

Deputy Sheriff

Your King County

Benefits



This collection of booklets describes coverage available to you and your eligible family members under the King County deputy sheriff benefit plans. It also explains how King County administers these plans and your rights and responsibilities under them.

Between printings, benefit information is updated through new hire guides, open enrollment materials and the county website (www.metrokc.gov/finance/benefits). Please refer to these other sources for details on plan changes, coverage options and costs.

This collection is divided into the separate booklets listed below. Each booklet has a table of contents following the title page (except for the Glossary and Resource Directory) to help you find specific items.

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If you're unsure about the meaning of terms used in these booklets, refer to the Glossary. If you don't find the information you need here, in your new hire guide, open enrollment materials or on the Web, please contact **Benefits and Retirement Operations** at 206-684-1556 or the plans listed in the Resource Directory.

Although these benefit descriptions include certain key features and brief summaries of King County deputy sheriff benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

Deputy Sheriff Booklet 1

Important Facts

Although these benefit descriptions include certain key features and brief summaries of King County deputy sheriff benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts and other legal documents, the contracts and legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

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How to Use This Booklet

This booklet explains how your benefit plans are administered and describes what to do when your family or work situation changes. It also includes information regarding your rights and responsibilities, plus required legal notices. To get a more complete understanding of each benefit, review this booklet along with the specific plan booklet. Together they will give you the details you need to use your plans effectively. If you have questions that are not answered here, you'll find phone numbers and websites for further information in the Resource Directory.

Remember, your best and most current source of information is King County's website – things change quickly and printed materials, such as this booklet, can't keep pace as well as the Web.

This collection of booklets contains general, not exhaustive, information about your plans. Additional details concerning terms and conditions of coverage for the life and accidental death and dismemberment plans are in policies and certificates filed with the State of Washington. Copies of the certificates are available from Benefits and Retirement Operations. Additional details concerning terms and conditions of coverage for all other plans are available from Benefits and Retirement Operations (see the Resource Directory booklet).

Benefit Eligibility

► Benefit Eligibility for You

If you're in a part-time regular (working at least half time), full-time regular, provisional, probationary or term-limited temporary position (your hiring authority can tell you if your position is benefit eligible), you're eligible:

- For county-paid medical/vision, dental and basic life coverage for you and the eligible family members you enroll
- For county-paid basic accidental death and dismemberment (AD&D) coverage for you
- To purchase enhanced life coverage for yourself.

You're also eligible to participate in other county benefit plans:

- You may set aside pretax dollars from your paycheck in a Health Care Flexible Spending Account (FSA) to pay for certain expenses not covered by your health plans (medical/vision and dental; see the Flexible Spending Accounts booklet)
- You may set aside pretax dollars from your paycheck in a Dependent Care FSA to pay for eligible dependent care expenses for your child, disabled spouse or dependent parent (see the Flexible Spending Accounts booklet)
- You receive a free Flexpass/employee ID
- You have access to Making Life Easier Program services (free and confidential counseling, home mortgage assistance, child and elder care referral and mildly sick child care)
- You may participate in the King County Employees Deferred Compensation Plan and other programs as described in the Other Benefits guide provided at New Employee Orientation.

You're not eligible for these benefits if you work less than half time or are a temporary or seasonal employee, or if you work in a capacity that, at the discretion of Human Resources, is considered contract labor or independent contracting. If you're not treated as a common law employee by King County for income tax withholding (regardless of any later determination of legal employment status), you're not benefit eligible.

► Benefit Eligibility for Family Members

Eligible family members include:

- Your spouse/domestic partner (copy of marriage certificate or an Affidavit of Marriage/Domestic Partnership must be filed with Benefits and Retirement Operations)

- Unmarried children of you or your spouse/domestic partner if they are under age 23 (life insurance doesn't cover children under 14 days old) and chiefly dependent on you for support and maintenance; they may be your:
 - Natural children
 - Adopted children (or children legally placed with you for adoption or for whom you assume total or partial legal obligation for support in anticipation of adoption)
 - Stepchildren
 - Legally designated wards (legally placed foster children, children placed with you as legal guardian or children named in a Qualified Medical Child Support Order as defined under federal law and authorized by the plans; see below)
- A child 23 or older if the child:
 - Was covered under your plans before age 23, and
 - Is incapacitated due to developmental or physical disability and chiefly dependent on you for support.

For a disabled child, you must submit a Continue Coverage for Disabled Adult Child form to Benefits and Retirement Operations within 31 days of the child's 23rd birthday, and provide proof of the child's continued disability periodically thereafter (not more than once per year after the child's 25th birthday; if the disabled child's coverage ceases for any reason after turning 23, the child is no longer eligible for continued coverage).

Parents and other relatives who are not members of your immediate family are not eligible for coverage.

Domestic Partners. There is no cost for family member health coverage if you qualify for deputy sheriff benefits. However, when you cover a domestic partner and domestic partner's children for health benefits (medical/vision and dental), the IRS taxes you on the value of the coverage. This value is added to the salary shown on your paycheck (and W-2 at year-end); federal income and Social Security (FICA) taxes are withheld on the higher salary amount, then the value is subtracted from your salary.

Qualified Medical Child Support Order (QMCSO). In accordance with applicable law, the plans provide health coverage (medical/vision and dental) to certain children of yours (called "alternate recipients") if directed by certain court or administrative orders. These include a decree, judgment or order from a state court (including approval of a settlement agreement) or an administrative order that requires these plans to include a child in your coverage.

A QMCSO is generally considered qualified and enforceable if it specifies:

- Employee name and last known address
- Each alternate recipient's name and address
- Coverage the alternate recipient will receive
- The coverage effective date
- How long the child is entitled to coverage
- Each plan subject to the order.

Benefits and Retirement Operations promptly notifies you and the alternate recipient when a QMCSO is received and explains what procedures will be used to determine if the order is qualified. Once the determination is made, Benefits and Retirement Operations notifies you and the alternate recipient by mail.

Enrolling in the Plans

You must submit the benefit enrollment forms included in your Deputy Sheriff New Hire Guide within 30 days of your hire date, or your eligible family members won't be covered and you'll be assigned the following default coverage:

- Regence BlueShield Medical/Vision
- Dental
- Basic life insurance
- Basic AD&D insurance.

If default coverage is assigned, you must wait until the next open enrollment to change medical/vision plans (you have several plan choices) and add eligible family members for coverage. You may add enhanced life at open enrollment (evidence of insurability is required) or between open enrollments when certain qualifying events occur (no evidence of insurability is required; see “Changes You May Make When a Qualifying Event Occurs”).

If you decide to participate in a Flexible Spending Account, you must submit an FSA Enrollment form available from Benefits and Retirement Operations (see the Resource Directory booklet) within 30 days of when your other benefits begin. Otherwise, you must wait for a qualifying change in status or the next open enrollment. You must re-enroll each year at open enrollment to continue participating in an FSA (see the Flexible Spending Accounts booklet).

When Coverage Begins

► When Coverage Begins for You

Coverage begins the first of the month following your hire date, as determined by the Sheriff’s Office. If your hire date is the first of the month, your coverage begins the same day.

When you change coverage during open enrollment, your new coverage begins January 1 of the following year and stays in effect for the entire calendar year, as long as you remain eligible.

When you’re first eligible, the start of some coverage may be delayed:

- **Medical/Vision.** If you’re hospitalized under another benefit plan and are in the hospital the day county coverage would normally start, the other plan generally continues to provide your coverage until you’re discharged.
- **Life.** If you’re not actively at work on the day coverage would start because of illness or injury, coverage begins on your first full day back at work.
- **AD&D.** If you’re not regularly performing the duties of your occupation on the date coverage would start, coverage begins on the first day of the month following your return to those duties.

► When Coverage Begins for Eligible Family Members

Coverage for the eligible family members you list on your enrollment form begins when your coverage begins, with the exceptions listed below. If you don’t enroll eligible family members when you enroll, you must wait until the next open enrollment or a qualifying change in status to add them for coverage (see “Changes You May Make When a Qualifying Event Occurs”).

Health. For eligible family members added due to a qualifying change in status, health coverage (medical/vision and dental) for you:

- Newborn or newly adopted child is retroactive to the date of birth or placement
- Child (other than newborn or adopted) begins the first of the month following the event that qualified him/her to be added; if the event occurs on the first of the month, coverage begins the same day
- New spouse/domestic partner begins the first of the month following the date you marry/establish your domestic partnership as indicated on the copy of your marriage certificate or Affidavit of Marriage/Domestic Partnership; if you marry or establish your domestic partnership on the first of the month, coverage begins the same day.

Coverage under all medical/vision plans is provided for newborns under the mother’s benefits for the first 21 days. To continue the newborn’s coverage after that, the newborn must be eligible and enrolled within 60 days of birth.

Life. Children younger than 14 days are not eligible for life insurance, so coverage does not begin until the 14th day.

Making Changes: General Information

The next four sections describe how to make changes to your benefit coverage between first enrolling and leaving county employment. Your change may require supporting documentation and one or more of these forms:

- Add New Family Member
- Affidavit of Marriage/Domestic Partnership
- Beneficiary Designation
- Continue Coverage for Disabled Adult Child
- Delete Family Member
- Enhanced Life/AD&D Change
- Flexible Spending Account Enrollment
- Opt Back In
- Personal Information Update.

All forms are available at www.metrokc.gov/finance/benefits or from Benefits and Retirement Operations (see the Resource Directory booklet).

You Must Drop Ineligible Family Members

You must drop family members from coverage when they are no longer eligible (see “Benefit Eligibility for Family Members”). To drop ineligible family members, submit a Delete Family Member Form to Benefits and Retirement Operations within 30 days of the date they become ineligible. The date a family member becomes ineligible is reported to the carriers, and any expenses incurred after that date are your responsibility.

When you drop ineligible family members:

- They may continue health coverage under COBRA or individual self-paid insurance (when you divorce and the divorce decree states you must provide health insurance for your ex-spouse, you must drop your ex-spouse from county-paid coverage and continue coverage through COBRA or individual self-paid insurance)
- You may add them back to your coverage when they become eligible again.

Changes You May Make Anytime

► You May Drop Eligible Family Members from Coverage

You may drop eligible family members from coverage anytime. To drop a family member, submit a Delete Family Member form to Benefits and Retirement Operations. The date a family member is dropped is reported to the carriers, and any expenses incurred after that date are your responsibility.

When you voluntarily drop family members, you may not add them back again for health coverage (medical/vision and dental) until the next open enrollment or a qualifying change in status occurs (see “Changes You May Make When a Qualifying Event Occurs”).

► You May Drop Self-Paid Coverage

You may drop enhanced life anytime. To drop coverage, submit a detailed written or email request (no form is available). Benefits and Retirement Operations must receive your request by the fifth of the month to stop or reduce payroll deductions for any premiums you pay that month for coverage.

If you drop enhanced life, you may add it again during open enrollment (evidence of insurability is required) or between open enrollments when certain qualifying events occur (no evidence of insurability is required; see the next section, “Changes You May Make When a Qualifying Event Occurs”).

Changes You May Make When a Qualifying Event Occurs

► You May Add Eligible Family Members for Health Coverage

Except for birth or placement for adoption, you must submit an Add New Family Member form within 30 days of these qualifying events (sooner if possible) to add an eligible family member for health coverage (medical/vision and dental):

- Placement of a legal ward
- Marriage or establishment of a domestic partnership
- Significant change in your spouse/domestic partner's employer-sponsored coverage.

If you do not submit the form within 30 days, you must wait until the next open enrollment to add the eligible family member for coverage.

Birth or Placement for Adoption. A newborn is automatically covered under the mother's coverage for the first 21 days. You have 60 days to add a newborn or a newly adopted child for health coverage. If you do not submit the form within 60 days, you must wait until the next open enrollment to add the eligible family member for coverage.

Qualified Medical Child Support Order. When Benefits and Retirement Operations receives a QMCSO, the child is automatically added for coverage according to the terms of the document (you do not need to submit an Add New Family Member form).

► You May Add Enhanced Life Coverage for Yourself

You must submit an Enhanced Life/AD&D Change form within 30 days of a qualifying event to add enhanced life coverage for yourself (the AD&D portion of the form does not apply to deputy sheriffs). You may add enhanced life insurance when you marry/establish a new domestic partnership or add a newly eligible child for coverage. No evidence of insurability is required.

If you don't submit the form within 30 days, you may not add enhanced life for yourself again until open enrollment. Evidence of insurability is required when enhanced life is added during open enrollment.

► You May Request Continuation of Coverage for a Disabled Adult Child

You may continue coverage for a child past age 23 if the child is covered under your plans, is incapacitated due to developmental or physical disability and is chiefly dependent on you for support. To do so, submit a Continue Coverage for Disabled Adult Child form six months before the child turns 23 or no later than 30 days after.

Changes You May Make at Open Enrollment

Open enrollment every October lets you make the following changes in coverage without qualifying changes in status:

- Change medical/vision plans
- Add eligible family members
- Add enhanced life for yourself (evidence of insurability is required)
- Enroll/reenroll in an FSA (you must reenroll each year to continue participating).

Changes you make at open enrollment become effective January 1 of the next year, with two exceptions:

- When you add enhanced life insurance for yourself it becomes effective when evidence of insurability is approved
- When you drop family members from coverage who are no longer eligible, they are dropped the date they became ineligible (the date is reported to the carriers, and any expenses incurred after that date are your responsibility).

When Coverage Ends

► When Coverage Ends for You

Your benefit coverage ends the:

- Last day of the month you lose eligibility, resign, are terminated, retire or fail to make any required payments for self-paid coverage
- Day the plan terminates or you die (for AD&D, coverage also ends the day you enter full-time active military duty).

► When Coverage Ends for Family Members

Family member benefit coverage ends the:

- Last day of the month they lose eligibility, your coverage ends or
- Day the plan terminates, they enter active military service or they die.

Family-Medical Leave

► Family-Medical Leave Eligibility

If you've worked for King County at least a year (need not be 12 consecutive months) and have worked 1,040 hours (if you're scheduled to work 40 hours a week) or 910 hours (if you're scheduled to work 35 hours a week) during the 12 months immediately preceding your leave request, you're eligible to take job-protected leave for certain family and medical reasons. Hours counted toward eligibility must be hours actually worked – vacation and sick leave hours do not count.

Under the federal Family and Medical Leave Act (FMLA), you're eligible for up to 12 weeks of leave in a rolling 12-month period, starting with any paid leave you have available and continuing as unpaid leave when your paid leave runs out. Under King County Family and Medical Leave (KCFML), you're eligible for up to 18 weeks of unpaid leave, including any unpaid leave you took under FMLA. However, if you've taken FMLA leave/KCFML during the 12 months immediately preceding your latest request, your maximum allotment is reduced by that amount.

FMLA applies to all county employees. KCFML applies to all nonrepresented employees and represented employees whose unions have agreed to the terms of KCFML (refer to your union contract). If you have questions about FMLA and KCFML eligibility, talk to your supervisor, department's human resources staff or union representative, or contact Benefits and Retirement Operations (see the Resource Directory booklet).

► Reasons for Taking Family-Medical Leave

You may take leave for these reasons:

- A serious health condition that makes you unable to perform your job
- Birth of a child
- Caring for your child after birth, adoption or placement for adoption or foster care
- Caring for your spouse with a serious health condition
- Caring for your or your spouse's son, daughter or parent with a serious health condition.

King County also allows FMLA benefits while caring for a domestic partner or domestic partner's son, daughter or parent with a serious health condition.

A serious health condition is an illness, injury, impairment or physical or mental condition that involves one or more of the following:

- An acute episode that requires more than three consecutive calendar days of incapacity and at least one follow-up treatment by a health care provider

- A chronic ailment continuing over an extended time that requires periodic visits by a health care provider and causes continuous or intermittent episodes of incapacity
- Inpatient care in a hospital, hospice or residential medical care facility
- An ailment requiring multiple interventions or treatment by a health care provider
- Any period of incapacity due to pregnancy or prenatal care.

► **Advance Notice and Medical Certification for Family-Medical Leave**

You must submit your leave request 30 days in advance when your leave is foreseeable or as soon as possible when your leave is not foreseeable.

You also must provide medical certification to support a leave request because of a serious health condition. And if requested, you'll need to submit second or third opinions (at King County's expense) as well as a fitness for duty report to return to work.

► **Use of Sick and Vacation Leave for Family-Medical Leave**

You must use all your sick leave for your own serious health condition (unless the condition is due to an on-the-job injury). After sick leave is exhausted, you may use vacation and other paid leave if approved by your supervisor and appointing authority.

To care for a family member, you may use sick leave or, if approved, vacation leave. If you use sick leave, you may reserve up to 80 hours of it for your own future use.

You may use donated sick leave and donated vacation leave for family-medical leave, but if you do, you must use all your own sick leave before using donated sick leave and all your own vacation leave before using donated vacation leave.

► **When Family-Medical Leave Begins**

FMLA leave begins the first day you're off the job. KCFML begins the first day you're no longer being paid from your own sick leave, vacation or other paid leave accruals. (In most cases, for an on-the-job injury, you may opt to go to unpaid leave status and begin KCFML immediately; refer to your union contract.)

Leave may be taken on a reduced or intermittent work schedule if approved by your supervisor.

► **Continuation of Benefits Under Family-Medical Leave**

Under FMLA leave or KCFML, county-paid health coverage (medical/vision and dental) continues while you're on leave. If you go on unpaid leave status, you may pay the full premium to continue your life insurance for up to 12 months and AD&D for up to six months. Benefits and Retirement Operations will contact you regarding continuation of benefits when it receives your approved leave request.

► **Job Protection Under Family-Medical Leave**

Upon return from FMLA leave or KCFML, you're restored to your original or equivalent position with equivalent pay, benefits, seniority and other employment terms. You won't lose any employment benefits that accrued before your leave began. No adverse personnel actions may be taken against you for taking FMLA leave or KCFML.

Your job is protected while on FMLA/KCFML. However, you may lose your job protection if you fail to return to work by the expiration date of your approved family-medical leave. Failure to return by the expiration date may be cause for removal and result in termination of your employment.

King County may not interfere with, restrain or deny the exercise of any right provided under FMLA. The county may not discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for

involvement in any proceeding under or relating to FMLA. The US Department of Labor is authorized to investigate and resolve complaints of violations, and an FMLA-eligible employee may bring a civil action against King County for violations.

FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

Leave of Absence Without Pay

If you do not qualify for leave under FMLA or KCFML, your health coverage (medical/vision and dental):

- Continues uninterrupted if your unpaid leave is less than 31 days
- May be continued under COBRA if your unpaid leave is 31 days or more (county-paid coverage ends the last day of the month you work before the leave begins).

If you're on leave past your FMLA/KCFML period on unpaid status, your benefit coverage may be continued under COBRA.

If You Become Disabled

► Accommodation Policy If You Become Disabled

Under federal (American with Disabilities Act), state and local laws, King County provides reasonable accommodations for you if you're disabled, regardless of how or when you become disabled, or whether the disability is permanent or temporary. Disabilities may be caused by injury, accident or disease, or may have been present since birth.

► What to Do If You Become Disabled

If you become disabled:

- File a workers' compensation claim with Safety & Claims Management if the disability is work related
- Contact the Disability Services Program
- Apply for family-medical leave (FMLA/KCFML) with your supervisor if your disability keeps you from working
- Contact Benefits and Retirement Operations about continuing your life insurance and Health Care Flexible Spending Account (see appropriate plan booklets)
- Contact the Washington State Department of Retirement Systems to discuss benefit options if your disability keeps you from working
- Contact T. Rowe Price, King County's deferred compensation plan administrator, if you're a participant and your disability has created an unforeseen financial hardship (you may qualify for a hardship withdrawal)
- Apply for Social Security disability income if your disability qualifies.

See the Resource Directory booklet for contact details.

► Continuation of Health Benefits If You Become Disabled

Under Family-Medical Leave. If your disability qualifies you for leave under FMLA, KCFML or both, your health coverage (medical/vision and dental) continues for the length of the leave.

Under Leave of Absence without Pay. If you do not qualify for leave under FMLA or KCFML, or you continue on leave past your FMLA/KCFML period on unpaid status, your health coverage ends. You may be eligible to pay to continue coverage under COBRA (see "COBRA").

► **Continuation of Life Insurance If You Become Disabled**

If you become disabled and notify Benefits and Retirement Operations within 30 days of your last day worked, your coverage may be continued for up to 12 months or longer. See the Aetna Life Insurance booklet for details.

► **Continuation of AD&D Insurance If You Become Disabled**

If you become disabled and notify Benefits and Retirement Operations within 30 days of your last day worked, your basic AD&D continues at no cost to you for up to six months after the disability occurs.

► **Job Reassignment and Search Assistance If You Become Disabled**

If you cannot be accommodated in your regular job and are separated from your position, employment placement assistance is provided through the Disability Services Program in two phases, lasting up to nine months. The program will help you:

- Be reassigned through a non-competitive hiring process during the first four months
- Find and apply to posted job positions as an internal candidate for an additional five months if reassignment is unsuccessful.

COBRA

► **COBRA Eligibility**

If you or your qualified family members lose county-paid health coverage due to certain events (called “qualifying events”), each of you has an independent right to self-pay under the Consolidated Omnibus Budget Reconciliation Act (COBRA) for health coverage (medical/vision and dental). This coverage may continue for 18 to 36 months after county-paid coverage ends (the last day of the month the qualifying event occurs). The maximum COBRA continuation coverage period depends on the event:

- Termination of employment if for reasons other than gross misconduct – 18 months.
- Layoff – 18 months.
- Reduction in work hours/no longer eligible for county-paid benefits – 18 months.
- Disability – 29 months if you or family members are determined Social Security disabled at the time of or within 60 days of when COBRA eligibility begins; the COBRA participant must provide a copy of the Social Security Administration’s disability determination to Associated Administrators Inc. (AAI, King County’s COBRA administrator) before the end of the first 18 months of COBRA coverage and within 60 days after being determined disabled under Social Security. If you or your qualified family member is determined by the Social Security Administration to no longer be disabled, you must notify AAI of the fact within 30 days of the determination.
- Death – 36 months for surviving qualified family members.
- Divorce/legal separation/dissolution of domestic partnership – 36 months for qualified family members.
- Dependent child ceases to be a dependent (may no longer be claimed as an IRS dependent or reaches age 23) – 36 months for child
- Your enrollment in Medicare – 36 months for qualified family members.

If a second qualifying event (such as your death, divorce or separation, enrollment in Medicare or dependent child ceasing to qualify for coverage under the county’s plan) occurs during an 18- or 29-month COBRA continuation coverage period, coverage may be continued for eligible family members for up to 36 months from the first qualifying event, but the total COBRA continuation coverage period will not exceed 36 months. You must notify AAI in writing within 60 days after a second qualifying event occurs.

You and your qualified family members may elect coverage even if covered under another employer-sponsored health plan or entitled to Medicare at the time you elect coverage.

If you're participating in a Health Care Flexible Spending Account when you become eligible for COBRA, you may continue participating through the end of the calendar year (see the Flexible Spending Accounts booklet).

► **COBRA Enrollment**

COBRA-qualifying events (other than divorce, dissolution of a domestic partnership or child reaching age 23) are reported to Benefits and Retirement Operations through your termination notice or payroll report. For family members who lose coverage through you because of divorce, legal separation, dissolution of a domestic partnership or child reaching age 23, you must notify Benefits and Retirement Operations within 60 days of the last of the month the qualifying event occurs or the date coverage ends, if later. Otherwise, the family member will not be offered the option to elect COBRA continuation coverage (see "You Must Drop Ineligible Family Members from Coverage").

When COBRA-qualifying information is received, Benefits and Retirement Operations notifies AAI (King County's COBRA administrator), who contacts you/family members regarding benefit plan options.

You have 60 days after coverage ends to make your COBRA elections or, if later, 60 days from the date of the AAI letter notifying you of your options. Failure to elect coverage on time will result in loss of the right to elect continuation coverage. You or your qualified family members may change a prior rejection of continuation coverage any time until that date by submitting a written request to AAI.

If you elect COBRA continuation coverage, you must make the initial premium payment by the 45th day after electing it. The amount you or your qualified family member may be required to pay may not exceed 102% of the cost of the county's plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150%). Thereafter, all premiums are due the first of the month; coverage automatically ends if payment is not made within 30 days. AAI will provide you with more detailed payment information.

Once you have elected COBRA and paid the premium, COBRA continuation coverage is retroactive. There is no lapse in coverage – self-paid benefits begin when county-paid benefits end, even if retroactive processing and payments are required. Your initial payment must include all applicable back premiums.

► **COBRA Options**

Your COBRA options will be explained in the enrollment information you receive from AAI. COBRA allows you to self-pay to continue all the health coverage (medical/vision and dental) you have on your last day of employment or one of these options:

- Medical/vision only
- Dental only (if you're a LEOFF 1 retiree).

You may continue covering the same family members who were covered the last day of your employment. Each family member has an independent right to elect continuation coverage. For example, both you and your spouse may elect continuation coverage, or only one of you may elect the coverage. Parents may elect to continue coverage on behalf of their dependent children only.

Life. It is not a provision of COBRA, but when you end employment with the county for reasons other than disability, you may be eligible to continue your life insurance coverage through the portability feature of the policy (see the Aetna Life Insurance booklet for more details on portability or converting your coverage).

► **Making Changes Under COBRA**

If you notify AAI (King County's COBRA administrator), you may:

- Drop dental and retain medical/vision coverage anytime (notice must be received by AAI in the month before you want the change to become effective)

- Drop yourself and family members from coverage anytime (notice must be received by AAI in the month before you want the change to become effective)
- Add new eligible family members to your health coverage when a qualified change in status occurs (see “Changes You May Make When a Qualifying Event Occurs”)
- Change medical/vision plans during open enrollment
- Change medical/vision plans between open enrollments if you move out of your current plan’s coverage area and provide proof of your new permanent address, and another King County plan offers coverage in your new location.

► **When COBRA Coverage Ends**

COBRA coverage ends the:

- Last day of the month you or your family member:
 - Fails to make the required payments within 30 days of the due date
 - Becomes covered under another group health plan after electing COBRA (unless the plan limits or excludes coverage for a preexisting condition of the individual continuing coverage)
 - Becomes entitled to Medicare benefits after electing COBRA
 - Reaches the end of your maximum COBRA coverage period or
 - Is no longer disabled as determined by Social Security and has exhausted designated months of COBRA coverage
- Day:
 - The plan terminates or
 - You die (if you die, your covered family members may extend their COBRA coverage up to 36 months from the date their COBRA coverage started).

The Health Insurance Portability and Accountability Act (HIPAA) restricts the extent group health plans may impose preexisting condition limits:

- If you become covered by another group health plan and that plan contains a preexisting condition limit that affects you, your COBRA continuation coverage cannot be terminated. However, if the other plan’s preexisting rule doesn’t apply to you, your COBRA continuation coverage will be terminated.
- You do not have to show you’re insurable to choose COBRA continuation coverage. However, COBRA continuation coverage is subject to your eligibility for coverage; King County reserves the right to terminate your coverage retroactively if you’re determined ineligible.

You may be entitled to purchase an individual conversion policy when you’re no longer covered under the county’s plan. An individual conversion policy usually provides different coverage from your group coverage; some benefits you have now may not be available. Also, a conversion policy may cost more than your current coverage.

► **For More Information**

More information regarding your rights to continuation coverage is available from AAI or Benefits and Retirement Operations (see the Resource Directory booklet). For more information about COBRA, the Health Insurance Portability and Accountability Act (HIPAA) and other laws affecting group health plans, contact the U.S. Department of Labor’s Employee Benefits Security Administration in your area or visit www.dol.gov/ebsa.

► **Keep Your Plan Informed of Address Changes**

To protect your family’s rights, keep King County and AAI informed of any changes in addresses of family members. You should also keep copies for your records of any address change notices you send the county or AAI.

Retiree Benefits

► Retiree Benefit Eligibility

County-paid coverage ends the last day of the month you retire. You may self-pay to continue medical/vision coverage (but not dental) if you:

- Have county benefits on your last day of employment
- Have worked for King County for at least five consecutive years before you retire
- Are not eligible for Medicare (unless you're enrolled in Group Health)
- Are not covered under another medical/vision group plan
- Meet the requirements for formal service or disability retirement under the Washington State Public Employees Retirement Act or the City of Seattle Retirement Plan (which applies only if you elected to remain under the City of Seattle system according to a formal agreement between King County and the City of Seattle).

Covered family members are eligible for continued coverage under your retiree benefits if they're not eligible for Medicare and meet the same eligibility requirements in effect when you were an active employee. Dental, life and AD&D coverage is not available under retiree benefits.

Retiree benefits are an alternative to COBRA; if you elect retiree benefits, you waive your COBRA rights. Consider these differences in choosing between retiree and COBRA benefits:

	Retiree Benefits	COBRA
Health coverage available	Medical/vision	Medical/vision and dental
Length of time coverage available	Generally, until you become eligible for Medicare (Group Health offers coverage for those eligible for Medicare)	18 months maximum (29 months if you leave employment due to a Social Security verified disability)
Allowed to change medical/vision plans between open enrollments	No	Yes, if you relocate out of your current plan's coverage area and notify AAI with proof of your new permanent address and availability of coverage under another King County plan in your new location

If you're participating in a Health Care Flexible Spending Account when you become eligible for retiree benefits or COBRA, you may continue participating through the end of the calendar year (see the Flexible Spending Accounts booklet).

► Retiree Benefit Enrollment

Your retirement is reported to Benefits and Retirement Operations through your termination notice or payroll report. Benefits and Retirement Operations then notifies Associated Administrators Inc. (King County's retiree benefit administrator), who contacts you regarding benefit plan options.

You have 60 days after coverage ends to make retiree elections or, if later, 60 days from the date of the AAI letter notifying you of your options. If you elect retiree benefits, you must make the initial premium payment by the 45th day after your election. Thereafter, all premiums are due the first of the month; coverage automatically ends if payment is not made within 30 days after the payment due date. AAI will give you payment information.

Because retiree benefit coverage is retroactive, there is no lapse in coverage – self-paid benefits begin when county-paid benefits end, even if retroactive processing and payments are required. Your initial payment must include all applicable back premiums.

► **Retiree Benefit Options**

If you elect retiree benefits, you self-pay to continue the same medical/vision coverage you had on your last day of employment.

When you elect retiree benefits, you may continue covering the same family members who were covered the last day of your employment. If you do not continue covering the same family members, they have their own COBRA rights. If you continue covering the same family members under your retiree benefits and they cease to be eligible for retiree benefits, your family members have COBRA rights only if there's a qualifying event (see "COBRA").

► **Making Changes Under Retiree Benefits**

If you notify AAI, you may:

- Drop medical/vision coverage anytime (notice must be received by AAI in the month before you want the change to become effective)
- Drop family members from coverage anytime (notice must be received by AAI in the month before you want the change to become effective)
- Add new eligible family members to your medical/vision coverage when a qualified change in status occurs (see "Changes You May Make When a Qualifying Event Occurs")
- Change medical/vision plans during open enrollment.

► **When Retiree Benefit Coverage Ends**

Retiree benefits end the:

- Last day of the month you:
 - Fail to make the required payments within 30 days of the due date
 - Become covered under another group health plan after electing retiree benefits (unless the plan limits or excludes coverage for your preexisting condition) or
 - Become entitled to Medicare after electing retiree benefits (unless you're enrolled in Group Health)
- Day:
 - The plan terminates or
 - You die (if you die, your covered family members may extend their coverage under COBRA for up to 36 months from the date of your death).

Federal laws restrict the extent group health plans may impose preexisting condition limits:

- If you become covered by another group plan and that plan contains a preexisting condition limit that affects you, your retiree coverage cannot be terminated. However, if the other plan's preexisting rule doesn't apply to you, your retiree coverage will end.
- You do not have to show you're insurable to choose retiree coverage. However, retiree benefits are subject to your eligibility for coverage; King County reserves the right to end your coverage retroactively if you're determined ineligible.

► **If You Return to Work in a Benefit-Eligible Position**

Your Washington State Department of Retirement Systems plan may allow you to return to work at King County after you retire while continuing to draw your pension benefits (certain restrictions apply; contact the Department at the number in the Resource Directory booklet).

If you return from retirement to work in a benefit-eligible position, you receive the same coverage a regular employee in the position receives. During this return-to-work period, the premiums you pay for retiree benefits are suspended. When the work period ends, you have the option of resuming your retiree benefits.

Anytime you fail to meet eligibility requirements (for instance, you don't work the required number of hours in a month) or when you leave post-retirement employment, you resume paying the full cost of your retiree benefits. You must contact AAI to resume your retiree benefits.

► **If You Lose Eligibility for Retiree Benefits Due to Medicare Eligibility**

If you're not eligible for retiree benefits when you retire due to Medicare A and B eligibility, the Secure Horizons Medicare+Choice plan is available to you from PacifiCare; contact PacifiCare before your active employee coverage ends to enroll. If you elect retiree benefits and lose eligibility to continue the coverage due to Medicare A and B eligibility, AAI notifies you regarding the Secure Horizons Medicare+Choice plan so you have the option of enrolling with PacifiCare before your retiree benefit coverage ends.

If you're enrolled in Group Health, you may continue your coverage even though you're eligible for Medicare.

If You Leave Employment to Perform Uniformed Service

You need to provide your supervisor, personnel representative and Benefits and Retirement Operations with written notice and a copy of your orders both when you leave employment to perform uniformed service (such as in the military) and when you return to employment after uniformed service. While performing uniformed service your benefit coverage may be continued, depending on the circumstances.

If you leave employment to serve in the military or are called to active duty, you may be eligible for benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and King County Ordinance 13377. Call Benefits and Retirement Operations for more information.

If You're on a Mutual Aid Assignment

Occasionally, for instance in the case of a natural disaster, you may be asked to work temporarily for another agency in need of extra help. If you need health care while you're working in this situation, you will not pay more for the care because you're outside your usual area. Submit claims directly to the Manager of Benefits and Retirement Operations for processing and payment.

If you're on loan to a Borrower under the Northwest Mutual Aid Group Omnibus Agreement, you will continue to be covered under your regular health plans (medical/vision and dental). If, as a result of this arrangement, you receive services outside of the normal network area covered by your plan, your care will be covered by the county at the network level.

PacifiCare Medical/Vision. If you're a PacifiCare plan participant, you must contact PacifiCare to register for and receive out-of-area coverage (see "Out-of-Area-Coverage" in the PacifiCare Medical/Vision booklet).

If You Enter Into a Labor Dispute

If you enter into a labor dispute, your King County coverage ends the last day of the month the labor dispute begins. If your pay is suspended directly or indirectly as a result of a strike, lockout or other labor dispute, you may be able to continue your benefit coverage temporarily by paying the full cost through COBRA. You may continue health coverage (medical/vision and dental) for up to 18 months. You may also continue participating in a Health Care FSA by contributing on an after-tax basis (see the Flexible Spending Accounts booklet).

In addition, you may pay to continue:

- Life insurance for up to six months
- AD&D coverage for up to six months.

It may be possible to continue benefit coverage longer than indicated above if you convert from county group coverage to an individual plan. Check with each plan (see the Resource Directory booklet) for details.

If You or a Covered Family Member Dies

► If You Die

If you die while a participant in King County benefit plans, your family/beneficiaries must provide a death certificate to Benefits and Retirement Operations. When that occurs, Benefits and Retirement Operations will assist your family/beneficiaries with:

- Completing a claim for any life insurance or accidental death insurance benefit they're entitled to receive (see the respective plan booklets; if death is due to accident, the accident report is required)
- Understanding COBRA and options for continuing the health coverage they had through you
- Submitting claims for reimbursement under an FSA if you were enrolled
- Contacting the:
 - King County Employees Deferred Compensation Plan coordinator if you were enrolled
 - Washington State Department of Retirement Systems
- Receiving the final paycheck
- Counseling and referral through the Making Life Easier Program.

► If a Family Member Dies

If your family member dies while you're a participant in King County benefit plans, contact Benefits and Retirement Operations for assistance with:

- Completing a claim for the life insurance benefit you're entitled to receive (death certificate is required)
- Completing other benefit forms as required
- Making benefit changes as appropriate
- Counseling and referral through the Making Life Easier Program.

Assignment of Benefits

Plan benefits are available to you and your covered family members only. In general, they cannot be assigned (or given away) to another person and are not subject to attachment or garnishment. However, there are exceptions; for details contact Benefits and Retirement Operations.

In paying for services, the plans may, at their option, make the payment to you, the provider or another carrier. The plans also will make payments on behalf of an enrolled child to his or her non-enrolled parent or a state Medicaid agency when required by federal or state law. In these cases, the plans also have the right to make joint payments.

All payments are subject to applicable federal and state laws and regulations. Payments made according to this section will discharge the plans to the extent of the amount paid, so that the plans will not be liable to anyone aggrieved by their choice of payee.

Third Party Claims

If you receive benefits for any condition or injury for which a third party is liable, the plans may have the right to recover the money they paid for benefits. This means the plans are not obligated to pay for services necessary because of an injury or condition for which you may have other recovery rights unless or until you (or someone legally qualified and authorized to act for you) promise in writing to:

- Include those amounts in any claim you or your representative makes for the injury or condition
- Repay the applicable plan those amounts to the extent the proceeds of your recovery for the injury or condition exceed the total loss, prorating any attorneys' fees incurred
- Cooperate fully with the plans in asserting their rights by supplying all information and executing all documents reasonably needed for that purpose.

Any sums collected by or for you or your covered family members by legal action, settlement or otherwise on account of these benefits are payable to the plans only after and to the extent they exceed the amount required to fully compensate your loss.

This provision does not apply to life or accidental death and dismemberment claims.

Recovery of Overpayments

The plans have the right to recover amounts they paid that exceed the amount for which they are liable. These amounts may be recovered from one or more of the following (to be determined by the plans):

- Persons to or for whom the payments were made
- Other insurers
- Service plans
- Organizations or other plans.

These amounts may be deducted from your future benefits (or your family members' benefits, even if the original payment was not made on that family member's behalf).

The plans' right of recovery includes benefits paid in error due to any false or misleading statements made by you or your family members.

Termination and Amendment of the Plans

The county fully intends to continue plan benefits indefinitely, but also reserves the absolute right to amend or terminate the plans for any reason at any time. If the county amends or terminates the plans, bona fide claims incurred before the amendment or termination will be paid.

Your Patient Rights

► Dignity and Respect Under Your Health Plans

You have the right to:

- Be treated with consideration, dignity and respect. You also have the responsibility to respect the rights, property and environment of all providers and other patients.
- See your own health records and to have those records kept private and confidential unless required to settle a claim, for plan operations, payment of claims and as required by law.

You have these rights regardless of your gender, race, sexual orientation, marital status, culture or economic, educational or religious background.

► Knowledge and Information Concerning Your Health Plans

You have the right – and the responsibility – to know about and understand your health care and your coverage, including:

- Names and titles of all providers involved in your care
- Your health condition and status
- Services and procedures involved in your treatment
- Ongoing health care you need once you're discharged or leave the provider's office
- How the plans work (see the appropriate plan booklets)
- Any medication prescribed for you – what it is, what it's for, how to take it properly and possible side effects.

You also have the right to take an active part in decisions about your care. Once you participate in and agree to a treatment plan, you're responsible for following that plan or telling your provider otherwise.

► **Continuous Improvement of Your Health Plans**

You have the right to:

- Call or write with any questions or concerns and make suggestions for improving the plans
- Ask your providers to explain or give you more information about any health advice or prescribed treatment
- Appeal any health care or administrative decisions (see claims appeals sections in the individual plan booklets).

► **Privacy Protection**

To protect your privacy, King County and your plans will use only the last four digits of your Social Security number (or no number at all) or a unique identifier number on ID cards, explanations of benefits or any other correspondence sent to you.

► **Medical/Vision Plan Participant Accountability and Autonomy**

As a partner in your own health care, you have the right to:

- Refuse treatment – as long as you accept the responsibility and consequences of that decision
- Complete an advance directive, such as a living will or durable power of attorney, for care
- Refuse to take part in any health care research projects
- Be advised on the full range of treatment options (whether covered under the plans or not) and their potential risks, benefits and costs
- Make the final choice among treatment alternatives.

You're also responsible to:

- Identify yourself and covered family members to providers when you receive services by showing your plan ID card (if provided by your plan) or complete Social Security numbers (or unique identifier numbers if issued by the plan)
- Give your current provider all previous and relevant health care records and submit accurate, complete health information to all physicians or other providers involved in your care
- Be on time for appointments and let your provider's office know as far in advance as you can if you need to cancel or reschedule
- Follow instructions given by those providing your care
- Send copies of claim statements or other documents if requested
- Let your medical/vision plan and primary care physician/provider (if applicable) know within 24 hours, or as soon as reasonably possible, if you receive emergency care or out-of-area urgent care
- Tell the plan and your primary care physician/provider (if applicable) about planned health care treatment, such as a surgery or an inpatient stay
- Pay all required copays when you receive health care.

If you decide to give someone else the legal power to make decisions about your health care, that person also will have all of these rights and responsibilities.

*Deputy Sheriff
Booklet 2*

**Regence
BlueShield
Medical/Vision**

Although these benefit descriptions include certain key features and brief summaries of King County deputy sheriff benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

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Overview

► Highlights of Regence BlueShield Coverage

This summary of benefits available under this plan was prepared by King County. For complete details on benefits, please refer to the Regence BlueShield brochure (contact Regence BlueShield; see the Resource Directory booklet).

Here are a few highlights of your coverage under the Regence BlueShield plan:

- You pay an annual deductible before the plan pays for most benefits, then the plan pays 80%-100% for most services
- The plan offers a wide choice of approved providers (see “Approved Service Area Providers” and “Approved Out-of-Area Providers”).

► Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just this plan and can change frequently. To be more efficient, and avoid repetition, the following related information appears only in the Important Facts booklet:

- Who’s eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends and options for continuing it after you leave employment
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

The county pays the full monthly cost of coverage for you and eligible family members you enroll under this plan.

When you receive medical care, you pay:

- The annual deductible (when applicable)
- Coinsurance amounts not covered by the plan
- Copays for emergency room care (waived if admitted) and prescription drugs
- Amounts in excess of allowed amounts (as determined by Regence BlueShield)
- Expenses for services or supplies not covered by the plan.

See “How the Plan Works” and “Covered Expenses Under Regence BlueShield” for details on deductible, coinsurance and copay amounts.

Preexisting Condition Limit

This plan does not have a preexisting condition limit.

If you end employment with King County, please refer to “Certificate of Coverage” in this booklet for information on how your participation in this plan can be credited against another plan with a preexisting condition limit.

How the Plan Works

► Plan Features

The following table identifies some plan features, including your out-of-pocket maximum and how benefits are determined for most covered expenses. The sections after the table contain more details.

Plan Feature	Regence BlueShield
Provider choice	You must use Regence BlueShield and recognized providers (described below) for all covered services received within the service area (except emergency care) and may use any approved provider for covered services outside the service area (also see “Accessing Care”)
Annual deductible	\$100/person, \$300/family Deductible doesn't apply to accidental injury care, prescription drugs, second surgical opinions, vision care or occupational injuries (LEOFF 1 only)
Copays	For emergency room care and prescription drugs (see “Summary of Covered Expenses” for amounts)
After the copays, the plan pays most covered services at this level ...	80%-100% of the allowed amount
Until you reach your annual out-of-pocket maximum...	\$375/person (excluding deductible and copays)
Then, most benefits are paid for the rest of the calendar year at ...	100%
Lifetime maximum	\$1,000,000/person

► Approved Service Area Providers

The providers listed in this section are all approved providers when you receive their services within the Regence BlueShield service area. For more about how benefits are paid when you see these providers, see “Accessing Care.”

Regence BlueShield (Participating) Providers. These are participating providers (hospitals, clinics, doctors and other health professionals) that have agreements with Regence BlueShield to provide services within its service area. When you receive services from one of these providers, benefits are paid as described in “Covered Expenses Under Regence BlueShield,” based on the allowed amount, and the provider files your claim

You must use these providers for care within the service area (except for emergency care).

For a list of Regence BlueShield providers and service area information, contact Regence BlueShield (see the Resource Directory booklet).

Recognized Providers. These are providers within the service area that do not have participating agreements with Regence BlueShield, but act within the scope of their licenses to provide specific benefits described in “Covered Expenses Under Regence BlueShield” (for example, ambulance and blood bank services). When you receive services from a recognized provider, benefits are paid at the level shown in “Covered Expenses Under Regence BlueShield,” based on allowed amounts.

Emergency Care Providers. You may see any provider within the service area for emergency care. For emergency care from a non-Regence BlueShield provider, benefits are paid for 24 hours or until you can reasonably be transferred to a Regence BlueShield provider. Benefits are based on the non-Regence BlueShield provider's actual charges, which must be reasonable and not increased because of plan coverage.

► **Approved Out-of-Area Providers**

The providers listed in this section are all approved providers when you receive their services outside the Regence BlueShield service area. For more about how benefits are paid when you see these providers, see “Accessing Care.”

BlueShield and/or Blue Cross (Participating) Providers. These are participating providers (hospitals, clinics, doctors and other health professionals) that have agreements with other Blue Shield and/or Blue Cross organizations outside the Regence BlueShield service area. When you receive services from one of these providers, benefits are paid as described in “Covered Expenses Under Regence BlueShield,” based on allowed amounts, and the provider files your claim.

For a list of these providers, contact Regence BlueShield (see the Resource Directory booklet).

Non-Participating Providers. These are providers (hospitals, clinics, doctors and other health professionals) outside the service area that do not have participating agreements with Blue Shield or Blue Cross organizations, but are qualified under plan benefits. When you receive services from one of these providers, benefits are paid as described in “Covered Expenses Under Regence BlueShield,” based on allowed amounts. If the provider charges more than the allowed amounts, you pay the difference (your share of the total cost is higher).

Emergency Care Providers. You may see any provider outside the service area for emergency care. For emergency care from a non-participating provider, benefits are paid for 24 hours or until you can reasonably be transferred to a participating provider. Benefits are based on the non-participating provider’s actual charges, which must be reasonable and not increased because of plan coverage.

► **Annual Deductible**

The annual deductible is the amount you must pay each year toward covered benefits before the plan starts paying. The annual deductible is \$100 per person to a maximum of \$300 for a family. Any amount you pay toward your deductible during the last three months of any calendar year applies toward next year’s deductible. If:

- Three or more family members incur \$300 in eligible deductible expenses, you meet the family deductible (no further deductible is required from any family member for the rest of that year)
- Two or more family members are in the same accident, only one individual deductible applies to any charges incurred in that and the next calendar year as a result of the accident
- Your hospitalization continues from one calendar year to the next, a second deductible is not required for any treatment received before your discharge from the hospital (additional coinsurance isn’t required if you’ve met your out-of-pocket maximum for the calendar year in which the hospitalization began; see “Annual Out-of-Pocket Maximum” below).

The annual deductible does not apply to accidental injury care, prescription drugs, vision care, occupational injuries for LEOFF 1 or properly obtained second surgical opinions.

► **Annual Out-of-Pocket Maximum**

The out-of-pocket maximum is the most you pay in coinsurance for covered expenses each plan year. This means once you reach your out-of-pocket maximum, the plan pays 100% of most covered expenses for the rest of the calendar year.

Your annual out-of-pocket maximum is \$375 per person. The following do not apply to the out-of-pocket maximum:

- Annual deductible
- Charges in excess of allowed amounts
- Charges beyond benefit maximums and limits
- Copays for emergency room care or prescription drugs
- Expenses not covered by the plan

- Services for:
 - Neurodevelopmental therapy
 - Outpatient mental health care
 - Outpatient rehabilitation
 - Smoking cessation
 - Tooth repair
- The amount you pay for inpatient care outside the service area from a non-participating provider if it's not approved by Regence BlueShield
- The amount you pay if you're a LEOFF 2 member and:
 - Certain surgeries are performed on an inpatient basis (see "Mandatory Outpatient Surgery for LEOFF 2 Members Only")
 - You don't obtain a mandatory second surgical opinion (see "Mandatory Second Surgical Opinions for LEOFF 2 Members Only").

► **Lifetime Maximum**

The total amount paid for all benefits under this plan is limited to a lifetime maximum of \$1,000,000. Up to \$20,000 of this maximum is restored automatically at the start of each year for benefits paid during the previous year.

Some individual benefits have lifetime maximums (see "Covered Expenses Under Regence BlueShield" for details):

- Occupational injury – combined lifetime maximum of \$250,000 (employee only)
- Smoking cessation – \$500
- Transplants – \$250,000.

► **Accessing Care**

Generally, to receive benefits, you:

- Make an appointment with a:
 - Regence BlueShield provider within the service area (see "Approved Service Area Providers") or
 - Any qualified provider outside the service area (see "Approved Out-of-Area Providers")
- Present your Regence BlueShield ID card to your provider before receiving services (remind your provider to submit your claim with the three-digit alpha prefix that's in front of your member ID number).

For emergency care, you may see any provider. If you receive emergency care from a non-participating provider outside the service area, contact Regence BlueShield within 48 hours.

Participating Providers. When you see participating providers, benefits are paid as described in "Covered Expenses Under Regence BlueShield," based on allowed amounts, and the provider files your claim. You pay the applicable copay to the provider when you receive services; Regence BlueShield processes the claim and provides you with an Explanation of Benefits. The EOB shows any additional amount you must pay the provider, based on the allowed amount, annual deductible and annual out-of-pocket maximum.

When you receive services from a participating provider outside the U.S. or its territories, follow these steps:

- For emergency medical care, go to the nearest hospital and show your Regence BlueShield ID card. If you're admitted, call the BlueCard Worldwide Service Center at 1-800-810-BLUE (2583) or call collect at 804-673-1177 (services are available 24 hours a day, seven days a week).
- For non-emergency medical care, call the BlueCard Worldwide Service Center to arrange your hospitalization if necessary at a BlueCard Worldwide hospital or make an appointment with a physician.

You're responsible for out-of-pocket expenses such as any applicable deductible, copays, coinsurance and non-covered services for your inpatient care. For outpatient, hospital care or professional services, you're responsible for paying the hospital or physician at the time of service; then complete an international claim form and send it to

the BlueCard Worldwide Service Center for reimbursement of covered services. International claim forms and more information about BlueCard Worldwide are available at www.bcbs.com.

Non-Participating Providers. When you see a non-participating provider outside the service area, benefits are paid at the level shown in “Covered Expenses Under Regence BlueShield,” based on allowed amounts. You may be required to pay the provider in full and file a claim for reimbursement, or the provider may file the claim for you. Either way, Regence BlueShield processes the claim and provides you with an EOB.

The EOB shows any amount you must pay the provider (if not already paid), based on the allowed amount, annual deductible, annual out-of-pocket maximum and any charges above the allowed amount. If the provider charges more than the allowed amount, you pay the difference (your share of the total cost is higher).

Emergency Care Providers. You may see any provider for emergency care. When you receive emergency care from a non-participating provider, benefits are based on the provider’s actual charges for 24 hours or until you can reasonably be transferred to a participating provider. The charges must be reasonable and not increased because of plan coverage.

► **Obtaining Preadmission Approval for Inpatient Care Outside the Service Area**

Preadmission approval is required if you seek inpatient care from a non-participating provider outside the service area; it is not required for emergency care or maternity admissions. All medical and surgical care received outside the service area (except emergency and maternity) must outpatient, unless Regence BlueShield determines inpatient care is medically necessary. (If you receive inpatient emergency or maternity care from a non-participating provider outside the service area, contact Regence BlueShield within 48 hours; see “Emergency Care” and “Maternity and Women’s Health Care.”)

When you seek non-emergency inpatient care from a non-participating provider outside the service area, the provider must contact Regence BlueShield by phone or submit a Preadmission Review Request form to the plan at least 10 days before your admission date (the form is available from Regence BlueShield; see the Resource Directory booklet). Regence BlueShield evaluates the information provided by your provider to determine if inpatient care is medically necessary.

If preadmission approval is not requested or Regence BlueShield determines inpatient care is not medically necessary, inpatient benefits, including any related physician's services, are paid at 50% or the amount that would have been paid for services received in an appropriate alternative setting, whichever is greater.

You’ll need a new approval for each admission or readmission. If approval is not obtained, Regence BlueShield will determine if inpatient care was medically necessary when the claim is submitted.

► **Mandatory Outpatient Surgery for LEOFF 2 Members Only**

The following medical and surgical procedures usually don’t require inpatient treatment and must be outpatient (such as in an ambulatory surgical center, physician’s office or hospital outpatient facility), unless Regence BlueShield determines inpatient care in a hospital or skilled nursing facility is medically necessary:

- Arthroscopy (instrumental examination of a joint); arthroscopic surgery of the knee
- Biopsy and excision of lesions that are readily accessible and can be done with local or topical anesthesia (such as skin, oral cavity, vagina, recto-sigmoid)
- Cataract extraction not complicated by serious medical conditions
- Diagnostic dilation and curettage – not in conjunction with major surgery, pregnancy or hemorrhage
- Endoscopic procedures (instrumental examinations) that are uncomplicated, do not require a general anesthetic and are not in conjunction with major surgery, including laryngoscopy, bronchoscopy, esophagoscopy, proctosigmoidoscopy and colonoscopy
- Foot surgery confined to one foot and not complicated by serious medical conditions
- Genito-urinary system procedures unless in conjunction with major surgery or complicating conditions
- Incision and drainage of uncomplicated abscesses and cysts including myringotomy (incision of the ear drum)

- Surgical sterilization (vasectomy and laparoscopic tubal ligation) unless in conjunction with major procedures or complicating conditions
- Tonsillectomy and/or adenoidectomy under age 12
- Uncomplicated nasal surgery such as surgery for nasal polyps or deviated septum.

When these procedures are performed on an outpatient basis or Regence BlueShield determines inpatient care is medically necessary, payment is at the full benefit level of the plan. If these procedures are performed on an inpatient basis without Regence BlueShield approval, payment, including payment for related professional services, is at 50% of the plan's allowed amount.

Benefits for the procedures listed are subject to the annual deductible and any other plan provisions.

► **Mandatory Second Surgical Opinions for LEOFF 2 Members Only**

A second physician's opinion for the surgeries listed below is required to receive the full benefit level. The second opinions are not subject to the annual deductible when requested according by the procedures described in this section.

The physician's services and any related x-ray and lab charges for the second opinion are covered in full. If the second opinion isn't obtained, benefits are 50% of the allowed amount for all covered professional services relating to the surgery, including but not limited to the surgeon's charges (hospital charges are not subject to the 50% reduction).

- Bunionectomy
- Cholecystectomy
- Coronary bypass
- Dilation and curettage
- Excision of cataracts
- Hemorrhoidectomy
- Hysterectomy
- Inguinal hernia repair
- Knee surgery
- Laminectomy or spinal fusion
- Mastectomy
- Prostatectomy
- Rhino-/septoplasty
- Tonsillectomy and/or adenoidectomy
- Varicose vein stripping and ligation.

The second opinion is required only if the surgical procedure is a non-emergency, meaning it can be scheduled at the patient's convenience without jeopardizing life or causing serious impairment of bodily functions. If the patient lives outside the service area, the second opinion requirement is waived.

Participating providers can obtain a second opinion referral by contacting Regence BlueShield. The second opinion must be obtained from a physician referred by Regence BlueShield who will not be performing the surgery. After the second opinion is received, benefits are provided if the surgery is performed within six months of the second opinion.

If second opinion procedures aren't followed, benefits for the opinion and any related charges are based on the allowed amounts and subject to the annual deductible.

A third opinion is covered if the first two opinions do not agree, but no additional opinions are covered. Once you receive the second opinion, even if the physicians don't agree, the decision to have the surgery rests with you.

► Voluntary Second Surgical Opinions for LEOFF 1

If you choose to get a second opinion before having surgery, the physician's services and any related x-ray and lab charges are paid in full for the second opinion. They're not subject to the annual deductible when performed by the physician referred to you as described in this section.

Your participating physician can obtain a second opinion referral by contacting Regence BlueShield. The second opinion must be obtained from a physician referred by Regence BlueShield who will not be performing the surgery.

If you don't follow the second opinion procedures, benefits will be paid at the payment level described for "Professional Services" in the "Summary of Covered Expenses" section, subject to the deductible.

A third opinion is covered if the first two opinions do not agree, but no additional opinions are covered. Once you receive the second opinion, even if the physicians don't agree, the decision to have the surgery rests with you.

► Individual Benefits Management

For certain illnesses or injuries, Regence BlueShield Individual Benefits Management staff work with you and your provider to determine the most cost-effective, beneficial treatment options for your specific case. In some instances, the Individual Benefits Management staff may preauthorize benefits that wouldn't normally be covered under this plan. The final decision on the course of treatment rests with you and your provider.

When provided at equal or lesser cost, benefits are available for home health care instead of hospitalization or other inpatient care by a licensed home care agency or by a home health or hospice agency covered under this plan. Substitution of less expensive or less intensive services can be made only with your consent and when recommended by your physician or other provider, based on your medical needs. Regence BlueShield may require a written treatment plan.

Coverage is limited to the plan maximum payable for hospital or other inpatient expenses, subject to any applicable deductible, coinsurance and plan limits. These benefits are provided only when your condition is serious enough to require inpatient care and you could qualify for the inpatient benefits of this plan; custodial care is not covered.

Covered Expenses Under Regence BlueShield

► Summary of Covered Expenses

The following table summarizes covered services and supplies under this plan (only medically necessary services and supplies are covered) and identifies related coinsurance, copays, maximums and limits. For more details, see the sections after the table as well as "Expenses Not Covered."

Covered Expenses	Regence BlueShield
Accidental injury care	100% up to \$600/injury Deductible does not apply
Acupuncture	100% up to 12 visits/calendar year to approved provider (acupuncture for chemical dependency treatment provided separately)
Ambulance services	80%
Ambulatory surgical center	100% professional services 80% hospital/facility services
Blood bank	80%

Covered Expenses	Regence BlueShield
Chemical dependency treatment (including acupuncture and prescription drugs)	100% inpatient/outpatient Up to \$12,000/2 calendar years (maximum subject to annual adjustment)
Diabetes care training	80%
Emergency care (in an emergency room)	80% after \$25 copay/visit (waived if directly admitted)
Growth hormones	90% when preauthorized up to \$25,000/calendar year
Home health care	90% up to 130 visits/calendar year
Home phototherapy (for newborn)	100%
Hospice care	90% (6-month maximum with up to 14 days inpatient care)
Hospital/facility services	80%
Infertility treatment (certain services only)	100% professional services 80% hospital/facility services
Injury to teeth	100% dentist/denturist services up to \$600/injury
Infusion therapy	90%
Lab, x-ray and other diagnostic testing	100% professional services 80% hospital/facility services
Maternity and women's health care	100% professional services 80% hospital/facility services
Medical equipment	80%
Mental health care	100% professional services, 80% hospital/facility services for inpatient up to 8 days/calendar year 50% for outpatient up to 12 visits/calendar year
Neurodevelopmental therapy for covered family members age 6 and under	80% up to \$2,000 annual benefit maximum
Newborn care (up to at least 3 weeks as mandated by state law)	100% professional services 80% hospital/facility services
Occupational injury	100% for LEOFF 1 only
Professional services	100% in an office, home, hospital or skilled nursing facility and for surgery 100% lab and x-ray
Prostheses and orthotics	80%
Phenylketonuria (PKU) formula	100%
Preadmission testing	100% professional services 80% hospital/facility services
Prescription drugs – up to 34-day supply through participating pharmacies	100% after \$7 copay/prescription for generic 100% after \$12 copay/prescription for brand-name 100% after \$27 copay/prescription for non-formulary Copays do not apply against the deductible or out-of-pocket maximum

Covered Expenses	Regence BlueShield
Prescription drugs - up to 90-day supply through mail order	100% after \$14 copay/prescription for generic 100% after \$24 copay/prescription for brand-name 100% after \$54 copay/prescription for non-formulary Copays do not apply against the deductible or out-of-pocket maximum
Preventive care (such as routine exams and immunizations)	100%
Radiation therapy and chemotherapy	100% professional services 80% hospital/facility services
Reconstructive services (including benefits for mastectomy-related services – reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema; call plan for more information)	100% professional services 80% hospital/facility services
Rehabilitative services	100% professional services and hospital/facility services for inpatient up to \$50,000/condition 80% for outpatient up to \$2,000/calendar year
Skilled nursing facility	80% up to 90 days/calendar year when preauthorized
Smoking cessation program	75% up to \$500 lifetime maximum
Spinal manipulation	100%
Sterilization procedures	100% professional services 80% hospital/facility services
Temporomandibular joint (TMJ) disorders	Not covered
Transplants (certain transplants/services only)	100% professional 80% hospital/facility services and travel expenses Donor organ procurement costs up to \$50,000/transplant; travel expenses up to \$2,500/transplant \$250,000 lifetime maximum
Urgent care	Covered at various levels; call plan for details
Vision care – exams	100% for 1 exam/calendar year Deductible does not apply
Vision care – lenses	Up to 2 lenses/calendar year: <ul style="list-style-type: none"> • \$20/single vision lens • \$30/bifocal lens • \$40/trifocal lens • \$65/lenticular or aphakic lens (external lens requiring a frame) Deductible does not apply
Vision care – frames	\$30 for 1 pair of frames/2 calendar years beginning with the initial date of service Deductible does not apply
Vision care – contact lenses (instead of glasses)	If medically necessary, up to \$100/lens for aphakia or for vision correctable to 20/70 or better only by use of contact lenses If elected, up to \$20/lens Deductible does not apply

► **Accidental Injury Care**

If benefits do not cover in full the treatment of accidental injury, this benefit pays in full up to a maximum of \$600 per occurrence (deductible does not apply). Treatment must begin within 30 days of the accident and is covered to a maximum of 12 consecutive months after the date of injury. If treatment continues beyond 12 months or the \$600 maximum, the plan pays benefits as any other illness or injury.

► **Ambulance Services**

The services of a recognized licensed ambulance company are covered if other transportation would endanger your health and the purpose is not for personal reasons or convenience. Benefits include licensed air ambulance, when medically necessary (as for all services and supplies, as determined by Regence BlueShield), to the nearest hospital equipped to provide the necessary treatment.

► **Chemical Dependency Treatment**

The services and supplies of an approved program are covered, including supportive services. Any benefits paid during the current or previous calendar year under this or a prior Regence BlueShield plan count toward the chemical dependency treatment benefit maximum of \$12,000 in two calendar years. Expenses for:

- Acupuncture related to chemical dependency treatment count toward the maximum, but not the regular 12 visit/calendar year acupuncture benefit
- Medically necessary detoxification are covered as emergency care and do not count toward the maximum benefit if you're not enrolled in other chemical dependency treatment
- Drugs prescribed and dispensed through an approved chemical dependency treatment facility are covered and count toward the maximum benefit.

Except for medically necessary detoxification, the program must submit treatment notice at least 10 days before treatment begins, whenever reasonably possible. When you're under court order to undergo chemical dependency assessment (or in other situations pending legal actions related to chemical dependency), Regence BlueShield reserves the right to require you, at your expense, to provide a chemical dependency treatment plan and initial chemical dependency assessment performed by a qualified counselor employed by an approved program at least 10 days before treatment begins.

(For benefit, "medically necessary" is defined by "Patient Placement Criteria for the Treatment of Substance Abuse-Related Disorders II," published in 1996 by the American Society of Addiction Medicine.)

Chemical dependency benefits exclude:

- Alcoholics Anonymous or similar chemical dependency programs
- Emergency service patrol
- Information or referral services
- Information schools
- Long-term care or custodial care
- Tobacco cessation programs or supplies (except as described under "Smoking Cessation").

No other chemical dependency benefits are provided under this plan, except as described above for detoxification.

► **Diabetes Care Training**

Outpatient diabetes self-management training and education, including nutritional therapy, is covered if recommended by an approved provider with expertise in diabetes.

► **Emergency Care**

A medical emergency is defined as the sudden onset of a condition or exacerbation of an existing condition requiring medically necessary care to safeguard your life or limb immediately after onset. To determine benefits,

Regence BlueShield considers symptoms of the condition and actions that would have been taken by a prudent person under such circumstances.

Conditions that might require emergency care include, but are not limited to:

- An apparent heart attack (chest pain, sweating, nausea)
- Bleeding that will not stop
- Convulsions
- Major burns
- Severe breathing problems
- Unconsciousness or confusion (especially after a head injury).

In the event of a medical emergency, you may receive services from any provider, including those not normally covered under the plan.

For emergency care from a provider not normally covered, treatment is:

- Covered for 24 hours or the time reasonably required to come under the care of a participating provider
- Based on the provider's actual charges for services when reasonable and not increased because of plan coverage.

► **Growth Hormones**

Services and supplies are covered for growth hormone when performed and billed by an approved infusion therapy, as described below:

- For children with:
 - Growth hormone deficiency
 - Neonatal hypoglycemia associated with growth hormone deficiency
 - Prader-Willi syndrome
 - Pre-transplant chronic renal insufficiency
 - Turner's syndrome
 - Other conditions determined by Regence BlueShield to be a covered benefit since this plan was issued
- For adults with growth hormone deficiency as a result of:
 - Hypothalamic or pituitary disease due to destructive lesion of the pituitary or surrounding area as a result of treatment or surgery
 - Other conditions determined by Regence BlueShield to be covered.

Growth hormone treatment of these conditions is covered when authorized by Regence BlueShield in advance. Benefits are provided to a maximum of \$25,000 per calendar year; no other benefits for growth hormone are provided under this plan.

► **Home Health Care**

The services and supplies of an approved home health care agency are covered in your home for treatment of an illness or injury if you meet all of these criteria:

- You're homebound – which means that leaving the home could be harmful, involving a considerable and taxing effort – and unable to use transportation without assistance
- Your condition is serious enough to require confinement in a hospital or skilled nursing facility in the absence of home health services
- Your provider establishes or approves and reviews at least every 60 days a written treatment plan specifying home health services and supplies (plan must be approved by Regence BlueShield).

Home health care benefits may be extended beyond the 130-visit per year maximum if you apply to Regence BlueShield and the plan determines continued treatment is medically necessary. Any home health care expenses that qualify under this benefit and under another benefit of this plan will be covered only under the benefit Regence BlueShield determines most appropriate.

Benefits are limited to the following services in your home and must be provided by employees of and billed by the home health agency:

- Home health aide services, including such care as:
 - Ambulation and exercise
 - Assistance with self-administered medications
 - Completing appropriate records
 - Personal care or household services that are needed to achieve the medically desired results
 - Reporting changes in your condition and needs
- Medical supplies dispensed by the home health care agency that would have been provided on an inpatient basis
- Skilled services by approved providers, including:
 - Medical social services
 - Intermittent skilled nursing services
 - Nutritional guidance
 - Physical, occupational, respiratory and speech therapy services.

For professional services, home medical equipment and infusion therapy see those sections.

Home health care benefits exclude:

- Custodial or maintenance care
- Financial or legal counseling services
- Food, clothing, housing or transportation (except as described)
- Homemaker or housekeeping services (except as described)
- Hourly care services
- Services normally provided under a hospice program
- Services of volunteers, household members, family or friends
- Services or supplies not specified as a covered benefit in the written treatment plan, or limited or excluded under the plan
- Services to other family members
- Supportive environmental materials, such as but not limited to ramps, handrails or air conditioners.

► **Home Phototherapy**

Services and supplies by an approved phototherapy provider are covered for newborn hyperbilirubinemia (newborn jaundice).

► **Hospice Care**

Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers. Services of an approved hospice are covered for medically necessary treatment or palliative care (relief of pain and other symptoms) if:

- You're terminally ill
- Your provider establishes or approves and reviews at least every 60 days a written treatment plan specifying hospice services and supplies (plan must be approved by Regence BlueShield).

Hospice benefits are limited to six months, but the benefits may be extended beyond the six-month maximum if you apply to Regence BlueShield and the plan determines continued treatment is medically necessary. Any hospice care expenses that qualify under this benefit and under another benefit of this plan will be covered only under the benefit Regence BlueShield determines most appropriate.

Home Care. Benefits are limited to the following services in your home and must be provided by employees of and billed by the hospice:

- Home health aide services (limited to visits of four or more hours when skilled care is required by an RN, LPN or home health aide, up to a combined total of 120 hours for nursing services and home health aide services), including such care as:
 - Ambulation and exercise
 - Assistance with self-administered medications
 - Completing appropriate records
 - Personal care or household services needed to achieve the medically desired results
 - Reporting changes in your condition and needs
- Medical supplies dispensed by the hospice that would have been provided on an inpatient basis
- Respite care to provide temporary relief to family members or friends providing care (limited to four or more hours a day when no skilled care is required up to a combined total of 120 per three-month period)
- Skilled services by qualified providers, including:
 - Medical social services
 - Nursing services (limited to visits of four or more hours when skilled care is required by an RN, LPN or home health aide, up to a combined total of 120 hours for nursing services and home health aide services)
 - Nutritional guidance
 - Physical, occupational, respiratory and speech therapy services.

Inpatient Care. When you're confined as an inpatient in an approved hospice that isn't a participating hospital or skilled nursing facility, the same benefits that are available in your home are covered, in addition to a semiprivate room. The services must be provided by employees of and billed by the participating hospice. This inpatient benefit is limited to 14 days during the six-month hospice benefit period.

Exclusions. Hospice benefits exclude:

- Custodial or maintenance care (except benefits for palliative care to a terminally ill patient, subject to the limits described)
- Financial or legal counseling services
- Food, clothing, housing or transportation (except as described)
- Homemaker or housekeeping services (except as described)
- Services of volunteers, household members, family or friends
- Services or supplies not specified as a covered benefit in the written treatment plan, or limited or excluded under the plan
- Services to other family members
- Spiritual or bereavement counseling
- Supportive environmental materials, such as but not limited to ramps, handrails or air conditioners.

► **Hospital/Facility Services**

Inpatient and outpatient hospital services of a service area or out-of-area hospital are covered for injury and illness (services of staff physicians billed by the hospital are paid under the professional services benefit). Room and board coverage is limited to the hospital's average semiprivate room rate.

You're responsible for the emergency room copay for each hospital emergency room visit unless you're directly admitted to the hospital.

Hospitalization for Dentistry. The plan covers hospitalization for dental services (including anesthesia) if medically necessary to safeguard your health. Benefits are provided up to \$1,000 per calendar year and cover:

- Inpatient and outpatient services of an approved hospital
- Services in an approved ambulatory surgical center
- Services of an approved physician.

The plan doesn't cover:

- Charges of a dentist
- Hospitalization for malocclusions or other abnormalities of the jaw, except when specified otherwise
- Hospitalization for myofascial pain syndrome or any related appliances.

► **Infertility Treatment**

Medical treatment is provided for infertility the same as any other condition.

The plan doesn't cover:

- Artificial insemination
- Embryo transfer procedures
- In vitro fertilization
- Infertility drugs (such as but not limited to Clomid, Pergonal or Serophene)
- Other artificial means of conception; however, a resulting pregnancy is covered under the maternity benefits as applicable.

► **Injury to Teeth**

Services of a licensed dentist or denturist and related hospital expenses are covered for repair of accidental injury to sound, natural teeth and injuries caused by biting or chewing; dental implants are not covered. Treatment must begin within 30 days of the injury and is covered to 12 consecutive months after the injury and \$600 per occurrence.

This benefit is supplemental to your dental plan coverage.

Charges for repair of teeth do not count toward the out-of-pocket maximum.

► **Infusion Therapy**

Services and supplies for infusion therapy are covered when performed and billed by an approved provider. Drugs and supplies used in conjunction with the therapy are covered only under this benefit.

► **Lab, X-ray and Other Diagnostic Testing**

Lab and x-ray services are covered.

Screening and diagnostic mammography services are covered if recommended by the following participating providers:

- Physician
- Advanced RN practitioner
- Licensed physician assistant.

► **Maternity and Women's Health Care**

Maternity services are treated the same as any other illness or injury. Covered maternity care expenses include:

- Complications from pregnancy (including but not limited to diabetes if onset is after conception, fetal distress and toxemia)
- Normal or cesarean delivery
- Prenatal and postnatal treatment of pregnancy (including false labor)
- Prenatal screening and diagnosis of congenital disorders (when medically necessary in accordance with Washington State Board of Health standards)
- Voluntary termination of pregnancy.

For emergency maternity care, you may see any provider. If you receive emergency care from a non-participating provider outside the service area, contact Regence BlueShield within 48 hours.

Under federal law, benefits for any hospital length of stay due to childbirth for the mother or newborn cannot be limited to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, the provider, after consulting with the mother, may discharge the mother or newborn before the 48 or 96 hours. If you receive inpatient maternity care from a non-participating provider outside the service area, contact Regence BlueShield within 48 hours.

These maternity benefits are not available for covered children. Complications of pregnancy are covered as any other condition.

Women's health care services are covered if performed by a participating provider, approved advanced RN practitioner specializing in women's health and midwifery or approved provider's assistant. Covered services include (in addition to the maternity care already described):

- General exams
- Gynecological care
- Preventive care.

► **Medical Equipment**

Home Medical Equipment. Home medical equipment to treat a medical condition, if generally not useful in the absence of the condition and can withstand repeated use, is covered under this benefit. (Equipment primarily for preventing illness or injury, designed to assist a person caring for the patient or generally useful in the absence of the medical condition is not covered.)

Home medical equipment must be ordered while coverage is in effect and delivered within 30 days after coverage terminates. The fact an item may serve a useful medical purpose does not ensure it's covered. Regence BlueShield may elect to provide benefits for a less costly alternative item. Rental (or purchase if approved by Regence BlueShield) of home medical equipment for therapeutic use includes:

- Crutches
- Diabetic equipment (when medically necessary), including:
 - Blood glucose monitors
 - Insulin infusion devices
 - Insulin pumps and accessories
- Equipment for the administration of oxygen
- Kidney dialysis equipment
- Standard hospital beds
- Wheelchairs.

Repair or replacement of home medical equipment is also covered if necessary due to normal use or growth of a child.

The following items are not covered:

- Adjustable beds
- Air conditioners or dehumidifiers
- Arch supports or casting for arch supports or corrective shoes
- Enuresis (bed wetting) training equipment
- Exercise equipment or weights
- Eyeglasses (see "Vision Care")
- Hearing aids
- Heating pads
- Home birthing tubs
- Keyboard communication devices

- Motorized equipment
- Orthopedic chairs
- Personal hygiene items
- Whirlpool baths.

Special Equipment and Supplies. Covered special equipment and supplies include:

- Casts
- Catheters
- Dressings for wounds, cancer, burns or ulcers (as with all services and supplies, must be medically necessary)
- FDA-approved contraceptive supplies, devices and implants requiring a prescription
- Orthotics (see “Prostheses and Orthotics”)
- Ostomy bags and supplies
- Prosthetics (covered for functional reasons when replacing a missing body part, but not for cosmetic reasons; see “Prostheses and Orthotics;” also see “Reconstructive Services” for details about prostheses used in mastectomy-related reconstructive breast surgery)
- Surgical appliances
- Syringes and needles for allergy injections (syringes and needles for other injectables are covered under “Prescription Drugs”).

► **Mental Health Care**

Inpatient. Inpatient mental health care is covered to a maximum of eight days per calendar year when you’re confined in an approved hospital or psychiatric hospital, state mental hospital or a licensed community mental health agency with an inpatient facility.

Partial hospital day treatment at an approved facility counts toward the eight-day inpatient maximum per calendar year; two partial days count as one inpatient day, regardless of partial day duration.

Outpatient. Outpatient mental health care is covered at 50% of the allowed amount of the plan for a maximum of 12 visits per calendar year when received from an approved provider:

- Licensed community mental health agency
- Marriage and family therapist (marriage and family counseling not covered)
- Masters of social work
- Mental health counselor
- Psychologist.

Covered outpatient services include (but are not limited to) diagnostic testing and treatment for mental disorders:

- Related to a learning disability
- Related to a self-inflicted injury or attempted suicide
- Related to an eating disorder (anorexia nervosa, bulimia or any similar condition is covered only for counseling under this benefit)
- With a congenital or physical basis.

Coinsurance paid for outpatient care doesn’t apply to your out-of-pocket maximum.

(You may also receive limited mental health care benefits at no cost through King County’s Making Life Easier Program by calling toll-free 1-888-874-7290.)

► **Neurodevelopmental Therapy**

Neurodevelopmental therapy is covered to treat neurodevelopmental delay (a delay in normal development that is not a documented illness or injury) when performed to restore and improve function for children six and younger. This benefit includes maintenance service if significant deterioration of the child’s condition would result without the service.

Coverage includes:

- Inpatient hospital and skilled nursing facility care for an inpatient neurodevelopmental therapy admission when care cannot safely be provided as an outpatient; hospital services must be received in a hospital approved for rehabilitative care
- Services of an approved provider for physical, speech and occupational therapy in the office, home or a hospital outpatient facility.

Benefits are limited to \$2,000 per calendar year for all neurodevelopmental therapy services combined and:

- All treatment must be provided in Regence BlueShield-approved hospitals
- All professional services must be performed by approved providers and
- A covered child is not eligible for services to treat the same condition under both this and the rehabilitative services benefit.

The provider must request pre-approval and Regence BlueShield must periodically review a written treatment plan specifically describing the neurodevelopmental services to be provided.

Coinsurance doesn't apply to your out-of-pocket maximum.

Neurodevelopmental therapy benefits exclude:

- Chemical dependency rehabilitative treatment
- Custodial care
- Gym or swim therapy
- Maintenance therapy (except as specified)
- Mental health care
- Nonmedical self-help, recreational, educational or vocational therapy.

► **Newborn Care**

This plan covers newborns for routine care, illness, accidental injury or physical disability (including congenital anomalies) under the mother's coverage for the first 21 days, as required by Washington State law. To continue the newborn's coverage after 21 days, the newborn must be eligible and enrolled by the deadline as described in the Important Facts booklet.

When the spouse/domestic is not eligible for the maternity benefit, a newborn receives the professional services and hospital benefits of this plan for routine care while hospitalized for the first 72 hours following birth.

Services and supplies by an approved home phototherapy provider are provided for newborn hyperbilirubinemia (newborn jaundice).

► **Occupational Injury for LEOFF 1 Members Only**

Services and supplies to treat occupational injury are covered only if you're legally exempt from and not covered by state industrial insurance, workers' compensation or similar coverage. The benefit is paid at 100% of the allowed amount for participating providers and 100% of the billed charges for non-participating providers; it is not subject to the annual deductible.

► **Phenylketonuria (PKU) Formula**

The plan covers medical dietary formula that treats phenylketonuria.

► **Preadmission Testing**

Services of an approved physician and an approved hospital are covered for outpatient preadmission testing for surgery at the hospital where you will be treated if you're admitted within 48 hours after testing begins.

► Prescription Drugs

Drugs requiring a prescription by federal or state law are covered when dispensed by an approved pharmacy or mail order supplier to treat a covered condition; these restrictions apply:

- The drug must be prescribed by a covered provider acting within the scope of his/her license
- The drug may require preauthorization by Regence BlueShield before it's covered (approved pharmacies have lists of drugs requiring preauthorization)
- Certain drugs may be limited to a lesser supply than indicated on your prescription or as determined by Regence BlueShield (approved pharmacies have lists of these drugs)
- Drugs related to transplants are covered under this benefit (claims for those drugs count toward the transplant benefit maximum)
- Regence BlueShield may require you to obtain all prescriptions from a single approved pharmacy
- Any drug purchased outside the United States must have an equivalent to an FDA-approved prescription drug and must be either:
 - Associated with a medical emergency while you're traveling (when submitting your claim, you're responsible for notifying Regence BlueShield that the drug was required for a medical emergency) or
 - Prescribed when you're living outside the United States and purchased in the country where you're residing, except for a medical emergency (when submitting your claim, you're responsible for notifying Regence BlueShield that you live outside the United States).

FDA-approved drugs used for off-label indications are covered only if recognized as effective for treatment in a standard reference compendium, in most relevant peer-reviewed medical literature or by the federal Secretary of Health and Human Services. Drugs the FDA has determined to be contra-indicated are not covered.

Other items covered under this benefit and requiring a prescription include:

- Diabetic supplies, including insulin and insulin syringes
- Legend vitamins for prenatal care
- Oral contraceptive drugs (provided for a single copay per prepackaged monthly cycle; a maximum of three prepackaged monthly cycles may be purchased at once)
- Smoking cessation prescription medicines (limited to 90-day lifetime maximum supply).

Copays for prescriptions do not apply to your annual deductible or annual out-of-pocket maximums.

Copays are lowest when you use generic drugs included in the formulary (list of generic and brand-name drugs maintained by Regence BlueShield) and highest when you use brand-name drugs with a generic equivalent or drugs not included in the formulary.

Prescription drugs are not subject to the coordination of benefit provision (see "Coordination of Benefits Between Plans").

Exclusions. The following are not covered under the prescription benefit:

- Any drugs or items obtained from an approved pharmacy when you fail to present your ID card
- Any items limited or excluded by this plan
- Appetite suppressants or drugs for weight loss
- Drugs or medications for cosmetic purposes
- Drugs dispensed by a non-approved pharmacy, except when specifically provided for emergencies or outside the service area
- Growth hormone, except as specified in the growth hormone benefit of this plan
- Injectable drugs, except as specified in the professional benefit of this plan
- Inside the United States, any prescription drug not approved by the FDA, including compounded products with active ingredient(s) that haven't been approved by the FDA
- Oral progesterone compounded products
- Over-the-counter medications or any prescription with the same active ingredients as an over-the-counter product

- Replacement prescriptions resulting from loss, theft or breakage

Using a Participating Pharmacy. You may order up to a 34-day supply from a participating retail pharmacy (certain maintenance drugs for chronic conditions listed in Regence BlueShield’s Value-Added List are limited to 100 tablets/capsules or a 34-day supply, whichever is greater). To order:

- Choose a participating pharmacy (contact Regence BlueShield for a list of participating pharmacies or to find one near you; see the Resource Directory booklet)
- Show your Regence BlueShield ID card to the participating pharmacist each time you want a prescription filled or refilled
- Pay the copay for each covered new prescription or refill.

There are no claim forms to submit; the participating pharmacy bills the plan directly.

Mail Order Service. To use the mail order service, send an order form with your copay directly to the address on the form each time you order a new prescription. You must include your physician’s written prescription with your order form and payment.

If you use the mail order service:

- Drugs requiring continuous refrigeration may not be available by mail order
- Certain drugs, including but not limited to antidepressants, narcotics and certain other medications may be limited to less than a 90-day supply
- You pay the 90-day copay amounts even if your prescription is written for less than a 90-day supply.

Your Right to Safe and Effective Pharmacy Services. Regence BlueShield as well as state and federal laws establish standards to assure safe, effective pharmacy services and guarantee your right to know what drugs are covered under this plan and any limits. If you would like more information about the plan’s drug coverage policies or if you have any question or concern, contact Regence BlueShield (see the Resource Directory booklet).

If you would like to know more about your rights under the law, or if you believe any of these prescription benefits may not conform to the plan or your rights, contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, call the State Department of Health at 360-236-4825.

► **Preventive Care**

The following preventive care services are covered on an outpatient basis as any other illness or condition, including women’s health care services, and must be recommended by your approved provider:

- Office calls as well as related lab and x-ray services for cancer screening (mammograms are covered as a regular plan benefit)
- Pediatric and adult immunizations (immunizations for travel are not covered)
- Routine pediatric and adult physical exams
- Routine well-baby care from birth.

► **Professional Services**

The plan covers diagnosis and treatment of illness, accidental injury and physical disability, including:

- Injectable drugs
- Medical care in the provider’s office or hospital
- Outpatient x-ray and lab
- Provider services for surgery, anesthesia, inpatient and emergency room visits
- Second opinions obtained before treatment (the provider giving the second opinion must be qualified, either through experience or specialist training).

► **Prostheses and Orthotics**

Benefits are provided under the plan for the purchase of:

- Braces
- Splints
- Orthopedic appliances
- Other orthotic supplies
- Prostheses to replace missing body parts for functional but not cosmetic reasons (except medically necessary external and internal breast prostheses after a mastectomy).

Prostheses and orthotics must be ordered while coverage is in effect and delivered within 30 days after coverage terminates. Regence BlueShield may elect to provide benefits for a less costly item.

► **Radiation Therapy and Chemotherapy**

Radiation therapy and chemotherapy are covered. (Respiratory therapy is covered under the home health care, hospice care and hospital care benefits.)

► **Reconstructive Services**

The plan covers reconstructive surgery:

- When related to an illness or injury
- For congenital anomalies
- For reconstructive breast surgery and associated procedures, following a mastectomy (regardless of when the mastectomy was performed) as determined in consultation with the patient and attending physician including:
 - Reconstruction of the breast on which the mastectomy was performed
 - Surgery and reconstruction of the healthy breast to produce a symmetrical appearance
 - Prostheses and treatment of physical complications of all stages of mastectomy, including lymphedemas.

► **Rehabilitative Services**

The benefits described below are for rehabilitative care when medically necessary to restore and improve function previously normal but lost following a documented illness (for example, stroke, viral infection or bacterial infection – prenatal, perinatal, childhood, adolescence or adulthood) or injury (prenatal, perinatal, childhood, adolescence or adulthood), including function lost as a result of congenital anomalies. Care must be provided by a participating provider.

The plan covers:

- Inpatient hospital and skilled nursing facility expenses for physical, speech or occupational therapy to a maximum of \$50,000 per condition. Services must be received in a hospital or skilled nursing facility approved by Regence BlueShield for rehabilitative services, and treatment must occur within three years from the date of your first hospital or skilled nursing facility rehabilitative care admission. At least every 60 days, your provider must submit for approval and review a written treatment plan specifying rehabilitative services before treatment is received, except in emergencies.
- Physical, occupational or speech therapy in the office, home or hospital outpatient facility is covered to \$2,000 per calendar year if performed by an approved provider (for physical, occupational and speech therapy only) or a hospital approved for rehabilitative care.

Charges for rehabilitative services do not contribute to the out-of-pocket maximum.

If you have a rehabilitative care admission and did not exhaust your \$50,000 inpatient maximum, you may apply to Regence BlueShield for additional outpatient benefits beyond the \$2,000 limit. Limited extensions will be granted, up to the balance of your unused inpatient benefit, if Regence BlueShield determines the services are medically necessary.

You're not eligible for the neurodevelopmental therapy benefit if you receive the same services for the same condition under this benefit.

No benefits are provided for:

- Chemical dependency rehabilitative treatment
- Custodial care
- Gym or swim therapy
- Learning disabilities or developmental delay
- Maintenance therapy (treatment to prevent disease, promote health or prolong and enhance life, or maintain/prevent deterioration of a chronic condition; once the maximum therapeutic benefit is achieved for a given condition, any additional therapy is considered to be maintenance therapy)
- Mental health care
- Non-medical self-help
- Recreational, educational or vocational therapy
- Treatment not prescribed by a participating provider.

► **Skilled Nursing Facility**

Inpatient services and supplies of an approved skilled nursing facility are covered for illness, accidental injury or physical disability, limited to 90 days per calendar year. Room and board is limited to the facility's average semiprivate room rate. Your approved physician must request Regence BlueShield approval and periodically review a written treatment plan specifically describing services to be provided. Custodial care is not covered.

The skilled nursing facility benefit is subject to these provisions:

- The patient must have been an inpatient in a participating hospital for three or more consecutive days for treatment of an illness, injury or physical disability
- The patient must have been admitted as an inpatient in an approved skilled nursing facility within 14 days after discharge from the hospital for treatment of the same condition
- The participating physician must certify that confinement that skilled nursing facility confinement is necessary for continued treatment of the condition for which the patient was hospitalized.

► **Smoking Cessation**

Services of an approved smoking cessation program are covered to a lifetime maximum of \$500. To receive benefits for smoking cessation, you must complete the full course of treatment.

This benefit does not cover:

- Acupuncture
- Books or tapes
- Hypnotherapy unless performed by an approved provider
- Inpatient services
- Over-the-counter drugs or prescription drugs prescribed by your covered provider to ease nicotine withdrawal (however, drugs prescribed to ease nicotine withdrawal are covered under the prescription drug benefit)
- Vitamins, minerals or other supplements.

This benefit is not subject to the annual out-of-pocket maximum.

► **Spinal Manipulation**

The plan covers spinal manipulation by an approved provider if the service is within the lawful scope of the provider's license.

► **Sterilization Procedures**

Sterilization procedures are covered, but not reversals of these procedures.

► Transplants

Benefits for medically necessary services and supplies related to all transplants are provided to a combined lifetime maximum of \$250,000, as determined by Regence BlueShield. A transplant recipient covered under this plan is eligible for these transplants, subject to certain conditions and limits:

- Cornea
- Heart
- Heart/lung (combined)
- Hematopoietic stem cell support; donor stem cells can be collected from either the bone marrow or the peripheral blood; hematopoietic stem cell support may involve autologous (self-donor), allogeneic (related or unrelated donor), syngeneic (identical twin donor), or umbilical cord blood (covered only for certain conditions; contact Regence BlueShield for details)
- Islet cell
- Kidney
- Kidney/pancreas (combined)
- Lungs (single/bilateral/lobar)
- Liver
- Pancreas
- Small bowel
- Small bowel/liver/multivisceral
- Other transplants determined by Regence BlueShield to be covered since this plan was issued (contact Regence BlueShield for the current list of covered transplants; see the Resource Directory booklet).

Benefits for all transplants must be preauthorized by Regence BlueShield, with approval based on:

- Recipient's medical condition
- Provider qualifications
- Appropriate medical indications for the transplant
- Proven medical procedures for the type of condition.

All transplants must be provided in a facility approved by Regence BlueShield. If a transplant is not successful, only one retransplant is covered, subject to the benefit limits specified in the "Summary of Covered expenses."

The plan does not cover:

- Donor or procurement services/costs incurred outside the United States (unless approved by Regence BlueShield) or when available through other group coverage
- Investigational procedures
- Lodging, food, or transportation costs, unless otherwise specified under this plan
- Nonhuman, artificial or mechanical transplants
- Services in a facility not approved by Regence BlueShield
- Stem cell support or high-dose chemotherapy associated with stem cell support, except as specified
- Transplants when government funding of any kind is provided or when the recipient is not covered under this plan.

Donor Benefits. Donor organ procurement benefits are limited to medically necessary procurement costs as determined by Regence BlueShield, to a maximum of \$50,000 per transplant. Donor benefits are charged against the recipient's benefit limits.

Travel Expenses. Travel and lodging expenses for you and your family are covered when you're required by Regence BlueShield to travel 75 miles or more from your residence to the facility where the transplant is received for medically necessary services related to an approved transplant. Benefits are paid at the level specified for participating hospitals to a maximum of \$2,500 per transplant episode requiring travel and must be preapproved by Regence BlueShield.

► Urgent Care

If you need urgent care for conditions that are not life threatening but require immediate medical attention, call your provider's office for assistance (after office hours, call and leave your name and number; the provider on call will call you back). Depending on your situation, the provider may give instructions over the phone, asking you to come into the office or advising you to go to the nearest emergency room.

Conditions that might require urgent care include, but are not limited to:

- Ear infections
- High fevers
- Minor burns.

► Vision Care

Services of an approved optical provider, physician or optometrist are covered in full for one routine eye exam per calendar year to determine the need for a new or changed prescription for corrective lenses. Fittings for contact lenses are not covered.

Lenses and frames are covered when prescribed by an approved optical provider, physician or optometrist to correct a refractive error. For lenses and frames from an approved optical provider, Regence BlueShield pays the provider directly; for lenses and frames obtained from any other optical provider, you're reimbursed (see "Summary of Covered Expenses" for benefit amounts and limits).

This benefit is not subject to any deductible.

Expenses Not Covered

In addition to the exclusions and limits described in other sections of this booklet, the Regence BlueShield plan does not cover:

- Benefits that are covered, or would be covered in the absence of this plan, by any federal, state or government program except:
 - For facilities included on the Regence BlueShield list of participating providers
 - As required by law, such as for medical emergency or for coverage provided by Medicaid
- Charges for services or supplies above the allowed amount, except for medical emergencies
- Charges there would be no obligation to pay in the absence of this plan
- Cochlear implants (unless preauthorized by Regence BlueShield)
- Conditions resulting from military service in the armed forces of any country or any act of war (declared or undeclared)
- Cosmetic surgery or supplies (including drugs), or treatment of any direct or indirect complications of such surgery except:
 - When related to an illness or injury
 - For congenital anomalies
 - For reconstructive breast surgery following mastectomies to the extent required under federal and state law as follows:
 - Reconstruction of the diseased breast
 - Reconstruction of the nondiseased breast to produce a symmetrical appearance
 - Protheses and physical complications of all stages of a mastectomy, including lymphedemas
- Custodial care
- Dental services except as specified
- Dyslexia treatment except as specified
- Hearing aids or exams
- Hospitalization for conditions for which hospitalization is unusual, such as common colds or removal of small tumors

- In vitro fertilization, artificial insemination, embryo transfer, fertility drugs (such as Clomid, Pergonal or Serophene) or any other artificial means of conception; however, a resulting pregnancy is covered under the regular benefits of this plan, as applicable
- Injuries sustained while practicing for or competing in a professional or semiprofessional athletics contest (“semiprofessional” means an athletic activity for gain or pay that requires an unusually high skill level and a substantial time commitment from participants not engaged in the activity as a full-time occupation)
- Investigational services or supplies
- Marital or family counseling
- Mental disorder treatment for anorexia nervosa, bulimia or other eating disorders, except as specified under “Mental Health Care”
- Nursing services, except as specified; private duty nursing or hourly nursing charges are not covered
- Occupational injury or disease (including any arising from self-employment), except as specified
- Over-the-counter contraceptive supplies or devices
- Physical or psychiatric exams or psychological testing for obtaining or continuing employment, licensure, legal proceedings, insurance, school admission or sports activities, or conducted for medical research
- Services by a family member
- Services by King County or any of its employees or agents
- Services or supplies:
 - From government facilities outside the service area except as required by law, such as for emergency services
 - Not medically necessary (as defined in the Glossary booklet) to treat an illness or injury, unless otherwise listed as covered
 - Payable under any automobile medical, personal injury protection, automobile no-fault, homeowner, commercial premises coverage or similar contract or insurance issued to or available to the participant (whether or not application is made)
 - Any benefits provided by or advanced by Regence BlueShield contrary to this exclusion are solely to assist the participant
 - By paying those benefits, Regence BlueShield is not acting as a volunteer or waiving any right to reimbursement or subrogation (when no-fault insurance is available and benefit payments are not exhausted or denied for reasons other than medical treatment not being reasonable, necessary, related to the accident or incurred within three years of the accident, it is the participant’s responsibility to pursue coverage through no-fault carrier to obtain the available limits of the no-fault coverage)
 - To the extent payable under Medicare Part A or B when, by law, this plan would not have been primary to Medicare if the participant had properly enrolled in Medicare when first eligible (regardless of whether the participant actually enrolled)
- Sexual dysfunction/impotence or transsexualism surgery or treatment
- Stem cell support or high-dose chemotherapy associated with stem cell support except as specified
- Treatment and any appliances used in connection with temporomandibular joint disorders, malocclusions or other abnormalities of the jaw
- Visual analysis, therapy or training; orthoptics
- Weight reduction, regardless of diagnosis, surgery (including reversals), treatment, programs or supplies.

Coordination of Benefits

► Coordination of Benefits Between Plans

If you or your dependents are covered under another health plan, Regence BlueShield coordinates benefits with the other plan so you receive up to but not more than 100% of covered expenses; the benefit paid by Regence BlueShield will not exceed the amount that would have been paid if no other plan was involved.

If another plan does not have a coordination of benefit (COB) provision, the other plan always pays first (the plan that pays first is called primary). Otherwise, the plan that covers the individual as an employee pays before the plan that covers the individual as a dependent.

The following guidelines determine what plan pays first for dependent children covered under two parents (“parents” in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)
- For a dependent child whose parents are divorced or legally separated, the plan that covers the child is determined in this order (unless there is a court decree establishing financial responsibility for the child’s health care):
 - The plan of the parent with custody
 - The plan of the spouse of the parent with custody
 - The plan of the parent without custody
 - The plan of the spouse of the parent without custody.

If a court decree establishes financial responsibility for the child’s health care, the plan of the parent with that responsibility pays first.

If these provisions don’t apply, the plan that has covered the participant longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn’t have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer this COB provision.

► **Coordination of Benefits With Medicare**

If you keep working for the county after age 65 you may:

- Continue your medical coverage under a county plan and integrate the county plan with Medicare (the county plan would be primary)
- Discontinue your county medical coverage and enroll in Medicare; if you choose this option, your covered family members are eligible for continuation of coverage under COBRA for up to 36 months (see “COBRA” in the Important Facts booklet).

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan covering a person as an active employee or family member of an active employee. Medicare is primary in most other circumstances.

If you have any questions about how your coverage coordinates with Medicare, contact your medical plan (see the Resource Directory booklet).

Filing a Claim

► **What to Do**

If you receive care from a participating provider, the provider submits claims for you; if you receive a bill from a provider or facility, be sure they have billed Regence BlueShield. If you receive emergency services from a non-participating provider, it’s your responsibility to submit a claim to Regence BlueShield or have the provider submit one for you.

When submitting any claim, you need to include your itemized bill. It should show:

- Patient’s name
- Provider’s tax ID number
- Diagnosis or ICD-9 code
- Date of service or date of purchase/rental of supplies
- Itemized charges from the provider for the services/supplies received.

You also need to provide:

- Your name (if you were not the patient)
- Your member ID number
- Group number (shown on your Regence BlueShield ID card and available from Benefits and Retirement Operations)
- Date, time, location and brief description of accident if treatment is the result of an accident.

For prompt payment, submit all claims as soon as possible. The plan will not pay a claim submitted more than 16 months after the date of service or date of purchase/rental of supplies (nine months if the plan is terminated).

► **If the Claim Is Approved**

If the claim is approved and there's no indication the bill has been fully paid, payment for covered services is made to the provider. If the bill indicates full payment has been made to the provider, payment for covered services is made directly to you.

► **If the Claim Is Denied**

If the claim is denied, you're notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that Regence BlueShield reviewed in making the determination.

If You Have a Problem

This is a brief summary of the steps and timeframes for filing a complaint or appealing a denied claim for reasons other than eligibility. When a claim is denied for eligibility reasons, follow the steps described in the "Claims Denied Due to Eligibility."

Washington State's "Patient Bill of Rights" law requires Regence BlueShield to provide this and other information about your rights when you first enroll, annually and upon request. If you have any questions or want more details, contact Regence BlueShield (see the Resource Directory booklet).

► **First Step Complaint/Appeal**

What You Do. To file a complaint or appeal, you or someone representing you must contact Regence BlueShield in writing or verbally within 180 days of receiving the written notice from Regence BlueShield prompting your complaint/appeal (for example, an explanation of benefits or letter denying a preauthorization request). Explain why you're dissatisfied with Regence BlueShield's decision or action. You may provide written materials supporting your complaint/appeal. If you or your provider is asking Regence BlueShield to reconsider a previously denied preauthorization, your provider may be able to talk directly with a medical director.

What Regence BlueShield Does. A Regence BlueShield member service specialist with contract benefits, enrollment and claim processing expertise accepts and logs your complaint/appeal and notifies you of receipt within five days. The specialist, working as needed with a medical director and medical services, legal or communication departments, investigates your complaint/appeal, gathers facts and prepares a complaint/appeal package of detailed information. Based on that package, the specialist makes a decision, records it in writing and sends it to you within 30 days of first receiving your complaint/appeal.

The decision must be understandable, describe how you may appeal the decision and the timing required, list the people at Regence BlueShield who helped make the decision, state the facts and refer to support documents. After receiving the decision, you may ask Regence BlueShield to reconsider by requesting a second step internal appeal review (see "Second Step Internal Appeal Review").

If more information is required to complete your initial complaint/appeal request, Regence BlueShield informs you of the delay in writing within the initial 30 days and provides a form for you to give written consent to an

extension of up to 15 days. Regence continues processing your complaint/appeal whether or not you return the form, unless you withdraw your complaint/appeal.

► **Second Step Internal Appeal Review**

What You Do. You may file an appeal of your first step complaint/appeal decision. To do so, you or someone representing you must contact Regence BlueShield in writing or verbally within 180 days of receiving the written decision notice from Regence BlueShield. You may provide written materials supporting your appeal and present your appeal in person.

What Regence BlueShield Does. A Regence BlueShield appeal coordinator (registered nurse) accepts and logs your appeal and notifies you of its receipt within five days. The appeal coordinator investigates your appeal, gathers facts and prepares an appeal package of detailed information for review by a panel of Regence Blue Shield representatives new to the case and not involved in the first step complaint/appeal decision. The panel is made up of the appeal coordinator, member service specialist with contract benefits, enrollment and claims processing expertise, and a medical director. The panel works as needed with Regence BlueShield medical services, legal or communication departments and other resources (the medical director may confer with an independent physician with medical training related to your appeal).

Based upon the appeal package and its investigation, the panel makes a decision, records it in writing and sends it to you by certified mail within 30 days of first receiving your appeal or within:

- 20 days if it concerns an investigational medical procedure
- 14 days if it concerns a service your provider wants for you but needs approval from Regence BlueShield to perform.

The decision must be understandable, describe how you may request another appeal and the timing required, list the people at Regence BlueShield who helped make the decision, state the facts and refer to support documents. After receiving the appeal decision, you may ask Regence BlueShield to reconsider by requesting a third step external appeal review (see below).

► **Third Step External Appeal Review**

What You Do. You may file an appeal of your second step appeal decision. To do so, you or someone representing you must contact Regence BlueShield in writing or verbally within 180 days of receiving the written appeal decision notice from Regence BlueShield.

What Regence BlueShield Does. A Regence BlueShield appeal coordinator accepts and logs your appeal and notifies you of its receipt within five days. The appeal coordinator gathers all facts and supporting documents together with the second step appeal package and delivers it for review by an Independent Review Organization (IRO) within three days of receiving your request for an external appeal. The IRO is made up of physicians with medical training in the area of your appeal; they are not associated with Regence BlueShield, nor have they been involved in your first step complaint/appeal decision or second step internal appeal decision.

Based on the appeal package and its investigation, the IRO makes a decision, records it in writing and sends it to Regence BlueShield. Regence BlueShield notifies you by certified mail within 20 days of first receiving your third step appeal review request.

The Regence BlueShield notification must be understandable, describe the next appeal level (if any) and the timing required, list the independent physicians who made the decision, state the facts and refer to support documents.

► **Optional Non-Binding Mediation**

An optional step may be available if your appeal is denied at the third step. The third step external appeal notification describes non-binding mediation and how to request the non-binding mediation process.

If Regence BlueShield fails to respond within 30 days to your or your representative's written request to have an appeal heard in person, you may proceed as if your appeal has been rejected, including submitting such appeal to non-binding mediation.

► **Expedited Appeal Process**

For members who need a faster process because of a life-threatening medical condition, there is an expedited appeal process. If the expedited appeal process is warranted, second step internal review decisions and third step external review decisions are made within one working day or 72 hours, whichever is less, after receiving your expedited appeal request.

Non-binding mediation may also be a final, optional step in the expedited appeal process. Regence BlueShield advises you if non-binding mediation is an option for you if the third level expedited external appeal is denied.

► **Claims Denied Due to Eligibility**

If you have eligibility questions or believe you've had a claim denied because the plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of this section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these timeframes:

- 72 hours for urgent appeals (call 206-684-1556 to file an urgent appeal)
- 14 days for pre-service appeals (within 30 days if an extension is filed)
- 20 days for post-service appeals (within 40 days if an extension is filed)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice includes the plan provision behind the decision and advises you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an eligibility appeal addendum within 60 days after

receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Recovery of Payments

If you or a covered dependent is injured by another party who is legally liable, or if you are entitled to be compensated under the terms of any automobile uninsured or underinsured motorist coverage, the benefits of this plan will be available if you agree to cooperate with Regence BlueShield in its rights to recover benefit payments and you agree to reimburse Regence BlueShield for the amount it has paid according to contract provisions.

Release of Medical Information

As a condition of receiving benefits under this plan, you and your family members authorize:

- Any provider to disclose to the plan any requested medical information
- The plan to examine your medical records at the offices of any provider in accordance with state and federal law
- The plan to release to or obtain from any person or organization any information necessary to administer your benefits
- The plan to examine records that would verify eligibility.

Regence BlueShield will keep this information confidential whenever possible, but under certain necessary circumstances, it may be disclosed without specific authorization.

Certificate of Coverage

When your coverage under this plan ends, Regence BlueShield, in most cases, sends you a certificate of health coverage. Regence BlueShield also issues a certificate at your request within 24 months of when your coverage ends and automatically, when required by law.

The certificate provides important information about your length of coverage under the plan. Please verify accuracy when you receive the certificate and keep it in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under this plan.

If you don't receive a certificate or misplace it, contact Regence BlueShield (see the Resource Directory booklet).

Converting Your Coverage

If you're no longer eligible for the medical coverage described in this booklet, you may transfer your coverage to an insured conversion plan. The plan you convert to will differ from the benefits described in this booklet. You must pay premiums, which may be higher than amounts you currently pay (if any) for these benefits.

You will not be able to convert to the conversion plan if you're eligible for any other medical coverage under any other group plan (including Medicare).

To apply for a conversion plan, you must complete and return an application form to Regence BlueShield within 31 days after this medical coverage terminates. Evidence of insurability will not be required. You will not receive this application or information about conversion plan coverage unless you request it from Regence BlueShield (see the Resource Directory booklet for contact information).

Extension of Coverage

If this plan is canceled, Regence BlueShield will continue to cover any participants who are hospital inpatients on the cancellation date. Coverage ends when the first of the following events occurs:

- Six consecutive months expire
- Your hospital/facility inpatient care benefits under the plan are exhausted (no benefits renew January 1)
- You become covered under another group contract with Regence BlueShield
- You're enrolled under a contract with another company that provides hospital inpatient care
- You're discharged from the hospital/facility.

This extension does not apply to the newborn who is eligible for coverage only for the first 21 days following birth as specified in "Newborn Care," nor does it apply if you're eligible for COBRA continuation.

Maternity Extension. A covered employee or spouse/domestic partner who's pregnant when coverage ends is eligible for the plan's maternity benefits until 14 days following termination of pregnancy if he/she transfers directly to a Regence BlueShield conversion plan and continues coverage until termination of pregnancy.

Disability Extension. If you or any covered family member is totally disabled due to a covered condition and apply to Regence BlueShield within 30 days of when your coverage would normally end, your plan benefits will continue for treatment of the condition for a maximum of 12 months, until benefits are exhausted or until you're enrolled under another group plan, whichever occurs first. Proof of disability is required. (If you continue coverage through COBRA, you're not entitled to this disability extension.)

If you or a covered family member is pregnant and your expected or actual due date is within two weeks of when your coverage would normally end, the disability extension doesn't require written application. It extends from two weeks before anticipated delivery to six weeks after and may be longer if certified by a physician. The disability extension applies whether or not you or a covered family member transfer to an individual plan.

For the disability extension to apply, you or a covered family member must be unable, solely because of non-occupational illness or accidental injury, to:

- Engage in any occupation for which you're reasonably qualified by education, training, or experience
- Perform any work for compensation
- If not previously employed, engage in most of the normal activities of a person of like age and sex in good health.

Payment of Benefits

The medical benefits offered by this plan are insured by Regence BlueShield, meaning this is not a self-funded plan. Regence BlueShield is financially responsible for claim payments and other costs.

Regence BlueShield does not provide health care services. All health care services for covered benefits are provided by facilities and professionals who are neither employees nor agents of Regence BlueShield. The fact a provider is listed in a directory of Regence BlueShield participating providers does not mean the provider is Regence BlueShield's employee or agent. Providers are responsible for the quality of care they render.

Deputy Sheriff Booklet 3

PacifiCare Medical/Vision

Although these benefit descriptions include certain key features and brief summaries of King County deputy sheriff benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

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Overview

► Highlights of PacifiCare Coverage

Here are a few highlights of your coverage under the PacifiCare plan:

- You do not pay an annual deductible under this plan (unless you live outside the PacifiCare service area; see “Out-of-Area Coverage”)
- You pay copays for office visits, prescription drugs and emergency room care (if not admitted)
- You must select a primary care provider (PCP) from the PacifiCare network
- Your PCP provides and coordinates all services through the PacifiCare network, unless you require emergency care
- Network benefits are generally paid at 100% after the copays.

► Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just this plan and can change frequently. To be more efficient, and avoid repetition, the following related information appears only in the Important Facts booklet:

- Who’s eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends and options for continuing it after you leave employment
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

The county pays the full monthly cost of coverage for you and eligible family members you enroll under this plan.

When you receive medical care, you pay:

- Any required copays at the time of service (and deductible and coinsurance if living outside the service area)
- Amounts in excess of usual, customary and reasonable (UCR) rates
- Expenses for services or supplies not covered by the plan.

Preexisting Condition Limit

This plan does not have a preexisting condition limit. However, there is a waiting period for transplants (see “Transplants” in the “Covered Expenses Under PacifiCare” section).

If you end employment with King County, please refer to “Certificate of Coverage” in this booklet for information on how your participation in this plan can be credited against another plan with a preexisting condition limit.

How the Plan Works

► Plan Features

The following table identifies some plan features, including your out-of-pocket maximum and how benefits are determined for most covered expenses. The sections after the table contain more details.

Plan Feature	PacifiCare
Provider choice	You choose a PacifiCare PCP who provides and coordinates services through the PacifiCare network; no non-network coverage unless indicated
Annual deductible	None (unless you live outside the PacifiCare service area)
Copays	See “Summary of Covered Expenses” for amounts
After the copays, the plan pays most covered services at this level ...	100% network
Until you reach your annual out-of-pocket maximum...	\$500/person, \$1,500/family for network care and limited emergency/out-of-area non-network care
Then, most benefits are paid for the rest of the calendar year at ...	100% network
Lifetime maximum	No limit except for transplant benefits

► Network Providers

PacifiCare is licensed by the Office of the Insurance Commissioner to arrange for medical and hospital services in certain geographic areas of Washington. These service areas are defined by ZIP codes. Please contact PacifiCare for service area information (see the Resource Directory booklet).

All providers (hospitals, clinics, doctors and other health care professionals) who make up the PacifiCare network are carefully screened by PacifiCare. To be considered for the network, hospitals must be accredited by the Joint Commission on Accreditation of Health Care Organizations and have a current state license as well as adequate liability insurance. Doctors or other health professionals must also complete a detailed application to be considered for the network. The application covers education, status of board certification, malpractice and state sanction histories. For a list of network providers, contact PacifiCare (see the Resource Directory booklet).

► Out-of-Area Coverage

Out-of-area coverage is available under this plan, as described below:

- For emergency and urgent care anytime you’re outside the PacifiCare service area (see “Emergency Care” and “Urgent Care” in the “Covered Expenses Under PacifiCare” section)
- If you live outside the PacifiCare service area for at least nine months out of a year and are more than 30 miles from the nearest PCP, you must contact PacifiCare to set up an out-of-area coverage plan (see the Resource Directory booklet). Under PacifiCare’s out-of-area coverage plan:
 - You pay a \$200 per person, \$600 per family annual deductible (the deductible doesn’t apply to prescription drugs)
 - You make an appointment with a licensed provider
 - The plan pays 80% for most services; if you reach a \$1,000 per person, \$2,000 per family out-of-pocket maximum, the plan pays 100% for most covered expenses the rest of the year
 - You must obtain preauthorization for certain procedures (see “Obtaining Preauthorization”)
 - Depending on your provider, you may have to pay the bill in full and file a claim for reimbursement
 - You’re responsible for any charges that exceed usual, customary and reasonable (UCR) rates.

If you live outside the PacifiCare service area and qualify for out-of-area-coverage, you don’t need to:

- See PacifiCare Behavioral Health providers for mental health care or chemical dependency treatment, but you or your provider must obtain preauthorization by contacting PacifiCare Behavioral Health (see the Resource Directory booklet).
- Fill your prescriptions at a network pharmacy, but must pay for the prescription in full and file a claim for reimbursement; the plan pays 100% minus the copay.

► **Selecting a Primary Care Provider**

Your primary care provider (PCP) is your personal doctor and the starting point for all your medical care. To receive benefits, your PCP must provide or coordinate all of your care (with the exceptions described in the “Accessing Care” section of this booklet).

Each family member may have a different PCP. PCPs can be family or general practitioners, internists or pediatricians. If you need a specialist, your PCP arranges it.

You and your covered family members must select PCPs when you enroll; otherwise PacifiCare will choose one for you. Except for situations where you may self-refer or in urgent or emergency situation, if you see another health care provider without the approval of your PCP, participating medical group (the group your PCP is affiliated with) or PacifiCare, services will not be covered. Contact PacifiCare for a list of PCPs (see the Resource Directory booklet). The name of your PCP will be printed on your ID card.

Continuity of your care is important and easier to achieve if you establish a long-term relationship with your PCP. However, you may find it necessary to change providers. Before you see another PCP, you must contact PacifiCare. You may see your new PCP the first of the month following the change.

► **Selecting a Primary Hospital**

When you choose a PCP, you also choose your primary hospital – the hospital the PCP is affiliated with and where you’ll go for most hospital services. To confirm the primary hospital you have chosen, ask your PCP or contact PacifiCare (see the Resource Directory booklet).

► **Specialists**

Your PCP is responsible for determining when it’s medically necessary for you to see a specialist, except for visits to obstetrical and gynecological providers (described in this section) and certain specialists as described in the “Accessing Care” section of this booklet. If your PCP determines you need a referral, he/she submits a request to your participating medical group or PacifiCare; then a Utilization Review Committee reviews the request. If approved by the committee, the referral is authorized and may require your specialist to provide your PCP with regular reports on your treatment and condition. If the request is not approved, the referral is denied; in this event, you can request an appeal of the decision (see “If You Have a Problem”).

Getting OB/GYN Care Without a Referral. Women may receive outpatient obstetrical and gynecological services directly – from a participating PacifiCare OB/GYN, family practice provider or surgeon identified by PacifiCare as providing these services – without preauthorization or PCP referral. In all cases, the doctor must be affiliated with PacifiCare (or preauthorized/referred); otherwise, you’re financially responsible for the services.

All OB/GYN inpatient or hospital services, except emergency or urgent care, need to be preauthorized by your PCP, participating medical group or PacifiCare.

To receive OB/GYN services:

- Call the number on the back of your ID Card and request the names and phone numbers of the OB/GYNs affiliated with PacifiCare
- Schedule an appointment with your selected participating OB/GYN.

If your condition requires follow-up care, your OB/GYN contacts your PCP about your condition, recommended treatment and any women’s health care services involving hospitalization.

► **Accessing Care**

Generally, to receive benefits:

- You make an appointment with your PCP

- You pay a \$5 office visit copay at the time you receive health care services
- Your PCP obtains preauthorization for your care as necessary
- After the copay, the plan pays 100% for most covered services and handles all forms and paperwork.

For some benefits, you may receive services from a PacifiCare network provider without PCP referral (see “Covered Expenses Under PacifiCare”):

- Chemical dependency treatment (must be preauthorized by PacifiCare Behavioral Health)
- Chiropractic care (must see a PacifiCare network provider and copay is higher when you self-refer)
- Mental health care (must be preauthorized by PacifiCare Behavioral Health)
- Urgent care
- Women’s health services (such as maternity care, reproductive health services and gynecological care).

For emergency care, you may see any provider (see “Emergency Care” in the “Covered Expenses Under PacifiCare” section).

► **Obtaining Preauthorization**

Generally, your PCP or specialist obtains preauthorization for services that require it through PacifiCare or your participating medical group. However, you must obtain preauthorization if you don’t see or coordinate with your PCP for these services:

- Chemical dependency treatment
- Mental health care
- Women’s health care services involving hospitalization or surgery.

Although you don’t need preauthorization for accidents or emergencies (including detoxification), you, a family member or hospital staff member are expected to call PacifiCare or your PCP within 24 hours from the start of your care (48 hours for mental health care or chemical dependency treatment).

To obtain preauthorization for:

- Care other than mental health care and chemical dependency treatment, have your provider call PacifiCare at 1-800-932-3004 (7 a.m.-9 p.m. Pacific time, Monday-Friday)
- Mental health care or chemical dependency treatment, you or your provider must call PacifiCare Behavioral Health at 1-800-577-7244 (24 hours a day, seven days a week).

When you call for preauthorization, be prepared to give:

- Your name
- Your group number (801012 retirees, 801013 active employees or 801723 COBRA participants) and member number (on your ID card)
- The reason for your call.

If you don’t obtain preauthorization as described above, your care will not be covered.

► **Second Opinions**

You have the right to a second opinion regarding any medical diagnosis or treatment plan. Requests must be submitted to your participating medical group or PacifiCare (your PCP can advise you which one). The second opinion will be provided by an appropriately qualified health care professional of your choice from within the:

- Participating medical group (the group your PCP is affiliated with) for care recommended by your PCP
- PacifiCare network for care recommended by a specialist or PCP not affiliated with a participating medical group.

You’re responsible for outpatient copays to the provider who gives you your second medical opinion.

The second opinion describing recommended procedures and tests will be made available to you and your treating provider. If it includes the recommendation for a particular treatment, diagnostic test or service PacifiCare covers

and is determined to be medically necessary by your participating medical group or PacifiCare, the recommended action will be covered. The fact an appropriately qualified provider gives a second opinion and recommends a particular treatment, diagnostic test or service doesn't necessarily mean it is medically necessary or covered.

► **Annual Deductible**

There is no annual deductible under the PacifiCare plan unless you live outside the service area (see “Out-of-Area Coverage”).

► **Annual Out-of-Pocket Maximum**

The out-of-pocket maximum is generally the most you pay toward copays each plan year. This means once you reach your out-of-pocket maximum, the PacifiCare plan pays 100% of most covered expenses for the rest of the calendar year.

The following do not apply to the out-of-pocket maximum:

- Amounts in excess of UCR rates
- Charges beyond benefit maximums
- Chiropractic care copays
- Emergency room copays
- Expenses for services and supplies not covered by the plan
- Mental health care copays
- Prescription drug copays.

► **Lifetime Maximum**

There is no lifetime maximum under the PacifiCare plan, except for transplant benefits (see “Transplants” in the “Covered Expenses Under PacifiCare” section).

Covered Expenses Under PacifiCare

► **Summary of Covered Expenses**

The following table summarizes covered services and supplies under this plan (only medically necessary services and supplies are covered) and identifies related copays, maximums and limits. To receive most services and supplies, a PCP referral is required. For more details, see “Accessing Care,” the sections after the table and “Expenses Not Covered.”

Covered Expenses	PacifiCare
Additional benefits for LEOFF 1 employees	Not covered
Alternative care	100% after \$5 copay/visit when referred by PCP
Ambulance services	100%
Chemical dependency treatment	100% for inpatient 100% for outpatient \$12,000 maximum/24 consecutive calendar months (maximum subject to annual adjustment)
Chiropractic care	100% after \$5 copay/visit when referred by PCP 100% after \$10 copay/visit up to 33 visits/year when self-referred (must see a network provider)
Circumcision (for newborns)	100%

Covered Expenses	PacifiCare
Diabetes care training	100%
Durable medical equipment, prosthetics and orthopedic appliances	100%
Emergency care (in an emergency room)	100% after \$50 copay/visit (waived if admitted)
Family planning	100%
Growth hormones	100% when preauthorized
Home health	100% up to 130 visits/year
Hospice care	100% (6-month lifetime maximum)
Hospital care	100% (\$50 copay/visit for emergency care, waived if admitted)
Infertility treatment	Not covered
Injury to teeth	100%
Inpatient care alternatives	100%
Lab, x-ray and other diagnostic testing	100% (includes mammograms, prenatal tests)
Manipulative therapy (including chiropractic services)	See chiropractic care
Maternity care - delivery and related hospital care	100%
Maternity care - prenatal and postpartum care	100% after \$10 copay/pregnancy
Mental health care	100% for inpatient up to 30 days/year; 100% for residential and day treatment (also subject to inpatient maximum; each day of care counts as half an inpatient day) 100% after \$5 copay/visit for outpatient up to 30 visits/year
Neurodevelopmental therapy for covered family members age 6 and under	100% for inpatient 100% after \$10 copay/visit for outpatient up to 60 visits/year when referred by PCP and preauthorized
Newborn care (up to at least 21 days as mandated by state law)	Covered at various levels; call plan for details
Physician and other medical/surgical services	100% inpatient 100% outpatient after \$5 copay/visit
Phenylketonuria (PKU) formula	100%
Prescription drugs up to 30-day supply through network pharmacies	100% after \$5 copay/prescription or refill for generic drugs and insulin (brand-name drugs are covered only when generic not available)
Prescription drugs up to 90-day supply through mail order	100% after \$10 copay/90-day supply for generic drugs and insulin (brand-name drugs are covered only when generic not available)
Preventive care (such as routine exams and immunizations)	100% after \$5 copay/visit
Radiation therapy, chemotherapy and respiratory therapy	100%
Reconstructive services (including benefits for mastectomy-related services – reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema; call plan for more information)	100% depending on services provided; copays may apply
Rehabilitative services	100% for inpatient 100% after \$10 copay/visit for outpatient up to 60 days or visits/year when referred by PCP and preauthorized

Covered Expenses	PacifiCare
Skilled nursing facility	100% up to 150 days lifetime maximum/condition (must be instead of a hospital stay) when referred by PCP and preauthorized
Smoking cessation	100% after \$20 copay/network program 100% after \$20 copay for each 4-week supply of nicotine replacement when prescribed by PCP (90-day treatment maximum)
Sterilization procedures	100% (see "Family Planning")
Supplemental accident benefits	Not covered
Temporomandibular joint (TMJ) disorders	Not covered
Transplants (certain transplants/services only)	100% up to \$500,000 lifetime maximum Medical coverage must have been continuous for more than 12 months under this plan – whether preexisting or emergency
Urgent care	100% after \$5 copay/visit
Vision care eye exams (comprehensive exam and prescription for eyeglasses are covered; dilated fundus exam included when deemed necessary by provider)	100% for 1 exam every 12 months from network provider (Cole Vision Service) 100% up to \$40 for 1 exam every 12 months from non-network provider
Vision care lenses (single vision, bifocal, trifocal or lenticular)	100% for 1 pair of lenses every 12 months from network provider(Cole Vision Service) 100% up to \$100 for 1 pair of lenses every 12 months from non-network provider
Vision care frames	100% up to \$150 retail value for 1 pair of frames every 24 months from network provider(Cole Vision Service) 100% up to \$100 for 1 pair of frames every 24 months from non-network provider
Vision care contact lenses (instead of glasses)	100% up to \$150 retail value for 1 pair of contacts every 24 months from network provider (Cole Vision Service) 100% up to \$100 for 1 pair of contacts every 24 months from non-network provider
Vision care – additional services	Unlimited additional pairs of glasses/contact lenses and lens options at discount from network provider (Cole Vision Service) No extra charge for high powered prescriptions, oversized lenses or prism Lasik Discount Program from Cole Vision Service Mail order contacts from Contact Direct

► **Alternative Care**

You must have a PCP referral to receive alternative care services, which include but are not limited to the professional services of a:

- Licensed acupuncturist
- Licensed naturopath
- Massage therapist (not covered for recreational, sedative or palliative reasons; remember, all care must be medically necessary).

This plan does not cover:

- Herbal preparations

- Nutritional supplements
- Teas.

► **Ambulance Services**

Services of an ambulance company are covered to transport you to a facility equipped to treat your condition in a medically necessary emergency, but only when other modes of travel would put you in danger.

► **Chemical Dependency Treatment**

The plan provides for chemical dependency treatment by an approved alcoholism or drug treatment program.

- “Medically necessary treatment of chemical dependency” is defined in the Patient Criteria for the Treatment of Substance Related Disorders II published in 1996 by the American Society of Addiction Medicine
- “Approved alcoholism or drug treatment program” is defined as any hospital or public or private treatment program that provides services for the treatment of chemical dependency, operates under the direction and control of the state and is approved by PacifiCare Behavioral Health.

No referral is required to access chemical dependency treatment, but it must be preauthorized by PacifiCare Behavioral Health and provided by a PacifiCare Behavioral Health provider to be covered (except in an emergency). Your PCP can arrange chemical dependency services or you may call PacifiCare Behavioral Health at 1-800-577-7244.

Chemical dependency services are provided up to the benefit maximum of \$12,000 in any consecutive 24 months. Covered services include:

- Family therapy for the patient and covered family members
- Individual and group therapy
- Inpatient care, including medical detoxification associated with acute alcohol, drug or other substance abuse
- Outpatient care
- Residential or day treatment.

In addition to the benefits listed in “Expenses Not Covered,” the chemical dependency benefit does not cover:

- Confinement, treatment, services, or supplies not preauthorized by PacifiCare Behavioral Health, or supplied by a non-PacifiCare Behavioral Health provider, even if referred by the PCP, except emergency care
- Treatment for addiction to, or dependency on, tobacco, nicotine, or caffeine
- Volunteer support groups.

► **Chiropractic Care**

You must see a network chiropractor for care; you do not need a PCP referral for up to 33 visits a year.

The plan covers services of licensed chiropractors, limited to:

- Diagnostic lab services directly related to your spinal care treatment
- Full spinal x-rays
- Noninvasive spinal manipulations.

► **Circumcision**

See “Newborn Care.”

► **Diabetes Care Training**

The plan covers diabetic care training when prescribed by your PCP.

► **Durable Medical Equipment, Prosthetics and Orthopedic Appliances**

Durable medical equipment and prosthetics are covered if they have a specific therapeutic purpose in treating your illness or injury and are:

- Designed for prolonged use
- Prescribed by your provider
- Primarily and customarily used only for medical purposes.

Covered items include:

- Artificial limbs and eyes (including implant lenses prescribed by a network provider and required as a result of cataract surgery or to replace a missing portion of the eye)
- Casts, splints, crutches, trusses and braces
- Diabetic equipment such as blood glucose monitor, diabetic shoes and inserts, and insulin pumps not covered under the prescription benefit (excluding batteries) when ordered by a provider to treat diabetes
- Initial external prosthesis and bra necessitated by breast surgery and replacement of these items when required by normal wear, a change in medical condition or additional surgery
- Ostomy supplies
- Oxygen and rental equipment for its administration
- Penile prosthesis when impotence is caused by a covered medical condition, a complication directly resulting from a covered surgery or an injury to the genitalia or spinal cord (and if other accepted treatment has been unsuccessful)
- Pressure stockings (when medically necessary)
- Rental or purchase (approved by PacifiCare) of durable medical equipment such as wheelchairs, hospital beds and respiratory equipment (combined rental fees may not exceed full purchase price)
- Wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition.

► **Emergency Care**

An emergency medical condition exists when symptoms and pain are severe enough that a reasonable person might expect loss of life or limb, or serious harm to his/her health if the condition is not treated immediately (see the Glossary booklet for more details). Examples of emergency medical conditions include, but are not limited to:

- Bleeding that won't stop
- Chest pain
- Convulsions
- Major burns
- Severe breathing problems
- Unconsciousness or confusion, especially after a head injury.

You don't need a PCP referral to receive emergency care. If you need emergency care:

- Call 911 or go to the nearest hospital emergency room immediately
- When you arrive, show your ID card
- Call PacifiCare or your PCP within 24 hours of receiving emergency care so your PCP can coordinate your care and schedule any follow-up treatment; if you, the hospital staff or someone else on your behalf doesn't contact PacifiCare within 24 hours, you may be responsible for all costs incurred before you call.

Once the emergency medical condition stabilizes, you may require more care before being discharged. In that case, the treating provider will contact your participating medical group or PacifiCare to obtain authorization. PacifiCare may, in certain circumstances, to transfer you to a network hospital instead of authorizing post-stabilization services at the treating facility.

Regardless of where you are in the world after being discharged from a hospital for emergency care, contact your PCP or PacifiCare's Utilization Management Department to authorize follow-up out-of-area care (call 1-800-762-8456 weekdays, 8 a.m.-5 p.m. Pacific time).

► **Family Planning**

Covered family planning expenses include:

- Intrauterine birth control devices (IUDs)
- Tubal ligation
- Vasectomy
- Voluntary termination of pregnancy.

The plan does not cover:

- Infertility treatment, sterility or sexual dysfunction treatment or diagnostic testing
- Procedures to reverse voluntary sterilization.

Birth control drugs are covered under the prescription drug benefit.

► **Growth Hormones**

The plan covers growth hormones when determined medically necessary (like all covered services and supplies) by your PCP and are preauthorized by your participating medical group or PacifiCare.

► **Home Health Care**

You must have PCP referral to receive home health care services. Services are covered if:

- Provided and billed by a licensed Washington State home health care agency
- Part of a home health care plan, and
- Care takes the place of a hospital stay.

Services and prescription drugs administered and billed by a home infusion therapy company are also covered if the company is licensed by the state as a home health agency.

Covered services include:

- Nursing care
- Occupational therapy
- Physical therapy
- Prescription drugs, if used during a period of covered home health agency care (prescription drugs included in a home health treatment plan don't require a copay)
- Respiratory therapy
- Restorative speech therapy
- Restorative therapy.

The following services are not covered:

- Custodial care, except by home health aides as ordered in the approved plan of treatment
- House cleaning
- Services of any social worker
- Services or supplies not included in the approved treatment plan
- Services by a person who lives in your home or is a family member
- Travel costs or transportation services.

► **Hospice Care**

You must have PCP referral to receive hospice care. Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers. The team may include a provider, nurse, medical social worker and/or physical, speech, occupational or respiratory therapist.

Hospice care services are covered if:

- Provided and billed by a licensed Washington State hospice

- Part of a hospice care treatment plan and
- Care takes the place of a hospital stay.

Covered services include:

- Physician services
- Drugs and medications
- Emotional support services
- Home health and homemaker services under the supervision of a registered nurse
- Inpatient and outpatient hospice care
- Respite care for family members who care for the patient.

The following services are not covered:

- Bereavement or pastoral counseling
- Funeral arrangements
- Financial or legal counseling (examples are estate planning or the drafting of a will)
- Homemaker, caretaker or other services such as:
 - Sitter or companion services for the patient who is ill or other family members
 - Transportation
 - House cleaning or upkeep
 - More than 5 days of respite care in any 3-month period of hospice care
- Any services provided by members of the patient's family.

► **Hospital Care**

Your PCP must have a preauthorization from the participating medical group or PacifiCare to receive hospital care other than emergency care.

Covered inpatient hospital care includes:

- Newborn nursery care after covered childbirth, including circumcision
- Hospital services, such as:
 - Anesthesia and related supplies administered by hospital staff
 - Artificial kidney treatment
 - Blood, blood plasma and blood derivatives
 - Drugs
 - Electrocardiograms, physiotherapy and hydrotherapy
 - Operating rooms, recovery rooms, isolation rooms and cast rooms
 - Oxygen and its administration
 - Splints, casts and dressings
 - X-ray and lab exams
 - X-ray, radium and radioactive isotope therapy
- Intensive care or coronary care units
- Physician services
- Semiprivate room, meals, general nursing care (private room charges are covered only up to the hospital's semiprivate rate, unless no semiprivate room is available)
- Surgery and anesthesia administration.

Covered outpatient hospital care includes:

- Diagnostic and therapeutic nuclear medicine in a hospital setting
- Hospital outpatient chemotherapy only for the treatment of malignancies
- Outpatient surgery
- Surgery in an ambulatory surgery center in place of inpatient hospital care.

► **Infertility Treatment**

The plan does not cover:

- Infertility treatment, sterility or sexual dysfunction treatment or diagnostic testing
- Procedures to reverse voluntary sterilization.

► **Injury to Teeth**

Accidental injury to mouth and natural teeth is covered but limited to stabilization services received within six months of the injury. Benefits for dental accidents include a licensed dentist and provider licensed as a denturist for services within the scope of that license, if those services would have been covered if performed by a dentist.

► **Inpatient Care Alternatives**

Your PCP must preauthorize inpatient care alternatives through his/her participating medical group or PacifiCare. Your physician may develop a written treatment plan for an equally or more cost-effective setting than a hospital or skilled nursing facility. All hospital or skilled nursing facility benefit terms, maximums and limitations apply to inpatient care alternatives.

► **Lab, X-ray and Other Diagnostic Testing**

You must have a PCP referral to receive these benefits (remember, all must be medically necessary). Covered services include:

- Diagnosis and treatment of medical conditions of the eye by a Washington State-licensed optometrist or ophthalmologist; eyewear and routine vision exams and tests for vision sharpness are not covered under this benefit (see “Vision Care”)
- Hearing tests by a physician or licensed audiologist (see “Preventive Care” for more information on routine tests)
- Lab or x-ray services, such as ultrasound, mammograms, nuclear medicine, allergy testing
- Screening and diagnostic procedures during pregnancy as well as related genetic counseling (when medically necessary for prenatal diagnosis of congenital disorders).

► **Manipulative Therapy**

See “Chiropractic Care.”

► **Maternity Care**

You may self-refer for women’s health care services (including maternity care), but inpatient hospital and outpatient surgery must be preauthorized.

Maternity care is covered if provided by a network:

- Physician
- Licensed registered nurse midwife
- Provider licensed as a midwife by Washington State.

Covered maternity care includes:

- Pregnancy care
- Screening and diagnostic procedures during pregnancy
- Related genetic counseling when medically necessary for diagnosing congenital disorders of the unborn child
- Hospitalization and delivery, including delivery at a licensed birthing center (while preauthorization is necessary for hospital admissions, you don’t need to preauthorize the length of the stay; see also “Hospital Care”)
- Complications of pregnancy or delivery
- Postpartum care.

Benefits for any hospital length of stay due to childbirth for the mother or newborn cannot be limited to less than 48 hours for a vaginal delivery or less than 96 hours for a cesarean section. However, the health care provider, after consulting with the mother, may discharge the mother or newborn before the 48 or 96 hours.

The plan does not cover:

- Home pregnancy tests
- Maternity services for dependent children.

Pregnancy to Preschool. This program helps women learn how to care for themselves during pregnancies and their new babies, complimenting prenatal medical care. To enroll, contact PacifiCare (see the Resource Directory booklet).

► **Mental Health Care**

PacifiCare, through PacifiCare Behavioral Health (PBH), provides a team approach to mental health care, working with behavioral and medical health care providers, contracted practitioners and community resources to restore and maintain your health and productivity.

Accessing Care. You do not need PCP referral for mental health care, but you must obtain preauthorization from PBH. Call PBH directly at 1-800-577-7244 or 1-800-833-6388 (TTY), 24 hours a day, seven days a week. You'll speak with a coordinator who checks your eligibility and gathers basic information. Depending on the type of help you need, a clinician may then talk with you about what provider and treatment are best for you. If you're referred to a PBH provider, you'll be authorized for a specific number of visits for a certain time. (For information about PBH participating providers or to obtain referrals for specialty care or after-hours care, call the numbers above.)

For services outside the service area, you're covered for emergencies only.

Emergency Care. In an emergency, do everything possible to ensure your physical safety; call 911 if necessary and get to a treatment center immediately. Then, within 48 hours of admission or as soon as reasonably possible, call PBH to coordinate services after emergency treatment. This may include transferring to a provider designated by PBH when you're stable and the transfer would not create an unreasonable risk.

If you get emergency treatment from a non-network provider, you may receive a bill. Send PBH a copy as soon as possible; PBH will not pay claims submitted more than a year after the date of service. Mail bills to:

PacifiCare Customer Service Department
PO Box 31053
Laguna Hills CA 92654-1053

You're responsible for any copays or coinsurance to the non-network provider.

What's Covered. To be covered, mental health care must be provided by a hospital, physician (such as a psychiatrist, psychologist or registered nurse), residential treatment facility, provider licensed or certified by the state as a mental health counselor or a community mental health agency, or state mental hospital.

- Inpatient care – Professional and facility services for inpatient diagnosis and treatment of mental illness are covered at 100% up to 30 days per year, subject to PacifiCare Behavioral Health's preauthorization requirements and use of network providers
- Outpatient care – Outpatient services for diagnosis and treatment of mental illness are covered at \$5 copay per visit to 30 visits per calendar year, subject to the preauthorization requirements and use of network providers (the average number of outpatient visits is ten or less per episode of treatment).

Covered services include:

- Diagnostic testing to determine if a mental disorder exists
- Individual and group psychotherapy
- Lab services related to the covered provider's approved treatment plan

- Marriage and family therapy
- Physical exams and intake history
- Psychological testing
- Treatment for:
 - Diagnosed eating disorders
 - Mental disorders with a congenital or physical basis, such as Tourette’s Syndrome (partial coverage may be under the medical services portion of this plan)
 - Self-inflicted harm, such as a suicide attempt.

What’s Not Covered. The plan does not cover:

- Certain nonorganic therapies:
 - Bioenergetic therapy
 - Confrontation therapy
 - Crystal healing therapy
 - Educational remediation
 - Guided imagery
 - Marathon therapy
 - Primal therapy
 - Rolfing
 - Sensitivity training
 - Training analysis
 - Transcendental meditation
 - Z therapy or milieu therapy
- Certain organic therapies:
 - Aversion therapy (such as electric shock for behavior modification)
 - Carbon dioxide therapy
 - Environmental ecological treatment or remedies
 - Herbal therapies
 - Hemodialysis for schizophrenia
 - L-tryptophan or vitamins
 - Narcotherapy with LSD or sedative action electrostimulation therapy
 - Vitamin or orthomolecular therapy
- Court-ordered treatment (unless determined medically necessary by PacifiCare)
- Custodial care
- Long-term, insight-oriented psychotherapies designed to regress the patient emotionally or behaviorally
- Mental retardation care
- Pathological gambling treatment
- Personal enhancement or wellness development, or related programs not considered medically necessary
- Private rooms or private duty nursing
- Spiritual counseling or dance, poetry, music or art therapy
- Substance use/abuse conditions (except as described in “Chemical Dependency Treatment”)
- Surgery as treatment for a mental disorder
- Treatment for:
 - Learning disabilities
 - Mental disorders related to sexual functioning or a sex change.

Without a psychiatric diagnosis of a mental condition, the plan also doesn’t cover:

- Bereavement or catastrophic illness counseling
- Biofeedback
- Counseling for adoption, custody, family planning or pregnancy
- Sex therapy or sexual addiction therapy.

Information Disclosure. What you discuss with PBH is kept confidential; PBH provides information only to the professionals delivering your treatment. However, PBH requires its contracted mental health providers to provide it with information used to coordinate your care, including:

- Name
- Date of birth
- Five Axis/DSM-IV diagnosis codes
- Description of your mental status, including symptoms and degree of functional impairment
- History of substance abuse
- Medication information
- Information on any adjunctive services being performed.

Your Rights. PacifiCare and state law establish standards to:

- Make certain you know which services are covered under this plan and any limits
- Assure the competence and professional conduct of mental health service providers
- Guarantee your right to informed consent to treatment
- Protect the privacy of your medical information.

If you:

- Have a concern about the qualifications or professional conduct of your mental health service provider, contact the Washington State Health Department at 360-236-4902
- Want more details on your mental health benefits covered under this plan, or if you have a question or concern about any aspect of your benefits, contact Pacific Behavioral Health at 1-800-577-7244 or PO Box 3009, Hillsboro OR 97123-3009
- Would like to know more about your rights under the law or believe any of these mental health benefits do not conform to the plan or your rights, contact the Washington State Insurance Commissioner at 1-800-562-6900.

► **Neurodevelopmental Therapy**

To receive neurodevelopmental therapy, your PCP must obtain preauthorization from the participating medical group or PacifiCare. The plan covers neurodevelopmental therapy for covered family members six and younger, including:

- Hospital care
- Physician services
- Occupational, speech and physical therapy (if ordered and periodically reviewed by a physician)
- Maintenance of the patient when his/her condition would significantly worsen without those services
- Services to restore and improve function.

► **Newborn Care**

The plan covers newborns under the mother's coverage for the first 21 days, as required by Washington State law (see "Maternity Care"). To continue the newborn's coverage after 21 days, the newborn must be eligible and enrolled by the deadline as described in "Changes You May Make When a Qualifying Event Occurs" in the Important Facts booklet.

Postnatal hospital services are covered including:

- Circumcision if desired and performed in the hospital (if the circumcision is delayed by the physician during newborn hospitalization, it's covered at the first check-up when specified by the physician)
- Special care nursery.

► **Physician and Other Medical/Surgical Services**

The plan covers:

- Immunization agents or biological sera, such as allergy serum (immunizations for travel are not covered)

- Medical care in the physician's or alternative provider's office
- Nutrition counseling by a registered nutritionist or dietitian when medically necessary for disease management
- Physician services for surgery, anesthesia, inpatient and emergency room visits
- Second opinions obtained before treatment (the provider giving the second opinion must be qualified, either through experience or specialist training; PacifiCare also has the right to ask for a second opinion to confirm the medical necessity of a proposed surgery or treatment plan).

► **Phenylketonuria (PKU) Formula**

The plan covers the medical dietary formula that treats phenylketonuria (PKU). You may order up to five cases in any month.

► **Prescription Drugs**

What's Covered. Prescription drugs are those that can be dispensed only by written prescription of a physician or someone else authorized to prescribe that drug under applicable state law. The plan covers:

- Birth control prescriptions (oral and injectable)
- Compound medications if the medication is made up of at least one prescription drug
- Devices and supplies that require a physician's prescription by law
- Glucagon emergency kits
- Glucose testing strips, injection devices and lancelets equaling the supply of covered insulin dispensed (you pay a prescription drug copay for these supplies in addition to the copay for the related drug)
- Insulin
- Needles and syringes equaling the supply of covered self-administered injectable drugs dispensed
- Other prescription drugs except those listed below.

What's Not Covered. The following prescription drugs and items are not covered:

- Appetite suppressants
- Drugs dispensed by a provider other than the mail order or network pharmacy (however, benefits may be available under other plan benefits, for example, hospital inpatient care)
- Drugs labeled "Caution – limited by federal law to investigational use" or experimental drugs
- Drugs prescribed by a provider not authorized by the state to prescribe the drugs or by a type of provider not covered under this plan
- Drugs used for cosmetic purposes
- Lifestyle drugs, such as for anti-obesity or anti-aging
- Nicotine-containing preparations in any form unless you're currently enrolled in the Free & Clear® StopSmokingSM Program and authorized for nicotine patches
- Non-prescription drugs, other than insulin and prescription drugs equivalent to non-prescription drugs
- Prescription medicine for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmia or hyporgasmia
- Therapeutic devices or appliances, support garments or other nonmedical supplies (except pressure stockings as described in "Durable Medical Equipment, Prosthetics and Orthopedic Appliances")
- Vitamins.

Preauthorization. PacifiCare reserves the right to require preauthorization by your physician and/or to limit the quantity of any prescription to meet these criteria:

- The prescription is for the treatment of a medical condition
- There is sufficient evidence to draw conclusions about the prescription's effect on the medical condition and health outcome
- Expected beneficial effects of the prescription outweigh expected harmful effects.

Preauthorization is also required when it's medically necessary to take medication above the preset limits for a particular condition/circumstance or if an exception to plan provisions is requested. Your provider may request

preauthorization by calling or faxing Prescription Solutions, PacifiCare's pharmacy benefit manager, Monday through Friday 6 a.m.-6 p.m. Pacific time (see the Resource Directory booklet).

Most preauthorization requests are processed within 24 hours unless your provider needs to submit more information about your diagnosis and medication history or to establish that the requested medication meets plan criteria.

You may appeal the decision by contacting PacifiCare (see "Appealing Claims or Treatment Preauthorization Requests Denied for Reasons Other Than Eligibility").

Filling a Prescription. To obtain covered prescription drugs, you may use the mail order program (up to a 90-day supply) or network pharmacies (up to a 30-day supply). Prescriptions from any other pharmacies are covered only in an emergency or for out-of-area plan participants.

Mail Order Pharmacy. The first time you use the mail order pharmacy, fill out the patient information questionnaire on your prescription drug order form (contact PacifiCare for a form; see the Resource Directory booklet). Questionnaire information is maintained to help the pharmacist cross check future medicines for drug allergies.

Each time you order, send the order form with the written prescription and your payment directly to the mail order pharmacy address on the form. Or have your physician call in the prescription directly to the mail order pharmacy (the toll-free number is on the form).

Prescriptions are usually sent in 10 to 14 days. If you don't receive your medicine within 14 days or if you have questions, contact the mail order pharmacy (see the Resource Directory booklet).

Network Pharmacies. Network pharmacies dispense covered prescription drugs to PacifiCare participants at a discount and don't bill for any amounts over the copay. You may go to any network pharmacy; a PCP referral is not necessary. For a list of network pharmacies, contact PacifiCare (see the Resource Directory booklet).

To fill a prescription at a network pharmacy:

- Show your ID card to the network pharmacist each time you want a prescription filled or refilled (PacifiCare issues an ID card for each participant; if you buy covered drugs for your child, show the child's ID card)
- Pay the copay for each covered prescription or refill; there are no claim forms to submit (the network pharmacy bills the plan directly).

If you don't show your ID card and the network pharmacy cannot reach PacifiCare to confirm you're covered, no benefits will be provided except for these cases where you pay the pharmacy in full and submit the claim to PacifiCare:

- Emergency and urgent situations
- Out-of-area plan participants
- Participants who haven't yet received their ID cards.

Your Rights. State and federal law establish standards to assure safe, effective pharmacy services and guarantee your right to know what drugs are covered under this plan and what coverage limits are in your contract. If you:

- Would like a more detailed description of prescription benefits covered under this plan, or if you have a question or a concern about any aspect of your benefits, contact PacifiCare (see the Resource Directory booklet)
- Would like to know more about your rights under the law, or if you believe any of these prescription benefits do not conform to the terms of the plan or your rights under the law, contact the Washington State Insurance Commissioner at 1-800-562-6900.

► Preventive Care

You don't need a PCP referral before seeing a network provider for routine women's health care services (maternity care, reproductive health services and gynecological care). However, depending on the service (for example, if you need surgery), you may need preauthorization.

The following preventive care is covered:

- Immunizations, including annual flu shots (immunizations for travel are not covered)
- Routine tests, such as physicals, Pap tests and hearing tests.

Mammograms are covered, but not under this preventive care benefit (see "Lab, X-ray and Other Diagnostic Testing"). Home cholesterol tests are not covered.

Preventive care benefits for children are payable according to the following schedule:

Age	Preventive Care
Birth to 1 year	Routine newborn care
1- 5 years	4 visits/year
6 - 12 years	1 visits/year

Additional Preventive Care and Health Management Programs. To help you stay healthy, PacifiCare makes these additional programs available to you (for details, contact PacifiCare; see the Resource Directory booklet):

- 24-Hour Health Information Line
- Free & Clear® StopSmokingSM
- Menopause: Understanding Your Options (online program)
- PacifiCare Perks (discounts for health and safety services/products)
- Pregnancy to Preschool (online program)
- Taking Charge of Diabetes®
- Taking Charge of Depression®
- Taking Charge of Your Health®.

► Radiation Therapy, Chemotherapy and Respiratory Therapy

Inpatient and outpatient services are covered for radiation, chemotherapy and respiratory therapy prescribed by your PCP.

► Reconstructive Services

The following reconstructive services are covered when preauthorized by PacifiCare:

- Corrections of a child's congenital anomaly or disease
- Treatment for an injury within six months after the accident causing the injury, or as soon as medically feasible
- Reconstructive breast surgery and associated procedures following a medically necessary mastectomy (regardless of when the mastectomy was performed) and determined in consultation with the patient and attending physician, including:
 - Reconstruction of the breast on which the mastectomy has been performed
 - Surgery and reconstruction of the healthy breast to produce a symmetrical appearance
 - Prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas
 - Reduction mammoplasty when established medical criteria are met
 - Removal of breast implants.

► **Rehabilitative Services**

To receive rehabilitative inpatient or outpatient care, your PCP must obtain preauthorization from his/her participating medical group or PacifiCare.

Inpatient rehabilitative care is covered if:

- Medically necessary to restore or improve normal body functions lost or impaired due to illness or injury
- Provided in a hospital or Medicare-certified inpatient rehabilitative facility and
- Services could not be done in a less intensive setting and are ordered by a physician.

Covered services include physical, speech and occupational therapy as well as other services normally a part of inpatient rehabilitative care.

Outpatient rehabilitative care is covered if:

- Received from a provider licensed, registered or certified as required by the state to provide the services
- Medically necessary to restore or improve normal body functions lost or impaired due to illness or injury and
- Ordered by a physician.

Covered services include physical, speech and occupational therapy.

Outpatient rehabilitative care does not cover:

- Care to halt or slow further physical deterioration
- Self-help training (such as Outward Bound or recreational therapy)
- Evaluation or treatment of learning disabilities except as provided for neurodevelopmental therapy
- Social, vocational or cultural rehabilitation.

► **Skilled Nursing Facility**

To receive skilled nursing facility care, your PCP must obtain preauthorization from the participating medical group or PacifiCare. Skilled nursing facility services are covered if:

- Provided and billed by a licensed Washington State skilled nursing facility
- The care takes the place of a hospital stay.

Prescription drugs are covered when provided by the skilled nursing facility and used by the patient during a period of covered skilled nursing facility care.

The following are not covered:

- Care or services not usually provided by a skilled nursing facility
- Confinement for developmental disabilities, mental conditions or primarily domiciliary, convalescent or custodial care
- Services or supplies not included in the approved treatment plan
- Services by a person who lives in your home or is a family member
- Travel costs.

► **Smoking Cessation**

You do not need a PCP referral to participate in PacifiCare's Free & Clear® StopSmokingSM program; simply call 1-800-292-2336 (TTY 1-877-777-6534) to register.

The program provides materials and phone counseling to help you quit smoking at your own pace. If you're interested in tobacco cessation aids, you'll be screened when you enroll and advised (if eligible) how to obtain them (you must continue participating in the program to receive the aids).

► **Sterilization Procedures**

See “Family Planning.”

► **Transplants**

There is a 12-month waiting period for transplants (except skin grafts); you become eligible to receive transplant services the first day of the 13th month you’re covered under this plan. The waiting period will be reduced or eliminated based on prior coverage in a PacifiCare plan; the coverage must be continuous with no lapse greater than 63 days. Every month of prior coverage in a PacifiCare plan will reduce the 12-month waiting period by one month.

To receive transplant services, your PCP must obtain preauthorization from the participating medical group or PacifiCare.

Once the waiting period is satisfied and preauthorization obtained, the following transplant services are covered for a recipient:

- Clinical services for a living donor once the donor is identified (there is no dollar limitation for donor related clinical transplant services, but transportation and other non-clinical expenses of a living donor are not covered under this benefit; remember, all services/supplies must be medically necessary to be covered)
- Donor searches performed by a provider in the National Preferred Transplant Network (see the Glossary booklet)
- Non-experimental/non-investigational organ transplants and autologous and allogeneic bone marrow and stem cell transplants performed at a National Preferred Transplant Network facility (you may be accepted by two network facilities for organ transplant listings if the regional organ procurement agency for each facility differs; if this happens, coverage is limited to the actual transplant at the second facility; you’re responsible for any duplicated diagnostic costs incurred at the second facility)
- Testing of your immediate blood relatives (sisters, brothers, parents or natural children) and unrelated donors identified through donor searches to determine donor compatibility.

If the National Preferred Transplant Network facility preauthorized by PacifiCare is more than 60 miles from your primary residence, additional services are covered for the recipient and one escort:

- Transportation
- Food (excluding liquor and tobacco) and housing, limited to \$125 a day for both recipient and escort.

The transplant benefit does not cover:

- Anti-rejection medications (covered under prescription drug benefit)
- Care related to the transplant and received during the 12-month transplant waiting period (see “Preexisting Condition Limit”)
- Donor costs when the donor is a plan participant but the recipient is not
- Experimental or investigational transplants
- Services for which government funding is available, other than Medicare, Medicaid or CHAMPUS
- Storage costs for any organ or bone marrow
- Tissue typing or matching for anyone other than the immediate blood relatives and identified unrelated donors described
- Transplants of mechanical or nonhuman organs
- Transportation or other non-clinical expenses of the living donor
- Transportation of any family members for typing and matching.

► **Urgent Care**

This plan covers urgent care for medical conditions that are not life threatening but may need immediate attention, for example:

- Ear infections

- High fever
- Minor burns.

If you need urgent care, call your PCP or Participating Medical Group (24-hour phone numbers are on the front of your ID card). If you call during non-business hours and a provider isn't immediately available, ask for the provider-on-call to be paged and call you back with instructions.

If your PCP, Participating Medical Group or provider-on-call is unavailable, seek services from any licensed medical professional and notify your PCP or Participating Medical group within 24 hours of receiving the services. Otherwise, if you, the hospital staff or someone else on your behalf does not contact PacifiCare within 24 hours, you may be responsible for all costs incurred before you call.

► Vision Care

The plan covers the vision care described in the "Summary of Covered Expenses," but does not cover:

- Any eye exam or corrective eyewear required by an employer as a condition of employment
- Any vision care services, supplies or treatment except as specifically described
- Any vision care services, supplies or treatment provided by another plan
- Contact lens fitting (K-reading) fees
- Initial lenses and/or frames provided in connection with post-cataract surgery
- Orthoptics or vision training and any associated supplemental testing
- Medical or surgical treatment of the eyes (which is a basic covered benefit for which you must be referred back to your PCP)
- Plain (non-prescription) lenses
- Replacement of lost or broken lenses or frames furnished through this plan (except at normal service intervals)
- Two pair of glasses instead of bifocals
- Subnormal (low) vision aids.

Expenses Not Covered

In addition to the exclusions or limits described in other sections of this booklet, the PacifiCare plan does not cover:

- Acupressurist or homeopath procedures or those supplied by a Christian Science practitioner/sanitarium or rabbi
- Charges in excess of UCR rates (see the Glossary booklet)
- Child's pregnancy, including complications or termination
- Claims not made to PacifiCare within 12 months of the date of service (if you can't submit the claim on time due to circumstances beyond your control, PacifiCare will consider the claim for payment if you write and explain the circumstances)
- Conditions for which the Veterans Administration, federal, state, county or municipal government or any of the armed forces is responsible or provides treatment
- Conditions resulting from service in the armed forces, declared or undeclared war or voluntary participation in a riot, insurrection or act of terrorism except as required by law
- Convalescent or custodial care, no matter where it's given, or any part of a hospital stay that is primarily convalescent or custodial (this exclusion does not apply to home health and hospice care if part of an approved treatment plan)
- Cosmetic, plastic or reconstructive procedures furnished primarily to improve or change appearance (for example, breast enlargement or uplift except as specified, reshaping the nose/rhinoplasty, revising scars or keloids, surgery for sagging skin of the eyelids, face, neck, abdomen, hips or extremities) except the items listed under "Reconstructive Services," if preauthorized
- Court-ordered programs, services or supplies unless considered medically necessary by PacifiCare

- Dental care, except as described in “Injury to Teeth”; hospital care to extract teeth or for other dental care is not covered unless adequate care cannot be provided outside the hospital and an underlying medical condition requires hospitalization
- Educational or self-help training, except as described by the plan
- Elective or voluntary enhancement procedures, services, supplies or medications including, but not limited to:
 - Anti-aging
 - Athletic performance
 - Cosmetic purposes
 - Hair growth
 - Mental performance
 - Sexual performance
 - Weight loss
- Enteral therapy or nutritional supplements
- Exams, tests or shots required for work, insurance, marriage, adoption, immigration, camp, volunteering, travel, license, certification, registration, sports, school or recreational activities
- Experimental or investigational procedures (see the Glossary booklet)
- Foot care, such as:
 - Treatment of fallen arches or other symptomatic complaints unless associated with a disease affecting lower limbs
 - Prosthetics, appliances or orthotics connected with or inserted in shoes or impression casting for them (unless associated with diabetes)
 - Trimming of nails, corns or calluses (unless associated with diabetes)
- Habilitative therapy for hyperkinetic syndromes of childhood
- Hearing aids or costs related to their fitting and upkeep
- Jaw augmentation or reduction (orthognathic surgery), except when medically necessary
- Methadone, except when used in conjunction with an approved inpatient detoxification program
- Obesity procedures such as weight control programs, surgery or its complications or wiring of the jaw
- Orthoptics
- Procedures that are:
 - Covered under motor vehicle medical or no fault coverage, personal injury protection or similar insurance (this exclusion does not apply to uninsured motorist or underinsured motorist insurance coverage)
 - Furnished by a provider not licensed, registered or certified to perform them as required by the state where the provider is practicing
 - Not covered by the provider’s malpractice insurance
 - Not medically necessary for the diagnosis, treatment or prevention of injury, unless otherwise noted
 - Obtained without referral or preauthorization if required from your PCP, participating medical group or PacifiCare
 - Outside the scope of the provider’s license, registration or certification
 - Performed by a provider related to you by blood, marriage, adoption or legal dependency
 - Received while you’re not covered, for which no charge is made or for which a charge is available only because this plan is in effect, except as required by law
- Prescription or non-prescription drugs, or medicines for outpatient use, including take-home drugs from inpatient stays, other than those covered under the specific prescription drug benefit of this plan; the plan does not cover food items (except PKU formula), over-the-counter items or prescription drugs that are not preauthorized (if preauthorization is required)
- Prescription medication to treat sexual dysfunction, including erectile dysfunction, impotence or anorgasm, or hyporgasm
- Radial keratotomy or any surgery to change the cornea’s refractive character or complications from the surgery
- Reproductive or sexual disorders or defects (whether or not the consequence of illness, disease or injury) such as:
 - Artificial insemination or in vitro fertilization
 - Reversal of sterilization

- Treatment for:
 - Frigidity
 - Infertility (fertility/sterility studies or procedures to restore/enhance fertility are not covered)
 - Impotence
 - Sexual reassignment
- Temporomandibular joint (TMJ) disorders
- Vision analysis, therapy or training relating to muscular imbalance of the eye
- Work-related illness or injury (unless you're a LEOFF 1 employee and workers' compensation has been denied).

Coordination of Benefits

► Coordination of Benefits Between Plans

If you or your dependents are covered under another health plan, PacifiCare coordinates benefits with the other plan so you receive up to but not more than 100% of covered expenses; the benefit paid by PacifiCare will not exceed the amount that would have been paid if no other plan was involved.

If another plan does not have a coordination of benefit (COB) provision, the other plan always pays first (the plan that pays first is always called primary). Otherwise, the plan that covers the individual as an employee pays before the plan that covers the individual as a dependent.

The following guidelines determine what plan pays first for dependent children covered under two parents ("parents" in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)
- For a dependent child whose parents are divorced or legally separated, the plans pay benefits in this order (unless there is a court decree establishing financial responsibility for the child's health care):
 - The plan of the parent with custody
 - The plan of the spouse of the parent with custody
 - The plan of the parent without custody
 - The plan of the spouse of the parent without custody.

If a court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility pays first.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer this COB provision.

► Coordination of Benefits With Medicare

If you keep working for the county after age 65 you may:

- Continue your medical coverage under a county plan and integrate the county plan with Medicare (the county plan would be primary)
- Discontinue your county medical coverage and enroll in Medicare; if you choose this option, your covered family members are eligible for continuation of coverage under COBRA for up to 36 months (see "COBRA" in the Important Facts booklet).

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan covering a person as an active employee or family member of an active employee. Medicare is primary in most other circumstances.

If you have any questions about how your coverage coordinates with Medicare, contact your medical plan (see the Resource Directory booklet).

Filing a Claim

► What to Do

If you receive care from a PacifiCare network provider, the provider submits claims for you. If you receive emergency services from a non-network provider, you pay the provider in full, and it's your responsibility to submit a claim form to PacifiCare or have the provider submit one for you. Claim forms are available from PacifiCare (see the Resource Directory booklet).

When submitting any claim, you need to include your itemized bill. It should show:

- Patient's name
- Provider's tax ID number
- Diagnosis or ICD-9 code
- Date of service/supply
- Itemized charges from the provider for the services/supplies received.

You also need to provide:

- Your name (if you were not the patient)
- Your Social Security number (or unique identifier number if assigned one by your plan)
- Group number (shown on your PacifiCare ID card and available from Benefits and Retirement Operations)
- Date, time, location and brief description of accident if treatment is the result of an accident.

Submit a claim within 90 days, or as reasonably possible, of receiving service/supply; the plan will not pay a claim submitted more than 12 months after the date of service/supply. (If you can't meet the 12-month deadline because of circumstances beyond your control, the claim may be considered for payment when accompanied by a written explanation of the circumstances.)

PacifiCare will make a determination within 30 days from the date you submit a complete claim. PacifiCare will not pay for any excluded service/supply unless authorized by your PCP, the participating medical group or directly by PacifiCare. Any payment assumes you've not exceeded your benefit limits; if you've reached or exceeded any applicable benefit limit, these bills will be your responsibility.

► If the Claim Is Approved

If the claim is approved and there is no indication the bill has been fully paid, payment for covered services is made to the provider. If the bill indicates full payment has been made to the provider, payment for covered services is made directly to you.

► If the Claim Is Denied

If the claim is denied, you're notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that PacifiCare reviewed in making the determination.

If You Have a Problem

► **Appealing Claims or Treatment Preauthorization Requests Denied for Reasons Other Than Eligibility**

If a properly filed claim or treatment preauthorization request is denied in whole or in part, PacifiCare notifies you and your provider with an explanation in writing. When a claim/request is denied for any reason other than eligibility, follow the steps described in this section. However, when a claim/request is denied for eligibility reasons, follow the steps described in “Appealing Claims or Treatment Preauthorization Requests Denied Due to Eligibility.”

If you or your representative disagrees with a claim/request denial, you may try to resolve any misunderstanding by calling PacifiCare and providing more information (see the Resource Directory booklet). If you’d rather communicate in writing or the issue isn’t resolved with a call, you may submit an appeal either orally or in writing by contacting PacifiCare within 180 calendar days of receiving an initial claims/request determination.

You may submit written comments, documents, records and any other information relating to your appeal regardless of whether this information was submitted or considered in the initial claims/request determination. You may obtain, upon request and free of charge, copies of all documents, records and other information relevant to your appeal.

Your appeal is reviewed by an individual who is neither the individual who made the initial claims/request determination nor the subordinate of that person. If the appeal involves a clinical issue, the necessity of treatment or the type of treatment or level of care proposed or used, the appeal determination is made by a medical reviewer health care professional who has the necessary education, training and relevant expertise in the field of medicine to evaluate the specific clinical issues that serve as the basis of your appeal.

PacifiCare reviews your appeal within a reasonable time appropriate to the medical circumstances and makes a determination within 30 calendar days of receiving the appeal. For appeals involving the delay, denial or modification of health care services, PacifiCare’s written response:

- Includes the specific reason for the decision
- Describes the criteria, guidelines or benefit provision on which the denial was based
- Explains that, upon request, you may obtain a copy of the actual benefit provision, guideline protocol or other similar criterion on which the denial is based.

If your appeal involves an imminent and serious threat to your health (including, but not limited to, severe pain or the potential loss of life, limb or major body function) it is immediately referred to PacifiCare’s clinical review personnel. PacifiCare immediately informs you of your review status in a written statement of the disposition or pending status of the expedited review no later than three calendar days from receiving your appeal.

Experimental or Investigational Treatment. A claim or treatment preauthorization request may be denied because PacifiCare determines the treatment is experimental or investigational. If your provider certifies you have a terminal illness (an incurable or irreversible condition with a high probability of causing death within a year or less) and the requested service or procedure would be significantly less effective if not promptly initiated, you may request a conference within 20 business days of receiving the denial.

Non-Binding Arbitration. You have the right to submit to arbitration under the commercial mediation rules of the Judicial Arbitration and Mediation Systems. There is no charge for this service; however, the decision is not binding to either party. To initiate this, contact PacifiCare.

► **External Review for Denied Appeals**

If an appeal of a denied claim or treatment preauthorization request is denied, or PacifiCare fails to respond to your appeal within the timeframe described in “Appealing Claims or Treatment Preauthorization Requests Denied

for Reasons Other Than Eligibility,” you may request an external, independent review. The review is provided by the Independent Review Organization (IRO), a group of providers qualified to determine the medical necessity of treatment. The IRO is under contract to the Washington State Department of Health and not materially affiliated with PacifiCare. There is no charge for the external review process, once you’ve exhausted the appeal process.

To request an external review, you, your provider or your designated representative must submit the request to PacifiCare (see the Resource Directory booklet) within 180 days following your appeal denial. Within three business days of receiving your request, PacifiCare forwards it to the IRO with:

- All relevant medical records and other documents used by PacifiCare to decide your case
- All information or evidence submitted by you and your provider, including any additional information you think is relevant that may not have been included with your denied appeal.

Neither you nor PacifiCare may meet with the IRO provider or otherwise participate in the provider’s decision.

Within 25 business days of receiving all review request materials (within eight business days if your provider certifies the requested service or procedure would be significantly less effective if not promptly initiated), an IRO provider or panel of providers (if deemed appropriate by the IRO) makes a decision. If the IRO providers need more information to make a decision, this time period may be extended.

The IRO provides you and PacifiCare with a written copy of its decision, a description of the provider qualification and any other information deemed appropriate. If the final external decision is to approve payment or preauthorization, PacifiCare will accept the decision and cover the service or procedure according to plan terms and conditions. If the final review decision is that payment or preauthorization should not be made, PacifiCare is not obligated to coverage the service or procedure.

For more information about this external, independent review process, contact PacifiCare (see the Resource Directory booklet).

► **Quality of Care Complaints**

To submit quality of service complaints, including those requiring clinical review, contact PacifiCare.

Complaints affecting your current condition are reviewed immediately. PacifiCare conducts this review by investigating the complaint and consulting with your participating medical group, treating providers and other PacifiCare departments. Medical records are reviewed as necessary; you may need to authorize their release.

PacifiCare notifies you in writing regarding quality of care issues within 30 calendar days of receiving your complaint. Results of the review are confidential and protected from legal discovery under Washington State law.

If a claim for benefits or reimbursement is part of your quality of care complaint, the claim is reviewed through the appeals process described in “Appealing Claims or Treatment Preauthorization Requests Denied for Reasons Other Than Eligibility.”

► **Claims Against Participating Medical Groups, Etc.**

Claims against participating medical groups, the group’s physicians, providers or hospitals (other than claims for benefits under your coverage) are not governed by the terms of this plan; you may seek any appropriate legal action against those persons and entities deemed necessary. However, in the event of such a claim, PacifiCare makes available the appeals process for resolution. If you and the other party agree to follow the PacifiCare appeals process to resolve your claim:

- All parties must agree to this resolution process
- Any decision reached through the appeals process is not binding upon the parties unless the parties agree
- Resolution of the claim is not subject to binding arbitration unless the parties agree
- If the grievance isn’t resolved, you and the other party may seek any appropriate legal action deemed necessary.

► **Appealing Claims or Treatment Preauthorization Requests Denied Due to Eligibility**

If you have eligibility questions or believe you've had a claim or treatment preauthorization request denied because the plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of this section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these timeframes:

- 72 hours for urgent appeals (call 206-684-1556 to file an urgent appeal)
- 14 days for pre-service appeals (within 30 days if an extension is filed)
- 20 days for post-service appeals (within 40 days if an extension is filed)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice includes the plan provision behind the decision and advises you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an eligibility appeal addendum within 60 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Release of Medical Information

As a condition of receiving benefits under this plan, you and your family members authorize:

- Any provider to disclose to the plan any requested medical information
- The plan to examine your medical records at the offices of any provider
- The plan to release to or obtain from any person or organization any information necessary to administer your benefits
- The plan to examine records that would verify eligibility.

The plan will keep this information confidential whenever possible, but under certain necessary circumstances, it may be disclosed without specific authorization.

Certificate of Coverage

When your coverage under this plan ends, you automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under this plan.

Converting Your Coverage

If you're no longer eligible for the medical coverage described in this booklet, you may transfer your coverage to an insured conversion plan. The plan you convert to will differ from the benefits described in this booklet. You must pay premiums, which may be higher than amounts you currently pay (if any) for these benefits.

You will not be able to convert to the individual policy if you're eligible for any other medical coverage under any other group plan (including Medicare).

To apply for a conversion plan, you must complete and return an application form to PacifiCare within 31 days after this medical coverage terminates. Evidence of insurability will not be required. You will not receive this application or information about conversion plan coverage unless you request it from PacifiCare (see the Resource Directory booklet).

Extension of Coverage

If this plan is canceled, PacifiCare will continue to cover any participants who are hospital inpatients on the cancellation date. Coverage ends on the date of discharge or when the participant reaches the plan maximums, whichever comes first.

Payment of Benefits

The medical benefits offered by this plan are insured by PacifiCare, meaning this is not a self-funded plan. PacifiCare is financially responsible for claim payments and other costs.

Deputy Sheriff Booklet 4

Group Health Medical/Vision

Although these benefit descriptions include certain key features and brief summaries of King County deputy sheriff benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts and other legal documents, the contracts and legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

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Overview

► Highlights of Group Health Coverage

Here are a few highlights of your coverage under the Group Health plan:

- You do not pay an annual deductible under this plan
- You pay copays for office visits, prescription drugs and emergency room care (if not admitted)
- You must select a Group Health primary care physician (PCP)
- Your PCP can provide and coordinate all services through the Group Health network unless you have an emergency or your PCP refers you outside the network
- You may self-refer to Group Health staff specialists directly, without going through your PCP
- Network benefits are generally paid at 100% after the copays.

If you're a LEOFF 1 employee, you may have certain additional benefits paid by the county. For more information, contact the LEOFF 1 Disability Retirement Board or Benefits and Retirement Operations (see the Resource Directory booklet).

► Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just this plan and can change frequently. To be more efficient, and avoid repetition, the following related information appears only in the Important Facts booklet:

- Who's eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends and options for continuing it after you leave employment
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

When you receive medical care, you pay:

- Required copays at the time of the service
- Coinsurance amounts not covered by the plan
- Expenses for services or supplies not covered by the plan.

A billing fee may be charged by Group Health if copays or bills reflecting expenses not covered by the plan are not paid within 30 days of the billing date.

See “Covered Expenses Under Group Health” for details on copays and coinsurance amounts.

Preexisting Condition Limit

This plan does not have a preexisting condition limit. However, there is a waiting period for transplants and growth hormones (see “Transplants” and “Growth Hormones” in the “Covered Expenses Under Group Health” section).

If you end employment with King County, please refer to “Certificate of Coverage” in this booklet for information on how your participation in this plan can be credited against another plan with a preexisting condition limit.

How the Plan Works

► Plan Features

The following table identifies some plan features, including your out-of-pocket maximum and how benefits are determined for most covered expenses. The sections after the table contain additional details.

Plan Feature	Group Health
Provider choice	You choose a Group Health PCP who provides and coordinates most services through the Group Health network; you may also self-refer to Group Health staff specialists; no non-network coverage unless indicated
Annual deductible	None
Copays	See “Summary of Covered Expenses” for amounts
After the copays, the plan pays most covered services at this level ...	100% network
Until you reach your annual out-of-pocket maximum...	\$1,000/person, \$2,000/family for network care and limited emergency/out-of-area non-network care
Then, most benefits are paid for the rest of the calendar year at ...	100% network
Lifetime maximum	No limit

► Network Providers

Network providers may be either staff members of Group Health or contracted professionals. All providers who make up the network are carefully screened by Group Health. Doctors and other health care professionals must complete a detailed application to be considered for the network. The application covers education, status of board certification, malpractice and state sanction histories. For a list of network providers, contact Group Health (see the Resource Directory booklet).

► Out-of-Area Coverage

Out-of-area benefits are limited under this plan.

Emergency and Urgent Care. Emergency and urgent care are covered while traveling anywhere in the world. If you receive care from a Group Health Cooperative or Group Health-associated Kaiser Permanente provider, coverage is the same as when you see your regular Group Health provider. If you receive care from a provider not associated with Group Health, you or a family member must call 1-888-457-9516 within 24 hours or as soon as possible to receive the same coverage. (If you’re unsure about when emergency and urgent care are covered, call the Group Health consulting nurse at 1-800-297-6877.)

Routine Care. Routine care is covered while temporarily living away from home for less than 90 days or living away from home as a student if received from a Group Health-associated Kaiser Permanente provider. Call 1-888-457-9516 to arrange the care.

► Selecting a Primary Care Physician

Your PCP is your personal doctor and can act as the coordinator of all your medical care. PCPs can be family or general practitioners, internists or pediatricians. If you need a specialist, your PCP can arrange it.

You’re strongly encouraged to select a PCP from the Group Health network provider directory when you enroll. Each family member may have a different PCP. The provider directory is updated periodically; for current information about providers, contact Group Health (see the Resource Directory booklet).

Continuity of your care is important, and easier to achieve if you establish a long-term relationship with your PCP. However, if you find it necessary to change your PCP, call Group Health.

► **Specialists**

Your PCP can provide or coordinate your medical care, including specialist care. In most cases, your doctor will refer you to a network specialist. Or, if you wish, you may make appointments directly with any Group Health staff specialist without a referral from your PCP. However, referrals are required to see contracted specialists. (You can tell the difference between a Group Health staff specialist and a contracted specialist because Group Health staff specialists practice in Group Health facilities.)

When you're referred to any network specialist (staff specialist or contracted specialist), be sure to get a copy of the referral form from your PCP and take it to the specialist. To allow your PCP to coordinate your care most effectively, check back with him or her after a specific time or number of specialist visits. If you have a complex or chronic medical condition, you may obtain a standing specialist referral.

If you see a non-network provider without a referral, benefits may not be payable.

► **Annual Out-of-Pocket Maximum**

The out-of-pocket maximum is generally the most you pay toward copays/coinsurance each calendar year. This means once you reach your out-of-pocket maximum, the Group Health plan pays 100% of most covered expenses for the rest of the calendar year.

The following do not apply to the out-of-pocket maximum:

- Coinsurance for mental health care and devices, equipment and supplies
- Charges beyond benefit maximums
- Services and supplies not covered by the plan.

► **Accessing Care**

Generally, to receive benefits:

- You make an appointment with a network provider
- You pay a \$7 office visit copay at the time you receive health care services
- After the copay, the plan pays 100% for most covered services and handles all forms and paperwork.

You may receive benefits when you see non-network providers in the following situations only:

- Emergency care
- If your network provider refers you to a non-network provider.

See also "Out-of-Area Coverage."

► **Second Opinions**

You may request a second opinion regarding a medical diagnosis or treatment plan from a network provider.

Covered Expenses Under Group Health

► **Summary of Covered Expenses**

The table beginning on the next page summarizes covered services and supplies under this plan (only medically necessary services and supplies are covered) and identifies related coinsurance, copays, maximums and limits. Also see the sections after the table as well as "Expenses Not Covered."

Covered Expenses	Group Health
Alternative care	Self-referrals to a network provider are covered up to 5 visits/medical diagnosis/calendar year for acupuncture and up to 2 visits/medical diagnosis/calendar year for naturopathy; all other alternative care may require PCP referral The \$7 copay/visit applies to alternative care
Ambulance services	80% for ground or air transport; 100% for ground transfers initiated by Group Health
Chemical dependency treatment	100% for inpatient 100% after \$7 copay/visit for outpatient \$11,841 maximum/24 consecutive months (maximum subject to annual adjustment)
Circumcision	100% after applicable copay
Devices, equipment and supplies	80% if authorized in advance by a network provider as medically necessary
Diabetes care supplies (insulin, needles, syringes, lancets, etc.)	Covered under the prescription drug benefit
Diabetes care training	100% after \$7 copay/visit
Emergency care	100% after \$75 copay/visit to network facility (copay waived if admitted) 100% after \$125 copay/visit to non-network facility (copay waived if admitted) Non-emergency care not covered
Family planning	Covered at various levels; call plan for details
Growth hormones	Covered under the prescription drug benefit (subject to 12-month waiting period)
Home health care	100%
Hospice care	100% (limits apply; call plan for details)
Hospital care	100%
Infertility treatment	Not covered
Injury to teeth	Not covered
Lab, x-ray and other diagnostic testing	100%
Manipulative therapy (including chiropractic services)	100% after \$7 copay/visit up to 10 visits/year
Maternity care	100% for delivery and related hospital care 100% after \$7 copay/visit for prenatal and post-partum care
Mental health care	80% up to 12 days/year for inpatient 100% after \$20 copay/individual, family or couple visit or \$10 copay/group session for outpatient Up to 20 outpatient visits/year
Neurodevelopmental therapy for covered family members age 6 and under	100% for inpatient up to 60 days/condition/year (combined with rehabilitative services) 100% after \$7 copay/visit for outpatient up to 60 visits/condition/year (combined with rehabilitative services)
Out-of-area coverage for your children away at school	Reciprocal benefits available through Kaiser Permanente and

Covered Expenses	Group Health
	affiliated HMOs; only emergency services covered in all other areas
Physician and other medical/surgical services	100% for inpatient 100% after \$7 copay/visit for outpatient
Phenylketonuria (PKU) formula	100%
Prescription drugs – up to 30-day supply through network pharmacies and mail order	100% after \$5 copay/prescription or refill No reimbursement for prescriptions filled at non-network pharmacies
Preventive care (check-ups, immunizations, routine health, etc.)	100% after \$7 copay/visit (according to well-child/adult preventive care schedule)
Radiation therapy, chemotherapy and respiratory therapy	100% after \$7 copay/visit
Reconstructive services (including benefits for mastectomy-related services – reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema; call plan for more information)	100% inpatient \$7 copay/visit for outpatient
Rehabilitative services	100% for inpatient services up to 60 days/condition/year (combined with neurodevelopmental therapy) 100% after \$7 copay/visit for outpatient services up to 60 visits/condition/year (combined with neurodevelopmental therapy)
Skilled nursing facility	100% up to 60 days/condition at a Group Health-approved nursing facility
Smoking cessation	100% for Group Health network provider program 1 course of nicotine replacement/year (prescription benefit copay applies) when prescribed by Group Health network provider
Sterilization procedures	100% after \$7 copay/visit for outpatient
Temporomandibular joint (TMJ) disorders	100% for inpatient 100% after \$7 copay/visit for outpatient Up to \$1,000/calendar year and a \$5,000 lifetime maximum
Transplants (certain transplants/services only)	Covered subject to applicable copay Limitations and exclusions apply
Urgent care (ear infections, high fevers, minor burns, etc.)	100% after \$7 copay/visit at a Group Health facility
Vision exams	100% after \$7 copay up to 1 exam in 12 consecutive months (must use Group Health providers)

► **Alternative Care**

Covered services, when medically necessary, include:

- Acupuncture, covered up to five visits per medical diagnosis in a calendar year
- Chiropractic, covered up to 10 visits per year
- Home births (see any Group Health network midwife for covered prenatal and home birth services)
- Massage therapy, as part of a formal rehabilitation program
- Naturopathy, covered up to two visits per medical diagnosis in a calendar year.

You can self-refer for acupuncture, chiropractic and naturopathy care but network provider referral is required for home births and massage therapy.

► **Ambulance Services**

Services of an ambulance company are covered if:

- Ordered or approved by your PCP
- Other transportation would endanger your health, and
- The transportation is not for personal or convenience reasons.

► **Chemical Dependency Treatment**

Your PCP can arrange chemical dependency services or for outpatient care, you may call Group Health Behavioral Health at 1-888-287-2680.

Treatment may include the following inpatient or outpatient services:

- Covered prescription drugs and medicines
- Diagnostic evaluation and education
- Organized individual and group counseling.

Detoxification services are covered as any other medical condition and are not subject to the chemical dependency limit. (Chemical dependency means a physiological and/or psychological dependency on a controlled substance and/or alcohol, where your health is substantially impaired or endangered, or your ability to function socially or to work is substantially disrupted.)

► **Devices, Equipment and Supplies**

Durable medical equipment is covered if:

- Designed for prolonged use
- It has a specific therapeutic purpose in treating your illness or injury
- Prescribed by your Group Health provider and part of the Group Health formulary, and
- Primarily and customarily used only for medical purposes.

Covered items include:

- Artificial limbs or eyes (including implant lenses prescribed by a network provider and required as a result of cataract surgery or to replace a missing portion of the eye)
- Diabetic equipment for home testing and insulin administration not covered under the prescription benefit (excluding batteries)
- External breast prosthesis and bra following mastectomy; one external breast prosthesis is available every two years (per diseased breast) and two post-mastectomy bras are available every six months (up to four in any consecutive 12 months)
- Non-prosthetic orthopedic appliances attached to an impaired body segment; these appliances must protect the body segment or aid in restoring or improving its function
- Ostomy supplies
- Oxygen and equipment for its administration
- Purchase of nasal CPAP devices and initial purchase of associated supplies (you must rent the device for one month before purchase to establish compliance)
- Rental or purchase (decided by the plan) of durable medical equipment such as wheelchairs, hospital beds and respiratory equipment (combined rental fees may not exceed full purchase price)
- Splints, crutches, trusses or braces.

► **Diabetes Care Training and Supplies**

Diabetes care training includes diet counseling, enrollment in diabetes registry and a wide variety of education materials.

Covered supplies include:

- Blood glucose monitoring reagents

- Diabetic monitoring equipment
- External insulin pumps
- Insulin syringes
- Lancets
- Urine testing reagents.

► **Emergency Care**

Emergency care is covered to treat medical conditions that threaten loss of life or limb, or may cause serious harm to the patient’s health if not treated immediately. You do not need a referral from your PCP before you receive emergency room care.

Examples of conditions that might require emergency care include:

- An apparent heart attack (chest pain, sweating, nausea)
- Bleeding that will not stop
- Convulsions
- Major burns
- Severe breathing problems
- Unconsciousness or confusion, especially after a head injury.

If you need emergency care, follow these steps:

- Dial 911 or go to the nearest hospital emergency room immediately. In cases when you can choose an emergency location, go to the nearest Group Health-contracted facility; this will allow Group Health to coordinate your care efficiently and perhaps reduce your expenses.
- When you arrive, show your Group Health ID card.
- If you’re admitted to a non-network facility, you must call 1-888-457-9516 within 24 hours; otherwise you may be responsible for all costs incurred before you call. If you’re unable to call, have a friend, relative or hospital staff person call for you. The plan’s phone number also is printed on the back of your ID card.

In general, follow-up care that is a direct result of the emergency must be received through Group Health. Outpatient medications prescribed by a non-Group Health provider and non-emergency use of an emergency facility are not covered.

► **Family Planning**

Covered family planning expenses include:

- Family planning counseling
- Services to insert intrauterine birth control devices (IUDs)
- Sterilization procedures
- Voluntary termination of pregnancy.

The plan does not cover:

- Infertility treatment, sterility or sexual dysfunction treatment or diagnostic testing
- Procedures to reverse voluntary sterilization.

Birth control drugs are covered under the prescription drug benefit.

► **Growth Hormones**

Growth hormones are covered, subject to the prescription drug copay. You or your family member will not be eligible for any growth hormone benefits until the first day of the 13th month of continuous coverage under this plan (unless continually covered under this plan from birth).

► Home Health Care

Home health care is covered if the patient is unable to leave home due to health problems or illness and the care is necessary because of a medically predictable, recurring need. Unwillingness to travel and/or arrange for transportation does not constitute an inability to leave home. If you have an approved treatment plan and referral from a network provider, covered expenses include:

- Medical social worker and limited home health aide services
- Nursing care
- Occupational therapy
- Physical therapy
- Respiratory therapy
- Restorative speech therapy.

The following services are not covered:

- Care provided by a member of the patient's family
- Custodial care or maintenance care
- Housekeeping or meal services
- Private duty or continuous care in the patient's home (some periodic nursing care is covered)
- Other services rendered in the home that are not specifically listed as covered.

► Hospice Care

Hospice care is a coordinated program of supportive care for a dying person by a team of professionals and volunteers. The team may include a physician, nurse, medical social worker, physical, speech, occupational or respiratory therapist or home health aide under the supervision of a registered nurse.

Hospice services are covered if:

- A network provider determines the patient's illness is terminal, with life expectancy of six months or less, and can be appropriately managed in the home or hospice facility
- The patient has chosen comforting and supportive services rather than treatment aimed at curing their terminal illness
- The patient has elected in writing to receive hospice care through the Group Health-approved hospice program, and
- The patient has a primary care person who will be responsible for the patient's home care.

One period of continuous home care hospice service is covered. A continuous home care period is skilled nursing care provided in the home 24 hours a day during a period of crisis to maintain a terminally ill patient at home. A network provider must determine the patient would otherwise require hospitalization.

Continuous respite care may be covered for up to five days per occurrence of hospice care. Respite care must be given in the most appropriate setting as determined by your network provider.

The following services are not covered:

- Custodial care or maintenance care
- Financial or legal counseling (examples are estate planning or the drafting of a will)
- Funeral arrangements
- Homemaker, caretaker or other services not solely related to the patient, such as:
 - House cleaning or upkeep
 - Meal services
 - Sitter or companion services for either the participant who is ill or for other family members
- Services provided by members of the patient's family
- Transportation.

► **Hospital Care**

The following hospital care expenses are covered under this plan:

- Drugs listed in the plan formulary and administered during a hospital stay
- Hospital services
- Room and board
- Special duty nursing.

► **Infertility Treatment**

The plan does not cover:

- Infertility treatment, sterility or sexual dysfunction treatment or drugs (such as penile implants or Viagra) or diagnostic testing
- Procedures to reverse voluntary sterilization.

See “Expenses Not Covered” for details.

► **Injury to Teeth**

Injuries to teeth are not covered under this plan.

► **Inpatient Care Alternatives**

See “Skilled Nursing Facility” and “Home Health Care.”

► **Lab, X-ray and Other Diagnostic Testing**

This plan covers diagnostic x-ray, nuclear medicine, ultrasound and laboratory services. See “Preventive Care” for more information on routine diagnostic testing (for example, mammograms).

► **Manipulative Therapy**

Manipulative therapy of the spine and extremities is covered. You do not need a referral from your PCP before you see a network chiropractor or osteopath. Associated x-rays are covered when provided at a Group Health radiology facility.

► **Maternity Care**

Maternity care is covered if provided by a:

- Physician
- Provider licensed as a midwife by Washington State.

Covered maternity care includes:

- Complications of pregnancy or delivery
- Hospitalization and delivery, including home births and certain birthing centers for low-risk pregnancies
- Post-partum care
- Pregnancy care
- Related genetic counseling when medically necessary for prenatal diagnosis of an unborn child’s congenital disorders
- Screening and diagnostic procedures during pregnancy (except routine ultrasound to determine fetal age, sex or size).

The plan does not cover home pregnancy tests.

Group health plans and health insurance issuers offering group coverage generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

► **Mental Health Care**

Inpatient and outpatient mental health services are covered. These services place priority on restoring social and occupational functioning; they include:

- Consultations
- Crisis intervention
- Evaluation
- Intermittent care
- Managed psychotherapy
- Psychological testing.

Your PCP can arrange for mental health services or you can contact Group Health Behavioral Health directly by calling 1-888-287-2680. (Counseling and referral services are also available through King County's Making Life Easier Program by calling 1-888-874-7290.)

The following mental health services are not covered:

- Custodial care
- Day treatment
- Specialty programs for mental health therapy not specifically authorized and approved by Group Health
- Treatment of personality disorders or learning, communication or motor skills disorders
- Treatment of sexual disorders, personal growth or relationship enhancement.

► **Neurodevelopmental Therapy**

The plan covers neurodevelopmental therapy for covered family members six and younger, including:

- Hospital care
- Maintenance of the patient when his or her condition would significantly worsen without such services
- Occupational, speech and physical therapy (if ordered and periodically reviewed by a physician)
- Physician services
- Services to restore and improve function.

The plan does not cover:

- Implementation of home maintenance programs
- Physical, occupational or speech therapy services when available through government programs
- Programs to treat learning problems
- Specialty/long term rehabilitation programs not offered by Group Health
- Therapy for degenerative or static conditions when the expected outcome is primarily to maintain the patient's level of functioning.

► **Newborn Care**

The plan covers newborns under the mother's coverage for the first 21 days, as required by Washington State law. To continue the newborn's coverage after 21 days, the newborn must be eligible and enrolled by the deadline as described in the Important Facts booklet.

► **Physician and Other Medical/Surgical Services**

Several other medical and surgical services are covered by this plan, including:

- Blood and blood derivatives and their administration
- Nonexperimental and noninvestigational implants limited to cardiac devices (excluding artificial hearts)
- Outpatient diagnostic radiology and lab services
- Outpatient radiation therapy and chemotherapy
- Outpatient surgical services
- Outpatient total parenteral nutrition therapy
- Podiatrist services (routine foot care not covered)
- Services performed by a network provider or oral surgeon, including reduction of a fracture or dislocation of the jaw or facial bones, excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof or floor of the mouth, incision of salivary glands and ducts (accidental injury to teeth not covered)
- Treatment of growth disorders by growth hormones.

► **Phenylketonuria (PKU) Formula**

The plan covers the medical dietary formula that treats phenylketonuria (PKU).

► **Prescription Drugs**

Benefits are provided for legend drugs (prescription drugs with an 11-digit code assigned by the labeler or distributor under FDA regulations) and other covered items (including insulin, injectables and contraceptive drugs and devices) when you use a network pharmacy or mail order, including off-label use of FDA-approved drugs. To be covered, prescriptions must be:

- Prescribed by a network provider for covered conditions
- Filled through a network pharmacy or mail order
- Included on the plan's formulary.

The plan does not cover:

- Dental prescriptions
- Drugs for cosmetic uses
- Drugs for treatment of sexual dysfunction
- Drugs not approved by the FDA and in general use as of March 1 of the previous year
- Drugs not on the formulary (unless approved in advance by Group Health)
- Over-the-counter drugs
- Vitamins, including prescription vitamins.

To fill your prescription through a network pharmacy, show the pharmacist your Group Health card. To fill your mail order prescriptions, contact the mail order service through the Group Health website (see the Resource Directory booklet) or call 1-800-245-7979. The service mails your prescription to your home.

If you need a refill, check the label on the prescription container; some may be refilled without consulting your provider. The number of refills is indicated on the label. If you need your provider's approval to refill your medication, call your pharmacy or the mail order service at least two weeks before you run out of medication. The pharmacy/mail order service will need time to order your medicine and contact your provider for approval.

You may receive up to a 30-day supply per \$5 copay/prescription or refill from a network pharmacy or network mail order service. Generic drugs are used whenever available. Brand-name drugs are used if there is no generic equivalent.

► **Preventive Care**

The plan covers the following preventive care:

- Hearing exams to determine hearing loss (once in 12 consecutive months)

- Most immunizations and vaccinations for adults and children (except immunizations for travel)
- Routine mammograms (age and risk factor determine frequency; contact the plan for details)
- Routine physicals for adults and children (age and risk factor determine frequency; contact the plan for details).

Routine physicals for travel, employment, insurance, licenses, etc. are not covered (see “Expenses Not Covered”) and routine vision exams (once in 12 consecutive months) are covered under a separate benefit (see “Vision Care”).

► **Radiation Therapy, Chemotherapy and Respiratory Therapy**

Covered expenses include radiation therapy, chemotherapy and respiratory therapy services. (High dose chemotherapy and stem cell support covered under “Transplants.”)

► **Reconstructive Services**

Reconstructive services are covered to correct a congenital disease/anomaly or a medical condition (following an injury or incidental to surgery) that had a major effect on the patient’s appearance (the reconstructive services must, in the opinion of a network provider, be reasonably expected to correct the condition).

Covered individuals who elect breast reconstruction following a mastectomy, as determined in consultation with the patient and attending physician, have these benefits:

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

These reconstructive benefits are subject to the same copays and coinsurance provisions as other medical and surgical benefits.

► **Rehabilitative Services**

Covered inpatient and outpatient rehabilitative services are limited to physical, occupational and speech therapy to restore function after illness, injury or surgery.

The plan does not cover:

- Implementation of home maintenance programs
- Physical, occupational or speech therapy services when available through government programs
- Programs for the treatment of learning problems
- Therapy for degenerative or static conditions when the expected outcome is primarily to maintain the patient’s level of functioning.

Rehabilitative services are covered only when the plan determines they are expected to result in significant, measurable improvement within 60 days. Rehabilitative services for chronic conditions are not covered.

► **Skilled Nursing Facility**

Skilled nursing facility services are covered when referred by a network provider to a maximum of 60 days each calendar year.

► **Smoking Cessation**

You do not need a PCP referral before you see a network provider for these services.

Covered services related to tobacco cessation are limited to:

- One course of nicotine replacement therapy a year if you're actively participating in a network provider program
- Educational materials.

► **Sterilization Procedures**

Therapeutic and non-therapeutic sterilization procedures are covered. Services to reverse a therapeutic or nontherapeutic sterilization are not covered.

► **TMJ Disorders**

Medical and surgical services and related hospitalizations to treat temporomandibular joint (TMJ) disorders are covered when medically necessary, subject to the maximums in the "Summary of Covered Expenses."

Orthognathic (jaw) surgery for the treatment of TMJ disorders, radiology services and TMJ specialist services, including the fitting and adjustment of splints, also are covered.

The following services, including related hospitalizations, are not covered by the plan regardless of origin or cause:

- All dental services (except as noted above), including orthodontic therapy
- Orthognathic (jaw) surgery in the absence of a TMJ diagnosis
- Treatment for cosmetic purposes.

► **Transplants**

You or your family member will not be eligible for any organ transplant benefits until the first day of the 13th month of continuous coverage under this Group Health plan (unless continuously covered under this plan since birth or the transplant is required as the result of a condition that had a sudden unexpected onset after the effective date of coverage).

The following transplants are covered:

- Bone marrow
- Cornea
- Heart
- Heart-lung
- Intestinal/multi-visceral
- Kidney
- Liver
- Lung (single or double)
- Pancreas/kidney (simultaneous).

Transplant services must be received at a facility designated by Group Health and are limited to:

- Evaluation testing to determine recipient candidacy
- Follow-up services for specialty visits, rehospitalization and maintenance medications
- Transplantation (limited to costs for surgery and hospitalization related to the transplant, as well as medications).

The plan covers the following donor expenses for a covered organ recipient:

- Excision fees
- Matching tests
- Procurement center fees
- Travel costs for a surgical team.

The plan does not cover:

- Donor costs reimbursable by the organ donor's insurance plan
- Living expenses
- Transportation expenses (except as listed above).

► **Urgent Care**

Sometimes you may need to see a physician for conditions that are not life threatening but need immediate medical attention, for example:

- Ear infections
- High fevers
- Minor burns.

For urgent care during office hours, call your PCP's office for assistance.

After office hours, call Group Health's Consulting Nurse Service at 1-800-297-6877. Depending on your situation, the consulting nurse may provide instructions over the phone for self-care, instruct you to make an appointment with your PCP for the next day or advise you to go to the nearest urgent care facility or emergency room.

Urgent care is covered the same as other care. Generally, urgent care involves an office visit and is paid at the level shown in the "Summary of Covered Expenses" in this booklet.

► **Vision Exams**

Routine eye exams are covered once every 12 consecutive months, when received at Group Health facilities.

After cataract surgery, one contact lens per diseased eye is covered, instead of an intraocular lens, including exam and fitting. Surgery must be performed by a Group Health provider and you must have been continuously covered by Group Health since the surgery. Replacement of a covered contact lens will be provided once a year if needed due to a change in your medical condition.

Evaluations and surgical procedures to correct refractive error not related to a disease of the eye are excluded. Complications related to that surgery are also excluded.

Expenses Not Covered

In addition to the exclusions or limits described in other sections of this booklet, the Group Health plan does not cover:

- Arch supports, including custom shoe modifications or inserts and their fitting (except for therapeutic shoes, modifications and shoe inserts for severe diabetic foot disease) and orthopedic shoes not attached to an appliance
- Artificial or mechanical hearts
- Benefits covered by other insurance
- Cardiac or pulmonary rehabilitation programs or behavior modification programs
- Complications of non-covered surgical services
- Conditions resulting from service in the armed forces, declared or undeclared war or voluntary participation in a riot, insurrection or act of terrorism
- Convalescent or custodial care
- Corrective appliances or artificial aids including eyeglasses, contact lenses or services related to their fitting
- Cosmetic services, including treatment for complications of elective or non-covered cosmetic surgery
- Court-ordered services or programs not judged medically necessary by the network provider
- Dental care, surgery, services or appliances, except as described in "Physician and Other Medical/Surgical Services"

- Diabetic meals and some diabetes education materials
- Evaluations and surgical procedures to correct refractions not related to eye pathology
- Exams, tests or shots required for work, insurance, marriage, adoption, immigration, camp, volunteering, travel, license, certification, registration, sports, recreational or school activities
- Experimental or investigational treatment
- Gambling or other specialty treatment programs
- Genetic testing or related services
- Hearing aids or related exams
- Herbal supplements
- Hypnotherapy or any related services
- Job-related injury, illness or treatment (except as provided for LEOFF 1 employees)
- Medicine or injections for anticipated illness while traveling
- Methadone maintenance programs
- Missed appointment or cancellation fees
- Obesity treatment, services or items, including prescribing or monitoring drugs, structured weight loss/exercise programs or specialized nutrition counseling (bariatric surgery and related hospitalization when Group Health criteria are met are covered)
- Orthoptic (eye training) therapy
- Over-the-counter drugs (medicines and devices not requiring a prescription)
- Personal comfort items, such as phones or television
- Rest cures or custodial, domiciliary or convalescent care
- Routine foot care
- Services or supplies resulting from the loss of or willful damage to covered appliances, devices, supplies or materials provided by Group Health
- Services provided by government agencies, except as required by federal or state law
- Sterility, infertility or sexual dysfunction testing or treatment including Viagra, penile implants, vascular or artificial reconstruction, sterilization reversal or sex transformations
- Weight reduction programs.

Coordination of Benefits

► Coordination of Benefits Between Plans

If you and your spouse/domestic partner are King County employees and both choose the Group Health medical plan, your copays (and those of the children you both cover) are waived. If you or your dependents are covered under another health plan, Group Health coordinates benefits with the other plan so you receive up to but not more than 100% of covered expenses; the benefit paid by Group Health will not exceed the amount that would have been paid if no other plan was involved.

If another plan does not have a coordination of benefit provision, the other plan always pays first. Otherwise, the plan that covers the individual as an employee pays before the plan that covers the individual as a dependent.

The following guidelines determine what plan pays first for dependent children covered under two parents (“parents” in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)
- For a dependent child whose parents are divorced or legally separated, the plan that covers the child is determined in this order (unless there is a court decree establishing financial responsibility for the child’s health care):
 - The plan of the parent with custody
 - The plan of the spouse of the parent with custody
 - The plan of the parent without custody

- The plan of the spouse of the parent without custody.

If a court decree establishes financial responsibility for the child's health care, the plan of the parent with that responsibility pays first.

If these provisions don't apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn't have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer this coordination of benefit provision.

► **Coordination of Benefits With Medicare**

If you keep working for the county after you become eligible for Medicare you may:

- Continue your medical coverage under Group Health and integrate the county plan with Medicare; Group Health is primary and Medicare is secondary
- Discontinue your Group Health coverage and enroll in Medicare; if you choose this option, your covered family members are eligible for continuation of coverage under COBRA for up to 36 months (see "COBRA" in the Important Facts booklet).

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan covering a person as an active employee or family member of an active employee. Medicare is primary in most other circumstances. For health maintenance organizations such as Group Health, special federal requirements apply.

If you go on a leave of absence or terminate employment with King County and are eligible for Medicare, you must enroll in Medicare A and B to continue your Group Health coverage under COBRA. Your Medicare-eligible dependents must also enroll in Medicare A and B to continue Group Health COBRA coverage.

If you have any questions about how your coverage coordinates with Medicare, contact Group Health (see the Resource Directory booklet).

Filing a Claim

► **What to Do**

If you receive care from a network provider, the provider submits claims for you. If you receive emergency services from a non-network provider, you pay the provider in full, and it's your responsibility to submit a claim form to Group Health or have the provider submit one for you. Claim forms are available from Group Health (see the Resource Directory booklet).

When submitting any claim, you need to include your itemized bill. It should show:

- Patient's name
- Provider's tax ID number
- Diagnosis or ICD-9 code
- Date of service/supply
- Itemized charges from the provider for the services/supplies received.

You also need to provide:

- Your name (if you were not the patient)
- Your Social Security number (or unique identifier number if assigned one by your plan)
- Group number (shown on your Group Health ID card and available from Benefits and Retirement Operations).

For prompt payment, submit all claims as soon as possible. The plan will not pay a claim submitted more than 12 months after the date of service/supply. If you can't meet the 12-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

► **If the Claim Is Approved**

If the claim is approved and there is no indication the bill has been fully paid, payment for covered services is made to the provider. If the bill indicates full payment has been made to the provider, payment for covered services is made directly to you.

► **If the Claim Is Denied**

If the claim is denied, you're notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that Group Health reviewed in making the determination.

If You Have a Problem

► **If You Have a Complaint**

If you're dissatisfied with Group Health services, submit a complaint by following these steps.

- **Step 1.** Contact the person involved and explain your concerns and what you'd like done to resolve your problem; be specific and make your position clear.
- **Step 2.** If Step 1 does not resolve the problem or you prefer not to talk with the person involved, ask the Group Health department head or manager of the medical center or department where you're having the problem to investigate your concerns; most complaints can be resolved this way.
- **Step 3.** If you are still not satisfied, call the Group Health Customer Service Center toll free at 1-888-901-4636; most phone complaints can be resolved within a few days. In some cases, however, you may be asked to submit your concerns and proposed resolution to the problem in writing. Written complaints may take up to 30 days to resolve; a customer service representative or service quality supervisor must consult with involved staff and their supervisors and review pertinent records and relevant plan policies in accordance with your rights and responsibilities under the plan. If you are still dissatisfied with the Step 3 outcome, you may appeal the decision.

► **If Your Complaint Is Not Resolved Through the Complaint Process or You're Denied Benefits for Reasons Other Than Eligibility**

If your problem is not resolved through the complaint process described above or you're denied benefits, submit an appeal by following the steps described in this section. Step 2 is optional; if your problem is not resolved at Step 1, you may proceed directly to Step 3.

Step 1. Submit an appeal either orally or in writing to the Appeals Department serving your area of the state. Your appeal must be submitted within 180 days of receiving your complaint decision or benefit denial and explain why you disagree with the decision/denial.

If you're located west of the Cascade Mountains, call 206-901-7359 or toll-free 1-888-901-4636, or mail your appeal to:

Group Health Appeals Department
P.O. Box 34593
Seattle WA 98124-1593

If you're located east of the Cascade Mountains, call 509-838-9100 or toll-free 1-800-497-2210, or mail your appeal to:

Group Health Appeals Department
P.O. Box 204
Spokane WA 99224-0204

An appeals coordinator will normally review your appeal and notify you of a determination or need for more time to consider your appeal within 14 days of receiving it; under no circumstances will the review of your appeal exceed 30 days (unless you agree to more time in writing). However:

- If your appeal concerns a request for an experimental or investigational exclusion or limitation, Group Health will make a determination and notify you within 20 working days of receiving a fully documented request; if more time is required, Group Health will notify you in writing, but under no circumstances will the review exceed 20 days unless you agree
- If your doctor indicates a clinical urgency exists (that a delay would jeopardize your life or materially jeopardize your health), you may request an expedited appeal; expedited appeal decisions are issued within 72 hours of receiving the qualified requests.

If Group Health fails to decide a Step 1 appeal within the applicable timeframe, you may proceed as if your appeal has been rejected.

Step 2 (Optional). If you disagree with an appeal coordinator's Step 1 decision, you may request a hearing by an appeals committee; the appeals committee is the final review authority within Group Health (its decisions are final). To request a hearing, submit a written request to the appropriate Appeals Department within 30 days of the date of your Step 1 decision letter.

You are encouraged to present your case in person to the appeals committee. The hearing will be scheduled and a written decision issued by the committee within 30 working days of the date you submit your hearing request.

Step 2 is optional; if your problem is not resolved at Step 1, you may proceed directly to Step 3.

Step 3. If you are not satisfied with a Step 1 or Step 2 appeal decision or if Group Health does not reach a decision without good cause in the timeframes described, you may request review of your complaint or benefit denial by an independent review organization not legally affiliated or controlled by Group Health. Once a decision is issued by an independent review organization, however, the decision is final and cannot be appealed through Group Health.

► **If Claims Are Denied Due to Eligibility**

If you have eligibility questions or believe you've had a claim denied because the plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of this section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these timeframes:

- 72 hours for urgent appeals (call 206-684-1556 to file an urgent appeal)
- 14 days for pre-service appeals (within 30 days if an extension is filed)
- 20 days for post-service appeals (within 40 days if an extension is filed)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an eligibility appeal addendum within 60 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Release of Medical Information

As a condition of receiving benefits under this plan, you and your family members authorize:

- Any provider to disclose to the plan any requested medical information
- The plan to examine your medical records at the offices of any provider
- The plan to release to or obtain from any person or organization any information necessary to administer your benefits
- The plan to examine records that would verify eligibility.

The plan will keep this information confidential whenever possible, but under certain necessary circumstances, it may be disclosed without specific authorization.

Certificate of Coverage

When your coverage under this plan ends, you automatically receive a certificate of health plan coverage. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under this plan.

Converting Your Coverage

If you're no longer eligible for the medical coverage described in this booklet, you may transfer your coverage to an insured conversion plan. The plan you convert to will differ from the benefits described in this booklet. You must pay premiums, which may be higher than amounts you currently pay (if any) for these benefits.

You will not be able to convert to the individual policy if you're eligible for any other medical coverage under any other group plan (including Medicare).

To apply for a conversion plan, you must complete and return an application form to Group Health within 31 days after this medical coverage terminates. Evidence of insurability will not be required. You will not receive this application or information about conversion plan coverage unless you request it from Group Health (see Resource Directory booklet).

Extension of Coverage

If this plan is canceled, Group Health will continue to cover any participants who are hospital inpatients on the cancellation date. Coverage ends on the date of discharge or when the participant reaches the plan maximums, whichever comes first.

Payment of Benefits

The medical benefits offered by this plan are insured by Group Health, meaning this is not a self-funded plan. Group Health is financially responsible for claim payments and other costs.

*Deputy Sheriff
Booklet 5*

**Washington
Dental
Service**

Although these benefit descriptions include certain key features and brief summaries of King County deputy sheriff benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts and other legal documents, the contracts and legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

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Overview

Highlights of Washington Dental Service (WDS) Coverage

Here are a few highlights of your dental benefits:

- You can use any dentist you wish (most dentists in Washington participate in the WDS plan)
- The plan pays benefits if you see a participating or non-participating dentist, but the benefits are generally higher (your out-of-pocket expenses are less) if you see a participating dentist
- Participating dentists file claims for you automatically.

Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just this plan and can change frequently. To be more efficient, and avoid repetition, the following related information appears only in the Important Facts booklet:

- Who’s eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends and options for continuing it after you leave employment
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

When you receive dental care, you pay:

- Coinsurance amounts not covered by the plan
- Amounts in excess of the allowable amounts (as determined by WDS) if you see a non-participating dentist
- Expenses for services or supplies not covered by the plan.

See “How the Plan Works” below for more information.

How the Plan Works

Summary Table

The following table summarizes covered services and supplies under this plan and identifies related coinsurance and maximums (see “Covered Expenses Under WDS” and “Expenses Not Covered” for more details).

Washington Dental Service	
Annual deductible	None
Annual maximum benefit (doesn't apply to orthodontic or orthognathic services)	\$2,500/person
Covered Expenses	Plan Pays
Diagnostic and preventive services <ul style="list-style-type: none">• Exam every 6 months• Complete x-rays every 3 years• Supplementary bitewing x-rays every 6 months• Cleaning every 6 months	70% - 100% based on patient's incentive level

Covered Expenses	Plan Pays
Basic services <ul style="list-style-type: none"> • Crowns (stainless steel) • Extractions • Fillings • Periodontics • Root canals 	70% - 100% based on patient's incentive level
Major services – restorative <ul style="list-style-type: none"> • Crowns • Fixed bridges • Onlays 	70% - 100% based on patient's incentive level
Major services – prosthodontics (for example, dentures)	70% (incentive levels do not apply)
Orthodontic services for adults and children	60% up to a \$2,500 lifetime maximum (incentive levels do not apply; benefit doesn't apply to the annual maximum benefit) Not more than \$1,250 is paid during the initial stage of treatment; the remaining plan benefit is paid 7 months after the initial stage if the covered participant still meets eligibility requirements described in the Important Facts booklet
Orthognathic surgery	70% up to \$5,000 lifetime maximum benefit
Accidental injury	100% for covered expenses incurred within 180 days of accident

Participating and Non-Participating Dentists

You may select any licensed dentist. Tell your dentist you're covered by a program administered by WDS for King County. The group number is 285. You must provide either your Social Security number or unique identifier (if assigned one by WDS).

If you go to a participating dentist, the dentist submits claim forms to WDS and receives payment directly. You're responsible for any remaining balance. If you see a non-participating dentist, it's your responsibility to see that the claim form is submitted (see "Filing a Claim").

Benefit Maximums

The maximum the plan pays each calendar year for most covered expenses is \$2,500 per person. The lifetime maximum payable by WDS for orthodontic treatment is \$2,500 per person. The lifetime maximum payable by WDS for orthognathic surgery is \$5,000 per person.

Charges for dental procedures requiring multiple treatment dates (such as crowns or bridgework) are considered incurred on the date the service is complete.

Incentive Program

WDS increases your payment levels through an incentive program as long as you see your dentist each year. For diagnostic and preventive services, basic services and restorative services, the payment level starts at 70% and increases 10% in January of each year until you reach 100%, as long as you see the dentist each year.

If you do not see the dentist during the calendar year, your payment level is reduced to the next lower payment level, but never below 70%. The reduction is from the level under which your last claim was paid. For example, if you saw your dentist in 2002 and your payment level was 80%, but you did not see your dentist in 2003, your payment level in 2004 is reduced from 80% to 70%.

Major prosthodontic services, orthodontia and orthognathic surgery are not under the incentive program.

The following table summarizes how the incentive program works.

If you receive these services and see the dentist each year ...	The plan pays ...
Diagnostic and preventive services, basic services and major services – restorative	70% first year
	80% second year
	90% third year
	100% fourth year and each year thereafter

Example 1. This is Rachel’s second year of plan participation. This year, Rachel visits her participating dentist for her annual cleaning. Since she visited the dentist last year, her coinsurance level for this year increased from 70% to 80%. Here’s how much Rachel pays:

Total Expense	Plan Pays	Rachel Pays
\$ 45 Exam	\$ 36 (80% of \$45)	\$ 9 (20% of \$45)

Example 2. Jim has participated in this plan for three years, but hasn’t been to the dentist during any of those years. This year Jim needs a root canal. Here’s how much Jim pays:

Total Expense	Plan Pays	Jim Pays
\$ 600 Root canal	\$ 420 (70% of \$600)	\$ 180 (30% of \$600)

If you’re a new hire, coverage begins at the 70% incentive level; levels “earned” under another group plan do not apply to the county plan. However, incentive levels are adjusted based on previous participation in the county plan if you’re a:

- Recalled or reinstated employee
- Rehired employee who’s continued county coverage uninterrupted under COBRA between your previous county employment and rehire (if county coverage has been interrupted, new hire incentive levels apply).

Predetermination of Benefits

If you think your dental care will exceed \$200 and for all orthodontic and orthognathic services, ask your dentist to submit a standard WDS claim form for predetermination. This way you’ll learn in advance exactly what procedures are covered, the amount WDS will pay toward the treatment and the amount you’ll need to pay. (WDS conducts professional clinical reviews of basic and major services. If professional dental standards indicate a condition can be treated by a less costly alternative than the service proposed by your dentist, WDS may limit your benefits to the less costly alternative, unless otherwise noted or restricted in the next section, “Covered Expenses Under WDS.” You’re responsible for any treatment costs exceeding the allowable amounts paid by WDS.)

Predetermination requires notification or approval before you receive dental care. WDS will provide notice of the claim decision within 15 days after receiving your claim form. If a predetermination is filed improperly, WDS will provide notice of the improper filing and how to correct it within five days after receiving the predetermination filing. If more information is required, WDS will notify you of what is needed within 15 days after receiving the claim.

WDS may request a one-time extension not longer than 15 days and hold your claim until all information is received. Once notified of the extension, you have 45 days to submit this information; WDS will make a determination within 15 days. If the information isn’t submitted within 45 days, the claim will be denied. A denial

notice will explain the reason for denial, refer to the part of the plan it's based on and describe claim appeal procedures (see "Appealing Denied Claims" for further details).

For an emergency, immediate treatment is allowed without predetermination, and your claim is evaluated after treatment.

Covered Expenses Under WDS

This section describes covered expenses and any related limits. To be covered, expenses must be medically necessary for treatment, diagnosis or prevention of a dental condition.

If professional dental standards indicate the condition can be treated by a less costly alternative to the service proposed by your dentist, in some cases this plan will limit benefits to the less costly alternative (WDS determines on a case-by-case basis). You're responsible for any treatment costs exceeding the allowable amounts paid by WDS (see "Predetermination of Benefits").

Diagnostic and Preventive Services

- Exam – comprehensive oral evaluation (once in a three-year period per dental office; benefit is counted as a routine exam for frequency limitations)
- Exam – emergency
- Exam – routine, once every six months
- Exam by a specialist in an American Dental Association-recognized specialty
- Fissure sealants for children through age 14 or younger; if eruption of permanent molars is delayed, sealants will be allowed if applied within 12 months of eruption with documentation from the attending dentist; payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface (the application of fissure sealants is a covered benefit only once in three years per tooth)
- Prophylaxis (cleaning), once every six months
- Space maintainers for the eruption of permanent teeth
- Topical application of fluoride is covered once in a six-month through age 18
- X-rays (complete series or panorex), once every three years; supplementary bitewing x-rays, once every six months.

Basic Services

- Amalgam, composite (filled resin) or glass ionomer fillings to treat decay or fracture resulting in significant tooth loss; if a composite or ionomer restoration is placed on a posterior tooth (except on buccal/front surface of bicuspid), an amalgam allowance will be made
- General anesthesia/intravenous sedation is covered (but not both) if administered in the same day:
 - If administered by a licensed dentist or other WDS-approved licensed professional who meets the state Dental Quality Assurance Commission guidelines in conjunction with certain covered endodontic, periodontal and oral surgery procedures as determined by WDS
 - When medically necessary, for children through age six, or a physically or developmentally disabled person, when in conjunction with covered dental procedures
- Preparation of the alveolar ridge and soft tissue of the mouth for insertion of dentures
- Pulp exposure treatment, pulpotomy and apicoectomy
- Pulpal and root canal treatment (root canal treatment on the same tooth is covered once in a two-year period)
- Removal of teeth and surgical extractions
- Restorations on the same surface(s) of the same tooth, once in a two-year period (if a filled resin, glass ionomer or composite filling is placed in a posterior tooth, the plan pays benefits as if it were an amalgam)
- Stainless steel crowns, once in a two-year period

- Surgical and non-surgical procedures to treat the tissues supporting the teeth, including periodontal scaling/root planing (once in a 12-month period), periodontal surgery (once in three years per site) and limited adjustment to occlusion (once in a 12-month period; eight teeth or less)
- Treatment of pathological conditions and traumatic facial injuries.

If teeth are restored with crowns, inlays or onlays, refer to the following sections.

Major Services – Restorative

- Crowns (on the same teeth, once in a five-year period)
- Crown buildups (once in a two-year period) when more than 50% of the natural coronal tooth structure is missing or there is less than 2mm of circumferential tooth structure remaining around the gingival portion (not covered within two years of a restoration on the same tooth)
- Fixed bridges and the adjustment or repair of an existing bridge, as well as inlays if used as an abutment for a fixed bridge (on the same teeth, once in a five-year period; replacement covered only if bridge is unserviceable and cannot be made serviceable).

Gold, porcelain, WDS-approved gold substitute castings (except processed resin) or combinations of these may be used in major restorative services.

Crowns are covered only to treat decay or fracture resulting in significant tooth loss (missing cusp), when teeth cannot reasonably be restored with filling materials such as amalgam or resin.

Major Services – Dentures

- Denture adjustments and relines – more than six months after the initial placement are covered, except as noted under temporary/interim dentures below; subsequent relines or rebases (but not both) will be covered once in a 12-month period
- Dentures (temporary/interim) – for partial or full, the plan pays as if you received a reline; after placement of the permanent prosthesis, an initial reline is covered after six months
- Dentures (partial) – if a more elaborate or precision device is used, the plan pays as if you received a cast chrome and acrylic partial denture
- Full, immediate and overdentures – for personalized restorations or specialized treatment, the plan pays as if you received a full, immediate or overdenture
- Implants – for appliances constructed on implants, the plan pays as if you received a standard crown, bridge, partial denture or full denture; the plan doesn't pay for any replacement within five years of initial placement
- Replacement of an existing prosthetic device – is covered only once every five years if it's unserviceable and cannot be made serviceable
- Root canal treatment performed in conjunction with overdentures – limited to two teeth per arch.

Orthodontic Services

This plan covers orthodontic care for adults and children. All orthodontic treatment must be authorized by WDS before treatment begins (see "Predetermination of Benefits").

Orthognathic Surgery

This plan covers orthognathic treatment for adults and children to correct malpositions of the upper jaw bone (maxilla) and/or lower jaw bone (mandible). All orthognathic treatment must be authorized by WDS before treatment begins (see "Predetermination of Benefits").

Treatment for complications is covered only within 30 days of the original treatment. Procedures that are covered under another portion of this plan are not covered with orthognathic surgery.

Accidental Injury

The plan pays 100% of covered expenses directly resulting from an accidental bodily injury, up to the annual maximum, if for diagnosis and treatment performed/incurred within 180 days after the accident. The accidental bodily injury and diagnosis/treatment must have occurred while the patient was eligible. Payment for accidental injury claims will not exceed the unused maximum. A bodily injury does not include teeth broken or damaged while chewing or biting on foreign objects.

Expenses Not Covered

In addition to the exclusions or limits described in other sections of this booklet, the WDS plan does not cover:

- Diagnostic and preventive services
 - Cleaning of prosthetic appliances
 - Consultations or elective second opinions
 - Decay susceptibility tests
 - Diagnostic services and x-rays related to temporomandibular (jaw) joints
 - Plaque control program (oral hygiene instruction, dietary instruction or home fluoride kits)
 - Replacement of a space maintainer previously paid for by WDS
 - Study models.
- Basic services
 - Bleaching of teeth
 - Crowns as part of periodontal therapy
 - General anesthesia/intravenous sedation for routine post-operative procedures
 - Gingival curettage
 - Iliac crest or rib grafts to alveolar ridges
 - Localized delivery of chemotherapeutic agents
 - Major (complete) occlusal adjustment
 - Materials placed in extraction sockets to generate osseous filling
 - Night (occlusal) guard or occlusal splint
 - Overhang removal, recontouring or polishing of restoration
 - Periodontal appliances
 - Periodontal splinting or crown and bridgework in conjunction with periodontal splinting
 - Restorations necessary to correct vertical dimension or to modify shape of teeth or occlusion
 - Ridge extension for insertion of dentures
 - Tooth transplants.
- Major services
 - Cleaning of prosthetic appliances
 - Crown buildups to improve tooth form, fill in undercuts or reduce bulk in castings
 - Crowns or copings in conjunction with overdentures
 - Crowns or onlays placed because of weakened cusps or existing large restorations without overt disease
 - Crowns used as an abutment to a partial denture for recontouring, repositioning or increasing retention (unless the tooth is decayed to the extent that a crown would be needed whether or not a partial denture is required)
 - Crowns used to repair micro-fractures of tooth when it displays no symptoms or existing restorations with defective margins when no disease exists
 - Duplicate dentures
 - Personalized dentures
 - Surgical placement or removal of implants or attachments to implants.
- Orthodontic services to replace or repair an appliance.

What Happens If

If You Need Emergency Care

If you need emergency dental care, you may see either a participating or non-participating dentist. Your benefits depend on the type of services you receive (see “Summary Table” and “Incentive Program” for benefit levels).

If You Need Care While Traveling

If you receive treatment from a dentist outside Washington State, you pay the dentist in full, then submit a claim form as described in “Filing a Claim” in this booklet. Payment is based on the dentist’s charge, or the amount that would have been payable if treatment had been provided by a participating WDS dentist, whichever is less.

If Your Family Member Lives Away From Home

Family members who live away from home either temporarily or permanently may see a non-participating dentist and still receive benefits from this plan. Your family member must file a claim (see “Filing a Claim”).

Coordination of Benefits Between Plans

If you or your dependents are covered under another dental plan, Washington Dental Service coordinates benefits with the other plan so you receive up to but not more than 100% of covered expenses; the benefit paid by Washington Dental Service will not exceed the amount that would have been paid if no other plan was involved.

If another plan does not have a coordination of benefit (COB) provision, the other plan always pays first (the plan that pays first is always called primary). Otherwise, the plan that covers the individual as an employee pays before the plan that covers the individual as a dependent.

The following guidelines determine what plan pays first for dependent children covered under two parents (“parents” in this case may not be blood related, but providing coverage through a marriage or domestic partnership):

- The plan of the parent whose birthday is first in the calendar year pays for covered children first unless the parents are divorced or legally separated. (If the other plan does not have this rule, its provisions apply.)
- For a dependent child whose parents are divorced or legally separated, the plans pay benefits in this order (unless there is a court decree establishing financial responsibility for the child’s health care):
 - The plan of the parent with custody
 - The plan of the spouse of the parent with custody
 - The plan of the parent without custody
 - The plan of the spouse of the parent without custody.

If a court decree establishes financial responsibility for the child’s health care, the plan of the parent with that responsibility pays first.

If these provisions don’t apply, the plan that has covered the employee longer pays first. Nevertheless, if either parent is retired, laid off or a family member of a retired or laid-off person, the plan of the person actively employed pays first (unless the other plan doesn’t have a provision regarding retired or laid-off employees).

The plans have the right to obtain and release data as needed to administer this COB provision.

Filing a Claim

What to Do

If you receive care from a participating provider, the provider submits claims for you. If you receive services from a non-participating provider, you pay the provider in full, and it's your responsibility to submit a claim form to WDS or have the provider submit one for you. Claim forms are available from WDS (see the Resource Directory booklet).

When submitting any claim, you need to include your itemized bill. It should show:

- Patient's name
- Provider's tax ID number
- Diagnosis or CDT-4 code
- Date of service/supply
- Itemized charges from the provider for the services/supplies received.

You also need to provide:

- Your name (if you were not the patient)
- Your Social Security number (or unique identifier number if assigned one by your plan)
- Group number 285.

For prompt payment, submit all claims as soon as possible. The plan will not pay a claim submitted more than 12 months after the date of service/supply. If you can't meet the 12-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

How the Claim Is Reviewed

WDS will review your claim and notify you or your provider in writing within the following timeframes:

- **Within 72 hours for urgent claims.** Urgent claims are claims for services where your provider believes a delay in treatment could seriously jeopardize your life, health or ability to regain maximum function, or cause severe pain that can't be controlled adequately without the care being considered. Urgent claims can be submitted by phone. You will be notified of the claim review decision by phone, followed by a written notice.
- **Within 15 days for pre-service claims (within 30 days if an extension is filed).** Pre-service claims are those where the plan requires you to obtain approval of the benefit before receiving the care. The plan may ask for a one-time extension of 15 days to request more information. Once notified of the extension, you have 45 days to provide any missing information.
- **Within 24 hours for concurrent claims.** Concurrent claims are those for continuation of services previously approved by the claim administrator as an ongoing course of treatment or to be provided over a certain period.
- **Within 30 days for post-service claims (within 60 days if an extension is filed).** Post-service claims are claims that aren't urgent, pre-service or concurrent. The plan may ask for a one-time extension of 30 days to request more information. Once notified of the extension, you have 45 days to provide any missing information.

The claim administrator reviews your claim, applying plan provisions and their discretion in interpreting plan provisions, then notifies you of the decision within the timeframes listed above.

If the Claim Is Approved

If the claim is approved and there is no indication the bill has been fully paid, payment for covered services is made to the provider. If the bill indicates full payment has been made to the provider, payment for covered services is made directly to you.

If the Claim Is Denied

If the claim is denied, you're notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that WDS reviewed in making the determination.

Appealing Denied Claims

Claims Denied for Reasons Other Than Eligibility

If a properly filed claim is denied in whole or in part, WDS notifies you and your provider with an explanation in writing. When a claim is denied for any reason other than eligibility, follow the steps described in this section. However, when a claim is denied for eligibility reasons, follow the steps described in the next section, "Claims Denied Due to Eligibility."

If you or your representative disagrees with a claim denial, you may try to resolve any misunderstanding by calling WDS and providing more information. If you'd rather communicate in writing or the issue isn't resolved with a call, you may file a written appeal (see the Resource Directory booklet for contact information).

You have 180 days after receiving a claim denial notice to file a written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

WDS will review the written appeal and notify you or your representative of their decision within these timeframes:

- 72 hours for urgent appeals
- 15 days for pre-service appeals
- 30 days for post-service appeals
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

Your appeal is reviewed by someone different from the original decision makers and without deference to the initial decision. The appeal reviewer applies the plan provisions and their discretion in interpreting plan provisions, then notifies you of the decision within the time frames listed above. If the claim appeal is denied, you're notified in writing of reasons for the denial.

If you disagree with the appeal decision, you may submit the matter to a mutually agreed upon nonbinding mediator. If you and WDS cannot agree upon a mediator within 15 days, WDS will submit the matter to the American Arbitration Association or Judicial Arbitration and Mediation Service.

WDS has sole discretionary authority to determine benefit payment under the plan; its decisions are final and binding.

If the appeal is denied, legal remedies may be pursued, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within six years after the event the claim is based on or you forfeit your right to legal action.

Claims Denied Due to Eligibility

If you have eligibility questions or believe you've had a claim denied because the plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you or your representative (referred to as "you" in the rest of this section) may file a written appeal. You have 180 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member's name and address (if applicable)
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
 Exchange Building EXC-ES-0300
 821 Second Avenue
 Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within these timeframes:

- 72 hours for urgent appeals (call 206-684-1556 to file an urgent appeal)
- 15 days for pre-service appeals (within 30 days if an extension is filed)
- 20 days for post-service appeals (within 40 days if an extension is filed)
- Within the timeframes for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

If your eligibility appeal is denied, the notice includes the plan provision behind the decision and advises you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your eligibility appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an eligibility appeal addendum within 60 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

Payment of Benefits

The dental benefits offered by this plan are funded by King County, making this a "self-funded" plan. Though Washington Dental Service is responsible for the payment of claims, King County is financially responsible for the cost of those claims.

Deputy Sheriff Booklet 6

Aetna Life Insurance

Although these benefit descriptions include certain key features and brief summaries of King County deputy sheriff benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts and other legal documents, the contracts and legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

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Overview

Highlights of Aetna Life Insurance

Here are a few highlights of your life insurance:

- Basic and enhanced life insurance is provided by Aetna Life Insurance Company
- You automatically receive \$6,000 basic life insurance paid by the county
- Family members you enroll each receive \$1,000 basic life insurance paid by the county
- You may purchase additional (“enhanced”) life insurance for yourself
- Accelerated or living benefits may be available in the event of terminal illness
- Premium waiver may be available if you become disabled
- You have options to continue life insurance when you leave county employment.

Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just this plan and can change frequently. To be more efficient, and avoid repetition, the following related information appears only in the Important Facts booklet:

- Who’s eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

The county pays the cost of \$6,000 basic life insurance for you and \$1,000 basic life insurance for each family member you enroll.

You may purchase enhanced life insurance equal to your base annual salary (rounded to the next higher \$1,000) less the \$6,000 basic life amount. If you purchase enhanced life insurance, you pay a monthly premium through payroll deduction. Cost depends on your base annual salary. (Enhanced life insurance is not available for your family members.)

Amount of Coverage

Basic Life for You and Your Family

You automatically receive county-paid basic life insurance. If you die, the beneficiaries you designate receive a lump sum of \$6,000. The lump sum is divided among your beneficiaries according to your beneficiary designation.

Family members you enroll receive basic life insurance paid by the county. If a family member dies, you receive a lump sum of \$1,000.

Enhanced Life for You

You may purchase enhanced life insurance equal to your base annual salary (rounded to the next higher \$1,000) less the \$6,000 basic life amount. If you die, your beneficiaries receive your enhanced life benefit in addition to your county-paid basic life insurance benefit. (Your base annual salary is your base pay excluding overtime, bonuses or premium or any other special pay.)

Increases in Coverage. Since the amount of your enhanced benefit is based on your base annual salary, it automatically increases as your salary increases.

Adjustments to the life insurance benefit due to a salary change (or change request based on a qualifying event; see “Changes You May Make When a Qualifying Event Occurs” in the Important Facts booklet) automatically occur the first of the month following the salary change or change request, if you’re actively at work that day. If the change occurs on the first of the month, the adjustment becomes effective the same day. Otherwise the adjustment occurs on the first of the month following the date you return to active work.

Adjustments to the life insurance benefit due to an open enrollment change request (when evidence of insurability is required; see next section) become effective the first of the month following the date EOI is approved, if you’re actively at work that day. If EOI is approved the first of the month, the adjustment becomes effective the same day. Otherwise the adjustment occurs on the first of the month following the date you return to active work.

Evidence of Insurability

EOI is any statement of proof of a person’s physical condition, occupation or other factor affecting his or her acceptance for insurance. An EOI application is provided by Benefits and Retirement Operations (when EOI is required under the policy) for you to complete and return directly to Aetna within 31 days of receipt.

EOI is not required for the basic coverage you and your enrolled family members receive, nor is it required for enhanced coverage if you elect it when you first enroll or when a qualifying event occurs (see “Changes You May Make When a Qualifying Event Occurs” in the Important Facts booklet). However, EOI is required if you elect enhanced coverage during open enrollment.

Beneficiaries

You automatically receive a basic life insurance benefit (and may elect enhanced life, too) and need to designate one or more beneficiaries – individuals who receive your benefit in the event of your death. A Beneficiary Designation form is provided when you first enroll and is available on the Web and from Benefits and Retirement Operations anytime you need to change beneficiaries (see the Resource Directory booklet).

You may name anyone you wish as your primary or contingent beneficiaries (contingent beneficiaries receive benefits if all primary beneficiaries are deceased at the time of your death). If you don’t designate beneficiaries as primary or contingent on your Beneficiary Designation, all beneficiaries you list are considered primary.

You may designate more than one primary and one contingent beneficiary. When you do, you must assign the percentage of your benefit each beneficiary receives on your Beneficiary Designation. Percentages for all primary beneficiaries must total 100% and percentages for all contingent beneficiaries must total 100%. If you don’t assign percentages, beneficiaries receive equal shares.

If you’re married and do not choose to list your spouse as a primary beneficiary with at least 50% of your benefit, your spouse should review and sign the spouse waiver section of the Beneficiary Designation.

You may change your beneficiary at any time by completing a new Beneficiary Designation and sending it to Benefits and Retirement Operations. Benefits are paid according to the most recently signed form on file. If you don’t name a beneficiary, benefits are paid to your spouse, your children, your parents or your siblings, in that order. If none of them survives you, benefits are paid to your estate.

If you enroll family members for basic life and a covered family member dies, you’re the beneficiary.

When Benefits Are Payable

Death Benefits

Life insurance benefits are payable if you or a family member dies. However, if a beneficiary is implicated in the death and convicted of the crime, the law usually prohibits the beneficiary from receiving the benefits. Benefits may then be distributed to the contingent beneficiary.

Insurance is paid in a lump sum and not subject to federal income tax (consult your tax advisor for more information on taxes and death benefits).

When a death benefit is under \$10,000, the beneficiary will receive a check. When a death benefit is \$10,000 or more, the beneficiary will receive a checkbook; the lump sum amount is deposited into an Aetna Benefits Checkbook Account in the person's name. This account will earn competitive money market interest rates. The beneficiary receives personalized checks for immediate access to all or part of the funds deposited in the account and may write a check for no less than \$250.

Accelerated Benefits

In the case of your terminal illness, certain benefits may be paid to you before death. You may elect to receive up to 50% of your life insurance benefit while you're living if the following requirements are met:

- You must have a minimum of \$10,000 of life insurance
- Your life expectancy must be 24 months or less
- Certification of the terminal illness must be provided by a physician legally licensed to practice medicine and accepted by Aetna before accelerated benefits are payable.

While an accelerated benefit claim is pending, Aetna has the right, as often as reasonably necessary, to have you examined by a health or vocational professional of Aetna's choice and at Aetna's expense.

Accelerated benefits are based on the amount of life insurance in effect according to county payroll records on the date Aetna accepts the physician's certification of terminal illness. Accelerated benefits are payable to you in a lump sum. The life insurance benefit is reduced by the amount of the accelerated benefit payment, and the remaining benefit is paid to your beneficiary after death.

Contact Benefits and Retirement Operations for more details about the accelerated benefit option. If you have enhanced life coverage and elect the accelerated benefit, you must continue paying for the enhanced coverage until the coverage ends.

Keep in mind:

- Accelerated benefits can be used to pay for special nursing requirements or hospice arrangements, needed medical equipment or custodial care and other expenses
- Accelerated benefits are payable only once for you
- Your accelerated benefit payment reduces the amount of your life insurance benefit that may be converted to an individual policy
- You're responsible for any taxes due to an accelerated benefit payment
- Your spouse/domestic partner must agree with your accelerated benefit election.

Disability Provision

If You Become Disabled Before Age 60

If you become disabled before age 60 and notify Benefits and Retirement Operations within 30 days of your last day worked, the county pays to continue the basic life coverage you had on your last day worked. You also have the option of paying to continue the enhanced life coverage you had on your last day for up to 12 months.

Between eight and nine months following your last day worked, apply to Aetna for a premium waiver. If Aetna determines your disability is permanent and total (approves your premium waiver application), it extends the basic and enhanced life coverage you had on your last day worked from the date of Aetna's determination until you reach age 65. This is at no cost to you as long as you remain disabled. (You may apply for premium waiver up to 12 months following your last day worked, but applications received after 12 months may be denied.)

If you convert coverage when you end employment (see "Converting to Individual Whole Life Insurance") and you're then approved for premium waiver, Aetna will cancel the individual policy and return the premiums to you.

You're permanently and totally disabled only if disease or injury stops you from working at your own job or any other job for pay or profit, and it must continue to stop you from working at any reasonable job. A "reasonable job" is defined as any job for pay or profit that you're (or may reasonably become) fitted for by education, training or experience.

To be eligible for premium waiver, you must meet all these requirements:

- Your life insurance must be in force when you become permanently and totally disabled
- You must be under age 60 on the date you last worked
- Your permanent and total disability must have lasted for at least nine months
- You must furnish all proof when requested (Aetna may ask you to have an exam, at its expense, before accepting the proof).

Premium waiver coverage ends when the first of these dates occurs:

- Aetna sends you a request for an exam, but you do not have the exam within 31 days of that date, or Aetna requests proof that you're still permanently and totally disabled and you don't provide the proof within 31 days of that date
- You're well enough to work in any reasonable job
- You start to work in any job for pay or profit
- You reach age 65.

After this coverage has been extended continuously for two years, Aetna will not request an exam or proof more often than once in 12 months. When the extended coverage period ends, you may be eligible to convert to an individual life insurance policy.

If you die while disabled, within 12 months of your last day worked and before applying for a premium waiver (or your application is approved), Aetna pays your beneficiaries the life insurance benefit they would have received had a premium waiver been approved. To pay this benefit, Aetna must receive written notice within 12 months of your death and proof your disability was permanent and total.

If You Become Disabled After Age 60

If you become disabled after age 60, before you retire or end county employment, and notify Benefits and Retirement Operations within 30 days of your last day worked, the county pays to continue the basic life coverage you had on your last day for up to 12 months or age 65, whichever occurs first. You also have the option of paying to continue the enhanced life coverage you had on your last day for up to 12 months or age 65, whichever occurs first.

Between eight and nine months following your last day worked, apply to Aetna for a disability determination. If Aetna determines your disability is permanent and total, the county will pay to continue your basic life coverage until you reach age 65, as long as you remain disabled and as long as the county continues to provide the benefit to active employees.

If you do not apply between eight and nine months or your disability determination is not approved by Aetna, your county-paid basic life insurance ends after 12 months or at age 65, whichever occurs first. You may then convert to individual coverage (see "Converting to Individual Whole Life Insurance").

Filing a Claim

For a death or accelerated claim, you or your beneficiary should contact Benefits and Retirement Operations; staff will help file the claim with Aetna and provide referrals to counseling and other resources as requested.

Aetna processes the claim within 90 days of receipt. If Aetna needs more time, you or your beneficiary will be notified in writing, before the initial 90 days end, of the need for an extension of up to 90 days.

Aetna may, at its own expense, have an autopsy performed to determine a death benefit payment, unless prohibited by law.

If the claim is denied, you or your beneficiary will be notified in writing of reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that the plan reviewed in making the determination.

Appealing Denied Claims

Claims Denied for Reasons Other Than Eligibility

When a claim is denied for any reason other than eligibility, follow the steps described in this section. However, when a claim is denied for eligibility reasons, follow the steps described in the next section, “Claims Denied Due to Eligibility.”

If you or your beneficiary disagrees with a claim denial, you, your beneficiary or representative (referred to as “you” in the rest of this section) may try to resolve any misunderstanding by calling Aetna and providing more information. If you’d rather communicate in writing or the issue isn’t resolved with a call, you may file a written appeal. You have 60 days after receiving a claim denial notice to file the written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

Aetna will review the written appeal and notify you of its decision within 60 days after receiving the appeal. If Aetna requires more time, you will be notified in writing that an additional period of up to 60 days is necessary.

Aetna will give you a written decision and explain the specific plan provisions behind the denial (if applicable).

Aetna has sole discretionary authority to determine benefit payment under the life insurance plan; its decision is final and binding. In reviewing your claim, Aetna applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Aetna determines you’re entitled to the benefits.

If the appeal is denied, you may pursue legal remedies, but you must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event the claim is based on. If you do not file a claim or appeal within the specified period, you forfeit the right to further appeal.

Claims Denied Due to Eligibility

If you have eligibility questions or believe you’ve had a claim denied because the plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you’d rather communicate in writing or your eligibility issue can’t be resolved with a phone call, you, your beneficiary or representative (referred to as “you” in the rest of this section) may file a written appeal. You have 60 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name and address as well as each covered family member’s name and address (if applicable)

- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a family member)
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
 Exchange Building EXC-ES-0300
 821 Second Avenue
 Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you in writing of the eligibility determination within 60 days. If more time is required, you will be notified in writing that an additional period of up to 60 days is necessary.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an appeal addendum within 30 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation. It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you were denied plan participation, or you forfeit your right to legal action.

Continuation of Coverage

Continuing Group Term Life Insurance

When you end employment with the county for reasons other than disability, you may continue the basic and enhanced group term life insurance that you had on your last day of employment. This is called "portability." Premiums for the continued coverage are paid directly to Aetna and the age-specific group rates may differ from the rates paid by active employees.

To continue coverage, you must request a Portability Application from Aetna and return the completed form with your first premium payment within 31 days of the date your county coverage ends (see the Resource Directory booklet). Coverage is effective on the 32nd day if Aetna has received your completed form and first payment. If you die during the 31 days, your beneficiary or estate will receive the full amount of your life insurance coverage in force before it ended. This payment is made under the group policy, whether or not you actually applied to continue coverage. If you applied, any fees or premiums you paid are refunded.

If you continue coverage for yourself, you may also continue the basic group term life insurance you had on your last day of employment for your spouse/domestic partner until age 65 and your dependent children's benefits until age 19 (23 if solely dependent on you for support).

Portability coverage for you is reduced to:

- 65% of the original amount on January 1 following the date you reach age 65
- 40% of the original amount on January 1 following the date you reach age 70
- 25% of the original amount (to a minimum of \$5,000) on January 1 following the date you reach age 75.

Coverage terminates when you turn age 99 or otherwise stop premium payments for continued benefits.

Continued coverage for your spouse/domestic partner and children ends when they attain the limiting age or when your benefits cease; however, they may convert to an individual whole life insurance policy (see "Converting to Individual Whole Life Insurance" below).

Converting to Individual Whole Life Insurance

You, your spouse/domestic partner and children may apply to convert group term life insurance to an individual whole life insurance policy if you (the county employee):

- Leave county employment for any reason
- Elect to continue group term life insurance when you leave county employment but discontinue it or lose eligibility for it later.

To convert group term life insurance to an individual whole life insurance policy, you or the covered family member must apply to Aetna within 31 days of the date your group term life insurance coverage ends (see the Resource Directory booklet). If you die during the 31-day conversion period, your beneficiary or estate will receive the full amount of your life insurance coverage. This payment is made whether or not you actually applied to continue coverage. If you applied, any fees or premiums you paid are refunded.

Payment of Benefits

The benefits offered by this plan are insured by Aetna, meaning this is not a self-funded plan. Aetna is financially responsible for claim payments and other costs.

*Deputy Sheriff
Booklet 7*

**CIGNA
Accidental
Death and
Dismemberment
Insurance**

Although these benefit descriptions include certain key features and brief summaries of King County deputy sheriff benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts and other legal documents, the contracts and legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

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Overview

Highlights of CIGNA Accidental Death and Dismemberment Insurance

Here are a few highlights of your AD&D insurance:

- Basic AD&D insurance is provided by CIGNA
- You automatically receive \$6,000 basic AD&D insurance paid by the county (AD&D coverage is not available to family members)
- If you die as the result of a covered accident, AD&D benefits are paid in addition to any life insurance benefits
- Additional benefits and services, depending on the how accidental death or injury occurs, are available through this plan
- If you travel 100 or more miles from home, predeparture, travel and health emergency help is available
- You have options to continue AD&D insurance when you leave county employment.

Important Facts

Many important topics – including laws, regulations and county provisions – affect more than just this plan and can change frequently. To be more efficient, and avoid repetition, the following related information appears only in the Important Facts booklet:

- Who's eligible for coverage
- How to enroll
- When coverage begins
- Changes you can make to your coverage
- When coverage ends and the options for continuing it after you leave employment
- What happens to coverage in different situations
- Your rights and responsibilities under the plans.

Cost

The county pays the cost of \$6,000 basic AD&D insurance for you.

Amount of Coverage

You automatically receive county-paid basic AD&D insurance. If you die within one year of a covered accident and your death is due to the accident, the beneficiaries you designate receive a lump sum of \$6,000. For specified dismemberment, paralysis and other losses, you receive a portion of or the full amount, depending on the type of loss (see "When Benefits Are Payable").

Evidence of Insurability

No evidence of insurability (EOI) is required to enroll for AD&D insurance.

Beneficiaries

You need to designate one or more beneficiaries – individuals who receive your benefit in the event of your death. A Beneficiary Designation form is provided when you first enroll and is available on the Web and from Benefits and Retirement Operations anytime you need to change beneficiaries (see the Resource Directory booklet).

You may name anyone you wish as your primary or contingent beneficiaries (contingent beneficiaries receive benefits if all primary beneficiaries are deceased at the time of your death). If you don't designate beneficiaries as primary or contingent on your Beneficiary Designation, all beneficiaries you list are considered primary.

You may designate more than one primary and one contingent beneficiary. When you do, you must assign the percentage of your benefit each beneficiary receives on your Beneficiary Designation. Percentages for all primary beneficiaries must total 100% and percentages for all contingent beneficiaries must total 100%. If you don't assign percentages, beneficiaries receive equal shares.

If you're married and do not choose to list your spouse as a primary beneficiary with at least 50% of your benefit, your spouse should review and sign the spouse waiver section of the Beneficiary Designation.

You may change your beneficiary at any time by completing a new Beneficiary Designation and sending it to Benefits and Retirement Operations. Benefits are paid according to the most recently signed form on file. If you don't name a beneficiary, benefits are paid to your spouse, your children, your parents or your siblings, in that order. If none of them survives you, benefits are paid to your estate.

When Benefits Are Payable

Benefits are payable for death, specified dismemberment, paralysis and other losses that occur within 365 days of the covered accident that caused the covered loss. To receive benefits, you must be covered by the plan on the date of the accident.

Loss of Life. If you die as the result of a covered accident, the full AD&D benefit amount is payable.

Accidental Dismemberment and Paralysis. AD&D insurance protects you against losses due to accidents. Depending on the type of loss or injury, this plan pays up to 100% of the full AD&D benefit amount. To help you adjust to new living circumstances after surviving a severe accident, certain benefits are payable for paralysis, dismemberment and loss of eyesight, speech or hearing according to the following table.

Type of Loss	Benefit Payable
<ul style="list-style-type: none"> Life Both hands or both feet, or sight in both eyes or any combination Speech and hearing in both ears Quadriplegia: total paralysis of both arms and legs 	Full benefit amount (see "Amount of Coverage")
<ul style="list-style-type: none"> Paraplegia: total paralysis of both legs 	75% of the full benefit amount
<ul style="list-style-type: none"> 1 hand or 1 foot or sight in 1 eye Speech Hearing in both ears Hemiplegia: total paralysis of an arm and leg on 1 side of the body 	50% of the full benefit amount
<ul style="list-style-type: none"> Thumb and index finger on the same hand 	25% of the full benefit amount

Only one amount (the largest you're entitled to receive) is paid for all losses resulting from a single accident.

A loss is defined as:

- Loss of eyesight – total and irrecoverable loss of sight
- Loss of hearing – irrecoverable loss of hearing that cannot be corrected by any hearing aid or device
- Loss of hand or foot – complete severance through or above the wrist or ankle joint
- Loss of speech – complete inability to communicate audibly in any degree
- Loss of thumb and index finger – severance of the thumb and index finger through or above the joint closest to the wrist
- Paralysis of a limb – complete and irreversible loss of use, without severance of a limb (this loss must be determined by a physician to be complete and not reversible)

- Severance – complete separation and dismemberment of the limb from the body.

Additional Benefits and Services

Felonious Assault Benefit

If you're injured or killed as a result of felonious assault while on county property or on county business, this plan pays up to an additional 25% of your basic AD&D benefit. This additional benefit is available if your injury or death is the result of actual or attempted robbery or holdup (or associated kidnapping). Felonious assaults inflicted by county employees or members of your family or household are not covered.

Coma Benefit

This plan pays an additional benefit if you enter a coma as a result of a covered accident within 31 days of the accident and remain comatose beyond this waiting period. After 31 days, the plan makes monthly payments of 1% of the full AD&D benefit amount (principal sum) – up to 11 monthly payments. If you recover, the payments will stop.

If you die as the result of a covered accident while receiving the monthly coma benefit, the plan pays the full benefit amount (the amount already paid is not subtracted from the death benefit amount).

If the coma continues after the 11 monthly payments, you're entitled to a lump sum equal to the full benefit amount, minus any amount the plan paid or owes under the dismemberment, loss of sight, speech or hearing, or paralysis benefit. No further benefit will be paid from this plan, and coverage will end.

No coma benefit will be paid for any loss excluded from the plan (see "Exclusions and Limitations"). In addition, the coma benefit is not payable for a loss resulting from sickness, disease, bodily infirmity, medical or surgical treatment or a bacterial infection (unless it results from an accidental external injury or food poisoning) or viral infection.

Rehabilitation Benefit

If you experience a covered loss or injury, this plan pays an additional benefit for covered rehabilitative expenses due to the loss or injury if they're incurred within two years of the accident. This benefit maximum is \$10,000 in rehabilitative expenses for all losses or injuries caused by the same accident. No rehabilitation benefit will be paid for any loss not covered by the plan or if you're entitled to benefits under any workers' compensation or similar law.

Seatbelt/Airbag Benefit

This plan pays an additional \$1,000 if a seatbelt fails to protect you. The accident causing death must occur while you're operating or riding as a passenger in an automobile and wearing a properly fastened, original, factory-installed seatbelt.

The plan pays an additional \$300 if a seatbelt benefit is payable and you're positioned in a seat protected by a properly functioning, original, factory-installed supplemental restraint system that inflates on impact (an airbag).

Verification of actual seatbelt use at the time of accident and airbag inflation at impact must be part of an official accident report or be certified, in writing, by the investigating officer.

Secure Travel Service

If you travel 100 or more miles from home, predeparture, travel and health emergency help is available through Worldwide Assistance Services Inc. (see the Resource Directory booklet).

Predeparture Services. These services include information on immunization requirements, visa and passport regulations, foreign exchange rates, embassy/consular referral, travel/tourist advisories, climate and cultural issues.

Travel Assistance. When you're traveling, Worldwide Assistance will:

- Help you locate and replace luggage, documents and any other lost or stolen possessions
- Arrange aid from local attorneys, embassies and consulates if you need legal assistance, and provide up to \$5,000 in bail bond, where permitted by law (you must guarantee reimbursement)
- Provide phone translation or local interpreters for all major languages
- Give you a cash advance up to \$250 (you must guarantee reimbursement)
- Change or make new airline, hotel or car rental reservations in the event of an emergency
- Relay urgent messages to and from friends, relatives and business associates through the Emergency Message Center.

Health Emergency Assistance. If an unforeseen health emergency arises while you're traveling, Worldwide Assistance will:

- Provide referrals to local physicians, dentists and medical treatment facilities
- Assist you with refilling a prescription that has been lost, stolen or depleted
- Arrange for payment of up to \$5,000 of your reimbursable medical expenses (as determined by your medical plan)
- Pay for your transportation to the nearest medical facility where a medical condition can be properly treated if medically necessary (determined by a Worldwide Assistance-designated physician)
- Arrange and pay for the safe return of any dependent children under age 16 if you're hospitalized and for a traveling companion's return in the event of delays due to your medical emergency
- Arrange and pay for a visit by a family member or friend if you're traveling alone and hospitalized for at least 10 days
- Arrange all necessary government authorizations and pay for the return of your remains to your place of residence for burial or cremation in the event you die.

Exclusions and Limitations

No AD&D benefits are paid for loss resulting from:

- Accident occurring while you're serving on full-time active duty in any Armed Forces (send CIGNA proof of service, and any premium paid for this time will be refunded); Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days
- Committing a felony
- Declared or undeclared war or act of war
- Intentionally self-inflicted injuries, or any attempted self-inflicted injuries, while sane or insane
- Sickness, disease, bodily or mental infirmity, medical or surgical treatment or bacterial or viral infection, regardless of how contracted (except bacterial infection that's the natural, foreseeable result of an accidental external cut or wound, or accidental food poisoning)
- Travel or flight (including getting in or out, on or off) in any aircraft or device that can fly above the earth's surface, if:
 - The aircraft or device is being used for any of these purposes:
 - For test or experiment
 - By or for any military authority (aircraft flown by the US Military Airlift Command or similar service of another country are not excluded)
 - For travel beyond the earth's atmosphere, or
 - You're doing any of the following:
 - Piloting, serving as a crew member or taking flying lessons (exclusion does not apply if riding as a passenger, nor does it apply if piloting or serving as a crew member in an aircraft owned, leased, operated of controlled by King County)
 - Hang-gliding

- Parachuting, except a parachute jump for self-preservation.

Filing a Claim

For a death, specified dismemberment or paralysis claim, you or your beneficiary should contact Benefits and Retirement Operations. Benefits and Retirement Operations staff will help file the claim with CIGNA and provide referrals to counseling and other resources as requested. The claim should be filed within 90 days of the loss or death.

CIGNA requires proof of loss (for example, a certified copy of death certificate or accident report) within 90 days of the loss, or as soon as reasonably possible, before benefits are payable. For a death claim, CIGNA may, at its own expense, have an autopsy performed to determine a death benefit payment, unless prohibited by law. While a dismemberment or paralysis claim is pending, CIGNA may have you examined by a health or vocational professional of its choice and expense, as often as reasonably necessary.

CIGNA processes the claim within 90 days of receipt. If CIGNA needs more time, you or your beneficiary is notified in writing, before the initial 90 days end, of the need for an extension of up to 90 days.

If the claim is denied, you or your beneficiary is notified in writing of reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that the plan reviewed in making the determination.

Appealing Denied Claims

Claims Denied for Reasons Other Than Eligibility

When a claim is denied for any reason other than eligibility, follow the steps described in this section. However, when a claim is denied for eligibility reasons, follow the steps described in the next section, “Claims Denied Due to Eligibility.”

If you or your beneficiary disagrees with a claim denial, you, your beneficiary or representative (referred to as “you” in the rest of this section) may try to resolve any misunderstanding by calling CIGNA and providing more information. If you’d rather communicate in writing or the issue isn’t resolved with a call, you may file a written appeal. You have 60 days after receiving a claim denial notice to file the written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

CIGNA will review the written appeal and notify you of its decision within 60 days after receiving the appeal. If CIGNA requires more time, you’ll be notified in writing that an additional period of up to 60 days is necessary.

CIGNA will give you a written decision and explain the specific plan provisions behind the denial (if applicable).

CIGNA has sole discretionary authority to determine benefit payment under the AD&D insurance plan; its decision is final and binding. In reviewing your claim, CIGNA applies the plan terms and use its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and CIGNA determines you’re entitled to the benefits.

If the appeal is denied, you may pursue legal remedies, but you must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within three years after the time written proof of loss is required to be furnished. If you do not file a claim or appeal within the specified period, you forfeit the right to further appeal.

Claims Denied Due to Eligibility

If you have eligibility questions or believe you’ve had a claim denied because the plan indicates you’re not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or your eligibility issue can't be resolved with a phone call, you, your beneficiary or representative (referred to as "you" in the rest of this section) may file a written appeal. You have 60 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name and address
- Hire letter or job announcement, or retirement determination of eligibility
- Your employee ID (as it appears on your pay stub) or Social Security number
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you in writing of the eligibility determination within 60 days. If more time is required, you will be notified in writing that an additional period of up to 60 days is necessary.

If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine benefit eligibility under this plan; its decision is final and binding. In reviewing your claim, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you're entitled to the benefits.

If you believe your appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an appeal addendum within 60 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address as for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager's exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you were denied plan participation, or you forfeit your right to legal action.

Converting Your Coverage

If this group AD&D coverage ends for any reason except non-payment of premium, you may convert to an individual policy. No medical certification is needed, but you must be under age 70.

To convert coverage, you must apply and pay your first premium within 31 days of the date your county coverage ends. If you die due to a covered accident during the 31-day conversion period, your beneficiary or estate receives the full amount of your AD&D coverage. This payment is made whether or not you applied to convert coverage. If you applied, any fees or premiums you paid are refunded.

For information about converting your coverage, contact CIGNA (see the Resource Directory booklet).

Payment of Benefits

The benefits offered by this plan are underwritten by Life Insurance Company of North America, a division of CIGNA Corporation, meaning this is not a self-funded plan. Life Insurance Company of North America is responsible for claim payments and other costs.

Deputy Sheriff Booklet 8

Flexible Spending Accounts

Although these benefit descriptions include certain key features and brief summaries of King County deputy sheriff benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts and other legal documents, the contracts and legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

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Overview

Flexible Spending Accounts (FSAs) allow you to set aside pretax dollars from your paycheck to pay for expenses not covered through your other benefits. When you put money into an FSA you don't pay federal or FICA (Social Security) taxes on it. As a result, your taxable income is reduced and your taxes are lower.

- Health Care FSAs allow you to set aside pretax dollars to pay for certain expenses not covered by your medical, dental and vision plans (for example, copays for office visits and the cost of orthodontia not fully paid by your dental plan).
- Dependent Care FSAs allow you to set aside pretax dollars to pay for eligible dependent care expenses for your child, disabled spouse or dependent parent while you and your spouse work.

Health Care and Dependent Care FSAs are also referred to as health care and dependent care Personal Choice Accounts by Associated Administrators, Inc., the provider that administers FSAs for King County.

Plan benefits are funded through employee pretax salary reduction contributions, as permitted by Internal Revenue Code Section 125. In general, King County pays the administrative expenses of the plan to the extent those expenses are not paid from the plan.

Eligibility

You become eligible to participate in the FSA plan when:

- You first become eligible for benefits (see the Important Facts booklet)
- A qualifying change in status occurs (the type of change determines the type of FSA for which you may become eligible):
 - Change in your legal marital status due to marriage, legal separation, annulment, divorce or death of a spouse
 - Change in the number of your tax dependents due to birth, adoption or placement for adoption, or death of a dependent
 - Change in employment status for you, your spouse or dependent due to ending or starting of employment, reducing or increasing work hours, switching from salaried to hourly/union to non-union/part time to full time, strike or lockout, beginning or returning from unpaid leave of absence or any other change that affects benefit eligibility
 - Change in place of residence or work of you, your spouse or dependent that affects benefit eligibility
 - Change that causes a dependent to satisfy or stop satisfying coverage requirements for age, gain or loss of student status, marriage or any similar circumstances
 - Change due to certain judgments and court orders
 - Change in cost of dependent care due to change in provider.

Enrolling

Enrollment forms are available on the Benefits and Retirement Operations website and by request from Benefits and Retirement Operations (see the Resource Directory booklet); enrollment forms are also provided each year at open enrollment.

If you decide to enroll in either or both FSAs, return the forms to Benefits and Retirement Operations:

- Within 30 days of your benefit eligibility date if you're a new employee enrolling for the first time
- Within 30 days of a qualifying status change if you're an established employee enrolling for the first time
- By the open enrollment deadline if you're an established employee enrolling or reenrolling for the next plan/calendar year.

When you enroll, you enroll for the plan/calendar year (January 1 through December 31) and must reenroll each year during open enrollment to continue participating. You may make changes to your FSAs during open enrollment, but otherwise changes are limited (see "Changes Outside Open Enrollment Are Restricted").

Appealing Eligibility

When you submit the FSA enrollment form, Benefits and Retirement Operations determines your eligibility based on the qualifying event (see “Eligibility”) and timeliness of receiving your form (see “Enrolling”). If you’re determined ineligible, Benefits and Retirement Operations will contact you.

If you’re denied eligibility and disagree with the determination, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the issue.

If you have eligibility questions or believe you’ve had a claim denied because the plan indicates you or a family member is not covered, call Benefits and Retirement Operations at 206-684-1556. A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you’d rather communicate in writing or your eligibility issue can’t be resolved with a phone call, you or your representative (referred to as “you” in the rest of this section) may file a written appeal. You have 30 days after receiving an eligibility determination notice (from the county or the plan) to submit a written appeal. It must include:

- Your name, address and a contact phone number
- Your employee ID (as it appears on your pay stub) or Social Security number
- Reason for the appeal.

Send eligibility appeals to:

King County Benefits and Retirement Operations
Exchange Building EXC-ES-0300
821 Second Avenue
Seattle WA 98104-1598

A Benefits and Retirement Operations staff member will review your appeal and notify you of the eligibility determination within 30 days. If your eligibility appeal is denied, the notice will include the plan provision behind the decision and advise you of your right to obtain free copies of relevant documentation.

Benefits and Retirement Operations has sole discretionary authority to determine participation under this plan; its decision is final and binding. In reviewing your eligibility appeal, Benefits and Retirement Operations applies the plan terms and uses its discretion in interpreting plan terms. FSA participation is allowed only if you meet the eligibility and participation requirements and Benefits and Retirement Operations determines you’re entitled to participate.

If you believe your eligibility appeal was denied because relevant information or documents were not considered, Benefits and Retirement Operations offers the option of filing an eligibility appeal addendum within 30 days after receiving the eligibility appeal denial notice. The addendum must include the relevant information or documents. Send eligibility appeal addenda to the same address for eligibility appeals, but to the attention of the Benefits and Retirement Operations Manager.

The manager will review the additional information you provide, consult with appropriate county personnel and notify you in writing of the eligibility determination. The notice will indicate the specific plan provision behind the decision and advise you of your right to obtain free copies of related documentation.

It is the manager’s exclusive right to interpret and apply the eligibility terms and exercise discretion to resolve all eligibility questions for county employees. Decisions of the manager are final and binding.

If you disagree with your eligibility appeal determination, you may file a grievance with your union or initiate legal action. Any legal action must be within two years of the date you or your family member is denied plan participation, or you forfeit your right to legal action.

How FSAs Work

You decide how much you want to contribute through payroll deduction to either a Health Care or Dependent Care FSA (or both) and indicate the amount(s) on the enrollment forms you return to Benefits and Retirement Operations. When Benefits and Retirement Operations receives the form it verifies your eligibility and transmits the information to Payroll (so deductions can be taken) and a third party administrator, Associated Administrators Inc. (AAI), sets up your FSA and administers it for King County.

As you incur eligible expenses, you submit Reimbursement Claim forms (provided when you enroll and available from AAI), receipts and other required documentation to AAI, and AAI reimburses you from your account. Generally, reimbursement requests are processed within 48 hours of receipt. If the reimbursement is approved, a check is issued or direct deposit transmitted the night your request is processed and an explanation of reimbursement is mailed to your home.

If you want reimbursements direct deposited, you may complete the Direct Deposit Request form included with the enrollment forms (see “Enrolling”).

You may submit reimbursement requests for expenses incurred during the calendar year any time through March 31 of the following year (requests must be received by AAI no later than March 31), and you may submit multiple bills or receipts with one Reimbursement Claim form.

Health Care FSAs

FSA Versus Federal Income Tax Deduction

The IRS allows you to take a federal income tax deduction for certain eligible health care expenses if they exceed 7.5 % of your adjusted gross income, or you may set aside from \$300 (minimum) to \$6,000 (maximum) in pretax dollars to pay for these same expenses from a Health Care FSA (also called a Medical Care FSA or health care Personal Choice Account). For most people, the Health Care FSA makes the most sense, but consult a tax advisor to be sure.

Dependent Eligibility

Generally, you may use a health care FSA to reimburse expenses for any family member who qualifies for coverage under your benefit plans. However, Internal Revenue Code Section 152 restricts use of a Health Care FSA to reimburse expenses for a domestic partner and domestic partner’s children unless they live with you as members of your household and you provide over half their support during the calendar/plan year.

Internal Revenue Code Section 152 also allows you to reimburse expenses for:

- Any child, grandchild, stepchild, brother, sister, stepbrother, stepsister, parent, grandparent, stepparent, niece, nephew, aunt, uncle, son-in-law, daughter-in-law, mother-in-law, father-in-law, brother-in-law or sister-in-law who receives over half his or her support from you during the calendar year
- Any person not related to you but who lives with you as a member of your household and receives over half his or her support from you during the calendar year.

If you reimburse expenses from a Health Care FSA for any dependents other than your spouse or dependent children, you may be required to provide an affidavit certifying them as eligible dependents based on the criteria described.

Eligible Expenses

Here is a partial list of health care expenses eligible for reimbursement through a Health Care FSA. Consult with your tax advisor, IRS Publication 502 or AAI (eligible expenses are listed on the AAI website; see the Resource Directory booklet) if you have any questions. (The IRS publication references insurance premiums and long-term

care insurance as eligible deductible expenses on an individual tax return, but they're not eligible for Health Care FSA reimbursement.)

- Acupuncture
- Ambulance
- Artificial limbs
- Birth control pills, condoms, spermicides, pregnancy/ovulation kits
- Braille books and magazines
- Car controls for a disabled person
- Care for a mentally disabled child
- Chiropractor fees
- Christian Science practitioner fees
- Coinsurance/copays
- Contact lenses and contact cleaning solutions
- Cosmetic procedures to correct a problem arising from a medical condition
- Crutches
- Deductibles for medical, dental and vision plans
- Dental fees
- Dentures
- Diagnostic fees
- Disabled person's cost for special home
- Drug addiction treatment
- Eyeglasses
- Eye exams
- Fertility treatment
- Hearing aids and batteries
- Home improvements for medical reasons
- Hospital bills
- Hypnosis for treatment of an illness
- Insulin
- Lab fees
- Learning disability
- Life fee to retirement home for medical care
- Maternity care
- Naturopathic treatment
- Naturopathic remedies (if prescribed by physician for medical condition)
- New baby expenses for medical conditions
- Obstetrical services
- Operations
- Optometrist
- Orthodontics (non-cosmetic purposes)
- Orthopedic shoes
- Over-the-counter drugs used to treat/prevent illness/injury (limited)
- Oxygen
- Physician fees
- Prescription drugs
- Psychiatric care
- Psychologist fees
- Radial keratotomy
- Routine physicals
- Seeing-eye dog and its upkeep
- Skilled nurse fees (including board and Social Security taxes you pay)
- Smoking cessation
- Spa/pool equipment prescribed by physician and allowed by the IRS
- Special schools for mentally impaired or physically disabled person
- Telephone designed for hearing impaired person
- Television/hearing impaired equipment
- Therapeutic care for drug and alcohol addiction
- Therapy received as medical treatment
- Transportation expenses for medical purposes
- Tuition at special school for disabled person
- Tuition fee portion that goes for medical care
- Vaccines
- Weight loss programs (if prescribed by physician for medical condition)
- Well-baby and well-child care
- Wheelchair
- Wigs required for medical purposes
- X-rays

Ineligible Expenses

Here is a partial list of health care expenses not eligible for reimbursement through a Health Care FSA. Again, consult with your tax advisor or AAI (see the Resource Directory booklet) if you have any questions.

- Cosmetic procedures for non-medical reasons
- Diaper services
- Divorce expenses (even if recommended by a physician)
- Domestic help fees (for services of a non-medical nature)
- General counseling (family, marital or couple)
- Health club programs (fitness clubs and gyms)
- Health insurance premiums
- Lens replacement insurance
- Long-term care insurance premiums and expenses
- Maternity clothes
- Parking fees
- Physical therapy treatments for general well-being
- Vitamins, supplements and remedies taken for general well-being.

Expense Estimator

All eligible expenses for you, your spouse and your eligible dependents are reimbursable from your Health Care FSA. Complete this worksheet to estimate eligible health care expenses not covered by your other benefits, then use AAI's online tax calculator (www.aai-pca.com/ee_cyts.htm) to calculate your potential tax savings.

Medical Expenses	Estimated Plan Year Expenses
Copays	\$ _____
Deductibles	\$ _____
Physical exams	\$ _____
Prescription drugs	\$ _____
Surgical fees	\$ _____
X-ray or lab fees	\$ _____
Other medical expenses	\$ _____
Dental Expenses	
Copays	\$ _____
Deductibles	\$ _____
Dentures	\$ _____
Exams	\$ _____
Orthodontia	\$ _____
Restorative work (crowns, caps, bridges)	\$ _____
Teeth cleaning	\$ _____
Other dental expenses	\$ _____
Total Column 1	\$ _____

Vision Expenses	Estimated Plan Year Expenses
Copays	\$ _____
Deductibles	\$ _____
Eye exams	\$ _____
Prescription contact lenses	\$ _____
Contact lens supplies	\$ _____
Prescription eyeglasses or sunglasses	\$ _____
Other Expenses	
Acupuncture, chiropractors, naturopaths	\$ _____
Hearing aids	\$ _____
Immunization fees	\$ _____
Psychiatrist, psychologist, counseling (allowed for treatment of specific physical or mental disorder, such as depression, alcohol or drug treatment; diagnosis is necessary for reimbursement)	\$ _____
Total Column 2	\$ _____

Total Column 1 \$ _____ + Total Column 2 \$ _____ = Total Estimated Expenses \$ _____

Expense Reimbursement

How eligible expenses are reimbursed from a Health Care FSA depends on the type of expense you have: partially covered by health insurance, not covered by health insurance, or orthodontia expenses.

- For expenses partially covered by insurance, you file a claim with your health plan. When you receive your Explanation of Benefits (EOB), you see how much the plan paid and the remaining balance due. You then

request reimbursement for the remaining balance. Complete the Reimbursement Claim form available from AAI (see the Resource Directory booklet), attach your EOB, and fax or mail the information to AAI.

- For expenses not covered by insurance, complete the claim form and attach your itemized receipt(s) for the expense. Receipt(s) must show date of service, cost, service performed and provider of service. Cancelled checks, credit card receipts or statements showing only "balance due" or "payment on account" cannot be accepted. Fax or mail the information to AAI.
- For orthodontia services, you and your provider need to complete an "Orthodontic Charges Worksheet" and submit it to AAI before services begin; the worksheet (available from AAI; see the Resource Directory booklet) is used to calculate reimbursement. To be reimbursed, you must provide documentation such as a receipt of payment, claim form or payment coupon and it must include the patient name, provider name and tax ID number, and date of service.

Reimbursement can be made only after eligible expenses are incurred/services are provided, not when you're formally billed, charged for or pay for them. For example, if you pay your orthodontia provider in advance for services, you cannot be reimbursed in a lump sum. Instead, AAI will reimburse you for the down payment (up to 25% of the total fee) after the patient has been banded, then reimburse you monthly as documentation showing continuation of treatment is received. To calculate your monthly reimbursement, AAI takes the net balance (amount you owe after the down payment is deducted and discounts as well as estimated insurance payments are applied) and divides it by the estimated months of treatment.

When your Health Care FSA reimbursement request is received and approved, you're reimbursed for your eligible expenses up to the maximum you elected, minus any previous reimbursements made during the calendar year. Even if your reimbursement request is greater than your current account balance, you will be reimbursed for the total amount of your request, up to the total Health Care FSA contribution you elected for the calendar year.

If Reimbursement Is Denied

If your claim for reimbursement is denied, AAI will notify you in writing within 30 days of your request, explaining the specific reasons for the denial, your right to appeal and your right to obtain free copies of documentation related to the decision. If matters beyond AAI's control require more time, the review period may be extended up to 15 days; you'll be notified of the extension before the initial 30-day period ends.

If your claim is denied, you (or your representative) may submit a written appeal to:

Appeal Coordinator
Associated Administrators Inc.
PO Box 3199
Portland OR 97208-3199

Your written appeal must be filed within 180 days after receiving the initial notice of denial from AAI. You must indicate the reason for your appeal and may include any relevant information or documents.

AAI will give you a written decision within 60 days of receiving your appeal, indicating the specific plan provision behind the decision and advising you of your right to obtain free copies of related documentation.

If the appeal is denied, you may pursue legal remedies, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event the claim is based on.

Dependent Care FSAs

FSA Versus Federal Income Tax Deduction

If you work full time or part time and have children, a disabled spouse, or elderly dependent parents and use dependent care services regularly, you may take an income tax credit for your dependent care expenses or you

may set aside pretax dollars to pay for these same expenses from a Dependent Care FSA (also called a dependent care Personal Choice Account).

The minimum you may contribute to a Dependent Care FSA is \$300 a calendar year. The maximum you may contribute depends on your family situation. If more than one of the following situations applies to you, your maximum contribution is the lesser of the two:

- If you're a working single parent, you may contribute up to \$5,000 a calendar year
- If you're married and filing a joint income tax return, you may contribute up to \$5,000 a calendar year; if your spouse also has access to a Dependent Care FSA, your combined limit is \$5,000
- If you're married and filing separate income tax returns, you may contribute up to \$2,500 a calendar year
- If you're married and your spouse earns less than \$5,000, you may contribute up to the amount of your spouse's annual income.

For the federal tax credit, if you're married and your spouse is a full-time student or disabled (defined by the IRS as physically or mentally incapable of self-care), you may claim up to \$3,000 a calendar year for one dependent, or up to \$6,000 a calendar year for two or more dependents.

To determine whether the Dependent Care FSA or the federal tax credit (or combination of both) is best for you, consult a tax advisor.

Your Eligibility

To qualify, you must be at work while your eligible dependents receive care. You must also meet one of the following eligibility requirements:

- You're a single parent
- You have a working spouse
- Your spouse is a full-time student at least five months during the calendar year while you're working
- Your spouse is mentally or physically unable to care for him/herself
- You're divorced or legally separated and have custody of your child most of the time (even though your former spouse may claim the child for income tax purposes).

Dependent Eligibility

Eligible dependents for this plan include children, spouse and dependent parents:

- Your child under age 13 if you have custody and are entitled to claim a deduction on your federal tax return (for children of divorced or separated parents, only the parent with custody can consider the child an eligible dependent under this plan)
- Incapacitated parent living in your household full time
- Your child of any age who is physically or mentally unable to care for him/herself
- Your spouse who is physically or mentally unable to care for him/herself.

Eligible Expenses

The following types of care are reimbursable from a Dependent Care FSA:

- Care provided inside or outside your home by anyone other than your spouse, a person you list as your dependent for income tax purposes or one of your children under age 19
- A dependent care center or child care center (if the center cares for more than six children, it must comply with all applicable state and local regulations)
- A housekeeper, au pair or nanny whose services include, in part, providing care for a qualifying dependent
- Adult care for an incapacitated spouse or parent; this includes only the day care expenses; nursing/medical care does not qualify for reimbursement through a Dependent Care FSA, but may qualify under a Health Care FSA.

To qualify for reimbursement, you must submit your dependent care provider's tax ID number, Social Security number or license number on your federal tax return. Otherwise, your Dependent Care FSA reimbursements may

be reclassified as taxable income by the IRS. You must still complete IRS Form 2441 when reporting taxes at the end of each calendar year.

You're responsible for making sure the expenses you submit for reimbursement are considered eligible by the IRS. If you're not sure whether an expense is eligible, consult a tax advisor or contact AAI.

Ineligible Expenses

Expenses for overnight camps and education (including kindergarten) are generally not reimbursable. However, if the cost of tuition and dependent care can be separated, the itemized cost for dependent care is reimbursable. Ask a tax advisor for details.

Expense Reimbursement

To get reimbursed from a Dependent Care FSA, complete the Reimbursement Claim form (provided when you enroll and available from AAI), attach any appropriate receipts, or have the dependent care provider sign the claim form instead of a receipt. Fax or mail the information to AAI.

If you submit a reimbursement request for an amount that is more than your account balance, you're reimbursed up to the amount you currently have in your account. When future contributions are made to your account, you automatically receive another reimbursement, until your total claim amount has been reimbursed or you reach your calendar year election amount.

If Reimbursement Is Denied

If your claim for reimbursement is denied, AAI will notify you in writing within 30 days of your request, explaining the specific reasons for the denial, your right to appeal and your right to obtain free copies of documentation related to the decision. If matters beyond AAI's control require more time, the review period may be extended up to 15 days; you'll be notified of the extension before the initial 30-day period ends.

If your claim is denied, you (or your representative) may submit a written appeal to:

Appeal Coordinator
Associated Administrators Inc.
PO Box 3199
Portland OR 97208-3199

Your written appeal must be filed within 180 days after receiving the initial notice of denial from AAI. You must indicate the reason for your appeal and may include any relevant information or documents.

AAI will give you a written decision within 60 days of receiving your appeal, indicating the specific plan provision behind the decision and advising you of your right to obtain free copies of related documentation.

If the appeal is denied, you may pursue legal remedies, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event the claim is based on.

Other Considerations

Health Care and Dependent Care FSAs Don't Mix

Health Care and Dependent Care FSAs are separate. The money you allocate for one cannot be used for the other and you cannot transfer dollars between accounts.

Use It or Lose It

You may request reimbursement from an FSA through March 31 of the following year for eligible expenses incurred during the calendar year (your request must be received by AAI no later than March 31). Any money left in your FSA after March 31 is forfeited under IRS regulations.

FSA Contributions Can Affect Social Security

Because you and the county don't pay Social Security (FICA) taxes on the money you contribute to an FSA, your future Social Security benefits may be reduced slightly. However, you may find that the tax savings gained through FSA participation outweighs any loss in benefits. Consult a tax advisor to be sure what's best for your situation.

Changes Outside Open Enrollment are Restricted

The election you make when you enroll for an FSA remains in effect for the entire calendar year. You may change your elections (begin, increase, decrease or stop contributions only) during open enrollment (for the next calendar year) or when you have a qualifying status change:

- Change in your legal marital status due to marriage, legal separation, annulment, divorce or death of a spouse
- Change in the number of your tax dependents due to birth, adoption or placement for adoption, or death of a dependent
- Change in employment status for you, your spouse or dependent due to ending or starting employment, reducing or increasing work hours, switching from salaried to hourly/union to non-union/part time to full time, strike or lockout, beginning or returning from unpaid leave of absence or any other change that affects benefit eligibility
- Change in place of residence or work of you, your spouse or dependent that affects benefit eligibility
- Change that causes a dependent to satisfy or stop satisfying coverage requirements for age, gain or loss of student status, marriage or any similar circumstances
- Change due to certain judgments and court orders
- Change in cost of dependent care due to change in provider.

You have 30 days from the date of a qualifying status change to modify your FSA election, and the change must be consistent with and on account of the status change. To make the change, return a Status Change form to Benefits and Retirement Operations. The form is provided when you enroll and available from AAI and Benefits and Retirement Operations (see the Resource Directory booklet).

If You Leave Employment

If you leave employment you may continue participating in your Health Care FSA (contributing to the account and requesting reimbursements) through the end of the calendar year as long as you elect to continue the FSA under COBRA or retiree benefits. You have until March 31 of the next year to submit reimbursement requests for expenses incurred during the previous calendar year while under COBRA or retiree benefits.

If you leave employment but don't continue your Health Care FSA under COBRA or retiree benefits, your FSA participation ends the day you leave employment. You have until March 31 of the next year to submit reimbursement requests for expenses incurred through the date you leave.

If you leave employment your Dependent Care FSA participation ends the day you leave. You have until March 31 of the next year to submit reimbursement requests for expenses incurred through the date you leave.

Deputy Sheriff Booklet 9

Glossary

Although these benefit descriptions include certain key features and brief summaries of King County deputy sheriff benefit plans, they are not detailed descriptions. If you have questions about specific plan details, contact the plan or Benefits and Retirement Operations. We've made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between the benefit descriptions and the insurance contracts or other legal documents, the legal documents will always govern. King County intends to continue benefit plans indefinitely, but reserves the right to amend or terminate them at any time in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents. King County, as plan administrator, has the sole discretionary authority to determine eligibility for benefits and to construe the terms of the plans. This information does not create a contract of employment between King County and any employee.

Call 206-684-1556 for alternate formats.

Glossary

Accident. A sudden and unforeseen event that occurs at a specific time and place and results in bodily injury. It is independent of illness other than infection of a cut or wound received in an accident.

Aetna. The organization contracted by King County to administer the life insurance plan.

Allowable Amount – WDS. The maximum dollar amount allowed toward reimbursement for any service provided for a covered dental benefit.

Allowed Amount – Regence. The amount Regence BlueShield pays for a service or supply. Inside the Regence BlueShield service area, the amount is determined by agreement between Regence BlueShield and its participating providers. Outside the service area, the amount is determined at Regence BlueShield's option, either by the local Blue Shield/Blue Cross plan or an independent entity. If you see a non-participating provider and the provider charges more than the allowed amount, you pay the difference (your share of the total cost is higher).

Alveolar. Pertaining to the ridge, crest or process of bone that projects from the upper and lower jaw and supports the roots of the teeth.

Amalgam. A mostly silver filling often used to restore decayed teeth.

Annual Deductible. The amount plan participants pay each plan year before a plan pays benefits. The annual deductible does not apply to any out-of-pocket maximums.

Apicoectomy/Root Tip Amputation. Excision of the apical portion of a tooth's root to gain access to the periapical area to remove diseased tissue.

Associated Administrators Inc. (AAI). The organization contracted by King County to administer flexible spending accounts, COBRA benefits and retiree benefits.

Beneficiary. The person or organization you designate to receive any life or AD&D insurance benefits payable at the time of your death.

Bitewing X-ray. An x-ray that simultaneously shows the top visible part of the upper and lower molar teeth as well as part of their roots and supporting structures.

Brand-Name Drugs. Trademark drugs patented for a limited period by a single pharmaceutical company.

Bridge. Replacement for a missing tooth or teeth, consisting of the artificial tooth (pontic) and attachments to the adjoining abutment teeth (retainers). Bridges are cemented in place and are not removable.

Caries. Decay – a disease process initiated by bacterially produced acids on the tooth surface.

Caries Susceptibility Test. A test to determine how likely a person is to develop tooth decay, usually by measuring the concentration of certain bacteria in the mouth.

Chemical Dependency. A psychological and/or physical dependence on alcohol or a state-controlled substance. The pattern of use must be so frequent or intense that the user loses self-control over the amount and circumstances of use, develops symptoms of tolerance and, if use is reduced or discontinued, shows symptoms of physical and/or psychological withdrawal. The result is that health is substantially impaired or endangered, or social or economic function is substantially disrupted.

Chiropractic Care. Manipulation of the spine or extremities to correct a subluxation (incomplete or partial dislocation) identified on an x-ray. The subluxation must be consistent with the patient's neuromusculoskeletal symptoms, and treatment must be within the limits of a specific documented treatment plan. Services must be

provided by a state-licensed chiropractor or osteopath (chiropractors are restricted by law to manipulation of the spine; osteopaths are licensed to perform manipulative therapy on all parts of the body).

CIGNA. The organization contracted by King County to provide AD&D benefits.

COBRA. Consolidated Omnibus Budget Reconciliation Act. Implemented in 1986, COBRA allows continuation of health coverage on a self-paid basis under certain circumstances for a limited time. King County offers all required COBRA rights and extends spouse rights to domestic partners.

Coinsurance. The amount a patient and a patient's plan share toward covered expenses after any annual deductible is met.

Cole Vision. An organization contracted by PacifiCare to provide participants vision benefits and services.

Composite. A tooth-colored filling, made of a combination of materials, used to restore teeth.

Comprehensive Oral Evaluation. Typically used by a general dentist/specialist, it is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues.

Contracted Professional/Contracted Specialist – Group Health. A network provider under the Group Health plan who is under contract to Group Health.

Controlled Substance 5. A federal legend drug that comes under the jurisdiction of the Controlled Substances Act. These medications consist of preparations containing limited quantities of certain narcotic drugs generally for antitussive (cough preparations) and antidiarrheal purposes. Examples include Robitussin A-C syrup and Naldecon-CX.

Copay. The fixed amount the patient pays at the time the covered service is received.

Covered Accident – AD&D. An event that causes bodily injuries while covered by the AD&D insurance plan. The bodily injury must directly result in a covered loss.

Crown. A restoration that replaces the entire surface of the tooth's visible portion.

Custodial or Convalescent Care. Care primarily to assist the patient in activities of daily living, including inpatient care mainly to support self-care and provide room and board. Examples are helping the participant to walk, get in and out of bed, bathe, dress, eat or prepare special diets or take medication that is normally self-administered.

Dental Care. Care of, or related to, the mouth, gums, teeth, mouth tissues, upper or lower jaw bones or attached muscle, upper or lower jaw augmentation or reduction procedures, orthodontic appliances, dentures and any care generally recognized as dental. This also includes related supplies and devices (but not prescription drugs).

Denture. A removable prosthesis that replaces missing teeth. A complete (full) denture replaces all upper or lower teeth; a partial denture replaces one to several missing upper or lower teeth.

DESI Drugs. Drugs that lack substantial evidence of effectiveness according to the FDA, but since they have been used and accepted for many years without significant safety problems, they continue to be used today. Examples include Donnatal, Librax and Tigan suppositories.

Disability – Life. You are considered permanently and totally disabled only if disease or injury stops you from working at your own job or any other job for pay or profit, and it must continue to stop you from working at any reasonable job. A "reasonable job" is defined as any job for pay or profit that you are (or may reasonably become) fitted for by education, training or experience.

Durable Medical Equipment. Mechanical equipment that can stand repeated use and multiple users, is primarily and customarily used to serve a medical purpose, is generally not useful to a person in the absence of illness or injury and is prescribed by a physician.

Emergency – Medical. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the person experiencing the condition, as a prudent layperson, might reasonably expect any of the following to result if immediate medical attention is not provided:

- Immediate harm to self/others and health put in serious jeopardy (mental health medical emergency)
- Serious impairment to his/her bodily functions
- Serious dysfunction of any bodily organ or part
- Active labor, meaning labor at a time that either of the following would occur:
 - There is inadequate time to effect a safe transfer to another hospital prior to delivery or
 - A transfer poses a threat to the health and safety of the mother or unborn child.

In a mental health medical emergency, a prudent layperson might also reasonably expect serious immediate harm to self/others to result if immediate medical attention is not provided.

Emergency Services. Medical screening, examination and evaluation by a provider or other personnel (to the extent provided by law) to determine if a medical emergency or psychiatric medical emergency exists. If this condition exists, emergency services include the care, treatment and/or surgery by a provider necessary to relieve or eliminate the medical emergency or psychiatric medical emergency within the capabilities of the facility.

Endodontics. The diagnosis and treatment of dental diseases, including root canal treatment, affecting dental nerves and blood vessels.

Evidence of Insurability (EOI). Any statement or proof of a person's physical condition, occupation or other factor affecting acceptance for insurance.

Exclusions. Services or supplies not covered under a plan.

Experimental or Investigational Services/Supplies. A treatment, procedure, facility, equipment, drug, drug usage, medical device or supply is considered experimental or investigational when it meets any of the following criteria at the time it is or will be provided to the plan participant:

- Cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA) and such approval has not been granted
- Is the subject of a current new drug or new device application on file with the FDA
- Is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial or in any other manner intended to evaluate the service's or supply's safety, toxicity or efficacy
- Is provided under written protocol or other document that lists an evaluation of the service's or supply's safety, toxicity or efficacy among its objectives
- Is under continued scientific testing and research concerning safety, toxicity or efficacy
- Is provided under informed consent documents that describe the service or supply as experimental or investigational, or in other terms that indicate it is being evaluated for safety, toxicity or efficacy
- The prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that:
 - Use should be substantially confined to research settings or
 - Further research is necessary to determine safety, toxicity or efficacy.

In determining whether a service or supply is experimental or investigational, the following sources of information are relied upon exclusively:

- The plan participant's medical records
- Written protocol(s) or other document(s) under which the service or supply has been or will be provided
- Any consent document(s) the plan participant or plan participant's representative has executed or will be asked to execute to receive the service or supply
- The files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service or supply has been or will be provided, and other information concerning the authority or actions of the IRB or similar body
- The published authoritative medical or scientific literature regarding the service or supply, as applied to the plan participant's illness or injury

- Regulations, records, applications and any other documents or actions issued by, filed with or taken by the FDA, the Office of Technology Assessment or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

If two or more services or supplies are part of the same treatment plan or diagnosis, all are excluded if one is experimental or investigational. The plans consult the appropriate professional staff and then use the previously specified criteria to decide if a particular service or supply is experimental or investigational.

For Regence BlueShield participants, a service or supply must be classified as experimental or investigational by the national Blue Cross Blue Shield Association.

Filled Resin. Tooth-colored plastic materials that contain glass-like particles to add strength and resistance to wear.

Fluoride. A substance that when topically applied or added to drinking water is effective in resisting tooth decay.

Fluoride Varnish. Fluoride treatment in a varnish base applied to reduce acid damage from bacteria that cause tooth decay.

FMLA. Family and Medical Leave Act. Implemented in 1993, FMLA allows up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons if eligibility requirements are met.

Formulary. A list of selected generic and brand-name prescription drugs established, reviewed and routinely updated by health plans.

General Anesthesia. A drug or gas that produces unconsciousness and insensibility to pain.

Generic Drugs. Medications that are not trademark drugs, but are chemically equivalent to the brand-name drug.

Gingival Curettage. The process of removing or cutting diseased soft tissue surrounding the tooth.

Group Health. Group Health Cooperative. The organization contracted by King County to provide the HMO medical plan option.

HIPAA. Health Insurance Portability and Accountability Act. Effective in 1996, HIPAA restricts the extent to which group health plans may impose preexisting condition limits and protects plan participants' personal health information.

Hospice. A private or public agency or organization with a hospice agency license that administers or provides hospice care.

Hospital. An institution licensed by the state and – for compensation on behalf of patients and on an inpatient basis – primarily engaged in providing diagnostic and therapeutic facilities for surgical and/or medical diagnosis as well as treatment and care of injured or ill persons by or under the supervision of a staff of physicians. The institution also continuously provides 24-hour nursing service by or under the supervision of registered nurses, or is any other licensed institution with which the medical plans have an agreement to provide hospital services. (Skilled nursing facilities, nursing homes, convalescent homes, custodial homes, health resorts, hospices or places for rest, the aged or the treatment of pulmonary tuberculosis are not hospitals.)

Iliac Crest. Top of the hip bone used for grafting bone onto the lower jaw.

Implant. A graft or insert set firmly onto or deeply into the alveolar area prepared for its insertion. It may support a crown or crowns, a bridge abutment, a partial denture or a complete denture.

Inlay. A dental filling shaped to the form of a cavity and then inserted and secured with cement.

Inpatient Services. Care provided to a patient who is hospitalized.

Intravenous Sedation. A form of sedation where the patient experiences a lowered level of consciousness but is still awake and can respond.

KCFML. King County Family and Medical Leave. Passed by King County Ordinance 13377 in 1998 and adopted by most but not all labor unions representing King County employees. Allows up to 18 weeks of unpaid, job-protected leave for certain family and medical reasons if eligibility requirements are met.

Legend Prescription Drugs. FDA-approved drugs that require a prescription from an authorized prescriber.

Lifetime Maximum. The maximum benefit amount a plan participant may receive from a plan in his or her lifetime.

Limitations. Restricting conditions, such as age, time covered and waiting periods.

Localized Delivery of Therapeutic Agents. Treating isolated areas of advanced gum disease by placing antibiotics or other germ-killing drugs into the gum pocket.

Medically Necessary. Health care services, supplies, treatments or settings considered appropriate and necessary, according to generally accepted principles of good medical practice, to diagnose or treat a medical condition. Services, supplies, treatments or settings must meet all of these requirements:

- Are not solely for the convenience of the patient, his or her family or the provider of the services or supplies
- Are the most appropriate level of service or supply that can be safely provided to the patient
- Are for the diagnosis or treatment of an actual or existing illness or injury unless being provided for preventive services
- Are not for recreational, life-enhancing, relaxation or palliative therapy (except to treat terminal conditions)
- Are not primarily for research and data accumulation
- Are appropriate and consistent with the diagnosis and, in accordance with accepted medical standards in Washington State, could not have been omitted without adversely affecting the patient's condition or the quality of health services rendered
- As to inpatient care, could not have been received in a provider's office, the outpatient department of a hospital or a non-residential facility without affecting the patient's condition or quality of health services
- Are not experimental or investigational.

The plan participant is responsible for the cost of services and supplies that are not medically necessary.

The plans reserve the right to determine whether a service, supply, treatment or setting is medically necessary. The fact a physician or other provider has prescribed, ordered, recommended or approved a service, supply, treatment or setting does not, in itself, make it medically necessary.

Mental Condition. A condition classified as such by the most current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Mental Disorder. Any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome, regardless of cause, including any biological or biochemical disorder or imbalance of the brain. Mental disorder includes, but is not limited to, bipolar affective disorder, organic brain syndrome, schizophrenia, psychotic illness, manic depressive illness, depression and depressive disorders, anxiety and anxiety disorders.

Mutual Aid Agreement. Allows certain benefits to continue while you're away from the county if you are needed to work temporarily for another agency.

National Preferred Transplant Network -- PacifiCare. A network of transplant facilities that are:

- Licensed in the state where they operate
- Certified by Medicare as a transplant facility for a specific organ transplant
- Designated by PacifiCare as a transplant facility for a specific organ program

- Able to meet reasonable access standards for organ transplants based on Regional Organ Procurement Agency statistics for the facility's location (a Regional Organ Procurement Agency is the geographic area designated by a state-licensed organ procurement organization for transplants in the State of Washington).

Network Benefits. The level of benefits you receive when you see a network provider. Network benefits are generally higher than non-network benefits.

Network Provider. A person, group, organization or facility under contract with a benefit plan to furnish covered services to plan participants.

Nightguard. See "Occlusal Guard."

Non-Network Benefits. The level of benefits you receive when you see a non-network provider.

Non-Network Provider. A person, group, organization or facility not under contract with a plan to furnish covered services to plan participants. Though some benefit plans allow use of non-network providers, they still must be licensed, registered or certified to provide covered services by the state where they operate.

Non-Formulary Prescription Drug – Regence BlueShield. A prescription drug not listed on a formulary.

Non-Preferred Brand – Group Health and Pacificare. Brand-name prescription drugs not preferred by a medical plan because they are considered no more effective but cost more than preferred brands.

Occlusal Adjustment. Modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth and neuromuscular mechanism, the temporomandibular joints and the structure supporting the teeth.

Occlusal Guard. A removable dental appliance, sometimes called a nightguard, to minimize the effects of grinding or gnashing the teeth.

Occlusal Splint. A device used to support, protect or immobilize oral structures that have been loosened, replanted, fractured or traumatized; also refers to devices used in the treatment of TMJ disorders.

Occlusion. The contact of the teeth of both jaws when closed or during the movements of the mandible in mastication (chewing).

Onlay. Restoration of the entire contact surface of the tooth.

Open Enrollment. The annual period when benefit-eligible employees may change plans, add life insurance coverage and add family members for coverage – within the limits of each benefit plan.

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

Orthognathic Surgery. Surgical treatment to correct malpositions of the upper jaw bone (maxilla) and/or lower jaw bone (mandible).

Outpatient Services. Care provided to a patient who is not hospitalized, but who receives treatment at a licensed medical facility.

Overdenture. A removable denture constructed over existing natural teeth or implanted studs.

PacifiCare. An organization contracted by King County to provide one of the deputy sheriff medical/vision plan options.

Panorex X-ray. An x-ray system using two points of rotation to obtain a panoramic view of the dental arches.

Periodic Oral Evaluation/Routine Exam. An evaluation performed on a patient to determine any changes in dental and medical health status following a previous comprehensive or periodic evaluation.

Periodontics. Diagnosis, prevention and treatment of diseases in gums and the bone that supports teeth.

Plan Year. The calendar year (January 1 through December 31).

Physical Disease. A physical disease entity or process that produces structural or functional changes in your body as diagnosed by a physician.

Physician. A provider licensed by the state in where he or she practices as:

- Chiropractor
- Dentist (DDS or DMD)
- Doctor of medicine or surgery
- Doctor of naturopathic medicine
- Doctor of osteopathy
- Doctor of ophthalmology
- Doctor of podiatry
- Psychologist (if licensed by the state to practice psychology and in private practice)
- Registered nurse.

The medical/vision plans also cover providers licensed as a physician's or osteopath's assistant, certified as a nursing assistant or licensed as a practical nurse or registered nurse's assistant, when that provider works with or is supervised by one of the above physicians.

Plaque. Flat masses of bacteria and debris on tooth surfaces.

Preauthorization/Preadmission – Medical. The medical plans' approval for services or supplies given before the patient receives them.

Predetermination – Dental. The dental plan's approval for services or supplies given before the patient receives them.

Preferred Brand. Brand-name prescription drugs preferred by a medical plan because of their clinical and economic value to the plan and participants. They're considered equally as effective but cost less than non-preferred brands.

Prescription Drug. Inside the United States, any medical substance approved by the FDA that requires a prescription, must be dispensed by a licensed pharmacist and, under the Federal Food, Drug and Cosmetic Act (as amended), must be labeled "Caution: Federal law prohibits dispensing without a prescription." Outside the United States, any drug equivalent.

Primary Care Physician (PCP). A physician who provides or coordinates care for plan participants.

Prophylaxis. The control of dental and oral diseases by preventive measures, especially the mechanical cleansing of the teeth.

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

Prosthodontics. The branch of dentistry that deals with the replacement of missing teeth or oral tissues by artificial means, such as bridges, dentures or implants.

Provider. A person, group, organization or facility licensed to provide plan services, equipment, supplies or drugs. For the medical/vision plans, this includes but is not limited to naturopaths, acupuncturists and massage therapists. The provider must be practicing within the scope of his or her license.

Pulp Exposure Treatment (Pulp Capping). The covering of an exposed dental pulp with a material that protects it from external influences and does not interfere with pulpal healing. It stimulates the formation of secondary dentin in an effort to maintain the health and vitality of the tooth's pulp.

Pulpotomy. An operation by which the bulbous or crown portion of the dental pulp is removed.

Qualified Medical Child Support Order (QMCSO). A decree, judgment or order from a state court (including approval of a settlement agreement) or administrative order that requires benefit plans to include a child in the employee's coverage and make any applicable payroll deductions.

Rebase. A process of refitting a denture by replacing the denture base material without changing the occlusal relationships of the teeth.

Regence BlueShield. An organization contracted by King County to provide one of the deputy sheriff medical/vision plan options.

Reline. To resurface the tissue side of a denture with a new base material so it will fit more accurately.

Respite Care. Time off or a break for someone who is the main caregiver for an aged, ill or disabled adult or child.

Restorative. A process used to replace a lost tooth or part, or the diseased portion of one, by artificial means as with a filling, crown, inlay or onlay to restore proper dental function.

Root Planing. A procedure done to smooth roughened root surfaces.

Salary. Your annual base pay excluding overtime, bonuses, premium pay or any other special pay.

Sealants. A resinous material designed for application to the surfaces of posterior teeth to seal surface irregularities and prevent tooth decay.

Service Area. The geographic area where the plans have arranged for covered services through agreements with various providers.

Skilled Nursing Facility. A facility that provides room and board as well as skilled nursing care 24 hours a day and is accredited as an extended care facility or is Medicare certified as a skilled nursing facility. It is not a hotel, motel or place for rest or domiciliary care for the aged.

Specialist – Washington Dental Service. A licensed dentist who has successfully completed an education program accredited by the Commission of Dental Accreditation, two or more years in length, as specified by the Council on Dental Education or by diplomats of an American Dental Association-recognized certifying board.

Staff Member/Staff Specialist – Group Health. A network provider under the Group Health plan who is part of the Group Health staff.

Temporomandibular Joint (TMJ) Disorders. Disorders with any of the following characteristics:

- Pain in the musculature associated with the TMJ
- Internal derangements of the TMJ
- Arthritic problems with the TMJ
- Abnormal range of motion or limited range of motion of the TMJ.

(The temporomandibular joint just ahead of the ear connects the mandible, or jawbone, to the temporal bone of the skull.)

Urgent Care. Medical services that do not constitute a medical emergency but need immediate medical attention.

USERRA. The Uniformed Services Employment and Reemployment Rights Act of 1994.

Usual, Customary and Reasonable Charge (UCR) – Medical. Rates consistent with those normally charged by the provider for the same services or supplies and within the general range of charges by other providers in the same area for the same services or supplies.

Washington Dental Service (WDS). The organization contracted by King County to administer dental plan benefits.

Women’s Health Care Services. These include the following health care services:

- Maternity care
- Reproductive health services
- Gynecological care
- General exams and preventive care.

Deputy Sheriff Booklet 10

Resource Directory

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Call 206-684-1556 for alternate formats.

Resource Directory

If no TTY phone number is listed, please call 711 to access the TTY Relay Service.

For Questions About ...	Contact ...
<p>Accidental Death and Dismemberment (AD&D) Insurance</p> <ul style="list-style-type: none"> • Conversion option • Secure travel services • For claims, contact Benefits and Retirement Operations 	<p>CIGNA Phone 1-800-441-1832 (conversion) ■ 1-800-336-2485 (TTY)</p> <p>Worldwide Assistance Services Inc. (secure travel services) Phone 1-888-226-4567/1832 (US/Canada) ■ Call collect 202-331-7635 (all other locations) Fax 202-331-1528 Email cigna@worldwideassistance.com</p>
<p>Benefits – Eligibility and New Hire Enrollment</p>	<p>Sheriff's Office Personnel Unit KC Courthouse KCC-SO-0100, 516 Third Ave., Seattle WA 98104-1598 Phone 206-205-7601/2/4 Fax 206-205-7608</p>
<p>Benefits – General</p> <ul style="list-style-type: none"> • Open enrollment and making changes • Flexible Spending Account enrollment • Life and AD&D insurance details • Alternate formats 	<p>Benefits and Retirement Operations Exchange Building EXC-ES-0300, 821 Second Ave., Seattle WA 98104-1598 Phone 206-684-1556 ■ 1-800-325-6165 x41556 (outside local calling area) Fax 206-684-1925 Email kc.benefits@metrokc.gov Web www.metrokc.gov/finance/benefits</p>
<p>COBRA and Retiree Benefits</p>	<p>Associated Administrators Inc. (AAI) PO Box 3988, Portland OR 97208-3988 Phone 1-800-320-2915 ■ 1-800-428-4833 (TTY) Fax 503-979-8987 Email cobra@aai-tpa.com</p>
<p>Counseling and Resource Referral</p> <ul style="list-style-type: none"> • Personal, family and work problems • Financial and legal matters • Child care, elder/adult care 	<p>Making Life Easier Program (24 hours a day, 7 days a week) Phone 1-888-874-7290</p>
<p>Deferred Compensation</p> <ul style="list-style-type: none"> • Enrollment • Changes (beneficiaries, contributions, allocations, etc.) • Quarterly worksite seminars 	<p>T. Rowe Price PO Box 17215, Baltimore MD 21297-1215 Phone 1-888-457-5770 Web http://rps.troweprice.com/kingcounty/retirementplan/index.html</p>
<p>Dental</p> <ul style="list-style-type: none"> • Providers • Claims and appeals • Other plan details 	<p>Washington Dental Service (WDS) PO Box 75688, Seattle WA 98125-0688 Phone 206-522-2300 ■ 1-800-554-1907 Fax 206-285-4926 Email cservice@deltadentalwa.com Web www.DeltaDentalWA.com</p>
<p>Disability Services</p> <ul style="list-style-type: none"> • Essential job function assessment • Job modification 	<p>Disability Services Program Yesler Building YES-HR-0540 400 Yesler Way, Seattle WA 98104-2683 Phone 206-263-4507 ■ 1-800-325-6165 x44507 (outside local calling area) Fax 206-684-2017 Intranet ohrm.metrokc.gov/safety/DAProgram/da.htm</p>

For Questions About ...	Contact ...
<p>Flexible Spending Accounts (FSAs)</p> <ul style="list-style-type: none"> • Account balances • Reimbursement • Other plan details 	<p>Associated Administrators Inc. (AAI) PO Box 3199, Portland OR 97208-3199 Phone 1-800-334-4340 ■ 1-800-428-4833 (TTY) Fax 1-800-979-8987 Email flex@aai-tpa.com Web www.aai-pca.com</p>
<p>LEOFF 1 Disability Retirement Board</p> <ul style="list-style-type: none"> • Disability retirement leave approval • Health benefit reimbursement 	<p>LEOFF 1 Disability Retirement Board Coordinator Exchange Building EXC-ES-0300, 821 Second Ave., Seattle WA 98104-1598 Phone 206-263-6394 ■ 1-800-325-6165 x31556 (outside local calling area) Fax 206-263-3692 Email KCLEOFF1@metrokc.gov Web www.metrokc.gov/finance/kcleoff1</p>
<p>Life Insurance</p> <ul style="list-style-type: none"> • Conversion or portability option • Evidence of insurability (EOI) • For claims, contact Benefits and Retirement Operations 	<p>Aetna Phone 1-800-826-7448 (conversion/portability) ■ 1-800-523-5065 (EOI)</p>
<p>Medical/Vision – General</p> <ul style="list-style-type: none"> • Providers (doctors, hospitals, pharmacies, etc.) • Claims and appeals • Drug formulary (covered drugs) • Identification cards • Preauthorization/preadmission • Other plan details (covered expenses, limits, exclusions) 	<p>Regence BlueShield PO Box 21267, 1800 Ninth Ave., Seattle WA 98111 Phone 1-800-458-3523 Web www.wa.regence.com (e-mail through Web site)</p> <p>PacifiCare PO Box 6092, Cypress CA 90630-0092 ■ PO Box 31053, Laguna Hills CA 92654-1053 (mental health and chemical dependency claims) Phone 1-800-932-3004 (weekdays 7 a.m.-9 p.m. Pacific) ■ 1-800-577-7244 (Behavioral Health) ■ 1-800-292-2336 (Free & Clear® StopSmokingSM) ■ 1-800-762-8456 (emergency care follow-up authorization) ■ 711 TTY Relay Service Web www.pacificare.com (e-mail through Web site)</p> <p>Cole Vision (for PacifiCare participant vision benefits) PO BOX 8056 Twinsburg OH 44087-8967 Phone 1-800-334-7591</p> <p>Group Health Cooperative PO Box 34585, Seattle WA 98124-1585 Phone 206-901-4636 ■ 1-888-901-4636 ■ 1-888-457-9516 (out-of-area authorization) Email info@ghc.org Web www.ghc.org</p>

For Questions About ...	Contact ...
Medical – Mail Order Prescriptions	<p>Postal Prescription Services (Regence BlueShield participants) Postal Prescription Services PO Box 2718, Portland OR 97208-2718 Phone 1-800-552-6694 Web www.ppsrx.com (e-mail through Web site)</p> <p>Walgreens Healthcare Plus (Regence BlueShield participants) PO Box 188, Beaverton OR 97075 Phone 1-800-797-3345 Web www.walgreenshealth.com/whc/mpharm/jsp/mpharm_cob_home.jsp (e-mail through Web site)</p> <p>Prescription Solutions (PacifiCare participants) PO Box 6037, Cypress CA 90630-0037 Phone 1-800-562-6223 ▪ 711 TTY Relay Service Web www.pacificare.com (e-mail through Web) (Group Health participants use Group Health)</p>
Secure Horizons Medicare+Choice Plan for Retirees	<p>PacifiCare Phone 1-800-829-2925 ext. 7482 ▪ 1-800-647-7328 ▪ 1-800-387-1074 (TTY)</p>
<p>Washington State Department of Retirement Systems</p> <ul style="list-style-type: none"> • General information • Beneficiary designation • Beneficiary and address changes • Disability benefit options 	<p>Washington State Department of Retirement Systems PO Box 48380, Olympia WA 98504-8380 Phone 1-800-547-6657 ▪ 360-664-7000 (Olympia area) ▪ 360-586-5450 (TTY) Email recep@drs.wa.gov Web www.drs.wa.gov</p>
<p>Workers' Compensation</p> <ul style="list-style-type: none"> • On-the-job illness or injury • Benefits • Claims 	<p>Safety & Claims Management Boeing Field AIR-HR-0103 PO Box 80283, Seattle WA 98108 Phone 206-296-0510 ▪ 1-800-325-6165 x60510 (outside local calling area) Fax 206-296-0514 Intranet ohrm.metrokc.gov/safety/claiminfo/comphome.htm</p>

