

2006 Summary of Material Modification



This Summary of Material Modification (SMM) describes changes to information in “Your King County Benefits,” the collection of booklets describing coverage available to you under the King County regular and Local 587 employee benefit plans:

- *Blue italic changes* became effective *January 1, 2004*
- *Blue bold italic changes* became effective on or after *January 1, 2005*, unless otherwise noted.
- Blue bold changes with an underline become effective *January 1, 2006*, unless otherwise noted.

To help you find the information that’s been changed, references to the corresponding pages in “Your King County Benefits” are provided.

Please refer to this and subsequent SMMs provided each year at open enrollment for updates to “Your King County Benefits.” The collection of plan booklets and a copy of this SMM are available on the Internet (www.metrokc.gov/finance/benefits), in the county e-mail system public folders (Public Folders\Finance\Benefits and Retirement) and from Benefits and Retirement Operations.

Questions? Contact Benefits and Retirement Operations at:

- Exchange Building EXC-ES-0300, 821 Second Ave., Seattle WA 98104
- kc.benefits@metrokc.gov
- 206-684-1556.

This Summary of Material Modification (SMM) describes the changes that affect your benefit plans and updates your plan descriptions. SMMs together with the plan booklets make up your official plan descriptions; please keep them together and refer to them as necessary. We’ve made every attempt to insure the accuracy of the information in this SMM and the plan booklets. However, if there is any discrepancy between them and the insurance contracts or other legal documents, the legal documents will always govern.

Call 206-684-1556 for alternate formats.

Important Facts

Benefit Eligibility

Changes to one subsection.

► **Benefit Eligibility and Cost If You're a Part-Time Local 587 Employee (page 7)**

If you're a part-time transit operator or an assigned or on-call employee represented by Local 587, you're eligible for one of [two benefit plans beginning January 1, 2006, when Plan 1 and Plan 3 become a new plan called Partial Benefits Plan, and when Plan 2 is renamed the Full Benefits Plan.](#)

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 medical, dental and vision plans (see 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 Flexible Spending Accounts booklet)
- You receive a free Flexpass/employee ID and 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 after your qualification date.

[Partial Benefits Plan \(the single benefit plan replacing Plan 1 and Plan 3 for employees who work less than half-time\). Effective January 1, 2006, you become eligible for the Partial Benefits Plan the first of the month following your qualification or hire date \(whichever is later\) or if you are in Plan 1 or Plan 3 on December 31, 2005. Your hire date is determined by your department. If your qualification or hire date is the first of the month, you become eligible that same day.](#)

[Under the Partial Benefits Plan, you may purchase medical, dental and vision coverage for you and the eligible family members you enroll \(the employee's medical coverage is partially subsidized by the county\). If you select medical coverage, you will receive fully paid basic life, accidental death and dismemberment \(AD&D\) and long term disability \(LTD\) insurance, and you may purchase enhanced life and AD&D for you and your family and enhanced long term disability for you \(this does not apply if you have previously declined enhanced life and enhanced LTD\).](#)

You pay for [benefits in the Partial Benefits Plan](#) through payroll deduction. The monthly cost of benefits is divided in half and deducted from your two regular paychecks each month. (When there are three paychecks in a month, no deductions are taken from the last one.)

You may have the deductions taken before or after federal income and Social Security taxes are withheld. If you have deductions taken after-tax, you do not reduce your taxes, but may drop coverage for yourself or a family member anytime. You may change how your payment deductions are taken (before-tax or after-tax) only during open enrollment.

Before-tax deductions do reduce your taxes. However, IRS restrictions apply:

- Any portion you pay to provide coverage to a domestic partner or domestic partner's children is an after-tax deduction
- You may not drop any coverage until the next open enrollment unless it's due to a qualifying change in status:
 - Death of a family member
 - Divorce, legal separation or dissolution of a domestic partnership
 - Significant change in your spouse's or domestic partner's coverage due to his/her employment
- You must re-enroll for before-tax deductions every year during open enrollment or you default to the after-tax arrangement.

Full Benefits Plan (formerly Plan 2). You become eligible for the Full Benefits Plan through 2006 in any of the following ways:

- **You are currently eligible for Plan 2 benefits (Plan 2 eligibility extends through December 31, 2006)**
- **You receive 338 paid hours in the four-month period of March 1-June 30, 2005 (fully paid benefits begin September 1, 2005, and extend through December 31, 2006)**
- **You pick 4 or more hours in the 2005 fall shakeup or the spring or summer shakeups of 2006 (fully paid benefits begin the first day of the month after you work the 4 or more hour assignment and extend through December 31, 2006)**
- **You receive 1,019 or more paid hours in the 26 pay periods ending August 12, 2005 (fully paid benefits begin January 1, 2006, and extend through December 31, 2006).**

Eligibility for **the Full Benefits Plan** is determined by an agreement between King County Metro Transit and Amalgamated Transit Union Local 587 based on working sufficient hours. Direct any questions regarding eligibility for **the Full Benefits Plan** to your base chief.

Under the Full Benefits Plan, you receive county-paid medical, dental and vision coverage for you and the eligible family members you enroll, plus basic life, AD&D and LTD insurance for you. When you first enroll under the Full Benefits Plan, you may also purchase additional enhanced life and AD&D for you and your family members, plus enhanced LTD for you.

If you and your spouse/domestic partner are both county employees, you may not be covered as both an employee and a dependent at the same time under enhanced life and enhanced AD&D, and only one of you may cover your children for enhanced life and enhanced AD&D. *Also, refer to "Retiree Benefits" on page 14 of this SMM for information on how your retiree medical benefits may be affected by your dual coverage as county employees. [This change has been added to clarify how your benefits are administered.]*

Enrolling in the Plans

Changes to one subsection.

► Enrolling If You're a Part-Time Local 587 Employee (page 11)

You receive enrollment materials for each plan as you become eligible.

If you decide to participate in a Flexible Spending Account, you must submit the FSA Enrollment form available from Benefits and Retirement Operations within 30 days of when you become eligible **for benefits in the Partial Benefits Plan or the Full Benefits Plan**. 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 Flexible Spending Accounts booklet).

Partial Benefits Plan. You must submit your enrollment form **for the Partial Benefits Plan** within 30 days of your eligibility date (sooner if possible). Otherwise, you must wait until the next open enrollment to enroll in the **Partial Benefits Plan**. (If you don't elect basic life insurance **and basic LTD insurance** when you are first eligible, you may not add it again.)

Full Benefits Plan. You must submit your enrollment form **for the Full Benefits Plan** by the deadline indicated in your **Full Benefits Plan** materials (the materials are mailed to you approximately one month before your **Full Benefits Plan** eligibility begins). Otherwise, only eligible family members you've previously enrolled in a county medical plan will be covered and you'll receive the following default coverage:

- KingCareSM Basic Medical (if you've never been enrolled in a county medical plan) or the last county medical plan you were in (if it's still available to you)
- Dental
- Vision
- Basic life insurance
- Basic AD&D insurance
- Basic LTD insurance.

When you become eligible for the **Full Benefits Plan** you may opt out of medical coverage and receive an additional \$65 in monthly pay taxed as ordinary income. To opt out of medical coverage, you must have coverage through another employer's health care plan and submit a copy of the other medical plan ID card with your enrollment form. (When you opt out of medical, your other **Full Benefits Plan** benefits are not affected.)

You may opt out only when you first enroll for **benefits in the Full Benefits Plan** or at open enrollment. Even if you become covered under another medical plan, you must wait until the next open enrollment to opt out of county medical coverage.

If you opt out of medical, you may opt back in before open enrollment if you lose your other medical coverage and return a completed Opt Back In form to Benefits and Retirement Operations within 30 days of losing that coverage (coverage becomes effective the first of the month after your other coverage ends). Otherwise, you must wait until the next open enrollment (coverage becomes effective January 1).

If you decide to participate in a Flexible Spending Account, you must submit an FSA Enrollment form available from Benefits and Retirement Operations (see Resource Directory booklet) within 30 days of when your **benefits in the Full Benefits Plan** 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 Flexible Spending Accounts booklet).

If default coverage is assigned:

- **Health Coverage and AD&D.** You must wait until the next open enrollment to change medical plans, elect enhanced AD&D and add eligible family members for coverage
- **Life.** You may not add enhanced life at open enrollment, but you may add it during the year if certain qualifying events occur (see "Changes You May Make When a Qualifying Event Occurs")
- **LTD.** You receive basic LTD but lose the opportunity to add enhanced LTD later.

When Coverage Begins

Changes to two subsections.

► **When Coverage Begins If You're a Regular Employee (page 12)**

Coverage begins the first of the month following your hire date, as determined by your department (unless modified by your collective bargaining agreement). 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.** 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.
- **LTD.** If you're not actively at work on the day coverage would start, coverage begins on the day you return to work; active work includes holidays, vacation days and approved paid leaves (other than sick leave), as long as you worked the day preceding the scheduled work day.

► **When Coverage Begins If You're a Part-Time Local 587 Employee (pages 12)**

Partial Benefits Plan. If you enroll, coverage begins the first of the month following your qualification or hire date, whichever is later. Your hire date is determined by your department. If your hire date is the first of the month, your coverage begins the same day.

When you first enroll in the Partial Benefits Plan, the start of some coverage may be delayed:

- **Medical.** 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.

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, unless you qualify for the Full Benefits Plan. *[Deleted reference to "(as long as you remain eligible)," which followed "entire calendar year"]*

Full Benefits Plan. Coverage begins January 1, March 1, July 1 or October 1, depending on your eligibility date.

When you're first eligible for the Full Benefits Plan, the start of some coverage may be delayed:

- **Medical.** 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.
- **LTD.** If you're not actively at work on the day coverage would start, coverage begins on the day you return to work; active work includes holidays, vacation days and approved paid leaves (other than sick leave), as long as you worked the day preceding the scheduled work 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.

Changes You May Make When a Qualifying Event Occurs

Addition of one subsection at the beginning.

► You May Change Your Health Plan (page 15)

New special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA) allow you and your eligible dependents to change to another medical plan benefit option offered at your workplace at the time of a qualifying event – provided you are receiving your medical coverage as an active employee or under COBRA, not under retiree medical.

Thus, upon the occurrence of a qualifying event, you and all of your eligible dependents may either:

- Enroll in your current medical coverage, or
- Enroll in any medical plan benefit option for which you and your dependents are eligible.

Before the new special enrollment rights, you could only add new family members to your existing medical coverage and make changes to life and AD&D insurance coverage.

The new special enrollment rights also allow you to change to another medical plan benefit option offered at your workplace when you reach the lifetime maximum for your medical benefits under your existing medical coverage option.

COBRA (pages 21-23)

*Changes and additions throughout the section. The administrator of COBRA remains the same, but the administrator name changes from Associated Administrators, Inc. (AAI) to **Personal Choice Account offered by Regence BlueCross and BlueShield of Oregon, referenced as PCA.** (16 references).*

► COBRA Eligibility

If you lose your health plan coverage through the county, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives you (the employee or the employee's family member) the right to continuation of coverage when you would otherwise lose it. A notice describing COBRA rights is mailed to your home within 30 days after you first enroll for your county coverage.

COBRA continuation coverage is a continuation of health plan coverage when coverage would otherwise end because of a life event known as a qualifying event. After a qualifying event, COBRA continuation coverage must be offered to each person who is a qualified beneficiary. You, your covered spouse, your covered domestic partner and your covered dependent children could become qualified beneficiaries if coverage under county health plans is lost because of a qualifying event.

► COBRA Qualifying Events

Employee. If you're an employee, you become a qualified beneficiary if you lose coverage under your King County health plans due to any of these qualifying events:

- *A change in your job status, such as a reduction in hours, causes you to lose coverage*
- *Your employment ends for any reason other than your gross misconduct.*

Spouse/Domestic Partner. If you're the covered spouse/domestic partner of an employee, you become a qualified beneficiary if you lose coverage under your King County health plans due to any of these qualifying events:

- *Your spouse/domestic partner dies*
 - *A change in your spouse's or domestic partner's job status, such as a reduction in hours, causes you to lose coverage*
 - *Your spouse's/domestic partner's employment ends for any reason other than his or her gross misconduct*
 - *You divorce from your spouse (legal separation is not a qualifying event) or end your domestic partnership.*
- [Reference to Medicare benefits as a qualifying event deleted]*

If you're the covered spouse dropped from coverage by the employee in anticipation of a divorce and a divorce later occurs, then the divorce is considered the qualifying event even though you lost coverage earlier. Contact Benefits and Retirement Operations within 60 days after the divorce with documentation of the event. COBRA eligibility begins the first of the month following the divorce. [References to legal separation deleted]

Dependent Children. Your covered dependent children become qualified beneficiaries if they lose coverage under your King County health plans due to any of these qualifying events:

- *Parent-employee dies*
 - *A change in your parent-employee's job status, such as a reduction in hours, causes you to lose coverage*
 - *Parent-employee's employment ends for any reason other than his or her gross misconduct*
 - *Parents divorce (legal separation is not a qualifying event) or end their domestic partnership*
 - *Child stops being eligible for coverage under the plan as a "dependent child."*
- [Reference to Medicare benefits as a qualifying event deleted]*

► **COBRA Plan Options and Cost**

Under the county health plans, qualified beneficiaries who elect COBRA continuation must pay for COBRA continuation coverage. Your plan options and the cost are explained in information you receive from PCA, the county's COBRA administrator, when you qualify for COBRA.

To continue coverage under COBRA, you must be covered under the plan on your last day of employment. For example, to continue medical, you must have medical on your last day; you can't continue medical if you don't have it.

| <i>If you're a</i> | <i>You may pay to continue</i> |
|---|---|
| <i>Regular employee Full-time Local 587 employee Part-time Local 587 employee in the Full Benefits Plan</i> | <i>These combinations of the health plans you have on your last day of employment:</i> <ul style="list-style-type: none"> ● <i>Medical, dental and vision</i> ● <i>Medical</i> ● <i>Dental and vision (if you're opted out of medical on your last day)</i> |
| <i>Part-time Local 587 employee in the Partial Benefits Plan</i> | <i>These combinations of the health plans you have on your last day of employment:</i> <ul style="list-style-type: none"> ● <i>Medical, dental and vision</i> ● <i>Medical</i> ● <i>Medical and dental (if you don't have vision on your last day)</i> ● <i>Medical and vision (if you don't have dental on your last day)</i> ● <i>Vision (if you don't have medical and dental on your last day)</i> ● <i>Dental (if you're a dependent and that's the only coverage you have on your last day)</i> |

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.

You and/or your qualified family members may continue Medicare or another group health plan, if the effective date is before the COBRA election date.

If you are 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 as long as you meet the requirements (see the Flexible Spending Accounts booklet).

Life Insurance. It is not a provision of COBRA, but if you end employment with the county (not if you leave employment due to a 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 additional details on portability or converting your coverage).

► *Reporting COBRA Qualifying Events*

COBRA qualifying events of termination, change in job status or employee death are reported to Benefits and Retirement Operations through the employee's termination notice or payroll report.

For the other qualifying events (divorce of employee and spouse, end of domestic partnership or a dependent child's loss of eligibility for coverage as a dependent child), you (employee or family member) must submit a Delete Family Member form to Benefits and Retirement Operations within 60 days of the last day of the month the qualifying event occurs or the date coverage ends, if later. The form is available from Benefits and Retirement Operations (see Resource Directory booklet). [Reference to legal separation deleted]

You can fax, mail, e-mail or hand-deliver the form to Benefits and Retirement Operations, but oral notice (including notice by telephone) is not acceptable.

If these procedures are not followed or if a Delete Family Member form is not received by the last day of the 60-day notice period (if mailed, it must be postmarked by the last day of the 60-day notice period), any spouse, domestic partner or dependent child who loses coverage will not be offered the option to elect COBRA continuation coverage.

► *COBRA Enrollment*

When COBRA-qualifying information is received, Benefits and Retirement Operations notifies PCA, the county's COBRA administrator, and PCA offers COBRA continuation coverage to each qualified beneficiary, explaining COBRA plan options and cost. Each qualified beneficiary has an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses or domestic partners, and parents may elect COBRA continuation coverage on behalf of their children.

*You have 60 days after coverage ends to make your COBRA elections or 60 days from the date of the **qualifying event notice sent by PCA, whichever is later**. 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 PCA. Failure to elect coverage **within 60 days** will result in loss of the right to elect continuation of coverage.*

*If you elect COBRA continuation coverage, you must make the initial **premium** payment by the 45th day after electing it. If you do not remit payment with your election form within the initial 45 days, your coverage will be suspended and then retroactively reinstated back to the loss of coverage under the employer's plan. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated. The amount you or your qualified family member may be required to pay may not exceed 102 percent of the cost of the county's plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). Thereafter, all premiums are due the first of the month; coverage automatically ends if payment is not made within 30 days. PCA will provide you with more detailed payment information.*

Once you have elected COBRA and paid the premium, COBRA continuation coverage is retroactive *to the first day of the month in which your coverage ended*. 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.

► *Length of COBRA Continuation Coverage*

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, divorce, end of domestic partnership or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months. [Reference to entitlement to Medicare benefits and reference to legal separation deleted]

If the covered employee's Medicare entitlement precedes the end of employment or reduction in hours of employment, then the employee's spouse and dependent children, if any, are entitled to COBRA coverage for up to the greater of 18 months from the end of employment or 36 months from the earlier Medicare entitlement date.

For example, if a covered employee becomes entitled to Medicare eight months before the date on which his/her employment ends, COBRA continuation coverage for the employee's spouse or domestic partner and children can last up to 28 months after the date of the qualifying event (36 months minus eight months).

Otherwise, when the qualifying event is the end of employment or a change in the employee's job status where there is a loss of coverage, COBRA continuation coverage lasts up to a total of only 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage. An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify PCA in writing of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. All of the qualified beneficiaries who have elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify PCA in writing of that fact within 30 days of SSA's determination.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage. If your family experiences another qualifying event while receiving 18 or 29 months of COBRA continuation coverage, the spouse or domestic partner and dependent children in your family can get additional months of COBRA continuation coverage, for a total maximum of 36 months from the date when COBRA coverage began, if notice of the second qualifying event is properly given to the plan. This extension may be available to the spouse or domestic partner and any dependent children receiving continuation coverage if the employee or former employee dies, divorces, ends a domestic partnership, or if the dependent child stops being eligible under the plan as a dependent child, but only if the event would have caused the spouse, domestic partner or dependent child to lose coverage under the plan had the first qualifying event not occurred. [References to legal separation deleted]

► **Making Changes under COBRA**

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

- Drop dental and vision and retain medical coverage anytime (notice must be received by **PCA** in the month before you want the change to become effective)
- Drop yourself and family members from coverage anytime (notice must be received by **PCA** 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" in this booklet)
- Change medical plans during open enrollment

- Change medical 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**

Continuation coverage will be terminated before the end of the maximum period if:

- *Any required premium is not paid on time*
- *A qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary*
- *A covered employee enrolls in Medicare*
- *The employer ceases to provide any group health plan for its employees*
- *For any reason the plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud)*
- The plan terminates (*whether by contract or county bankruptcy*) or you first become covered under another group health plan after the date of your COBRA election (unless the plan limits or excludes coverage for a preexisting condition of the individual continuing coverage).

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 are 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 are determined ineligible.

You may be entitled to purchase an individual conversion policy when you are 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 **PCA** or **Benefits and Retirement Operations** (see *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 nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration (ESBA)**. **Addresses and phone numbers for the nearest regional or district offices are available at www.dol.gov/ebsa.***

► *Keep Your Plan Informed of Address Changes*

*In order to protect your family's rights, you should keep King County and **PCA** 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 **PCA**.*

Retiree Benefits

*New subsection added at the end for 2004; its language is changed for 2005. Changes to two subsections. The administrator of retiree benefits remains the same, but the administrator name changes from Associated Administrators, Inc. (AAI) to **Personal Choice Account offered by Regence BlueCross and BlueShield of Oregon, referenced as PCA.** (5 references).*

► Retiree Benefit Eligibility

County-paid coverage ends the last of the month you retire. You may self-pay to continue medical and 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
- Are not covered under another medical group plan, *and*
- 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). *[This change has been added to clarify how your benefits are administered.]*

However, there is an exception. You are not eligible to self-pay under retiree medical if you:

- *Are an employee with a spouse/domestic partner who is also a county employee, and*
- *Have opted out of your own coverage to be covered under your spouse's/domestic partner's county coverage (this means your coverage is in your spouse's/domestic partner's name, not your own), and*
- *Retire before your spouse/domestic partner does.*

Your county health coverage must be in your name at the time of your retirement for you to be eligible for retiree medical. However, you may continue your coverage under your spouse's/domestic partner's county health benefits. [This change has been added to clarify how your benefits are administered.]

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, AD&D and LTD 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 and vision | Medical, dental and vision |
| Length of time coverage is available | Until you become eligible for Medicare | 18 months maximum (29 months if you leave employment due to a disability as determined by Social Security) |
| Allowed to change medical plans between open enrollments | No | Yes, if you relocate out of your current plan's coverage area and notify <i>PCA</i> with proof of your new permanent address and availability of coverage under another King County plan in your new location |

If you are 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).

► *If You Lose Eligibility for Retiree Benefits Due to Medicare Entitlement (page 25)*

If you retire and elect retiree benefits for you and your qualified family members before you become entitled to Medicare, the retiree benefits end for everyone when you become Medicare entitled. When this occurs:

- *You may apply for Medicare supplemental insurance for yourself through PCA. The supplemental insurance is provided through the PacifiCare Secure Horizons plan within specific counties. To qualify, you must contact PCA and apply within 30 days of when your retiree benefit coverage ends.*
- *Your family members may continue their county benefits coverage under COBRA for up to 36 months from the date of your Medicare entitlement – PCA will notify them of this option by sending a COBRA qualifying event notice with an election form to be returned to PCA to enroll the family members. (COBRA may provide a longer period of continuation coverage for qualified family members than retiree benefits, based on the date you retire and the date you become Medicare entitled. For more information, contact Benefits and Retirement Operations.)*

If you retire when or after you become entitled to Medicare, you and your family members are not eligible for retiree benefits but:

- *You may apply for Medicare supplemental insurance for yourself through PCA, as described in the previous paragraph.*
- *Your qualified family members may continue county benefit coverage under COBRA (up to 36 months from the date of your Medicare entitlement).*

KingCareSM Basic and Preferred Medical

Throughout the Booklet

The prescription drug provider for the KingCareSM plans remains the same, but the provider name changes from AdvancePCS to **Caremark** (33 references).

How the Plans Work

Changes to one subsection and a new subsection added at the end.

► Obtaining Preauthorization (pages 37-38)

Medical Services. If you see an Aetna network provider, the provider will obtain preauthorization for your care as required. If you see a non-network provider, you are responsible for obtaining preauthorization for certain services or supplies. This means you must call or ask your physician to call for preauthorization on your behalf. You may then call Aetna to check that your physician followed through (see Resource Directory booklet).

With preauthorization, benefits will be paid according to plan provisions and limits, if your benefits are in force when you receive care. Aetna will confirm the preauthorization in writing. It will be valid for three months, if your condition does not change.

If you see a non-network provider, you must obtain preauthorization for these covered services:

- Anorexiant for treatment of attention deficit disorder or narcolepsy
- Durable medical equipment
- Growth hormones
- Home health care
- Hospice care
- Injectable prescription drugs (with certain exceptions like insulin, Depo-Provera and some others)
- Inpatient chemical dependency treatment
- Inpatient hospital care (other than for most stays in connection with childbirth)
- Inpatient mental health care
- Inpatient neurodevelopmental therapy for children age six and younger
- **Obesity surgery or other procedures, treatment or services such as gastric intestinal bypass surgery (preauthorization requires successful completion of a weight management program)**
- **Orthognathic surgeries (to correct jaw abnormalities or malocclusions when medically necessary)**
- Skilled nursing facility care
- TMJ disorders
- Transplants.

If you are having surgery or being admitted to a hospital (except for childbirth), Aetna must be notified at least seven days before the (non-emergency) surgery or admission. Before admission, be sure to confirm with the hospital that your stay has been preauthorized.

You must call Aetna within 48 hours from the start of your care (or as soon as reasonably possible) for:

- Accidents
- Emergencies (including detoxification)
- Involuntary commitment to a Washington state mental hospital
- Maternity admissions.

To obtain preauthorization for non-emergency care (or certification afterward), have your physician contact Aetna at 1-800-654-7714. [Reference to Making Life Easier Program deleted]

When calling, be prepared to supply these details:

- Admission date
- Diagnosis or surgery
- Employer name (King County)
- Employee name and Social Security number (or unique identifying number if assigned one by the plan)
- Hospital name and address or phone number
- Patient name, address and date of birth
- Physician name and address or phone number
- Proposed treatment plan, including length of stay and discharge planning needs.

If your care is not preauthorized as described above and Aetna determines your care was not medically necessary, the charges for your care may be only partially paid or may not be paid at all.

Prescription Drug Services. Certain prescriptions and quantities require preauthorization. You or your doctor can find out if preauthorization is required by contacting **Caremark** (see Resource Directory booklet) before you have a prescription filled. Otherwise, your pharmacist or the **Caremark** mail order service will advise you of the preauthorization procedures required to fill the prescription.

To preauthorize a prescription, your doctor or his/her representative must initiate the process with a phone call to **Caremark**. Your eligibility is then confirmed and your prescription records checked to see if the prescription has been preauthorized before.

Preauthorization requests are evaluated using criteria approved by your plan; the request is then approved, denied or held for further information. If more information is required, **Caremark** will notify your physician's office; once the doctor provides the information, your request can be approved or denied.

If the preauthorization is approved, **Caremark** notifies your physician and updates its database so you can fill the prescription.

If preauthorization is denied, a pharmacist verifies the denial is valid according to plan criteria and then **Caremark** notifies:

- Your physician verbally
- You and your physician in writing.

When you receive a written denial you may appeal (see "Appealing Denied Claims" in this booklet).

► ***Special Services (a new section, page 39)***

In addition to your health benefits, Aetna offers several other services that you can use to manage your health and the health of your family.

Informed Health® Line. You can talk to a registered nurse 24 hours a day to get information on a variety of health and wellness topics at 1-800-556-1555. You can also listen to Aetna's Audio Health Library, a recorded collection of more than 2,000 health topics in English and Spanish, and transfer to a registered nurse at anytime during the call. In addition, you can access Healthwise® Knowledgebase, Aetna's database of health information, through Aetna Navigator™ at the KingCareSM member Web site: www.kingcare.com.

AexcelSM Specialty Network. You can identify AexcelSM specialty providers who meet certain standards for effectiveness and cost-efficiency in cardiology, cardiothoracic surgery, gastroenterology, general surgery, obstetrics/gynecology, orthopedic surgery, otolaryngology, neurology, neurosurgery, plastic surgery, urology and vascular surgery. You can locate AexcelSM physicians through Aetna NavigatorTM DocFind[®] at the KingCareSM member Web site: www.kingcare.com or by calling 1-800-654-3250.

Disease Management. If you are a patient with coronary artery disease, chronic heart failure or diabetes, you can receive:

- *Help in following your doctor's treatment plan*
- *Help in managing illness-related depression*
- *Assistance in getting some medical equipment*
- *Access to a case management nurse*
- *Information on your disease*
- *Tools, programs and resources to improve your quality of life.*

You can enroll by logging onto Aetna NavigatorTM at the KingCareSM member Web site: www.kingcare.com, calling 1-800-814-3543 or by being referred by a physician or Enhanced Member Outreach nurse. Aetna has a contract with LifeMasters to provide this service.

Enhanced Member Outreach. You can get extra support for health conditions through this service. An Enhanced Member Outreach nurse will contact you to:

- *Discuss the details of an upcoming hospital stay so you know more about what to expect during your stay and after you get home*
- *Answer questions and provide guidance before or after a surgical procedure*
- *Direct you to care and disease management programs to ensure you have access to up-to-date treatment*
- *Help you follow your treatment plan*
- *Address emerging health issues early and effectively*
- *Provide coaching and education about your benefit plan, available programs and tools.*

MedQuery. This service keeps your doctor informed of the best practice treatments for a wide variety of conditions, such as diabetes, coronary artery disease and influenza. As a result, your doctor may update your treatment to ensure you are getting the best care.

Covered Expenses under KingCareSM

Changes to seven subsections and one new subsection added in alphabetical order.

► Summary of Covered Expenses (page 39)

*The chemical dependency treatment maximum described in the summary table increased from \$11,285 to **\$12,500** in 2005 and increases to **\$13,000** in 2006.*

Coinsurance for outpatient mental health care will increase from 50% to 90% (preferred) and 80% (basic) for network providers and 70% (preferred) and 60% (basic) for non-network providers.

One medical service added to table of covered expenses in alphabetical order.

| Covered expenses | KingCare SM Basic Plan | KingCare SM Preferred Plan |
|---|--|--|
| <i>Jaw abnormalities, or malocclusions (covered when medically necessary)</i> | <i>80% network when preauthorized 60% non-network when preauthorized</i> | <i>90% network when preauthorized 70% non-network when preauthorized</i> |

► **Chemical Dependency Treatment (page 43)**

Aetna network providers obtain preauthorization for this care as necessary. If you see a non-network provider, you must obtain preauthorization from Aetna for inpatient chemical dependency treatment. For additional counseling and referral services, you may also call the King County Making Life Easier Program at 1-888-874-7290.

Chemical dependency benefits are covered up to *the maximum described in the summary table (see page 39)*.

Inpatient and outpatient chemical dependency treatment is covered, including:

- Detoxification services
- Diagnostic evaluation and education
- Organized individual and group counseling
- Prescription drugs and medicines.

Aetna processes claims for prescription drugs used during inpatient hospitalization; AdvancePCS processes claims for outpatient, retail pharmacy and mail order drugs.

► *Jaw abnormalities (page 47)*

Surgical corrections of jaw abnormalities, or malocclusions, are covered when medically necessary.

► **Mental Health Care (page 48)**

Inpatient and outpatient mental health care is covered if provided by a licensed psychiatrist (MD), licensed psychologist (PhD), licensed master’s level mental health counselor, licensed nurse practitioner (ARNP), community mental health agency licensed by the Department of Health or licensed state hospital. *(For additional counseling and referral services, you may also call the King County Making Life Easier Program at 1-888-874-7290.)*

Covered services include:

- Individual and group psychotherapy
- Inpatient care or day treatment care instead of hospitalization (must be in a licensed medical facility)
- Lab services related to the covered provider’s approved treatment plan
- Marriage and family therapy
- Physical exams and intake history
- Psychological testing.

Depending on individual medical needs, other benefit options may be available under the medical case management provision of these plans (see “Case Management” in this booklet).

Inpatient mental health care is limited to 30 days per year. Outpatient mental health care is limited to 52 visits per year. When deemed appropriate by Aetna, two unused outpatient visits may be traded for one inpatient day, or vice versa. Network providers obtain preauthorization for your care as necessary. If you see a non-network provider, you must obtain preauthorization for inpatient mental health care. *[Reference to Making Life Easier Program deleted]*

[Outpatient mental health care is now covered the same as other outpatient medical care, as a result of the Washington State Mental Health Parity Law, but visit limits can remain. Coinsurance for outpatient mental health care, increases from 50% to 90% \(preferred\) and 80% \(basic\) for network providers and 70% \(preferred\) and 60% \(basic\) for non-network providers. The law, which passed in 2005, begins phasing in requirements to place mental health treatments on parity with physical health treatments on January 1, 2006.](#)

The plans do not cover:

- Biofeedback
- Custodial care
- Specialty programs for mental health therapy not provided by these plans
- Treatment of sexual disorders.

► **Prescription Drugs (pages 49-51)**

Prescription drug services for KingCareSM members are provided by *Caremark*, a separate provider not affiliated with Aetna. *Caremark* issues a separate prescription card to KingCareSM members to use when filling prescriptions at *Caremark* network pharmacies or from the *Caremark* mail order service (*see Resource Directory Booklet*).

You may order up to a 30-day supply from a retail network pharmacy or up to a 90-day supply per prescription or refill through the mail order service (if you use the mail order service, you pay the 90-day copay amounts even if your prescription is written for less than a 90-day supply).

What's Covered. The following items are covered (*Caremark* processes the claims):

- Contraceptives (oral, injectable, vaginal, topical and implantable)
- Controlled substance 5 over-the-counter drugs (see Glossary booklet for a definition)
- DESI drugs (see Glossary booklet for a definition)
- Emergency allergic reaction kits
- Emergency contraceptives
- Glucagon emergency kit
- Injectable prescription drugs purchased at a retail pharmacy or through mail order (for some, preauthorization may be required; some injectables may be covered under medical services)
- Insulin and diabetic supplies
 - Alcohol swabs
 - Blood glucose testing strips
 - Glucose tablets
 - Injection devices (such as Novopen)
 - Insulin administered by pen/cartridge or other special injection devices
 - Insulin needles and syringes
 - Insulin/predrawn syringes
 - Keytone testing strips
 - Lancets
 - Lancet devices
 - Monitors
 - Urine glucose testing strips
- Legend drugs unless specified otherwise (see Glossary booklet for a definition)
- Ostomy supplies
- Prenatal vitamins
- Smoking cessation drugs requiring a prescription (claims for non-prescription nicotine patches are covered through Aetna and reimbursed at network rates)
- Smoking cessation drugs, [inhalers and nasal sprays](#) requiring a prescription [– covered at 100% after copay through Caremark \(non-prescription nicotine patches and gum are covered at 100% through Aetna – contact Aetna for claim reimbursement procedures\)](#)

- Topical smoking cessation patches whether prescription or over-the-counter
- Viagra, if used to treat impotency or penile dysfunction and preauthorized.

What's Not Covered. The following items are not covered by *Caremark*:

- Anorexiant
- Any over-the-counter medication, unless otherwise noted
- Blood products
- Cosmetic/hair loss medications
- Experimental medications that do not have the 11-digit code assigned under FDA regulations
- Infertility medications
- Therapeutic devices or appliances, including hypodermic needles, syringes (except those used for insulin and in the course of administering medical treatment), support garments and other non-medical substances regardless of intended use
- Vitamins (except prenatal).

An extensive nationwide network of pharmacies has agreed to dispense covered prescription drugs to plan participants at a discounted cost and not to bill plan participants for any amounts over the copays.

Using a Network Pharmacy. Here's how it works:

- Choose a network pharmacy (contact *Caremark* for a list of network pharmacies or to find one near you; see Resource Directory booklet)
- Show your AdvancePCS/*Caremark* prescription card to the network pharmacist each time you want a prescription filled or refilled (your Aetna medical card is not used for prescription drug services)
- Pay the copay for each covered new prescription or refill
- There are no claim forms to submit; the network pharmacy bills the plan directly.

If you do not show your prescription card, and the network pharmacy cannot *confirm you are covered through Caremark*, you will need to pay the pharmacy in full and submit a claim for reimbursement to *Caremark*.

Using a Non-Network Pharmacy. If you fill a prescription through a non-network pharmacy, you must pay the cost of the prescription first and then submit a claim for reimbursement from *Caremark*. Reimbursement is based on the rates *Caremark* pays its network pharmacies. Generally, a non-network provider charges more than what *Caremark* pays its network pharmacies. If so, you or your family members pay the difference.

Regular Mail Order. The mail order service is for maintenance drugs (drugs you must take on an ongoing basis). The first time you use the mail order service, fill out the patient information questionnaire on the order form available *from Caremark* (see Resource Directory booklet). This questionnaire needs to be completed only once. The information is maintained by *Caremark* and assists in cross-checking future medicines for drug allergies.

Each time you order a new prescription, send the order form with your payment directly to the address on the form. You must include your physician's written prescription with your order form and payment. Once you've submitted the order form, you may obtain refills through the *Caremark* website or by calling the toll-free number on the back of your prescription card.

All prescriptions are processed promptly and are usually returned to you within 14 days. If you don't receive your medicine within 14 days or have questions, contact the mail order service through the Web or by phone.

If you use the mail order service, you pay the 90-day copay amounts even if your prescription is written for less than a 90-day supply. (There is no non-network mail order service.)

Specialty Pharmacy. If you take specialty injectable/biotech prescription drugs for chronic or genetic disorders, you may fill your specialty prescriptions at local retail pharmacies or through the Caremark Specialty Pharmacy in Bothell, Washington.

[Mental health prescriptions. Prescription drugs intended to treat any mental health disorders are covered the same as other prescription drugs, as a result of the Washington State Mental Health Parity Law. The law, which passed in 2005, begins phasing in requirements to place mental health treatments on parity with physical health treatments on January 1, 2006.](#)

► **Preventive Care (page 51)**

The following preventive care is covered:

- Breast exams, pelvic exams and Pap tests every year for women
- Immunizations, including annual flu shots (immunizations for travel are not covered)
- Mammograms every year for women over 40 (or as determined by provider for high-risk patients)
- Routine physicals and hearing tests.

Immunizations (well-baby), routine physicals and hearing tests are covered according to the following schedule. The schedule is a guideline; benefits may be available for more frequent care depending on the situation. Contact Aetna for details (see Resource Directory booklet).

| Age | Preventive Care |
|----------------------------|--|
| Birth to 1 year | Routine newborn care plus 7 well-baby office exams |
| 1-2 years | Two well-child visits |
| 2- 5 years | 3 well-child visits, with 1 visit in each of these age groups: 2-3, 3-4, 4-5 |
| 6 - 12 years | 3 well-child visits, with 1 visit in each of these age groups: 6-8, 8-10, 10-12 |
| 13 - 17 years | 2 well-teen visits, with 1 visit between ages 13-15 and 1 visit between ages 15-17 |
| 18 - 25 years | 1 well-adult visit |
| 26 - 49 years | 1 well-adult visit every 4 years |
| 50 years and older | 1 well-adult visit every 2 years |

► **Rehabilitative Services (page 52)**

The plans cover medically necessary inpatient and outpatient rehabilitative care designed to restore and improve a physical function lost due to a covered illness or injury. This care is considered medically necessary only if significant improvement in the lost function occurs while the care is provided and the attending physician expects significant improvement to continue. To verify whether coverage for rehabilitative services applies or continues to apply, Aetna has the right to obtain written opinions from the attending physician concerning whether and to what extent the significant improvement is occurring.

Inpatient services are covered to a maximum of 60 days per calendar year and must be in a licensed hospital or skilled nursing facility. *Outpatient services, which must be furnished by a licensed medical provider, are covered to a maximum of 60 visits for all therapies combined per calendar year if provided by a network provider. Services from a non-network provider require a progress review every 20 visits, up to a maximum of 60 visits if approved after each review. [Information added as a clarification]*

These plans do not cover services or expenses related to schools or other non-medical facilities that primarily supply educational, vocational, custodial and/or rehabilitative support training or similar services.

► **Smoking Cessation (page 52)**

These plans cover:

- Acupuncture to ease nicotine withdrawal
- Hypnotherapy to ease nicotine withdrawal

- Prescription drugs to ease nicotine withdrawal, inhalers and sprays are covered through *Caremark and are covered at 100% after copay*; non-prescription nicotine patches and gum are covered at 100% through Aetna
- Smoking cessation programs, including a Tobacco Quit Line, through Harris HealthTrends Inc. (covered at 100%); other smoking cessation programs are covered at the non-network rate, but to receive benefits for non-network smoking cessation programs, you must complete the full course of treatment.

No medical plan benefits are provided for:

- Books or tapes
- Inpatient services
- Vitamins, minerals or other supplements.

The lifetime maximum for smoking cessation has been removed (it was \$500).

Expenses Not Covered (page 55)

Delete one bullet in list of medical services not covered: Jaw abnormalities, malocclusions or any related appliances.

Coordination of Benefits

Changes to two subsections.

► Coordination of Benefits between Plans (page 56)

Changes in this subsection have been added to clarify how your benefits are administered.

King County plans coordinate benefits under a non-duplication policy between primary and secondary plans. That means if a plan is primary, it pays first; if it is secondary, it pays only the difference between what the primary plan paid and what the secondary plan would have paid if it was primary.

If you and a *spouse/domestic partner* both have your own health coverage (medical, dental and vision) and you cover each other as dependents under your plans, your own plans are primary for each of you and secondary for each other. *This non-duplication policy applies to you and your spouse/domestic partner if:*

- *You are both county employees and insured by county plans*
- *You are a county employee and your spouse/domestic partner has coverage through another employer or a self-insured plan.*

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine what plan is primary 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.)
- If the parents are divorced or legally separated, these rules apply:
 - If a court decree establishes financial responsibility for the child’s health care, the plan of the parent with that responsibility pays first
 - If there is no court decree, the plan of the parent with custody (or primary residential placement) pays before the plan of the parent without custody
 - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody.

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 *spouse/domestic partner* 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 these coordination of benefit procedures.

► **Coordination of Benefits with Medicare (page 56)**

If you keep working for the county after you *become eligible for Medicare* you may:

- Continue your medical coverage under *KingCareSM* and integrate the county plan with Medicare; *KingCareSM is primary and Medicare is secondary.*
- Discontinue your *KingCareSM* 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 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 *KingCareSM* (see the Resource Directory booklet).

Group Health Medical

How the Plan Works

Additional information in one subsection, and a new subsection added at the end.

► **Out-of-Area Coverage**

This plan does not provide out-of-area benefits except for emergency care. If you or a family member is away from home you may be able to access urgent or emergency care at network benefit levels in HMOs associated with Group Health. You or your family member can use the Kaiser Permanente network for urgent or emergency care while traveling. For out-of-area emergency care, contact 1-888-901-4636 or 1-888-457-9516.

If you retire and continue to live in Washington – even if you move out of the Group Health service area – you may continue to be covered by Group Health under the following conditions:

- *All services, except emergencies, must be provided by a Group Health provider or contracted provider.*
- *Emergency services are available outside the Group Health network, but they are subject to the increased emergency room payments. Emergency admissions must be reported within 24 hours or as soon as reasonably possible (phone numbers for reporting emergency admission to a hospital are on the back of your Group Health card).*
- *If you reside in an area served by Kaiser Permanente, you will not be able to access care through the Kaiser network. Group Health’s reciprocity agreement with Kaiser only covers members on short-term travel. [This change has been added to clarify how your benefits are administered.]*

► *Special Services (page 69)*

This subsection added to provide information about existing services not previously mentioned in Your King County Benefits and the Summary of Material Modifications.

In addition to your health benefits, Group Health offers several other services that you can use to manage your health and the health of your family.

Consulting Nurse Line. You can talk to a registered nurse 24 hours a day to get information on a variety of health and wellness topics, including advice on when to seek emergency care, at 1-800-297-6877.

Living Well with Chronic Diseases. Through this service, you can learn skills for managing your chronic conditions (such as arthritis, stroke, heart disease, chronic pain and diabetes), manage pain and medications, get help with emotional challenges, design an exercise program, manage stress, improve your quality of life and get help working with your health care team. You can access this service by logging onto MyGroupHealth at www.ghc.org or by calling 1-800-992-2279.

Covered Expenses under Group Health

Changes to seven subsections.

► Summary of Covered Expenses (pages 70-71)

There are several changes to benefits described in the summary table:

- **Alternative care (page 70) – Self-referrals to a network provider are covered up to 8 visits/medical diagnosis/calendar year for acupuncture and up to 3 visits/medical diagnosis/calendar year for naturopathy; with the exception of chiropractic services, all other alternative care may require PCP referral; all services are subject to the \$20 copay/visit**
- *Ambulance services (page 70) – Coverage changed to 80% for ground or air transport; 100% for ground transfers when initiated by Group Health in 2004 and changes to 80% (except hospital-to-hospital ground transfers covered 100% when initiated by Group Health)*
- *Chemical dependency (page 70) – Maximum increased from \$12,500 in 2005 to \$13,000 in 2006*
- *Emergency room care (page 70) – 100% after \$75 copay to network facility (\$75 copay waived but \$200 copay/admission for hospital care applies if admitted); 100% after \$125 copay/visit to non-network facility (\$125 copay waived but \$200 copay/admission for hospital care applies if admitted); non-emergency care not covered*
- *Mental health care (page 70) – 100% after \$200 admission copay per visit, up to 12 days/year for inpatient; 100% after \$20 copay/individual, family, couple or group session for up to 20 outpatient visits/year*
- *Neurodevelopmental therapy (page 71) – 100% for inpatient services after \$200 copay/admission up to 60 days/year (combined with rehabilitative services); 100% after \$20 copay/visit for outpatient up to 60 visits/year (combined with rehabilitative services)*
- *Preventive care (page 71) – 100% after \$20 copay/visit (according to well-child/adult preventive schedule)*
- *Rehabilitative Services (page 71) – 100% for inpatient services after \$200 copay/admission up to 60 days/calendar year (combined with neurodevelopmental therapy); 100% after \$20 copay/visit for outpatient services up to 60 visits/calendar year (combined with neurodevelopmental therapy).*

► Alternative Care (page 72)

Covered services, *when medically necessary*, include:

- Acupuncture, covered up to eight visits per medical diagnosis in a calendar year
- ***Chiropractic [limit of 10 visits per year deleted]***
- 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 three 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.

► Chemical Dependency Treatment (page 72)

Your PCP can arrange chemical dependency services, or for outpatient care, you may call Group Health Behavioral Health at 1-888-287-2680. (*For additional counseling and referral services, you may also call the King County Making Life Easier Program at 1-888-874-7290.*)

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 (pages 72-73)**

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
- *Orthopedic appliances*
- Ostomy supplies
- Oxygen and equipment for its administration
- *Prosthetic devices*
- Purchase of nasal CPAP devices and initial purchase of associated supplies (*Group Health provides a referral; you must rent the device for two months before it may be purchased; you pay 20% of the rental and purchase cost*)
- 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.*

► **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 provided by Group Health
- Treatment of sexual disorders.

Outpatient mental health care is now covered the same as other outpatient medical care, as a result of the Washington State Mental Health Parity Law, but visit limits can remain. The copay for outpatient mental health care is \$20 per individual session and group session, with a limit to 20 outpatient visits per year. Coverage for inpatient mental health care will change from 80% to 100% after a \$200 copay per hospital admission, with a limit to 12 days per year. The law, which passed in 2005, begins phasing in requirements to place mental health treatments on parity with physical health treatments on January 1, 2006.

► **Smoking Cessation (page 79)**

You do not need a PCP referral before you see a network provider for these services.

Services related to tobacco cessation are covered, limited to:

- One course of nicotine replacement therapy a year if you're actively participating in *a Group Health-designated tobacco cessation program*
- Educational materials
- Participation in one program a year from a network provider.

► **Transplants (pages 79-80)**

A new bullet is added to the list of covered transplants: [Intestinal/multi-visceral](#).

Expenses Not Covered

Addition of one exclusion (in alphabetical order).

- *Services covered by the national health plan of any other country.*

Coordination of Benefits

Clarification for one subsection and changes to another subsection.

► **Coordination of Benefits between Plans**

Changes in this subsection have been added to clarify how your benefits are administered.

If you and a *spouse/domestic partner* both have your own Group Health coverage *and cover each other*, your copays are waived; *your children's copays are also waived if you and your spouse/domestic partner both cover your children*. Otherwise, if you and a *spouse/domestic partner* have coverage through different plans (*in other words, one plan is not Group Health*), the King County Group Health plan coordinates benefits under its standard coordination of benefits (COB) policy between primary and secondary plans. If Group Health is primary, it pays first; if it is secondary, it pays up to an amount equal to the difference between the total charge and what the primary plan paid (the exact amount depends on a calculation of COB savings to Group Health).

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine what plan is primary for dependent children covered under two parents with different medical plans (“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.)
- If the parents are divorced or legally separated, these rules apply:
 - If a court decree establishes financial responsibility for the child’s health care, the plan of the parent with that responsibility pays first.
 - If there is no court decree, the plan of the parent with custody (or primary residential placement) pays before the plan of the parent without custody.
 - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody.

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 *spouse/domestic partner* 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 these coordination of benefit procedures.

► **Coordination of Benefits with Medicare (page 82)**

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 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 medical 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).

Washington Dental Service

How the Plan Works

New paragraph added to the end of one subsection.

► Incentive Program (pages 92-93)

WDS increases your payment levels through an incentive program as long as you see your dentist [for a covered benefit](#) each year:

- For diagnostic and preventive services as well as basic services, the payment level starts at 70% and increases 10% in January of each year until you reach 100%
- For major restorative services the payment level increases from 70% to 80%, then to 85%

If you do not see the dentist [for a covered benefit](#) 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 [for a covered benefit](#) in 2001 and your payment level was 80%, but you did not see your dentist [for a covered benefit](#) in 2002, your payment level in 2003 is reduced from 80% to 70%.

Major prosthodontic services, orthodontia, TMJ treatment and night (occlusal) guards are not under the incentive program.

The following table summarizes how the incentive program works.

| If you receive these services ... | The plan pays ... |
|------------------------------------|---|
| Diagnostic and preventive services | 70% first year |
| Basic services | 80% second year |
| | 90% third year |
| | 100% fourth year and each year thereafter |
| Major services – restorative | 70% first year |
| | 80% second year |
| | 85% third 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%. She doesn’t need to meet the annual deductible before the plan pays for covered diagnostic and preventive services. Here’s how much Rachel pays:

| Total Expense | Plan Pays | Rachel Pays |
|---------------|---------------------|-----------------------|
| \$ 45 Exam | \$ 36 (80% of \$45) | \$ 9 (20% of \$45) |
| | | + 0 <u>Deductible</u> |
| | | \$ 9 |

The annual deductible does not apply to the type of service Rachel received (preventive).

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 | \$ 402.50 (70% of \$575) | \$ 172.50 (30% of \$575) |
| - 25 Deductible | | + 25.00 Deductible |
| <u>\$ 575</u> | | <u>\$ 197.50</u> |

The annual deductible does apply to the type of service Jim received (basic). His deductible for the calendar year is met on this claim.

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).*

Covered Expenses under WDS

Changes to three subsections.

► Diagnostic and Preventive Services (pages 93-94)

There are several changes to the list of covered services:

- *The first bullet, WDS-approved caries (decay) susceptibility tests, changes to WDS-approved caries (decay) and periodontal susceptibility/risk tests*
- *A new bullet is added: Exam – comprehensive oral evaluation (once in three years per dental office; benefit is counted as a routine exam for frequency limitations; comprehensive exams done after the first in a three-year period will be paid as routine exams).*

► Basic Services (page 94)

The first bullet in the list of covered services (page 94), Amalgam, filled resin or composite fillings to treat decay or fracture resulting in significant tooth loss, changes to Amalgam fillings and in anterior teeth, resin-based composite 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 the buccal/front surface of bicuspid), an amalgam allowance will be made.

The second bullet in the list of covered services (page 94), General anesthesia/intravenous sedation, changes to General anesthesia/intravenous sedation:

- *If administered by a licensed dentist or other WDS-approved licensed professional who meets the state Dental Quality Assurance Commission guidelines or as determined by the state in which the services are rendered in conjunction with certain covered surgical 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*

► Major Services – Restorative (page 94)

A new bullet is added to the list of covered service: *Crown buildups 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.*

Coordination of Benefits (page 96)

Changes in this section have been added to clarify how your benefits are administered.

King County plans coordinate benefits under a non-duplication policy between primary and secondary plans. That means if a plan is primary, it pays first; if it is secondary, it pays only the difference between what the primary plan paid and what the secondary plan would have paid if it was primary.

If you and a *spouse/domestic partner* both have your own health coverage (medical, dental and vision) and you cover each other as dependents under your plans, your own plans are primary for each of you and secondary for each other. *This non-duplication policy applies to you and your spouse/domestic partner if:*

- *You are both county employees and insured by county plans*
- *You are a county employee and your spouse/domestic partner has coverage through another employer or a self-insured policy.*

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine what plan is primary 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.)
- If the parents are divorced or legally separated, these rules apply:
 - If a court decree establishes financial responsibility for the child’s health care, the plan of the parent with that responsibility pays first
 - If there is no court decree, the plan of the parent with custody (or primary residential placement) pays before the plan of the parent without custody
 - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody.

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 *spouse/domestic partner* 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 these coordination of benefit procedures.

Vision Service Plan

How the Plan Works

Changes to one subsection.

► Summary Table (pages 104-105)

The *following table* summarizes covered eye care services and eyewear under this plan and identifies related limits (see “Covered Expenses under VSP” and “Expenses Not Covered” in this booklet for more details).

| Vision Service Plan | | |
|--|---|---|
| Covered Expenses | If you see a VSP provider you pay a \$10 copay (once during any 12 month period) and the plan pays ... | If you see a non-VSP provider you pay the bill in full and the plan reimburses you the following amounts, minus a maximum \$10 copay* (once during any 12-month period) ... |
| Exams (once every 12 months) | 100% | Up to \$40 |
| Lenses (1 pair every 12 months) | | |
| <ul style="list-style-type: none"> • Single vision • Bifocal • Trifocal • Lenticular • <i>Polycarbonate for children</i> • Progressive • Tints • Coatings | <ul style="list-style-type: none"> • 100% • 100% • 100% • 100% • <i>100%</i> • 100% • 100% • 100% | <ul style="list-style-type: none"> • Up to \$40 • Up to \$60 • Up to \$80 • Up to \$125 • <i>Not covered</i> • Up to \$5 for upgrade to progressives, tints and coatings combined |
| Frames (once every 24 months) | Covered up to \$130; if you choose a frame that costs more than the VSP allowable amount, you'll receive 20% off your out-of-pocket costs | Up to \$45 |
| Contacts (once every 12 months in place of eyeglass lenses and frames) | | |
| <ul style="list-style-type: none"> • Elective (providers may bill you for contact lenses separately or they may include the lenses, fittings and follow-up fees in a single bill; all of these contact lens fees apply to the \$105 maximum paid by the plan) • Medically necessary (see “Covered Expenses under VSP” for details) | <ul style="list-style-type: none"> • 100% up to \$105 • 100% | <ul style="list-style-type: none"> • Up to \$105 • Up to \$210 |

* Your copay depends on the amount your non-VSP provider charges and the amount VSP pays for the covered expense (see “Cost” in this booklet for details).

Covered Expenses under VSP (page 106)

A change to one item in the list of covered vision expenses.

This section describes expenses covered by your VSP benefits. For information on the level of benefits you receive (for example, related limits) see “Summary Table” in this booklet.

Covered vision expenses include:

- Vision exams – a complete analysis of the eye and related structures to determine the presence of vision problems or abnormalities
- Elective contact lenses
- Frames
- Medically necessary contact lenses when preauthorized by VSP and prescribed by an eye care provider for the visual welfare of the patient due to specific medical conditions such as:
 - Cataract surgery
 - Conditions of anisometropia
 - Extreme visual acuity problems that cannot be corrected with eyeglasses
 - Keratoconus
- Spectacle lenses (progressive multifocal lenses; *tints and coatings* are covered *for all members and polycarbonate lenses are covered for children to age 23* when *obtained from* a VSP provider).

VSP providers generally require two to three working days to make lenses, based on the lab and eyewear selected. If you don't have a back-up pair of glasses and would like faster turnaround, your provider may be able to accommodate you, depending on their arrangements with the lab. The cost and arrangements vary by provider; contact your VSP provider for details.

Helpful Hint. Each time you receive contact lenses under the plan, you must wait 12 months before you are eligible for lenses (spectacle or contact) and 24 months before you're eligible for frames. If you are interested in getting both glasses and contacts, purchase the glasses first, then you can replace lenses (either contact lenses or spectacle lenses) each year.

Coordination of Benefits (page 108)

Changes in this section have been added to clarify how your benefits are administered.

King County plans coordinate benefits under a non-duplication policy between primary and secondary plans. That means if a plan is primary, it pays first; if it is secondary, it pays only the difference between what the primary plan paid and what the secondary plan would have paid if it was primary.

If you and a *spouse/domestic partner* both have your own health coverage (medical, dental and vision) and you cover each other as dependents under your plans, your own plans are primary for each of you and secondary for each other. *This non-duplication policy applies to you and your spouse/domestic partner if:*

- *You are both county employees and insured by county plans*
- *You are a county employee and your spouse/domestic partner has coverage through another employer or a self-insured policy.*

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine what plan is primary 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.)
- If the parents are divorced or legally separated, these rules apply:
 - If a court decree establishes financial responsibility for the child’s health care, the plan of the parent with that responsibility pays first
 - If there is no court decree, the plan of the parent with custody (or primary residential placement) pays before the plan of the parent without custody
 - If the parent with custody has remarried, the plan that covers the child is determined in this order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody.

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 *spouse/domestic partner* 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 these coordination of benefit procedures.

Aetna Life Insurance

Beneficiaries (pages 118-119)

Changes to two paragraphs in the section.

All employees (except part-time Local 587 employees in [the Partial Benefits Plan who don't elect medical coverage to receive life insurance](#)) receive a life insurance benefit 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 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 elect enhanced life coverage for your family members and a covered family member dies, you are the beneficiary.

Continuation of Coverage

Changes to one subsection.

► Continuing Group Term Insurance (page 123)

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 up to \$500,000. 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.

If you continue coverage, you may also continue the enhanced group term life insurance you had on your last day of employment for your spouse/domestic partner until he/she is age 65 up to \$25,000 and your dependent children's benefits until they are age 19 (23 if solely dependent on you for support) up to \$5,000.

Employee or covered family member life benefits in excess of the portability maximums may be converted to a whole life policy (see “Converting to Individual Whole Life Insurance”).

Portability coverage is reduced by:

- *35% of the original amount on January 1 following the date you reach age 65*
- *60% of the original amount on January 1 following the date you reach age 70*
- *75% of the original amount 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).

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 Resource Directory booklet). 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.

CIGNA Accidental Death and Dismemberment Insurance

Beneficiaries (pages 130)

Changes to one paragraph in the section.

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 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 form.

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 elect enhanced AD&D coverage for your family members and a covered family member dies, you are the beneficiary. Benefits for dismemberment, paralysis and other losses to you or your covered family members are paid to you.

Ⓜ CIGNA Group Insurance products and services are provided by underwriting subsidiaries of CIGNA Corporation, including Life Insurance Company of North America. "CIGNA" is used to refer to these subsidiaries and is a registered service mark.

CIGNA Long Term Disability Insurance

Other Income Benefits (page 142)

Changes in this subsection have been added to clarify how your benefits are administered.

If you are disabled and eligible, you should apply for benefits from the income sources listed below. If you don't apply, CIGNA will estimate your benefit from these other sources and deduct it from your county LTD benefit.

- The Canada and Quebec Pension Plans
- The Railroad Retirement Act
- Any local, state, provincial or federal government disability or retirement plan or law as it pertains to the county
- Any sick leave plan or other salary continuation plan of the county
- Any work loss provision in mandatory no-fault auto insurance
- Disability benefits under any workers' compensation, occupational disease, unemployment compensation law or similar federal, state or local government program, including all permanent as well as temporary disability benefits; this includes damages, compromises or settlements paid in place of such benefits, whether or not liability is admitted
- Any Social Security disability benefits you or a third party receives (or is assumed to receive) on your behalf or for your dependents or, if applicable, which your dependents receive (or are assumed to receive) because of your entitlement to Social Security benefits (see "Coordination with Social Security" in this booklet)
- Any proceeds payable under any franchise or group insurance or similar plan
- Any amounts paid on account of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable regardless of whether liability is determined
- Any wage or salary for work performed; if you're covered for the return-to-work incentive, CIGNA will reduce disability benefits only to the extent stated under the return-to-work incentive above.

If you are disabled and eligible and you choose not to apply for either reduced or early benefits from the county retirement plan, CIGNA will not estimate your retirement benefits and deduct them from your county LTD benefit. However, if you do apply for retirement benefits and are receiving those benefits, CIGNA will deduct your retirement benefits from your county LTD benefit.

When you or your dependents receive benefits from other income sources, CIGNA notifies you of the amount of any overpayment; you must repay CIGNA in full before receiving county LTD benefits.

CIGNA Group Insurance products and services are provided by underwriting subsidiaries of CIGNA Corporation, including Life Insurance Company of North America. "CIGNA" is used to refer to these subsidiaries and is a registered service mark.

Appealing Denied Claims

Changes to one subsection.

► **Claims Denied for Reasons Other Than Eligibility (page 145)**

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 your claim is denied, you’ll be notified in writing of the reasons for the denial, your right to appeal and your right to obtain copies of all documents related to your claim that were reviewed by CIGNA in making the determination.

If you disagree with the claim denial, you or your representative (referred to as “you” in the rest of this section) may attempt to resolve any misunderstanding by calling CIGNA and providing additional details. If you prefer to communicate in writing or are unable to resolve the issue with a phone call, you may file a written appeal. You have 180 days after receiving the claim denial notice to file a written appeal. Be sure to include the reasons for your appeal and any information or documentation helpful in reviewing your claim.

CIGNA will review the written appeal and notify you of its decision within 45 days after receiving your appeal. If CIGNA requires additional time, you’ll be notified in writing that an additional period of up to 45 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 payment of LTD benefits; its decision is final and binding. In reviewing your claim, CIGNA 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 CIGNA determines you’re entitled to the benefits.

If your 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 or you forfeit your right to legal action. If you do not file a claim or appeal within the specified period, you forfeit the right to further appeal.

Flexible Spending Accounts

Throughout the Booklet

The Flexible Spending Accounts provider remains the same, but the provider name changes from Associated Administrators, Inc. (AAI) to **Personal Choice Account offered by Regence BlueCross and BlueShield of Oregon, referenced as PCA**. (32 references).

Enrolling (page 150-151)

Changes to one paragraph in the section.

Enrollment forms are available on the [Benefits and Retirement Operations website](#) and by request from [Benefits and Retirement Operations](#) (see [Resource Directory](#)); enrollment forms are also provided each year at open enrollment.

If you decide to enroll in an FSA, 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-December 31) and must reenroll each year during open enrollment to continue participating. You may make changes to your FSAs during open enrollment, but changes outside open enrollment are restricted (see "Changes Outside Open Enrollment Are Restricted").

Health Care FSAs

Changes to three subsections.

► Eligible Expenses (page 153)

A new bullet is added to the partial list of eligible expenses: **Over-the-counter drugs used to treat/prevent illness/injury (limited)**.

► Ineligible Expenses (page 154)

The bullet, nonprescription over-the-counter drugs, medicines, vitamins and other remedies not prescribed by a physician changes to: **Vitamins, supplements and remedies taken for general well-being**.

► Expense Reimbursement (page 155)

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 [PCA](#) (see Resource Directory booklet), attach your EOB, and fax or mail the information to [PCA](#).

For expenses not covered by insurance, complete the claim form and attach your itemized receipt(s) for the expense. Receipts 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 [PCA](#).

For orthodontia services, you *and your provider need to complete an "Orthodontic Charges Worksheet" and submit it to PCA before services begin; the worksheet (available from PCA; see 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 are formally billed, charged for or pay for them. Therefore, if you pay your orthodontia provider in advance for services, you cannot be reimbursed in a lump sum. Instead, PCA 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, PCA takes the net balance (amount you owe after the down payment is deducted, and discounts and 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 are reimbursed for your eligible expenses up to the maximum amount 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.

Dependent Care FSAs

Changes to two subsections.

► FSA Versus Federal Income Tax Deduction (page 156)

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 are a single parent
- You have a working spouse
- Your spouse is a full-time student at least 5 months during the calendar year while you are working
- Your spouse is mentally or physically unable to care for him/herself
- You are 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:

- *A child under age 13 with whom you have a “specified relationship” and for whom you are entitled to claim a deduction on your federal tax return. For children of divorced or separated parents, the parent **with whom the child resides for more than half of the calendar year can claim** the child an eligible dependent under this plan.*
- *Incapacitated parent residing in your household **for more than half of the calendar year***
- *Your child of any age who is physically or mentally unable to care for him/herself **and who resides with you for more than half of the calendar year***
- *Your spouse who is physically or mentally unable to care for him/herself **and who resides with you for more than half of the calendar year.***

A qualifying “specified relationship” to the taxpayer for a child under 13 is defined as a son, daughter, stepson, stepdaughter, brother, sister, stepbrother, stepsister or a descendant of any such individual. Legally adopted children and foster children are considered as children of the taxpayer.

Under the Working Families Tax Relief Act, you are no longer required to provide more than one-half of the cost of maintaining your household for your dependents to be eligible for Dependent Care FSA expenses. This change became effective January 1, 2005.

Glossary

Throughout the Booklet

*The prescription drug provider for the KingCareSM plans remains the same, but the provider name changes from AdvancePCS to **Caremark** (four references).*

*The administrator of COBRA and the Flexible Spending Accounts provider remains the same, but the name changes from Associated Administrators, Inc. (AAI) to **Personal Choice Account offered by Regence BlueCross and BlueShield of Oregon, referenced as PCA**. (one reference).*

Resource Directory

Resource Directory (page 177)

*The name of the prescription drug provider for the KingCareSM plans changes from AdvancePCS to **Caremark** (address, phone, fax and Web information remains the same).*

*The administrator of COBRA and the Flexible Spending Accounts provider remains the same, but the name changes from Associated Administrators, Inc. (AAI) to **Personal Choice Account offered by Regence BlueCross and BlueShield of Oregon, referenced as PCA**. (two references).*