Privacy Rules restrict the Plan Sponsor's ability to use and disclose PHI. The following HIPAA definition of PHI applies to this section:

Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental

health or condition of a participant; the provision of health care to a participant; or the past, present, or future payment for the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Plan Sponsor shall have access to, use and disclose PHI relating to the Health Plan ("Plan PHI"), received from and through the Administrator, only as permitted under this section, or as otherwise required or permitted by HIPAA.

## II. Provision of Protected Health Information to the Plan Sponsor

- A. Permitted Disclosure of Enrollment/Disenrollment Information: The Health Plan, by and through the Administrator for the Plan, may disclose to the Plan Sponsor information relevant to whether an individual is participating in the Plan, or is enrolled in or has disenrolled from the Plan.
- B. Permitted Uses and Disclosures of Summary Health Information: The Health Plan, by and through the Administrator for the Plan, may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of: (1) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (2) modifying, amending, or terminating the Plan.

"Summary Health Information" means: information that: (a) summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor had provided health benefits under a Health Plan; and (b) from which the information described at 45 CFR § 164.514(b)(2)(i) has been deleted, except that the geographic information described in 45 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

- C. Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administrative Purposes: Unless otherwise permitted by law, and subject to the conditions of disclosure described in paragraph D. and obtaining written certification pursuant to paragraph F., the Plan may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for Plan Administrative Functions ("Shared PHI"). "Plan Administrative Functions" means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan Administrative Functions do not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor, and they do not include any employment-related functions.

Notwithstanding the provisions of this section to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

- D. Conditions of Disclosure for Plan Administrative Purposes: Plan Sponsor agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to the Sponsor by the Administrator on behalf of the Plan, Plan Sponsor shall:
1. Not use or further disclose the Shared PHI other than as permitted or required by the Coverage Booklet or as required by law.
  2. Ensure that any agents, including any subcontractor to whom the Plan Sponsor provides the Shared PHI, agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to Shared PHI.
  3. Not use or disclose the Shared PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
  4. Report to the Administrator, acting on behalf of the Health Plan, any use or disclosure of the Shared PHI that is inconsistent with the uses or disclosures provided for of which it becomes aware.
  5. Make available Shared PHI to comply with the right of a Plan Participant to have access to his or her own PHI in the possession of the Plan Sponsor, in accordance with 45 CFR § 164.524.
  6. Make available Shared PHI to comply with the right of a Plan Participant to request amendment of his or her PHI and to incorporate proper amendments agreed to by the Plan Sponsor, in accordance with 45 CFR § 164.526.
  7. Make available the information required to comply with the right of a Plan Participant to receive an accounting of the uses and disclosures that have been made of the Shared PHI relating to the Participant, in accordance with 45 CFR § 164.528.
  8. Make the Plan Sponsor's internal practices, books, and records relating to the use and disclosure of Shared PHI available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan Sponsor with the Privacy Rules.
  9. If feasible, return or destroy all Shared PHI that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.
  10. Ensure that the separation (i.e., the "firewall") required by the Privacy Rules between the Health Plan (i.e., the "Authorized Employees" of the Plan Sponsor that handle PHI on behalf of the Plan) and the Plan Sponsor (i.e., the rest of the Plan Sponsor's employees that have no access to the PHI) is consistently maintained.
- E. Adequate Separation Between Health Plan and Plan Sponsor: The Plan Sponsor shall allow only those members of its workforce that are identified by name, title, class of employee or department in the Plan Sponsor's Privacy Notice to have access to and use of the Shared PHI ("Authorized Employees"). No other persons shall have access to the Shared PHI. The Authorized Employees shall only have access to and use of the Shared PHI to the extent necessary to perform the Plan Administrative Functions that

the Plan Sponsor performs for the Plan. In the event that any Authorized Employee does not comply with the provisions of this paragraph, that employee shall be subject to disciplinary action by the Plan Sponsor for non-compliance pursuant to the Plan Sponsor's employee discipline and termination procedures.

- F. Certification of Plan Sponsor: The Administrator shall disclose Shared PHI to the Plan Sponsor only upon the receipt by the Administrator, on behalf of the Health Plan, of a written certification by the Sponsor that the documents that govern the Plan ("Plan Documents") have been amended to incorporate the provisions of 45 CFR § 164.504(f) (2) (ii), and that the Plan Sponsor agrees to the conditions of disclosure set for the in paragraph D. of this Plan Amendment.

### **XIII. DENTAL BENEFITS**

#### **SPECIAL ORTHODONTIC BENEFITS**

The employee will be reimbursed up to an amount equal to 70 percent of the reasonable and customary charges made for orthodontic treatment incurred while covered under this plan up to a lifetime maximum of \$1,800. Benefits provided under this provision apply to the maximum limits of \$2,000 per person per calendar year.

#### **DENTAL COVERAGE IN GENERAL**

The dental benefits are an addition to your group medical coverage and the eligibility provisions of this plan are the same as those of your medical plan. All provisions and conditions of your medical coverage will apply which do not directly conflict with these dental benefits, including provisions relating to subrogation, coordination of benefits, and exclusions and limitations.

You choose the Dentist: You may choose with complete freedom anyone of the many licensed dentists in the community.

Maximum Benefit: This dental plan will provide benefits for the services of licensed dentist for those services listed in the Summary of Benefits to a maximum of \$2,000 per calendar year.

Annual Deductible Amount: There is no annual deductible under this dental plan.

#### **HOW TO FILE A CLAIM**

In most instances, the dentist who performs the examination and treatment will bill the Administrator for his/her services. Should you receive a private billing statement, submit an itemized billing including your name, Social Security Number and group name to our office to receive reimbursement.

## **SUMMARY OF BENEFITS**

All payment of benefits is based on the appropriate percentage of the usual, customary and reasonable charge. This means the lesser of:

- ⌘ The charge made by a covered provider of service; or
- ⌘ The prevailing charge for the service in the area by those of a similar professional standing.

You will be responsible for the balance for your dentist's charges that are not paid by the plan.

## **PREVENTATIVE AND DIAGNOSTIC SERVICES**

This plan pays 100% of the usual, customary and reasonable charges for the following services:

- ⌘ Oral examination -limited to two examinations in any calendar year.
- ⌘ Dental x-rays. (A complete series of intra-oral films and panoramic films is limited to once in any calendar year.)
- ⌘ Prophylaxis (cleaning, scaling and polishing)-limited to two treatments in any calendar year.
- ⌘ Topical application of fluoride.
- ⌘ Oral hygiene instruction-limited to three sessions.
- ⌘ Plastic sealants for permanent teeth.
- ⌘ Space maintainers.

## **BASIC SERVICES**

This plan pays 90% of the usual, customary and reasonable charges for the following services:

- ⌘ Amalgam and composite restorations. (Composite covered only on teeth anterior to the first molar; otherwise, amalgam allowances will apply.)
- ⌘ Gold foil restorations.
- ⌘ Extractions.
- ⌘ General anesthesia. (Local anesthesia included in allowance for procedure.) Benefits are not available for nitrous oxide.
- ⌘ Endodontics, including direct pulp capping, pulpotomy and root canal therapy.
- ⌘ Stainless steel crowns.
- ⌘ Apicoectomy and root resections.
- ⌘ Repair of relining of dentures.
- ⌘ Re-cementing onlays or crowns.
- ⌘ Repair or re-cementing bridges.
- ⌘ Oral surgery, root surgery, alveoplasty, replantation, removal of odontogenic cyst and incision and drainage of abscesses, and surgical extractions.
- ⌘ Periodontal procedures, including:
  - Examination
  - Scaling and root planing
  - Occlusal adjustment and guards
  - Gingivectomy and gingivoplasty (gum surgery)
  - Gingival curettage (scraping of gums)
  - Osseous (bone) surgery

## MAJOR SERVICES

This plan pays 75% of the usual, customary and reasonable charges of the following:

- ☒ Gold inlay restorations.
- ☒ Plastic, porcelain, non-precious metal, semi-precious metal or gold crown. (Porcelain crowns covered only on teeth anterior to first molar; otherwise, the metal allowance is provided.)
- ☒ Temporary dentures, tissue conditioning prosthetics - for replacement of anterior teeth extracted with the previous 30 days. (No other temporary prosthetics provided.)
- ☒ Temporary crowns - for immediate out-of-area emergency treatment only. (No other temporary crowns provided.)
- ☒ Prosthetics, including implants, bridges, dentures, or partials.

## TEMPOROMANDIBULAR JOINT DISORDERS

Treatment of temporomandibular joint disorders not paid as any other injury or musculoskeletal disorder covered under the contract to a maximum of \$1,000 per calendar year and limited to a combined lifetime limit of \$5 ,000 as to anyone patient.

“Temporomandibular joint disorders” shall include those disorders which have one or more of the following characteristics: Pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

Covered services are limited to those that are:

- A. Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint, under all the factual circumstances of the case; and
- B. Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food; and
- C. Recognized as effective, according to the professional standards of good dental practice; and
- D. Not experimental or primarily for cosmetic purposes.

## LIMITATIONS

1. Benefits for oral examinations and prophylaxis, including fluoride treatment, will be limited to two per covered individual in any 12-month period.
2. Benefits for full-mouth x-rays will be limited to one set per individual in any 12-month period.
3. Benefits for crowns and gold inlays will be payable only when the tooth serves as an abutment to a bridge or when there is not other means of restoring the tooth; otherwise, the amount for amalgam restoration will apply.
4. Benefits for bridges, dentures, or partials will be payable for initial installation only if the patient was covered under this plan at the time of

extraction, or for replacement only if additional teeth were extracted after initial installation and the patient was covered under this plan at the time of extraction, or the existing dentures or bridgework was installed at least five years prior to its replacement and cannot be made serviceable.

Where more than one procedure may be considered as an alternative treatment, the applicable amount for the procedure customarily provided for similar cases will apply.

### **EXCLUSIONS**

1. Appliances or restorations for the purpose of increasing vertical dimension or to restore occlusion except as provided in the Special Orthodontic Benefits.
2. Charges from any provider other than a licensed dentist or denturist.
3. Charges for broken appointments or filling out forms.
4. Charges as a result of injuries related to semi-professional or professional athletic contests, including practice.
5. Conditions related to military service or acts of war.
6. Congenital malformations, except as provided to a dependent child covered at birth under this contract.
7. Correction of malocclusion, including extraction of teeth for tooth guidance procedures, and other orthodontic services, except as specifically provided for treatment of temporomandibular joint disorders or as provided in the Special Orthodontic Benefits.
8. Cosmetic dentistry or surgery, except as provided to a dependent child covered at birth under the contract for treatment of a congenital condition.
9. Crowns and bridges or other prosthetic devices, or fitting of, if ordered prior to patient's effective date under this plan; or installed or delivered more than 30 days after the patient's coverage terminates.
10. Replacement of lost or stolen items.
11. Services payable by any government agency or through Worker's Compensation or similar laws.
12. Expenses for replacement, within five years, of a prosthetic appliance or fixed bridge furnished under this exhibit.
13. Expenses not recommended by a dentist, denturist, or dental hygienist working within the scope of his or her license.
14. Services or supplies not specifically provided in the Summary of Benefits.

### **PHYSICIAN/HOSPITAL SERVICES FOR DENTAL TREATMENT**

Physician and/or hospital benefits of the medical/surgical/hospital contract will be provided in connection with a covered procedure of the dental plan when such care is necessary to safeguard the patient's life.

### **XIV. APPEAL OF A CLAIM DENIAL - ALL CLAIMS**

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

#### **XV. CUSTOMER SERVICE DIRECTORY**

Phone: 1.800.562.5226

Fax: 206.248.0130

Administrator:

Richard (Dick) Rodruck

Claims Consultants:

Diane Christensen

Bambi Harrison

Coverage Questions:

Diane Christensen

Bambi Harrison

Ryan VanAckeren

Eligibility:

Ryan VanAckeren

Bambi Harrison

Diane Christensen

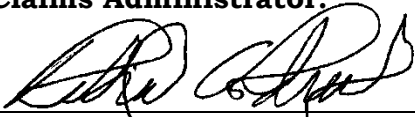
Correspondence and Claim Filing Address:

Pacific Underwriters

P.O. Box 66040

Seattle, WA 98166

**Claims Administrator:**



Signature

12/1/2009

Date