

# HEALTH CARE

When it comes to choosing benefits, we all have different needs, and those needs change as our lives change. Marriage, the birth or adoption of a child, divorce, the loss of a family member, the need to care for an older family member—these are just a few examples of life events that can directly impact the type of benefits and levels of coverage that suit you best.

Because the county appreciates that your health care needs are unique, we provide you with medical (including prescription drug), dental and vision coverage that offers flexibility and choice. You can choose the health care plan that’s right for you and your eligible dependents.

## In This Section See Page

<b>Participating in the Health Care Plans</b> .....	<b>45</b>
Who Is Eligible .....	45
Employee .....	45
Spouse/Domestic Partner .....	47
Dependent Children .....	47
How and When to Enroll .....	49
Enrolling When First Eligible .....	49
Enrolling During the Annual Open Enrollment .....	53
When and How to Make Changes .....	54
Changes You May Make After Qualifying Life Events .....	54
Changes You May Make Any Time .....	58
Changes You Must Make .....	59
Change Forms .....	60
What Coverage Costs .....	61
When Coverage Begins .....	62
Eligible Dependents .....	63
When You Have Other Coverage .....	63
Coordinating with Other Health Plans .....	63
Coordinating with Medicare .....	65
Acts of Third Parties .....	65
Overpayment .....	69
When Coverage Ends .....	70
When Coverage Ends for You .....	70
When Coverage Ends for Dependents .....	71
Certificates of Coverage .....	71

How to Continue Coverage .....	71
How to Convert Coverage .....	71
KingCare <sup>SM</sup> .....	71
Group Health .....	72
<b>Medical Plans .....</b>	<b>73</b>
Your Medical Plan Choices .....	73
How the Healthy Incentives <sup>SM</sup> Program Works .....	73
Out-of-Pocket Expense Levels .....	74
Your Medical Benefits at a Glance .....	74
KingCare <sup>SM</sup> Benefits at a Glance .....	75
Group Health Benefits at a Glance .....	81
<b>KingCare<sup>SM</sup> .....</b>	<b>86</b>
Accessing Care .....	86
Network Providers .....	86
Out-of-Network Providers .....	87
If Your Dependent Lives Away from Home .....	87
Paying for Your Care .....	87
Other Features of KingCare <sup>SM</sup> .....	89
Preauthorization .....	89
Second Opinions .....	91
Case Management .....	91
Health Care Management .....	91
Knowing What's Covered and What's Not .....	93
Covered Expenses .....	94
Expenses Not Covered .....	108
Filing a Claim .....	112
How Aetna Reviews Claims .....	113
If Aetna Approves the Claim .....	114
If Aetna Denies the Claim .....	114
Using Your Prescription Drug Plan .....	114
Accessing Care .....	115
Preauthorization .....	116
What's Covered and What's Not .....	118
Managing Your Medications .....	120
Filing a Claim .....	120
<b>Group Health .....</b>	<b>122</b>
Accessing Care .....	122
Network Providers .....	122
Out-of-Area Coverage .....	122
Your Primary Care Physician (PCP) .....	122
Specialists .....	123
If You Live Outside the Network Service Area .....	123
If Your Dependent Lives Away from Home .....	124
Paying for Your Care .....	124

Other Features of Group Health .....	125
Disease Management.....	125
Second Opinions.....	125
Knowing What's Covered and What's Not .....	126
Covered Expenses .....	126
Expenses Not Covered .....	138
Filing a Claim.....	143
How Group Health Reviews Claims .....	144
If Group Health Approves the Claim.....	144
If Group Health Denies the Claim .....	144
<b>Dental Plan.....</b>	<b>145</b>
How the Dental Plan Works .....	145
Your Dental Benefits at a Glance.....	145
Using the Dental Plan.....	147
Participating Dentists.....	147
Paying for Your Care .....	149
Other Features of the Dental Plan.....	151
Predetermination of Benefits .....	151
Oral Health Assessment Program.....	152
Knowing What's Covered and What's Not .....	153
Covered Expenses .....	153
Expenses Not Covered .....	161
Filing a Claim.....	163
How the Claim Is Reviewed.....	164
If WDS Approves the Claim .....	165
If WDS Denies the Claim.....	165
<b>Vision Plan.....</b>	<b>166</b>
How the Vision Plan Works.....	166
Your Vision Benefits at a Glance .....	166
Using the Vision Plan .....	168
The VSP Network .....	169
Paying for Your Care .....	169
Knowing What's Covered and What's Not .....	171
Covered Expenses .....	171
Expenses Not Covered .....	172
Filing a Claim.....	173
How VSP Reviews the Claim.....	174
<b>Continuing Coverage Under COBRA.....</b>	<b>175</b>
How COBRA Works .....	175
Who's Eligible for COBRA Coverage and Why.....	175
How to Enroll for COBRA Coverage .....	177
How Much COBRA Coverage Costs.....	179
How Long COBRA Coverage Lasts.....	179
Additional Qualifying Events .....	179

COBRA and Unpaid Leaves of Absence .....	181
When You Can Make Changes Under COBRA .....	181
When COBRA Coverage Ends .....	182
HIPAA Certificate of Creditable Coverage .....	183
How to Contact the COBRA Administrator .....	183
<b>Continuing Coverage When You Retire .....</b>	<b>184</b>
How Retiree Medical Benefits and COBRA Compare.....	184
Who's Eligible for Retiree Medical Benefits .....	185
How to Enroll for Retiree Medical Benefits .....	186
What Your Coverage Options Are .....	187
How to Make Changes Under Retiree Medical Benefits.....	187
When Retiree Medical Benefits End .....	188
If You Return to Work .....	188
If You Lose Eligibility Because You're Medicare-Eligible.....	189
<b>Glossary.....</b>	<b>191</b>

## PARTICIPATING IN THE HEALTH CARE PLANS

To effectively use your health care benefits, you need to know how they work. This section explains who is eligible to participate in the King County health care benefits, how and when to enroll, when coverage begins and ends, and how certain life event changes affect your eligibility to participate in the health care plans.

### HEALTH CARE PARTICIPATION INFORMATION ONLY

The information about eligibility and changing coverage in this section applies to the county's health care benefits only—medical, dental and vision coverage.

For eligibility and participation information regarding other benefits, see the separate descriptions of each benefit in this guide.

## Who Is Eligible

You and your eligible dependents are eligible for the county's health care plans.

### Employee

As a part-time transit operator or an assigned or on-call employee represented by Local 587, you're eligible for one of two health care plans:

- Partial Benefits Plan; and
- Full Benefits Plan.

#### Partial Benefits Plan

You become eligible for the Partial Benefits Plan on the first of the month following your hire date or qualification date, whichever is later. Your hire date is determined by your department. If the later of your hire date or qualification 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 yourself and the eligible dependents (spouse/domestic partner and children) you enroll. Your own medical coverage is partially subsidized by the county, but dependent coverage isn't. You must elect medical coverage to receive dental coverage. You may elect vision coverage without electing medical coverage. To cover dependents, you must elect medical coverage for yourself.

You pay for coverage under the Partial Benefits Plan through payroll deductions. The monthly cost of benefits is divided in half and deducted from your two regular paychecks each month. (When there are three pay periods in a month, no deductions are taken from your third paycheck that month.) You may have the deductions taken before or after federal income and Social Security (FICA) taxes are withheld.

## IMPORTANT!

**Your deductions for coverage for your domestic partner and/or his/her children must be taken on an after-tax basis according to IRS guidelines.**

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

- you may not discontinue any coverage until the next annual open enrollment unless you have a qualifying life event, including:
  - divorce or dissolution of a domestic partnership;
  - the death of a dependent; or
  - your spouse/domestic partner's loss of employer-sponsored coverage; and
- you must re-enroll for before-tax deductions every year during the annual open enrollment period; otherwise, your deductions will be taken on an after-tax basis.

When your contributions are made on a before-tax basis, your taxable income is reduced. This may mean that your eventual Social Security benefit could be reduced. However, the reduction is generally minimal, and the current tax advantages generally offset any reduction in Social Security benefits.

If you have deductions taken on an after-tax basis, you don't reduce your taxes, but you may discontinue coverage for yourself or a dependent at any time.

You may change how your deductions are taken (on a before-tax or after-tax basis) only during the annual open enrollment.

### Full Benefits Plan

You become eligible for the Full Benefits Plan when:

- you select a work assignment of four or more hours during any pick from 2007 through 2009. (Your fully paid benefits begin on the first day of the month after you work that assignment and extend through December 31, 2009); or
- you work 1,019 or more paid hours in the 26 pay periods ending with the pay period that includes July 31 in 2007, 2008 or 2009. (Your fully paid benefits begin on the first day of the following year and extend through December 31, 2009.)

Paid hours include hours worked (including overtime) and paid time off (including vacation and sick leave), although no credit is given for hours paid as a part-time transit operator trainee. If you're detailed out of classification during the review period, the hours paid in the out-of-class position are included. You receive credit for a picked assignment for the first 30 days of unpaid union leave accrual. Cash-outs and premium pay aren't included, and no credit is given for job-injury time-loss.

Eligibility for the Full Benefits Plan is determined by an agreement between King County and Amalgamated Transit Union Local 587 based on working the required number of hours. If you have any questions regarding eligibility for the Full Benefits Plan, discuss them with your base chief.

Under the Full Benefits Plan, you receive county-paid medical, dental and vision coverage for yourself and the eligible dependents (spouse/domestic partner and children) you enroll.

## Spouse/Domestic Partner

If you're in the Partial Benefits Plan, your spouse/domestic partner is eligible for medical, dental and vision coverage, but you must pay for it. If you're in the Full Benefits Plan, the county pays for your spouse/domestic partner's medical, dental and vision coverage.

When you enroll your spouse/domestic partner, you must complete the Marriage/Domestic Partnership form, which contains an Affidavit of Marriage/Domestic Partnership, online. If you want, you may also submit a copy of your marriage certificate.

Parents and relatives other than "dependent children" are not eligible for coverage. (See "Dependent Children" on page 47 for details.)

### HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits and Retirement Web site at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits). At the Web site, click "My Benefits" in the left navigation menu and follow the directions. Most non-county forms are available on the Benefits and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

### Domestic Partners

If you're in the Partial Benefits Plan, the IRS doesn't tax you on the value of your domestic partner's medical, dental and vision coverage because you're paying for it. However, if you're in the Full Benefits Plan, the IRS taxes you on the value of that coverage because the county pays for it. This value is added to the gross pay shown on your paycheck (and on your W-2 at year-end); federal income and Social Security (FICA) taxes are withheld on the higher amount; and then the value is subtracted from your gross pay.

## Dependent Children

If you're in the Partial Benefits Plan, your children are eligible for health care coverage, but you must pay for it. If you're in the Full Benefits Plan, the county pays for your children's medical, dental and vision coverage. Eligible children include:

- your unmarried children or your spouse/domestic partner's unmarried children if they are under age 23 and chiefly depend on you for support and maintenance, and you may claim them on your federal tax return. "Children" or "child" means:
  - biological children;
  - adopted children, or children legally placed with you for adoption or for whom you assume total or partial legal obligation for support in anticipation of adoption;

### IMPORTANT!

**If you and your spouse/domestic partner are both county employees, you may not cover each other as a dependent under your medical, dental and vision plans.**

- stepchildren; and
- legally designated wards, who include legally placed foster children, children placed with you as legal guardian or children named in a Qualified Medical Child Support Order (QMCSO) as defined under federal law and authorized by the plan (For more information, see “Qualified Medical Child Support Order (QMCSO)” on page 48);
- a child (as defined above) age 23 or older if the child:
  - was incapacitated and covered under your plans before age 23;
  - continues to be incapacitated due to a developmental or physical disability; and
  - is chiefly dependent on you for support and you may claim him/her on your federal tax return. (For more information, see “Disabled Dependent Children” on page 48.)

### Domestic Partner’s Children

If you’re in the Partial Benefits Plan, the IRS doesn’t tax you on the value of the medical, dental and vision coverage for your domestic partner’s children because you’re paying for it. However, if you’re in the Full Benefits Plan and your child meets the definition of “dependent child” above, the IRS taxes you on the value of that coverage because the county pays for it. As with your domestic partner’s coverage, this value is added to the gross pay shown on your paycheck (and on your W-2 at year-end); federal income and Social Security (FICA) taxes are withheld on the higher amount; and then the value is subtracted from your gross pay.

### Disabled Dependent Children

If you want to continue coverage for a disabled child when he/she turns 23, you must submit a Continue Coverage for Disabled Adult Child form to Benefits and Retirement Operations within 30 days of the child’s 23<sup>rd</sup> birthday. You also must provide proof of the child’s continued disability annually thereafter.

#### FORMS

Forms are available at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits) or from Benefits and Retirement Operations. (See *Contact Information*.)

### Qualified Medical Child Support Order (QMCSO)

In accordance with applicable law, the county provides medical, dental and vision coverage for certain children of yours, called “alternate recipients,” if directed by certain court or administrative orders. These orders include a decree, judgment or order from a state court (including approval of a settlement agreement) or an administrative order that requires these plans to include a child in your coverage and make any applicable payroll deductions.

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

- the employee’s name and last known address;

- each alternate recipient's name and address;
- coverage the alternate recipient will receive;
- the coverage effective date;
- how long the child is entitled to coverage; and
- each health plan subject to the order.

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

## How and When to Enroll

You may enroll in the King County health care plans:

- when you're first eligible;
- during the annual open enrollment; or
- after a qualifying life event.

## Enrolling When First Eligible

You receive enrollment materials for the Partial Benefits Plan and the Full Benefits Plan once you become eligible.

Your coverage begins the first day of the month following your hire date (that is, the first day you report to work) or qualification date, whichever is later. However, if your hire date or qualification date is the first day of the month, your coverage begins the same day.

### Partial Benefits Plan

When you first become eligible for benefits as a part-time transit operator, you receive enrollment materials in a Part-Time Local 587 New Hire Guide and wellness assessments for you and your spouse/domestic partner at a benefits orientation during your part-time transit operator training.

On your benefit enrollment forms, you have two medical plans to choose from: KingCare<sup>SM</sup> and Group Health. All part-time transit operators receive the same dental coverage with Washington Dental Service and the same vision coverage with Vision Service Plan.

When you first become eligible for benefits, you and your spouse/domestic partner are given the opportunity to take a confidential wellness assessment, which asks questions about lifestyle and behavior to assess your risk level for developing a chronic health condition. Your decision to take or not to take the wellness assessment determines the out-of-pocket expense level for your medical benefits. (See "Taking the Wellness Assessment" on page 50.)

### *Enrolling in the Health Care Plans*

If you plan to enroll in the Partial Benefits Plan, you must submit your benefit enrollment forms to Benefits and Retirement Operations **within 30 days of your hire date or qualification date, whichever is later**. If you don't submit your benefit enrollment forms within 30 days, you must wait until the next annual open enrollment to enroll in the Partial Benefits Plan.

### *Taking the Wellness Assessment*

In addition to returning your benefit enrollment forms, you and your spouse/domestic partner must each decide whether to take the wellness assessment if you're planning to enroll for medical benefits. You and your spouse/domestic partner, if he/she will receive county medical benefits, have **14 days from the day you receive your benefits orientation during training** to take the wellness assessment and return it to Benefits and Retirement Operations.

If you and your spouse/domestic partner **complete and return** the wellness assessment within 14 days, you'll receive the **gold (lowest) out-of-pocket expense level for your medical benefits**. If you and your spouse/domestic partner **don't complete and return** the wellness assessment within 14 days, you'll receive the **bronze (highest) out-of-pocket expense level for your medical benefits**. (See "How the Healthy Incentives<sup>SM</sup> Program Works" on page 73 in "Medical Plans.")

If you aren't planning to enroll in the county's medical coverage, you and your spouse/domestic partner don't have to take the wellness assessment when you first become eligible for the Partial Benefits Plan. You'll be given the opportunity to take the wellness assessment later when you either sign up for medical coverage during the next annual open enrollment or become eligible for the Full Benefits Plan.

### **Full Benefits Plan**

When you first become eligible for the Full Benefits Plan as a part-time transit operator, enrollment materials are mailed to your home.

### *Enrolling in the Health Care Plans*

On your benefit enrollment forms, you have two medical plans to choose from: KingCare<sup>SM</sup> and Group Health. All part-time transit operators receive the same dental coverage with Washington Dental Service and the same vision coverage with Vision Service Plan.

You must submit your enrollment forms to Benefits and Retirement Operations for the Full Benefits Plan by the deadline indicated in the enrollment materials sent to you. If you don't submit your enrollment forms by the deadline:

- only eligible dependents you've previously enrolled in a King County medical plan will be covered;
- you'll be assigned KingCare<sup>SM</sup> as your default medical coverage at the out-of-pocket expense level you and your spouse/domestic partner have most recently achieved by your participation in the Healthy Incentives<sup>SM</sup> program (See "Taking the Wellness Assessment" on page 51); and
- you'll have to wait until the next annual open enrollment to change your medical plan.

### *Taking the Wellness Assessment*

If you were previously covered under one of the county's medical plans, you and your spouse/domestic partner will continue to receive the out-of-pocket expense level you have most recently achieved by your participation in the Healthy Incentives<sup>SM</sup> program.

However, if you haven't previously been covered under one of the county's medical plans, you and your spouse/domestic partner will be given the opportunity to take the wellness assessment by the deadline indicated in the Full Benefits Plan materials sent to you.

If you and your spouse/domestic partner each **complete and return** the wellness assessment by the deadline, you'll receive the **gold (lowest) out-of-pocket expense level for your medical benefits**. If you **don't complete and return** the wellness assessment by the deadline, you'll receive the **bronze (highest) out-of-pocket expense level for your medical benefits**. (See "How the Healthy Incentives<sup>SM</sup> Program Works" on page 73 in "Medical Plans.")

Your spouse/domestic partner doesn't need to take the wellness assessment if you don't intend to cover him/her under the county's medical coverage.

### **HEALTHY INCENTIVES<sup>SM</sup> IN BRIEF**

The Healthy Incentives<sup>SM</sup> program is an incentives program that encourages employees and their spouse/domestic partners to take ownership of their health by participating in a wellness assessment and individual action plan.

The wellness assessment asks questions about lifestyle and behavior to assess your risk level for potentially developing a chronic health condition. The individual action plan supports you in maintaining and/or improving your health based on the confidential information from your wellness assessment.

Your participation in the wellness assessment and individual action plan determines the out-of-pocket expense level for your medical benefits. (See "How the Healthy Incentives<sup>SM</sup> Program Works" on page 73 in "Medical Plans.")

## OPTING OUT

**Only employees may opt out of medical coverage.**

### Opting Out of Medical Coverage

You may opt out of medical coverage only when you're first eligible for benefits under the Full Benefits Plan or during the annual open enrollment. Even if you become covered under another medical plan during the year, you must wait until the next annual open enrollment to opt out of county medical coverage.

When you first become eligible for the Full Benefits Plan, you have a unique opportunity that your dependents do not—you may opt out of medical coverage and receive an additional \$65 in monthly pay, which is taxed as ordinary income. To opt out of medical coverage, you must have coverage through another employer's medical plan (or a county plan if you're covered by a spouse/domestic partner who is a county employee) and submit a copy of the other medical plan ID card or other verification of coverage with your enrollment form.

If you're in the Partial Benefits Plan, you must elect to receive medical coverage or not to receive medical coverage for the following year—you don't have the opt-out option.

If you opt out of medical coverage and lose your other medical coverage during the year, you may opt back in before the next annual open enrollment. You must return a completed Opt in for Health Coverage form to Benefits and Retirement Operations within 30 days of losing that coverage, and you must provide proof of loss of coverage. Your coverage will take effect on the first of the month after your other coverage ends.

If you don't opt back in within 30 days, you'll have to wait until the next annual open enrollment, which will take effect January 1 of the following year, to receive coverage.

#### FORMS

Forms are available at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits) or from Benefits and Retirement Operations. (See *Contact Information*.)

## Enrolling During the Annual Open Enrollment

During the annual online open enrollment, you may:

- change medical plans;
- add eligible dependents; and
- discontinue dependent coverage.

Coverage takes effect January 1 of the following year.

If you don't go online to make elections during the annual open enrollment, you and your covered dependents will remain in your current medical plan and, if you're in the Full Benefits Plan, automatically receive dental and vision coverage for the following year.

However, you must go online to make elections during the annual open enrollment if you want to:

- opt out of medical coverage;
- opt out of the benefit access fee;
- add or discontinue dependent coverage; or
- participate in a flexible spending account (FSA) in the following year.

When you opt out of medical coverage, you must still enroll in your own dental and vision coverage if you want to have it, even if you have medical coverage through another county employee. That's because county employees who are spouse/domestic partners cannot cover each other for dental and vision coverage.

If you opt out of medical coverage and lose your other medical coverage during the year, you may opt back in before the next annual open enrollment. (For information on opting back in, see "Opting Out of Medical Coverage" on page 52 in "Enrolling When First Eligible.")

Every year, you'll need to go online during the annual open enrollment to opt out of the benefit access fee if you don't want to be charged \$35 a month for covering a spouse/domestic partner under your medical benefits. (For more information about the benefit access fee, see "What Coverage Costs" on page 61.)

You may add coverage for eligible dependents during the annual open enrollment. During the annual open enrollment, you may also discontinue coverage for dependents. However, if you don't discontinue coverage for eligible dependents within 30 days of the date they become ineligible, you may have to reimburse the county for expenses incurred following the date your dependent became ineligible for coverage.

You must also enroll or re-enroll in FSAs online during the annual open enrollment if you want to participate in the FSA program in the following year. (See *Flexible Spending Accounts*.)

### DISCONTINUING COVERAGE FOR DEPENDENTS

**If you discontinue an eligible dependent's medical coverage, his/her dental and vision coverage will continue.**

## WHAT ARE “QUALIFYING LIFE EVENTS”?

“Qualifying life events” allow you to make midyear changes to your health care coverage that you normally wouldn’t be allowed to make.

## When and How to Make Changes

You may make certain changes to your health care coverage after qualifying life events, while you may make other changes at any time. In addition, as the result of certain changes in your life, you’re required to discontinue dependent coverage. This section helps you through the maze of changes you can or must make.

### For Benefits Other Than Health Care

When making changes, you may want to update other information that may affect your benefits—for example, if you and your spouse divorce, you may want to update your beneficiary information for life insurance with Aetna Life Insurance and for accidental death and dismemberment (AD&D) insurance and long-term disability (LTD) insurance with CIGNA Group Insurance. (See *Contact Information*.)

## Changes You May Make After Qualifying Life Events

“Qualifying life events” allow you to make midyear changes to your health care coverage that you normally wouldn’t be allowed to make. Qualifying life events include:

- marriage or establishment of a domestic partnership;
- divorce or dissolution of a domestic partnership;
- birth of a child, adoption of a child or placement of a child as a legal ward;
- dependent’s loss of eligibility under the terms of the plan;
- death of a dependent; and
- your spouse/domestic partner’s loss of employer-sponsored coverage.

However, if you’re in the Partial Benefits Plan and your premiums are deducted on a before-tax basis, you may not discontinue health care coverage until the next annual open enrollment unless you have one of the following qualifying life events:

- marriage or establishment of a domestic partnership;
- divorce or dissolution of a domestic partnership;
- dependent’s loss of eligibility under the terms of the plan;
- death of a dependent; or
- your spouse/domestic partner’s loss of employer sponsored coverage.

## Changing Your Medical Plan

Special enrollment rights under the Health Insurance Portability and Accountability Act (HIPAA) allow you and your eligible dependents to change to another county medical plan at the time of a qualifying life event, provided you're receiving medical coverage as an:

- active employee;
- employee on leave without pay under COBRA (Consolidated Omnibus Budget Reconciliation Act); or
- employee on medical leave under the Family Medical and Leave Act (FMLA) or King County Family Medical Leave (KCFML).

If you have a qualifying life event, you and your eligible dependents may either:

- keep your existing medical plan; or
- enroll in another medical plan for which you and your dependents are eligible.

The special enrollment rights also allow you to change to another county medical plan when you or a covered dependent reach the lifetime maximum for your medical benefits under your existing medical coverage.

To enroll in another medical plan, you must make the change online within 30 days of the qualifying life event.

### HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits and Retirement Web site at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits). At the Web site, click "My Benefits" in the left navigation menu and follow the directions. Most non-county forms are available on the Benefits and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

## Adding Eligible Dependents

If you add a spouse or domestic partner, you must complete the Marriage/Domestic Partnership form, which contains an Affidavit of Marriage/Domestic Partnership, online. If you want, you may also submit a copy of your marriage certificate.

When completing the Marriage/Domestic Partnership form, you'll need to elect the benefit access fee option that applies to your situation. If you don't make an election, you'll automatically be charged the \$35 benefit access fee to cover a spouse/domestic partner when he/she has access to other medical coverage.

Except for birth or placement for adoption, you must complete the Add/Change Dependent form online within 30 days of a qualifying life event to add an eligible dependent for health care coverage, which includes medical, dental and vision coverage.

When you add an eligible dependent within 30 days, your dependent's coverage begins on the first of the month after the qualifying life event occurs. If you don't complete the online form within 30 days, you must wait until the next annual open enrollment to add the eligible dependent for coverage.

At this time, you may enroll in a new flexible spending account (FSA) or adjust the amount of an existing FSA online. (For more information, see *Flexible Spending Accounts*.)

#### HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits and Retirement Web site at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits). At the Web site, click "My Benefits" in the left navigation menu and follow the directions. Most non-county forms are available on the Benefits and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

#### *Birth or Placement for Adoption*

A newborn is automatically covered under the mother's health care plan for the first three weeks. You have 60 days to enroll a newborn or a newly adopted child for health care (medical, dental and vision) coverage. Coverage will be retroactive to the child's birth or adoption placement date. However, because you have only 30 days to make changes to supplemental life and accidental death and dismemberment (AD&D) coverage, it's highly recommended that you complete the Birth/Adoption form online within 30 days of birth or placement for adoption to take advantage of your life/AD&D change options.

#### HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits and Retirement Web site at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits). At the Web site, click "My Benefits" in the left navigation menu and follow the directions. Most non-county forms are available on the Benefits and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

#### *Qualified Medical Child Support Order (QMCSO)*

When Benefits and Retirement Operations receives a QMCSO, the child is automatically added for coverage according to the terms of the document—you don't need to complete the Add/Change Dependent form online.

#### **Opting Back Into Health Coverage After Opting Out**

If you previously opted out of medical coverage, you must submit an Opt in for Health Coverage form within 30 days of losing health care coverage through another employer if you want to opt back into the county's health care plans. You must provide proof of loss of coverage when you submit the form. If you don't submit the form within 30 days, you may not opt back in until the next annual open enrollment.

**FORMS**

Forms are available at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits) or from Benefits and Retirement Operations. (See *Contact Information*.)

If you opted out when you first became eligible for county benefits because you had COBRA coverage, the COBRA coverage must be exhausted before you can opt back into county coverage midyear; you can also opt in during the annual open enrollment. For other than COBRA coverage, you may opt in if your loss of coverage is due to:

- divorce or dissolution of a domestic partnership;
- a change in job status such as reduction of hours;
- termination of employer contributions toward the other coverage;
- termination of employment; or
- death.

**Requesting Continuation of Coverage for a Disabled Adult Child**

You may continue medical, dental and vision coverage for a child past age 23 if the child:

- was incapacitated and covered under your plans before age 23;
- continues to be incapacitated due to developmental or physical disability; and
- is chiefly dependent on you for support so that you may claim him/her on your federal tax return.

To continue coverage, you need to submit a Continue Coverage for Disabled Adult Child form six months before the child turns age 23 or no later than 30 days after the child turns age 23.

**FORMS**

Forms are available at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits) or from Benefits and Retirement Operations. (See *Contact Information*.)

## Changes You May Make Any Time

There are a number of changes you may make to your health care coverage at any time.

### Discontinuing Dependent Coverage

You may discontinue health care coverage for eligible dependents at any time if you're in the Full Benefits Plan. If you're in the Partial Benefits Plan, you may discontinue health care coverage for eligible dependents at any time if you're paying for coverage on an after-tax basis. If you're paying for coverage on a before-tax basis, you may not discontinue health care coverage until the next annual open enrollment unless you have one of the following qualifying life events:

- divorce/dissolution of a domestic partnership;
- child's loss of eligibility;
- death of a family member; or
- your spouse/domestic partner's loss of employer-sponsored coverage.

However, discontinuing coverage for a spouse/domestic partner doesn't change your level of out-of-pocket expenses under your medical coverage in the year you discontinue coverage for your spouse/domestic partner. If you've earned the lowest out-of-pocket expense level and your spouse/domestic partner has earned the highest out-of-pocket expense level for a given year, for example, your family coverage is at the highest out-of-pocket expense level. Your family coverage remains at the highest out-of-pocket expense level for the remainder of that year even though you've discontinued coverage for your spouse/domestic partner. (For information about the county's Healthy Incentives<sup>SM</sup> program and how participation affects the cost of medical coverage, see "How the Healthy Incentives<sup>SM</sup> Program Works" on page 73 in "Medical Plans.")

When you discontinue coverage for a dependent, your dependent has 60 days from the date he/she loses coverage to enroll in COBRA coverage. (For more information, see "Continuing Coverage Under COBRA" on page 175.) To discontinue coverage for an ineligible dependent, complete the Discontinue Dependent Coverage form online as soon as possible, preferably within 30 days but no later than 60 days from the date he/she becomes ineligible, so he/she will be eligible for COBRA coverage.

#### HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits and Retirement Web site at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits). At the Web site, click "My Benefits" in the left navigation menu and follow the directions. Most non-county forms are available on the Benefits and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

When you voluntarily discontinue dependent coverage, you may not re-enroll your dependents until the next annual open enrollment or when a qualifying life event occurs. (For more information, see “Changes You May Make After Qualifying Life Events” on page 54.)

### Discontinuing or Reducing Self-Paid Coverage

If you’re in the Partial Benefits Plan, you pay for your health care coverage. As a result, you may discontinue your medical, dental and vision coverage at any time unless you pay for your coverage on a before-tax basis. If you pay for health care coverage on a before-tax basis, you may discontinue coverage only when a relevant qualifying life event occurs—for example, you become eligible for other health care coverage. If you don’t have a relevant qualifying life event, you must wait until the next annual open enrollment to discontinue coverage.

To discontinue coverage, submit a detailed written or e-mail request (no form is available) to Benefits and Retirement Operations. (See *Contact Information*.) You’re responsible for any expenses incurred after the date coverage is discontinued.

If you discontinue health care coverage under the Partial Benefits Plan, you may not enroll until the next annual open enrollment unless you subsequently lose the coverage that originally qualified you to discontinue your self-paid county coverage. (For more information, see “Opting Back Into Health Coverage After Opting Out” on page 56 in “Changes You May Make After Qualifying Life Events.”)

## Changes You Must Make

The one change you must make is to notify Benefits and Retirement Operations when a dependent is no longer eligible for health coverage.

### Discontinuing Coverage for Ineligible Dependents

You must discontinue dependent coverage when:

- you and your spouse divorce or you end a domestic partnership;
- your spouse/domestic partner becomes a King County employee and doesn’t opt out of his/her own coverage (you may cover your dependent children but not your spouse/domestic partner);
- your child turns age 23 unless he/she depends on you because he/she is incapacitated due to a developmental or physical disability; or
- your child becomes insured under his/her own health care coverage or becomes no longer dependent on you (in other words, you may no longer claim him/her on your federal tax return).

### INELIGIBLE DEPENDENTS

**You must discontinue coverage for dependents as soon as they become ineligible for benefits.**

**IMPORTANT**

**If you don't discontinue your dependent's coverage within 30 days of the date he/she becomes ineligible, you may have to reimburse the county for expenses incurred following the date your dependent became ineligible for coverage.**

When you discontinue coverage for a dependent, your dependent has 60 days from the date he/she loses coverage to enroll in COBRA coverage. (For information about COBRA coverage, see "Continuing Coverage Under COBRA" on page 175.) To discontinue coverage for an ineligible dependent, complete the Discontinue Dependent Coverage form online as soon as possible, preferably within 30 days but no later than 60 days from the date your dependent becomes ineligible, so he/she will be eligible for COBRA coverage.

**HOW TO MAKE CHANGES ONLINE**

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits and Retirement Web site at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits). At the Web site, click "My Benefits" in the left navigation menu and follow the directions. Most non-county forms are available on the Benefits and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

When you discontinue dependent coverage:

- your dependents may continue health care coverage under COBRA (as long as enrollment and payment of premium have been timely) or under individual self-paid insurance; and
- you may re-enroll them if and when they become eligible again.

However, when you divorce and the divorce decree states you must provide health insurance for your ex-spouse, you must discontinue your ex-spouse's county-paid coverage, and he/she may continue coverage through COBRA or individual self-paid insurance.

**Change Forms**

Use the following forms to make these changes online:

- Marriage/Domestic Partnership, which includes an Affidavit of Marriage/Domestic Partnership;
- Change Spouse or Domestic Partner, which includes an Affidavit of Marriage/Domestic Partnership;
- Add/Change Dependent;
- Birth/Adoption;
- Discontinue Dependent Coverage.

**HOW TO MAKE CHANGES ONLINE**

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits and Retirement Web site at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits). At the Web site, click "My Benefits" in the left navigation menu and follow the directions. Most non-county forms are available on the Benefits and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

Use the following forms to make these changes on paper:

- Continue Coverage for Disabled Adult Child; and
- Opt in for Health Coverage.

#### FORMS

Forms are available at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits) or from Benefits and Retirement Operations. (See *Contact Information*.)

## What Coverage Costs

Part-time transit operators in the Full Benefits Plan don't pay for their medical, dental and vision coverage. However, part-time transit operators in the Partial Benefits Plan do pay partial premiums.

The county pays about 80% of the premium for employee coverage for Group Health; if you elect Group Health, you pay the remaining 20%. If you elect KingCare<sup>SM</sup>, the county applies the 80% of the premium it pays for Group Health to the King Care<sup>SM</sup> premium, and you pay the remaining amount.

If you're in the Partial Benefits Plan, refer to the Part-Time Local 587 New Hire Guide for the 2007 monthly premiums you pay for your coverage, based on your participation in the Healthy Incentives<sup>SM</sup> program. The new hire guide is available under "New Employee" at the Benefits and Retirement Web site. (See *Contact Information*.) Information about the Healthy Incentives<sup>SM</sup> program is available in "How the Healthy Incentives<sup>SM</sup> Program Works" on page 73 in "Medical Plans.")

However, if you're in the Full Benefits Plan, you pay a benefit access fee of \$35 a month to cover your spouse/domestic partner when he/she has access to medical coverage through:

- his/her own employer;
- a union trust paid by an employer; or
- the military while in active duty status.

You don't pay this fee if:

- your covered spouse/domestic partner is unemployed, a King County employee or covered under Medicare, Medicaid, retiree medical, COBRA or disability (whether Social Security or military); or
- your covered spouse/domestic partner has coverage because he/she is a veteran or retired from the military or has private coverage, Canadian coverage or other foreign government-supported coverage.

If you're in the Partial Benefits Plan, you don't pay the benefit access fee because you're paying the premium for your spouse/domestic partner's coverage.

## When Coverage Begins

### ID CARDS

When you enroll for medical coverage, which includes prescription drug coverage, you receive ID cards that identify you as a plan member. Carry your card with you because physicians, hospitals and pharmacies will ask to see it when you receive care.

If you need care before you receive your card, or if you lose your card, call your plan for information about your coverage before you receive treatment to be sure the plan you're in covers the treatment you're about to receive. (See *Contact Information*.)

You do not receive ID cards for your dental and vision coverage. For more information on using your dental and vision benefits, see "Using the Dental Plan" on page 147 in "Dental Plan" and "Using the Vision Plan" on page 168 in "Vision Plan."

The day your coverage begins depends on whether you're in the Partial Benefits Plan or the Full Benefits Plan.

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

When you enroll in the Full Benefits Plan, the date your coverage begins is:

- the first day of the month after you begin the work assignment of 4 or more hours that qualified you for the Full Benefits Plan; or
- the first day of the following year if you work 1,019 or more paid hours in the 26 pay periods ending with the pay period that includes July 31 in 2007, 2008 or 2009.

Your eligibility for the Full Benefits Plan is determined by an agreement between King County and Amalgamated Transit Union Local 587. When you're eligible, your coverage extends through December 31, 2009.

If you're hospitalized under another benefit plan and you're in the hospital the day county coverage would normally begin, the other plan usually continues to provide your coverage until you're discharged.

When you change coverage during the annual 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, unless you qualify for the Full Benefits Plan.

When you return from an unpaid leave of absence, your coverage resumes on the first day of the month following your return. If you return on the first day of the month, your coverage resumes the same day.

## Eligible Dependents

Coverage for the eligible dependents you enroll in your county health care plan begins when your coverage begins, with the exceptions listed below. If you don't enroll eligible dependents when you enroll, you must wait until the next annual open enrollment or a qualifying life event to add them for coverage. (For more information, see "Changes You May Make After Qualifying Life Events" on page 54.)

For eligible dependents added because of a qualifying life event:

- health care coverage for your new spouse/domestic partner begins on the first day of the month following the date you marry or establish your domestic partnership. If you marry or establish your domestic partnership on the first day of the month, coverage begins the same day;
- health care coverage for your newborn or newly adopted child is retroactive to the date of birth or placement; and
- health care coverage for a child who isn't a newborn or adopted begins the first day of the month following the event that qualified him/her to be added. If the event occurs on the first day of the month, coverage begins the same day.

Coverage for newborns is provided under the mother's health care plan for the first three weeks of life. To continue the newborn's coverage after that, the newborn must be eligible and enrolled within 60 days of his/her birth. (For information on how to change coverage, see "Adding Eligible Dependents" on page 55.)

## When You Have Other Coverage

If you or an eligible dependent has coverage under the King County health care plans and coverage under another health care plan or Medicare, the county's benefits are coordinated with those provided by the other plan so that your combined coverage doesn't exceed the provider's fees for eligible expenses.

## Coordinating with Other Health Plans

The county's KingCare<sup>SM</sup> plan, dental plan and vision plan coordinate benefits under a non-duplication coordination of benefits policy between the primary and secondary plans. That means when a plan is primary, it pays benefits 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 had been primary.

The county's Group Health plan coordinates benefits under a standard coordination of benefits (COB) policy between primary and secondary plans. That means 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 the calculation of COB savings to Group Health). If your children have double coverage through the county's Group Health plan because both you and your spouse work at the county and each of you has employee and dependent coverage, then your children's copays are waived.

The following applies to KingCare<sup>SM</sup>, Group Health, the dental plan and the vision plan:

If you're a county employee whose spouse/domestic partner has coverage through another plan and you cover each other under your respective plans, then your plan is primary for you and secondary for your spouse/domestic partner, and your spouse/domestic partner's plan is primary for him/her and secondary for you.

However, if you and your spouse/domestic partner are both county employees and insured by a county plan, you may **not** cover each other under your plans. Instead, one of you may opt out of medical coverage and be covered by the other. If each of you remains covered under your own county plan and neither of you opts out to be covered by the other, each of you may cover your dependent children under your plan. (For more information on opting out, see "Enrolling When First Eligible" on page 49.)

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine which plan is primary for dependent children covered under both parents' plans:

- 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 doesn't have this rule, its provisions apply.
- If the parents are divorced or legally separated, the following 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 the following order: plan of the parent with custody, plan of the spouse of the parent with custody, plan of the parent without custody, plan of the spouse of the parent without custody.

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 procedures for coordination of benefits.

## Coordinating with Medicare

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

- continue your county medical coverage and integrate the county plan with Medicare (in this case, the county medical plan is primary and Medicare is secondary); or
- discontinue your county medical coverage and enroll in Medicare.

If you discontinue your county medical coverage as an employee and enroll in Medicare, you may not cover your dependents under the county medical plan. However, you may continue your county dental and vision coverage and continue to cover dependents under the county dental and vision plans.

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

If you have any questions about how your coverage coordinates with Medicare, contact your medical plan directly. (See *Contact Information*.)

## Acts of Third Parties

The subrogation and right of recovery rules apply to KingCare<sup>SM</sup>, Group Health, the dental plan and the vision plan.

### *KingCare<sup>SM</sup>*

When you or your covered dependent is injured or becomes ill because of the actions or inactions of a third party, KingCare<sup>SM</sup> may cover your eligible medical and prescription drug expenses. However, to receive coverage, you must notify the plan that your illness or injury was caused by a third party, and you must follow special plan rules. This section describes the KingCare<sup>SM</sup> procedures with respect to subrogation and right of recovery.

“Subrogation” means that if an injury or illness is someone else’s fault, KingCare<sup>SM</sup> has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A “right of recovery” means that the plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party who caused the illness or injury.

By accepting plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree that KingCare<sup>SM</sup>:

- has an equitable lien on any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the plan paid benefits for such illness or injury;
- may appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the plan paid benefits for such illness or injury; and
- may bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the illness or injury.

If you (or your attorney or other representative) receive any payment from the sources listed below—through a judgment, settlement or otherwise—when an illness or injury is the result of a third party, you agree to place the funds in a separate, identifiable account and that KingCare<sup>SM</sup> has an equitable lien on the funds, and/or you agree to serve as a constructive trustee over the funds to the extent that the plan has paid expenses related to that illness or injury. This means that you will be deemed to be in control of the funds.

You must repay KingCare<sup>SM</sup> first, in full, out of such funds for any health care expenses the plan has paid related to such illness or injury. You must repay KingCare<sup>SM</sup> up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses.

Furthermore, you must repay KingCare<sup>SM</sup> whether the third party admits liability and whether you've been made whole or fully compensated for your injury. If any money is left over, you may keep it.

In addition, KingCare<sup>SM</sup> isn't required to participate in or contribute to any expenses or fees (including attorneys' fees and costs) you incur in obtaining the funds.

The plan's sources of payment through subrogation or recovery include (but aren't limited to) the following:

- money from a third party that you, your guardian or other representative receives or is entitled to receive;
- any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representative receives;

- any equitable lien on the portion of the total recovery owed to the plan for benefits it paid; and
- any liability or other insurance—for example, uninsured motorist, underinsured motorist, medical, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage—that is paid or payable to you, your guardian or other representative.

As a participant in KingCare<sup>SM</sup>, you're required to:

- cooperate with the plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the plan's subrogation or recovery rights outlined in this section;
- notify the plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained illness or injury; and
- provide all information requested by the plan, the claims administrator or their representatives, or the plan administrator or its representatives.

KingCare<sup>SM</sup> may terminate your participation and/or offset your future benefits in the event that you fail to provide the information and authorizations or to otherwise cooperate in a manner that the plan considers necessary to exercise its rights or privileges.

### *Group Health*

When you or your covered dependent is injured or becomes ill because of the actions or inactions of a third party, Group Health may cover your eligible medical and prescription drug expenses. However, to receive coverage, you must notify Group Health that your illness or injury was caused by a third party, and you must follow special plan rules. This section describes Group Health's procedures with respect to subrogation and right of recovery.

Group Health's subrogation and reimbursement rights will be limited to the excess or the amount required to fully compensate the injured party or the loss sustained, including general damages.

"Subrogation" means that if an injury or illness is someone else's fault, Group Health has the right to seek expenses it pays for that illness or injury directly from the at-fault party or any of the sources of payment listed later in this section. A "right of recovery" means that the plan has the right to recover such expenses indirectly out of any payment made to you by the at-fault party or any other party who caused the illness or injury.

By accepting plan benefits to pay for treatments, devices, or other products or services related to such illness or injury, you agree to:

- cooperate fully with Group Health in its efforts to collect medical expenses it is entitled to recover;

- provide Group Health with information about any third parties related to the injury, including any settlement or other payments related to the injury;
- allow Group Health to associate with the injured party or intervene in any legal or other action related to the injury; and
- allow Group Health to initiate its own direct action for reimbursement, including billing you if you don't take action to recover funds from any third party.

If you fail to cooperate with Group Health or settle a claim without protecting Group Health's interest, you will be held responsible for reimbursing Group Health for all your medical expenses associated with the injury.

To the extent that you recover funds from any third party, you agree to hold the funds in trust or your possession until Group Health's rights are fully determined.

Group Health will not cover the cost of attorneys' fees or collection costs to attorneys representing you unless there is a written fee agreement with Group Health before any collection efforts are made. When reasonable collection costs have been incurred with Group Health's prior written agreement, Group Health agrees to an equitable apportionment of the collection costs between you and Group Health up to a maximum responsibility of one-third of the amount recovered on behalf of Group Health. Group Health will not pay legal fees for services that are not reasonable and necessary, do not benefit Group Health and/or are incurred without a written fee agreement.

If Group Health finds that it must initiate action against you to enforce its rights, you agree to pay Group Health attorneys' fees and costs associated with the action.

#### *Dental Plan*

When you or your covered dependent is injured or develops a condition possibly caused by another person, Washington Dental Service (WDS) may cover your eligible dental expenses. However, to receive coverage, you must notify WDS that your injury or condition was caused by a third party, and you must follow special plan rules.

So that WDS can pursue its rights to collect reimbursement from the third party, WDS will not be obligated to pay for your dental expenses or prorate any attorneys' fees incurred in pursuing its rights, unless and until you, or someone legally qualified and authorized to act for you, agrees to:

- include those amounts in any insurance claim or liability claim made against the third party for the injury or condition;

- repay WDS for those amounts included in the claim that exceed your full compensation; and
- cooperate fully with WDS in pursuing its rights, supply WDS with any and all information requested, and execute any and all instruments WDS reasonably needs for that purpose.

### *Vision Plan*

When you or your covered dependent is injured or develops a condition caused by the wrongful act or omission of another person, Vision Service Plan (VSP) may cover your eligible eye care expenses. However, to receive coverage, you must notify VSP that your injury or condition was caused by a third party, and you must follow special plan rules.

As long as you're made whole for all other damages resulting from the wrongful act or omission before VSP is entitled to reimbursement, you will:

- reimburse VSP for the reasonable cost of services paid by VSP, to the extent permitted by law, immediately upon collecting damages, whether by action or law, settlement or otherwise; and
- fully cooperate with VSP in pursuit of its rights, to the extent permitted by law, to be reimbursed by the third party, his/her agent or the court for the reasonable value of services provided by VSP.

## **Overpayment**

The county's health care plans have the right to recover amounts they paid that exceed the amount for which they're liable. These amounts may be recovered from one or more of the following as determined by the plans:

- persons to or for whom the payments were made;
- other insurers;
- service plans; and
- organizations or other plans.

These amounts may be deducted from your future benefits or a dependent's benefits, even if the original payment wasn't made on that individual's behalf.

The recovery rights of the plans include benefits paid in error due to any false or misleading statements made by you or your dependents, or your failure to discontinue coverage for a dependent who became ineligible.

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

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

## When Coverage Ends

Coverage under the health care plans ends under certain circumstances.

### EXTENSION OF COVERAGE

If you or your covered dependent is hospitalized when your medical coverage terminates, your coverage under KingCare<sup>SM</sup> or Group Health continues until discharge. Coverage ends on the date of discharge or when you or your covered dependent reaches the plan maximum, whichever comes first.

The Group Health extension of coverage also ends when:

- it is no longer medically necessary to be an inpatient;
- you or your dependent becomes covered under another group plan that provides benefits for the hospitalization;
- another carrier would provide benefits for the hospitalization if this coverage didn't exist; or
- you or your dependent becomes eligible for Medicare.

If you or your dependent is covered under KingCare<sup>SM</sup> while totally disabled and coverage ends for any reason other than plan termination, KingCare<sup>SM</sup> coverage for only the disabling condition may be extended for 12 months at no cost to you. The disabled person may choose either this extension of medical coverage or COBRA coverage. However, electing the extension means forfeiting the right to elect COBRA coverage and convert to an individual policy. Other dependents may be able to elect coverage through COBRA. (For more information, see "Continuing Coverage Under COBRA" on page 175.)

When you or a covered dependent is no longer eligible for county benefits, Washington Dental Service (WDS) will cover only those expenses for single procedures begun before your loss of coverage and completed within three weeks of your last day of coverage.

When you or a covered dependent is no longer eligible for county benefits, Vision Service Plan (VSP) will cover only those expenses for services authorized by VSP in a benefit authorization to a VSP provider before your loss of coverage and completed before the expiration date of the benefit authorization.

## When Coverage Ends for You

Your health care coverage (medical, dental and vision) ends on:

- the last day of the month you lose eligibility, resign, are terminated, retire, fail to make any required payments for self-paid coverage or die; or
- the day the plan terminates.

(For information about extending coverage, see "When Coverage Ends" on page 70.)

## When Coverage Ends for Dependents

Health care coverage (medical, dental and vision) for your covered dependents ends on:

- the last day of the month they lose eligibility, your coverage ends, you fail to make any required payments for their coverage or they die, or
- the day the plan terminates.

(For information about extending coverage, see “When Coverage Ends” on page 70.)

## Certificates of Coverage

When coverage under your medical plan ends, you'll automatically receive a certificate of medical plan coverage from your plan. If you'd like to request a copy of the certificate, you may contact the plan directly. Certificates of coverage aren't available for your dental and vision coverage. (See *Contact Information*.)

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

## How to Continue Coverage

If you or your eligible dependents lose county-paid health care coverage due to certain qualifying life events, each of you has an independent right to continue medical, dental and vision coverage through COBRA. This coverage, which is paid entirely by you, may continue for 18 to 36 months after county-paid coverage ends, which is the last day of the month in which the qualifying life event occurs. (For more information, see “Continuing Coverage Under COBRA” on page 175.)

## How to Convert Coverage

You may be able to convert your county health care coverage to an individual policy.

### KingCare<sup>SM</sup>

If you're no longer eligible for KingCare<sup>SM</sup> coverage, you may convert your coverage to an Aetna-insured plan without providing evidence of insurability (EOI). The plan you convert to will differ from your county KingCare<sup>SM</sup> plan. If the plan includes a prescription drug benefit, claims will be processed by Aetna, not by Express Scripts. You may not transfer your Express Scripts coverage to an insured conversion plan.

If you convert your coverage to an Aetna-insured plan, you must pay premiums, which may be higher than the amount you currently pay (if any) for these benefits.

#### WHAT IS “EVIDENCE OF INSURABILITY”?

“Evidence of insurability” is any statement or proof of a person's physical condition, occupation or other factor affecting his/her acceptance for insurance.

## WHAT IS “EVIDENCE OF INSURABILITY”?

**“Evidence of insurability” is any statement or proof of a person’s physical condition, occupation or other factor affecting his/her acceptance for insurance.**

You will not be able to convert coverage to an individual policy if you’re eligible for any other medical coverage under any other group plan, including Medicare.

To apply for an individual policy, you must complete and return an application form to Aetna within 31 days after your medical coverage ends. You will not receive the application or information about conversion coverage unless you request it from Aetna. (See *Contact Information*.)

## Group Health

If you’re no longer eligible for Group Health coverage, you may convert your coverage to an insured conversion plan without providing evidence of insurability (EOI). The plan you convert to will differ from your county Group Health plan. You must pay premiums, which may be higher than amounts you currently pay (if any) for this coverage.

You will not be able to convert coverage to an individual policy if you’re eligible for any other medical coverage under any other group plan, including Medicare.

To apply for an individual policy, you must complete and return an application form to Group Health within 31 days after your medical coverage ends. You will not receive this application or information about conversion coverage unless you request it from Group Health. (See *Contact Information*.)

## MEDICAL PLANS

When it comes to medical care, everyone has different needs. For this reason, the county provides you with medical coverage that offers flexibility and choice. That way, you can choose the medical plan that's right for you.

### Your Medical Plan Choices

As a benefit-eligible employee, you may be covered by one of two medical plans: KingCare<sup>SM</sup> (administered by Aetna) and Group Health.

#### KingCare<sup>SM</sup>

Medical benefits under KingCare<sup>SM</sup> are administered by Aetna; prescription benefits under the plan are administered by Express Scripts, Inc.

The medical and prescription drug benefits of the KingCare<sup>SM</sup> plan are "self-funded" by King County. This means that the county is financially responsible for and pays all claims and other costs associated with KingCare<sup>SM</sup>.

#### Group Health

Medical and prescription benefits under the Group Health plan are administered by Group Health. Group Health is a health maintenance organization in the Pacific Northwest, with reciprocal agreements for out-of-area services with Kaiser Permanente.

### How the Healthy Incentives<sup>SM</sup> Program Works

The Healthy Incentives<sup>SM</sup> program is designed to maintain and improve the health of county employees and their spouse/domestic partners if they're covered under a county medical plan, while simultaneously helping to slow the rise of medical expenses for the county.

Each year, employees and their spouse/domestic partners have the opportunity to take a wellness assessment. A wellness assessment provides a snapshot of your current health risks that are affected by behavior and identifies the potential for future health problems. Employees and their spouse/domestic partners also can participate in an individual action plan which gives support in healthy lifestyle behavior changes.

Participation in the program is voluntary, but your level of participation in the program determines the out-of-pocket expense level for you, your spouse/domestic partner and your children each year. The out-of-pocket level you earn is based solely on participation in the program, not on a specific outcome or the existence of a specific health condition.

#### DEFINED TERMS

Be sure you understand the meaning of the terms used in this summary, such as "copay" and "coinsurance." (See "Glossary" on page 191.)

## Out-of-Pocket Expense Levels

Under the Healthy Incentives<sup>SM</sup> program, there are three out-of-pocket expense levels in the KingCare<sup>SM</sup> and Group Health plans:

- gold—the lowest out-of-pocket expense level;
- silver—the middle out-of-pocket expense level; and
- bronze—the highest out-of-pocket expense level.

If you take the wellness assessment in January of a given year and complete an individual action plan by June 30 of that same year, you'll receive the gold out-of-pocket expense level for the following year.

If you only take the wellness assessment by June 30 in a given year, you'll receive the silver out-of-pocket expense level for the following year.

If you don't participate in the Healthy Incentives<sup>SM</sup> program at all in a given year, you'll receive the bronze out-of-pocket expense level for the following year.

The out-of-pocket expense level for your family is based on the lowest level of participation by both you and your spouse/domestic partner, if applicable—for example, if you earn the gold out-of-pocket expense level and your spouse/domestic partner earns the silver out-of-pocket expense level, your family out-of-pocket expense level for the following year will be silver.

### NEW EMPLOYEES

New employees and their spouse/domestic partners are given 14 days to take the wellness assessment after their qualification or hire date, whichever is later, to earn the gold out-of-pocket expense level for the current year and the following year. If a new employee or his/her spouse/domestic partner doesn't take the wellness assessment within 14 days, he/she will receive the bronze expense level for the current year and the following year.

For details on how the three out-of-pocket expense levels affect your medical benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75 or "Group Health Benefits at a Glance" on page 81. For more information about the Healthy Incentives<sup>SM</sup> program, visit the benefits Web site or contact Benefits and Retirement Operations. (See *Contact Information*.)

## Your Medical Benefits at a Glance

This section provides a quick overview of your KingCare<sup>SM</sup> and Group Health benefits. (See "KingCare<sup>SM</sup>" on page 86 and "Group Health" on page 122 for more details about each plan.)

## KingCare<sup>SM</sup> Benefits at a Glance

The following tables show what KingCare<sup>SM</sup> pays for covered expenses, depending on whether you receive the gold, silver or bronze out-of-pocket expense level. (For important details, be sure to read “How the Healthy Incentives<sup>SM</sup> Program Works” on page 73 and “Knowing What’s Covered and What’s Not” on page 93.) All covered out-of-network expenses are paid based on reasonable and customary (R&C) charges, as determined by the plan. That means if you go to an out-of-network provider and the charges are more than R&C charges for those services, **you** pay the additional charges. (For important details about reasonable and customary charges, see “Reasonable and Customary (R&C) Charges” on page 88.)

### Plan Features

The following table identifies some plan features, including your annual deductibles, out-of-pocket maximums and how benefits are determined for most covered expenses.

Plan Feature	KingCare <sup>SM</sup> Gold	KingCare <sup>SM</sup> Silver	KingCare <sup>SM</sup> Bronze
<b>Provider choice</b>	You may choose any qualified provider, but you receive higher coverage when you use network providers.  Reimbursement for out-of-network medical services is based on reasonable and customary (R&C) rates, and reimbursement for out-of-network prescription drug services is based on the rates Express Scripts pays its network pharmacies. You pay amounts in excess of these rates.		
<b>Annual deductible</b>	\$100/person; \$300/family  Deductible amounts applied to charges incurred in the last three months of the calendar year are carried over and applied to the next year’s deductible.  <b>The deductible doesn’t apply to prescription drugs, preventive care or hearing aids.</b>	\$300/person; \$900/family  Deductible amounts applied to charges incurred in the last three months of the calendar year are carried over and applied to the next year’s deductible.  <b>The deductible doesn’t apply to prescription drugs, preventive care or hearing aids.</b>	\$500/person; \$1,500/family  Deductible amounts applied to charges incurred in the last three months of the calendar year are carried over and applied to the next year’s deductible.  <b>The deductible doesn’t apply to prescription drugs, preventive care or hearing aids.</b>
<b>Copays</b>	Applicable only to emergency room care and prescription drugs (See “Covered Expenses” on page 94 for amounts)		
<b>After the deductible/copays, the plan pays most covered services at these levels until you reach the annual out-of-pocket maximum</b>	Network: 90% (You pay 10% coinsurance)  Out-of-network: 70% (You pay 30% coinsurance)  100% of network rate after applicable copays for prescription drug claims (Deductible doesn’t apply)	Network: 80% (You pay 20% coinsurance)  Out-of-network: 60% (You pay 40% coinsurance)  100% of network rate after applicable copays for prescription drug claims (Deductible doesn’t apply)	Network: 80% (You pay 20% coinsurance)  Out-of-network: 60% (You pay 40% coinsurance)  100% of network rate after applicable copays for prescription drug claims (Deductible doesn’t apply)

Plan Feature	KingCare <sup>SM</sup> Gold	KingCare <sup>SM</sup> Silver	KingCare <sup>SM</sup> Bronze
<b>Annual out-of-pocket maximum</b>	Network: \$800/person or \$1,600/family, plus deductible Out-of-network: \$1,600/person or \$3,200/family, plus deductible Doesn't apply to prescriptions (See "Annual Out-of-Pocket Maximum" on page 89 for details)	Network: \$1,000/ person or \$2,000/ family, plus deductible Out-of-network: \$1,800/ person or \$3,600/ family, plus deductible Doesn't apply to prescriptions (See "Annual Out-of-Pocket Maximum" on page 89 for details)	Network: \$1,200/ person or \$2,400/ family, plus deductible Out-of-network: \$2,000/person or \$4,000/family, plus deductible Doesn't apply to prescriptions (See "Annual Out-of-Pocket Maximum" on page 89 for details)
<b>After you reach the out-of-pocket maximum, most benefits are paid for the rest of the calendar year at this level</b>	Network: 100% Out-of-network: 100% of R&C charges		
<b>Lifetime maximum</b>	\$2,000,000	\$2,000,000	\$2,000,000

### Covered Expenses

The following table summarizes covered services and supplies under KingCare<sup>SM</sup> (only medically necessary services, prescription drugs and supplies are covered) and identifies related coinsurance, copays, maximums and limits. (For more details, see "Knowing What's Covered and What's Not" on page 93.)

#### IMPORTANT!

Aetna processes medical claims; Express Scripts processes outpatient, retail pharmacy and mail-order prescription drug claims. Where a benefit involves claims processed by both Aetna and Express Scripts, you'll find information in the following table or under "Covered Expenses."

Covered Expenses	KingCare <sup>SM</sup> Gold	KingCare <sup>SM</sup> Silver	KingCare <sup>SM</sup> Bronze
<b>Alternative care (including medically necessary acupuncture, hypnotherapy and massage therapy)</b>	Network: 90% Out-of-network: 70% Massage services must be prescribed by a physician. A total of 60 covered visits/year (may include any combination of acupuncture, hypnotherapy and/or massage therapy visits)	Network: 80% Out-of-network: 60% Massage services must be prescribed by a physician. A total of 60 covered visits/year (may include any combination of acupuncture, hypnotherapy and/or massage therapy visits)	Network: 80% Out-of-network: 60% Massage services must be prescribed by a physician. A total of 60 covered visits/year (may include any combination of acupuncture, hypnotherapy and/or massage therapy visits)
<b>Ambulance services</b>	90%	80%	80%

Covered Expenses	KingCare <sup>SM</sup> Gold	KingCare <sup>SM</sup> Silver	KingCare <sup>SM</sup> Bronze
<b><i>Chemical dependency treatment (requires preauthorization)</i></b>	Network: 100% Out-of-network: 70% Up to \$15,000 in 24 consecutive months for combined network and out-of-network services (maximum subject to annual adjustment)	Network: 80% Out-of-network: 60% Up to \$15,000 in 24 consecutive months for combined network and out-of-network services (maximum subject to annual adjustment)	Network: 80% Out-of-network: 60% Up to \$15,000 in 24 consecutive months for combined network and out-of-network services (maximum subject to annual adjustment)
<b><i>Chiropractic care and manipulative therapy (like all services, must be medically necessary)</i></b>	Network: 90% Out-of-network: 70% Up to 33 visits/year for combined network and out-of-network services Limited to diagnosis and treatment of musculoskeletal disorders	Network: 80% Out-of-network: 60% Up to 33 visits/year for combined network and out-of-network services Limited to diagnosis and treatment of musculoskeletal disorders	Network: 80% Out-of-network: 60% Up to 33 visits/year for combined network and out-of-network services Limited to diagnosis and treatment of musculoskeletal disorders
<b><i>Diabetes care training</i></b>	Network: 90% when prescribed by your physician Out-of-network: 70% when prescribed by your physician	Network: 80% when prescribed by your physician Out-of-network: 60% when prescribed by your physician	Network: 80% when prescribed by your physician Out-of-network: 60% when prescribed by your physician
<b><i>Diabetes supplies (insulin, needles, syringes, lancets, etc.)</i></b>	Covered under prescription drugs		
<b><i>Durable medical equipment, prosthetics and orthopedic appliances</i></b>	80% when preauthorized		
<b><i>Emergency room care (Also see "Urgent Care")</i></b>	Emergency care, network or out-of-network: 90% after \$100 copay/visit (waived if admitted) Non-emergency care, network or out-of-network: 70% after \$100 copay/visit	Emergency care, network or out-of-network: 80% after \$100 copay/visit (waived if admitted) Non-emergency care, network or out-of-network: 60% after \$100 copay/visit	Emergency care, network or out-of-network: 80% after \$100 copay/visit (waived if admitted) Non-emergency care, network or out-of-network: 60% after \$100 copay/visit
<b><i>Family planning</i></b>	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%	Network: 80% Out-of-network: 60%
<b><i>Growth hormones</i></b>	Network: 90% when preauthorized Out-of-network: 70% when preauthorized May also be covered under the prescription drug benefit (See "Using Your Prescription Drug Plan" on page 114)	Network: 80% when preauthorized Out-of-network: 60% when preauthorized May also be covered under the prescription drug benefit (See "Using Your Prescription Drug Plan" on page 114)	Network: 80% when preauthorized Out-of-network: 60% when preauthorized May also be covered under the prescription drug benefit (See "Using Your Prescription Drug Plan" on page 114)
<b><i>Hearing aids</i></b>	100%, up to \$500 in 36 months for combined network and out-of-network services Deductible doesn't apply		

Covered Expenses	KingCare <sup>SM</sup> Gold	KingCare <sup>SM</sup> Silver	KingCare <sup>SM</sup> Bronze
<b>Home health care</b>	100% when preauthorized, up to 130 visits/year for combined network and out-of-network services		
<b>Hospice care</b>	100% when preauthorized 6-month lifetime maximum 120-hour maximum for respite care in any 3-month period		
<b>Hospital care</b>	Network: 90% when preauthorized Out-of-network: 70% when preauthorized	Network: 80% when preauthorized Out-of-network: 60% when preauthorized	Network: 80% when preauthorized Out-of-network: 60% when preauthorized
<b>Infertility</b>	Network: 90% Out-of-network: 70% Limited to specific services and \$25,000 lifetime maximum for combined network and out-of-network services	Network: 80% Out-of-network: 60% Limited to specific services and \$25,000 lifetime maximum for combined network and out-of-network services	Network: 80% Out-of-network: 60% Limited to specific services and \$25,000 lifetime maximum for combined network and out-of-network services
<b>Injury to teeth</b>	Network: 90% Out-of-network: 70% Up to \$600/accident for combined network and out-of-network services	Network: 80% Out-of-network: 60% Up to \$600/accident for combined network and out-of-network services	Network: 80% Out-of-network: 60% Up to \$600/accident for combined network and out-of-network services
<b>Inpatient care alternatives</b>	Network: 90% when preauthorized Out-of-network: 70% when preauthorized	Network: 80% when preauthorized Out-of-network: 60% when preauthorized	Network: 80% when preauthorized Out-of-network: 60% when preauthorized
<b>Jaw abnormalities, or malocclusions (covered when medically necessary)</b>	Network: 90% when preauthorized Out-of-network: 70% when preauthorized	Network: 80% when preauthorized Out-of-network: 60% when preauthorized	Network: 80% when preauthorized Out-of-network: 60% when preauthorized
<b>Lab, X-ray and other diagnostic testing</b>	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%	Network: 80% Out-of-network: 60%
<b>Maternity care</b>	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%	Network: 80% Out-of-network: 60%
<b>Mental health care (when deemed appropriate, 2 unused outpatient visits may be traded for 1 inpatient day, or vice versa; requires preauthorization)</b>	Network: 90% Out-of-network: 70% <i>For inpatient care:</i> Up to 30 days/year; combined network and out-of-network services <i>For outpatient care:</i> Up to 52 visits/year; combined network and out-of-network services	Network: 80% Out-of-network: 60% <i>For inpatient care:</i> Up to 30 days/year; combined network and out-of-network services <i>For outpatient care:</i> Up to 52 visits/year; combined network and out-of-network services	Network: 80% Out-of-network: 60% <i>For inpatient care:</i> Up to 30 days/year; combined network and out-of-network services <i>For outpatient care:</i> Up to 52 visits/year; combined network and out-of-network services
<b>Naturopathy</b>	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%	Network: 80% Out-of-network: 60%

Covered Expenses	KingCare <sup>SM</sup> Gold	KingCare <sup>SM</sup> Silver	KingCare <sup>SM</sup> Bronze
<b>Neurodevelopmental therapy for dependents age 6 and under</b>	Network: 90% when preauthorized Out-of-network: 70% when preauthorized Up to \$2,000/year for combined network and out-of-network services	Network: 80% when preauthorized Out-of-network: 60% when preauthorized Up to \$2,000/year for combined network and out-of-network services	Network: 80% when preauthorized Out-of-network: 60% when preauthorized Up to \$2,000/year for combined network and out-of-network services
<b>Obesity surgery or other procedures, treatment or services, such as gastric intestinal bypass surgery</b>	Network: 90% when preauthorized and medically necessary Out-of-network: 70% when preauthorized and medically necessary Successful completion of a physician-supervised weight management and exercise program required before preauthorization.	Network: 80% when preauthorized and medically necessary Out-of-network: 60% when preauthorized and medically necessary Successful completion of a physician-supervised weight management and exercise program required before preauthorization.	Network: 80% when preauthorized and medically necessary Out-of-network: 60% when preauthorized and medically necessary Successful completion of a physician-supervised weight management and exercise program required before preauthorization.
<b>Out-of-area coverage—for example, while traveling or for your children away at school</b>	Same coverage as when home, through Aetna and Express Scripts national providers		
<b>Phenylketonuria (PKU) formula</b>	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%	Network: 80% Out-of-network: 60%
<b>Physician and other medical/surgical services</b>	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%	Network: 80% Out-of-network: 60%
<b>Prescription drugs—Up to a 30-day supply through network pharmacies</b>	Generic: 100% after \$10 copay Preferred brand: 100% after \$15 copay (\$20 if generic is available; but if you're unable to take it for medical reasons, the \$15 copay applies) Non-preferred brand: 100% after \$25 copay (\$30 if generic is available; but if you're unable to take it for medical reasons, the \$25 copay applies) Prescriptions filled at out-of-network pharmacies are reimbursed at the rate Express Scripts pays to network pharmacies, less your copay		
<b>Prescription drugs—Up to a 90-day supply through mail-order network only</b>	Generic: 100% after \$20 copay Preferred brand: 100% after \$30 copay (\$40 if generic is available; but if you're unable to take it for medical reasons, the \$30 copay applies) Non-preferred brand: 100% after \$50 copay (\$60 if generic is available; but if you're unable to take it for medical reasons, the \$50 copay applies)		
<b>Preventive care (well-child check-ups, immunizations, routine health and hearing exams, etc.)</b>	Network: 100% Out-of-network: 70% Deductible doesn't apply	Network: 100% Out-of-network: 60% Deductible doesn't apply	Network: 100% Out-of-network: 60% Deductible doesn't apply
<b>Radiation therapy, chemotherapy and respiratory therapy</b>	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%	Network: 80% Out-of-network: 60%

Covered Expenses	KingCare <sup>SM</sup> Gold	KingCare <sup>SM</sup> Silver	KingCare <sup>SM</sup> Bronze
<b><i>Reconstructive services (includes benefits for mastectomy-related services; reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema) Call plan for more information.</i></b>	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%	Network: 80% Out-of-network: 60%
<b><i>Rehabilitative services— Inpatient and outpatient</i></b>	Network: 90% Out-of-network: 70% <i>Inpatient:</i> Up to 60 days/year <i>Outpatient:</i> Up to 60 visits/all therapies combined (progress review every 20 visits for out-of-network outpatient)	Network: 80% Out-of-network: 60% <i>Inpatient:</i> Up to 60 days/year <i>Outpatient:</i> Up to 60 visits/all therapies combined (progress review every 20 visits for out-of-network outpatient)	Network: 80% Out-of-network: 60% <i>Inpatient:</i> Up to 60 days/year <i>Outpatient:</i> Up to 60 visits/all therapies combined (progress review every 20 visits for out-of-network outpatient)
<b><i>Skilled nursing facility</i></b>	Network: 90% when preauthorized Out-of-network: 70% when preauthorized	Network: 80% when preauthorized Out-of-network: 60% when preauthorized	Network: 80% when preauthorized Out-of-network: 60% when preauthorized
<b><i>Smoking cessation</i></b>	Network: 100% Out-of-network: 70% Prescription drugs to ease nicotine withdrawal, inhalers and sprays are covered by Express Scripts at 100% (no copay); non-prescription nicotine patches, lozenges and gum are covered by Aetna at 100%.	Network: 100% Out-of-network: 60% Prescription drugs to ease nicotine withdrawal, inhalers and sprays are covered by Express Scripts at 100% (no copay); non-prescription nicotine patches, lozenges and gum are covered by Aetna at 100%.	Network: 100% Out-of-network: 60% Prescription drugs to ease nicotine withdrawal, inhalers and sprays are covered by Express Scripts at 100% (no copay); non-prescription nicotine patches, lozenges and gum are covered by Aetna at 100%.
<b><i>Temporomandibular joint (TMJ) disorders</i></b>	Network: 90% when preauthorized Out-of-network: 70% when preauthorized Night guards are covered if prescribed by a medical doctor for a TMJ disorder. Up to \$2,000/year for combined network and out-of-network services	Network: 80% when preauthorized Out-of-network: 60% when preauthorized Night guards are covered if prescribed by a medical doctor for a TMJ disorder. Up to \$2,000/year for combined network and out-of-network services	Network: 80% when preauthorized Out-of-network: 60% when preauthorized Night guards are covered if prescribed by a medical doctor for a TMJ disorder. Up to \$2,000/year for combined network and out-of-network services

Covered Expenses	KingCare <sup>SM</sup> Gold	KingCare <sup>SM</sup> Silver	KingCare <sup>SM</sup> Bronze
<i>Transplants (certain services only)</i>	Network: 100% when preauthorized Out-of-network: 70% when preauthorized Medical coverage must have been continuous for more than 12 months under KingCare <sup>SM</sup> before a transplant will be covered.	Network: 100% when preauthorized Out-of-network: 60% when preauthorized Medical coverage must have been continuous for more than 12 months under KingCare <sup>SM</sup> before a transplant will be covered.	Network: 100% when preauthorized Out-of-network: 60% when preauthorized Medical coverage must have been continuous for more than 12 months under KingCare <sup>SM</sup> before a transplant will be covered.
<i>Urgent care (ear infections, high fevers, minor burns, etc.)</i>	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%	Network: 80% Out-of-network: 60%

## Group Health Benefits at a Glance

The following tables show what Group Health pays for covered expenses, depending on whether you have the gold, silver or bronze out-of-pocket expense level. (For important details, be sure to read “How the Healthy Incentives<sup>SM</sup> Program Works” on page 73 and “Knowing What’s Covered and What’s Not” on page 126.)

There’s no coverage for out-of-network care unless it has been indicated and approved/referred.

### Plan Features

The following table identifies some plan features, including copays, out-of-pocket maximums and how benefits are determined for most covered expenses.

Plan Feature	Group Health Gold	Group Health Silver	Group Health Bronze
<i>Provider choice</i>	You choose a Group Health primary care physician (PCP), who provides and coordinates most of your care through the Group Health network; you may also self-refer to Group Health staff specialists. There’s no coverage for out-of-network care unless indicated and approved/referred.		
<i>Annual deductible</i>	None		
<i>Copay, unless otherwise indicated</i>	You pay \$20	You pay \$35	You pay \$50
<i>After copays, the plan pays most covered services at these levels until you reach the annual out-of-pocket maximum</i>	Network: 100% Out-of-network: Limited emergency/out-of-area care		
<i>Annual out-of-pocket maximum</i>	Network: \$1,000/ person or \$2,000/ family Out-of-network: Limited emergency/out-of-area care	Network: \$2,000/ person or \$4,000/ family Out-of-network: Limited emergency/out-of-area care	Network: \$3,000/ person or \$6,000/ family Out-of-network: Limited emergency/out-of-area care
<i>After you reach the annual out-of-pocket maximum, most benefits are paid for the rest of the calendar year at this level</i>	Network only: 100%		
<i>Lifetime maximum</i>	No limit		

## Covered Expenses

The following table summarizes covered services and supplies under Group Health (only medically necessary services, prescription drugs and supplies are covered) and identifies related copays, maximums and limits. (For more details, see “Knowing What’s Covered and What’s Not” on page 126.)

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
<b><i>Alternative care (including medically necessary acupuncture, massage therapy and naturopathy)</i></b>	Self-referrals to a network provider: \$20 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy; except for chiropractic services All other alternative care may require PCP referral.	Self-referrals to a network provider: \$35 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy; except for chiropractic services All other alternative care may require PCP referral.	Self-referrals to a network provider: \$50 copay/visit Up to 8 visits/medical diagnosis/calendar year for acupuncture Up to 3 visits/medical diagnosis/calendar year for naturopathy; except for chiropractic services All other alternative care may require PCP referral.
<b><i>Ambulance services</i></b>	80% (except hospital-to-hospital ground transfers, which are covered at 100% when initiated by Group Health)		
<b><i>Chemical dependency treatment (requires preauthorization)</i></b>	<i>For inpatient care:</i> 100% after \$200 copay/admission <i>For outpatient care:</i> 100% after \$20 copay/visit Up to \$13,500 in 24 consecutive months (maximum subject to annual adjustment)	<i>For inpatient care:</i> 100% after \$400 copay/admission <i>For outpatient care:</i> 100% after \$35 copay/visit Up to \$13,500 in 24 consecutive months (maximum subject to annual adjustment)	<i>For inpatient care:</i> 100% after \$600 copay/admission <i>For outpatient care:</i> 100% after \$50 copay/visit Up to \$13,500 in 24 consecutive months (maximum subject to annual adjustment)
<b><i>Chiropractic care and manipulative therapy (like all services, must be medically necessary)</i></b>	100% after \$20 copay/visit	100% after \$35 copay/visit	100% after \$50 copay/visit
<b><i>Diabetes care training</i></b>	100% after \$20 copay/visit	100% after \$35 copay/visit	100% after \$50 copay/visit
<b><i>Diabetes supplies (insulin, needles, syringes, lancets, etc.)</i></b>	Covered under prescription drugs	Covered under prescription drugs	Covered under prescription drugs
<b><i>Durable medical equipment, prosthetics and orthopedic appliances</i></b>	80% when preauthorized	50% when preauthorized	50% when preauthorized

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
<b>Emergency room care</b>	Network: 100% after \$100 copay/visit (\$100 copay is waived, but \$200 copay/admission for hospital care applies if admitted) Out-of-network: 100% of reasonable and customary expenses after \$150 copay/visit (\$150 copay is waived but \$200 copay/admission for hospital care applies if admitted) <b>Non-emergency care is not covered.</b>	Network: 100% after \$100 copay/visit (\$100 copay is waived, but \$400 copay/admission for hospital care applies if admitted) Out-of-network: 100% of reasonable and customary expenses after \$150 copay/visit (\$150 copay is waived, but \$400 copay/admission for hospital care applies if admitted) <b>Non-emergency care is not covered.</b>	Network: 100% after \$100 copay/visit (\$100 copay is waived, but \$600 copay/admission for hospital care applies if admitted) Out-of-network: 100% of reasonable and customary expenses after \$150 copay/visit (\$150 copay is waived, but \$600 copay/admission for hospital care applies if admitted) <b>Non-emergency care is not covered.</b>
<b>Family planning</b>	100% after \$20 copay/visit <b>Infertility treatment is not covered.</b>	100% after \$35 copay/visit <b>Infertility treatment is not covered.</b>	100% after \$50 copay/visit <b>Infertility treatment is not covered.</b>
<b>Growth hormones</b>	Covered under prescription drugs if medical coverage has been continuous for more than 12 months under this plan whether or not the growth disorder existed before plan coverage		
<b>Hearing aids</b>	100%, up to \$300/ear in 36 months		
<b>Home health care</b>	100%		
<b>Hospice care</b>	100% when preauthorized Certain limits apply; call plan for details.		
<b>Hospital care</b>	100% after \$200 copay/admission	100% after \$400 copay/admission	100% after \$600 copay/admission
<b>Inpatient care alternatives</b>	100% when preauthorized		
<b>Lab, X-ray and other diagnostic testing</b>	100%		
<b>Maternity care</b>	<i>For delivery and related hospital care:</i> 100% after \$200 copay/admission <i>For prenatal and postpartum care:</i> 100% after \$20 copay/visit	<i>For delivery and related hospital care:</i> 100% after \$400 copay/admission <i>For prenatal and postpartum care:</i> 100% after \$35 copay/visit	<i>For delivery and related hospital care:</i> 100% after \$800 copay/admission <i>For prenatal and postpartum care:</i> 100% after \$50 copay/visit
<b>Mental health care (when deemed appropriate, 2 unused outpatient visits may be traded for 1 inpatient day, or vice versa; requires preauthorization)</b>	<i>For inpatient care:</i> 100% after \$200 copay per admission, up to 12 days/year <i>For outpatient care:</i> 100% after \$20 copay/individual, family, couple or group session, up to 20 visits/year	<i>For inpatient care:</i> 100% after \$400 copay per admission, up to 12 days/year <i>For outpatient care:</i> 100% after \$35 copay/individual, family, couple or group session, up to 20 visits/year	<i>For inpatient care:</i> 100% after \$600 copay per visit, up to 12 days/year <i>For outpatient care:</i> 100% after \$50 copay/individual, family, couple or group session, up to 20 visits/year

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
<b>Neurodevelopmental therapy for dependents age 6 and under</b>	<i>For inpatient care:</i> 100% after \$200 copay/admission, up to 60 days/year (combined with rehabilitative services) <i>For outpatient care:</i> 100% after \$20 copay/visit, up to 60 visits/year (combined with rehabilitative services)	<i>For inpatient care:</i> 100% after \$400 copay/admission, up to 60 days/year (combined with rehabilitative services) <i>For outpatient care:</i> 100% after \$35 copay/visit, up to 60 visits/year (combined with rehabilitative services)	<i>For inpatient care:</i> 100% after \$600 copay/admission, up to 60 days/year (combined with rehabilitative services) <i>For outpatient care:</i> 100% after \$50 copay/visit, up to 60 visits/year (combined with rehabilitative services)
<b>Out-of-area coverage—for example, while traveling or for your children away at school</b>	Reciprocal benefits are available through Kaiser Permanente and affiliated HMOs; otherwise, only emergency services are covered out of area.		
<b>Phenylketonuria (PKU) formula</b>	100%		
<b>Physician and other medical/surgical services</b>	<i>For inpatient care:</i> 100% <i>For outpatient care:</i> 100% after \$20 copay/office visit	<i>For inpatient care:</i> 100% <i>For outpatient care:</i> 100% after \$35 copay/office visit	<i>For inpatient care:</i> 100% <i>For outpatient care:</i> 100% after \$50 copay/office visit
<b>Prescription drugs—Up to a 30-day supply through network pharmacies</b>	Generic: 100% after \$10 copay Preferred brand: 100% after \$20 copay Non-preferred brand: 100% after \$30 copay Growth hormones: 100% There's no reimbursement for prescriptions filled at out-of-network or out-of-area pharmacies.		
<b>Prescription drug—Up to a 90-day supply through mail-order network only</b>	Generic: 100% after \$20 copay Preferred brand: 100% after \$40 copay Non-preferred brand: 100% after \$60 copay		
<b>Preventive care (well-child check-ups, immunizations, routine health and hearing exams. etc.)</b>	100% after \$20 copay/visit (according to well-child/adult preventive schedule)	100% after \$35 copay/visit (according to well-child/adult preventive schedule)	100% after \$50 copay/visit (according to well-child/adult preventive schedule)
<b>Radiation therapy, chemotherapy and respiratory therapy</b>	100% after \$20 copay/visit	100% after \$35 copay/visit	100% after \$50 copay/visit
<b>Reconstructive services (includes benefits for mastectomy-related services; reconstruction and surgery to achieve symmetry between the breasts, prostheses and complications resulting from mastectomy, including lymphedema) Call plan for more information.</b>	100% depending on services provided; copays may apply (including \$200 copay/admission if hospital care is required)	100% depending on services provided; copays may apply (including \$400 copay/admission if hospital care required)	100% depending on services provided; copays may apply (including \$600 copay/admission if hospital care required)

Covered Expenses	Group Health Gold	Group Health Silver	Group Health Bronze
<b>Rehabilitative services— Inpatient and outpatient</b>	<p><i>For inpatient care:</i> 100% after \$200 copay/admission, up to 60 days/calendar year (combined with neurodevelopmental therapy)</p> <p><i>For outpatient care:</i> 100% after \$20 copay/visit for outpatient services, up to 60 visits/calendar year (combined with neurodevelopmental therapy)</p>	<p><i>For inpatient care:</i> 100% after \$400 copay/admission, up to 60 days/calendar year (combined with neurodevelopmental therapy)</p> <p><i>For outpatient care:</i> 100% after \$35 copay/visit, up to 60 visits/calendar year (combined with neurodevelopmental therapy)</p>	<p><i>For inpatient care:</i> 100% after \$600 copay/admission, up to 60 days/calendar year (combined with neurodevelopmental therapy)</p> <p><i>For outpatient care:</i> 100% after \$50 copay/visit, up to 60 visits/calendar year (combined with neurodevelopmental therapy)</p>
<b>Skilled nursing facility</b>	100% up to 60 days/calendar year at a Group Health-approved nursing facility		
<b>Smoking cessation</b>	<p>100% for one Group Health network provider program/calendar year</p> <p>One course of nicotine replacement/calendar year (prescription benefit copay applies) when prescribed by Group Health PCP if the member is actively participating in the Free and Clear Program</p> <p>No lifetime limit</p>		
<b>Temporomandibular joint (TMJ) disorders</b>	<p><i>For inpatient care:</i> 100% after \$200 copay/admission</p> <p><i>For outpatient care:</i> 100% after \$20 copay/visit</p> <p>Up to \$1,000/calendar year and a \$5,000 lifetime maximum</p>	<p><i>For inpatient care:</i> 100% after \$400 copay/admission</p> <p><i>For outpatient care:</i> 100% after \$35 copay/visit</p> <p>Up to \$1,000/calendar year and a \$5,000 lifetime maximum</p>	<p><i>For inpatient care:</i> 100% after \$600 copay/admission</p> <p><i>For outpatient care:</i> 100% after \$50 copay/visit</p> <p>Up to \$1,000/calendar year and a \$5,000 lifetime maximum</p>
<b>Transplants (certain services only)</b>	<p>100% after applicable copays</p> <p>Medical coverage must have been continuous for more than 12 months under this plan before a transplant will be covered.</p>		
<b>Urgent care (ear infections, high fevers, minor burns)</b>	100% after \$20 copay/visit	100% after \$35 copay/visit	100% after \$50 copay/visit
<b>Vision exams</b>	100% after \$20 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)	100% after \$35 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)	100% after \$50 copay/visit, up to 1 exam/person in 12 consecutive months (Group Health covers exams only; your separate Vision Service Plan covers eye exams, prescription lenses and frames)

## KINGCARE<sup>SM</sup>

To make the most out of the benefits available under KingCare<sup>SM</sup>, you need to understand how the plan works.

### Accessing Care

When you're enrolled in KingCare<sup>SM</sup>, you may receive network benefits or out-of-network benefits. The level of coverage depends on the provider you see.

To receive network benefits:

- you must choose an Aetna network provider;
- for certain procedures and services, your network provider obtains preauthorization from Aetna;
- your provider files your claims, and Aetna reimburses the provider;
- you receive an explanation of benefits (EOB) from Aetna, informing you of applicable deductibles, coinsurance and copays, and indicating your share of the cost; and
- you receive a bill from your provider, and you pay the provider the amount indicated on the EOB.

To receive out-of-network benefits:

- you choose an out-of-network provider;
- you must obtain preauthorization from Aetna for certain procedures and services (For more information, see "Preauthorization" on page 89);
- you pay the bill in full and file a claim for reimbursement from Aetna;
- Aetna reimburses you based on the out-of-network benefit at reasonable and customary rates (For important details about reasonable and customary charges, see "Reasonable and Customary (R&C) Charges" on page 88); and
- you're responsible for paying any amount in excess of the R&C rates.

### Network Providers

Aetna has a nationwide network of health care providers and is solely responsible for determining which providers participate in its network.

All network hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations and have a current state license, as well as adequate liability insurance. Physicians and other health care professionals meet credentialing requirements, including completion of a detailed application that covers education, status of board certification, malpractice and state sanction histories.

#### WHAT KINGCARE<sup>SM</sup> PAYS FOR NETWORK CARE

For details on what KingCare<sup>SM</sup> pays when you see network providers, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.

You may select a network provider by contacting Aetna or visiting [www.kingcare.com](http://www.kingcare.com). If you already have a provider, you may check with Aetna to see if your provider is part of the Aetna network. **You're responsible for determining whether a provider is a member of the Aetna network or is an out-of-network provider.**

## Out-of-Network Providers

Aetna's network of health care providers and pharmacies is nationwide. As a result, even when you're out of the area, you may use network providers and pharmacies to receive network coverage almost anywhere in the United States.

You may also use out-of-network providers. However, when you choose out-of-network providers, you must file your own claims.

- For medical claims, you're reimbursed at reasonable and customary rates. (For important details about reasonable and customary charges, see "Reasonable and Customary (R&C) Charges" on page 88.)
- For prescription drug claims, you're reimbursed at the rates Express Scripts pays its network pharmacies, and you pay amounts that out-of-network providers or pharmacies charge in excess of these rates.

## If Your Dependent Lives Away from Home

Dependents living away from home may use any network provider or pharmacy and receive the same coverage as if they were living at home.

If a dependent uses an out-of-network provider or pharmacy, you'll need to file a claim for reimbursement on behalf of your dependent.

- For medical claims, you're reimbursed at reasonable and customary rates. (For important details about reasonable and customary charges, see "Reasonable and Customary (R&C) Charges" on page 88.)
- For prescription drug claims, you're reimbursed at the rates Express Scripts pays its network pharmacies, and you pay amounts that out-of-network providers or pharmacies charge in excess of these rates.

## Paying for Your Care

Network providers have agreed to provide care at negotiated rates. This means that the dollar amount you pay for your share of covered expenses when you see a network provider is generally lower than what you'll pay when you use an out-of-network provider.

The following describes the basic cost-sharing features of KingCare<sup>SM</sup> with respect to how benefits are paid.

### WHAT KINGCARE<sup>SM</sup> PAYS FOR OUT-OF-NETWORK CARE

For details on what KingCare<sup>SM</sup> pays for out-of-network care, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.

## IMPORTANT!

The amount you pay toward your deductible during the last three months of any calendar year will also apply toward the following year's deductible.

### Deductible

The “annual deductible” is the amount you must pay each year toward covered expenses before Aetna begins paying. The KingCare<sup>SM</sup> annual deductibles are as follows:

- KingCare<sup>SM</sup> Gold: \$100/person, \$300/family;
- KingCare<sup>SM</sup> Silver: \$300/person, \$900/family; and
- KingCare<sup>SM</sup> Bronze: \$500/person, \$1,500/family.

The deductible doesn't apply to certain covered services and supplies, including prescription drugs (which require copays), preventive care and hearing aids.

### *Family Deductible*

If three or more dependents (including yourself) together incur the total value of the family deductible for the plan in which you're enrolled, no further deductible will be required from any dependent for the rest of that year.

If you and your dependents are in the same accident, individual deductibles will be applied until the family deductible is met.

### Coinsurance

After you've met your annual deductible, you begin paying a percentage—“coinsurance”—of the allowed amount for most medical services and supplies until you reach the annual out-of-pocket maximum. Coinsurance doesn't apply to prescription drugs. (For details, see “Covered Expenses” on page 94.)

### Copay

You pay copays for prescription drugs at the time you receive your prescription. Copays don't apply to medical services other than emergency room care. (For details, see “Covered Expenses” on page 94.)

### Reasonable and Customary (R&C) Charges

“Reasonable and customary charges” are the allowable charges that Aetna will pay for medical services by contract with providers in its network. Rates are consistent with those normally charged by the provider for the same services or supplies and within the general range of rates charged by other providers in the same area for the same services or supplies. When you use a network provider, you pay only the coinsurance on the allowable charges. When you use an out-of-network provider, Aetna pays the allowable charges it would pay a network provider, and you pay the difference.

## Annual Out-of-Pocket Maximum

The “annual out-of-pocket maximum” is the most you pay in coinsurance for covered medical expenses each year. Once you reach your annual out-of-pocket maximum, KingCare<sup>SM</sup> pays 100% for most covered expenses for the rest of that year. If you have three or more dependents (including yourself), each dependent’s covered expenses accumulate toward the family out-of-pocket maximum.

The following don’t apply to the annual out-of-pocket maximum:

- amounts in excess of reasonable and customary (R&C) charges;
- annual deductible;
- charges above benefit maximums;
- copays for emergency room care and prescription drugs; and
- expenses not covered under KingCare<sup>SM</sup>.

## Lifetime Maximum

The “lifetime maximum” is the maximum benefit amount you may receive from KingCare<sup>SM</sup> during the course of your lifetime. The lifetime maximum applies only to medical services; there is no lifetime maximum for prescription drugs.

The lifetime maximum under KingCare<sup>SM</sup> is \$2,000,000 per covered person. Up to \$20,000 of this maximum is restored automatically at the beginning of each calendar year for benefits paid during the previous year. Some expenses are also subject to annual or lifetime benefit limits. (For more information, see “Covered Expenses” on page 94.)

## Other Features of KingCare<sup>SM</sup>

It’s important to understand other features of KingCare<sup>SM</sup> such as preauthorization, second opinions, case management and health care management. Having a better understanding of how the plan works will enable you to use the plan wisely and take advantage of all the benefits that the plan has to offer.

## Preauthorization

If you see a network provider, he/she will obtain preauthorization for your care as required by Aetna. In this case, benefits will be paid according to plan provisions and limits. Aetna will confirm the preauthorization in writing. It will be valid for three months, if your condition doesn’t change.

If you see an out-of-network provider, you must call Aetna for preauthorization or ask your physician to call Aetna on your behalf. You may then call Aetna to see if your physician followed through on your behalf.

If you see an out-of-network provider, you must obtain preauthorization from Aetna for the following covered services:

- anorexiant for treatment of attention deficit disorder or narcolepsy;
- durable medical equipment;
- growth hormones (billed through Aetna);
- home health care;
- hospice care;
- injectable prescription drugs, with certain exceptions such as insulin, Depo-Provera and some others (billed through Aetna);
- 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 that the procedure is medically necessary and that a physician-supervised weight management and exercise program has been successfully completed);
- orthognathic surgeries (to correct jaw abnormalities or malocclusions when medically necessary);
- skilled nursing facility care;
- TMJ disorders; and
- transplants.

Whether you see a network or an out-of-network provider, Aetna must be notified at least seven days before you have surgery or are admitted to a hospital on a non-emergency basis, except for childbirth. Before your admission, be sure to confirm with the hospital that your stay has been preauthorized.

You must call Aetna within 48 hours from the beginning of your admission, or as soon as reasonably possible, for:

- accidents;
- emergencies, including detoxification;
- involuntary commitment to a Washington State mental hospital; and
- maternity admissions.

To obtain preauthorization for non-emergency care or to obtain certification afterward, ask your physician to contact Aetna.

When calling Aetna, be prepared to supply these details:

- admission date;
- diagnosis or surgery;
- employer name (King County);
- employee name and unique identifying number assigned by KingCare<sup>SM</sup>;
- hospital name and address or phone number;
- patient name, address and birth date;
- physician name and address or phone number; and
- proposed treatment plan, including length of stay and discharge planning needs.

If your care isn't preauthorized as just described and Aetna determines that your care wasn't medically necessary, KingCare<sup>SM</sup> may pay only a portion of the charges or none at all.

(For information on preauthorization for prescription drugs, see "Using Your Prescription Drug Plan" on page 114.)

## Second Opinions

On occasion, you may want a second opinion from another physician regarding a medical diagnosis or treatment plan. To receive network benefits, you must obtain the second opinion from an Aetna network provider. At any point, you may decide to see an out-of-network provider and receive out-of-network benefits.

## Case Management

Aetna may offer or approve other medical options on a case-by-case basis when the options are determined to be medically necessary, effective and cost-effective. These alternative options will be approved only when traditional benefits would otherwise be available under KingCare<sup>SM</sup>—for example, when provided at equal or lesser cost, benefits could be available for home health care, instead of hospitalization or other institutional care, by a licensed home health, hospice or home care agency. The amount of coverage for approved alternative options will not exceed the amount that would otherwise be available for approved traditional benefits.

Less expensive or less intensive services will be approved for alternative options only with your consent and when your physician confirms that the services are adequate. Aetna may require an approved written treatment plan.

## Health Care Management

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

### IMPORTANT!

**The decision to offer or approve other benefit options remains with Aetna and will be determined based on individual medical needs.**

## IMPORTANT!

You can contact Informed Health® Line at 1-800-556-1555.

### Informed Health® Line

You may talk to a registered nurse 24 hours a day to get information on a variety of health and wellness topics.

You may 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 any time during the call.

In addition, you may access Healthwise® Knowledgebase, Aetna's database of health information, through Aetna Navigator™ at the KingCare<sup>SM</sup> member Web site: [www.kingcare.com](http://www.kingcare.com).

### Aexcel<sup>SM</sup> Specialty Network

Aexcel<sup>SM</sup> specialty network providers meet certain standards for effectiveness and cost-efficiency in the following medical disciplines:

- cardiology;
- cardiothoracic surgery;
- gastroenterology;
- general surgery;
- obstetrics/gynecology;
- orthopedic surgery
- otolaryngology
- neurology;
- neurosurgery;
- plastic surgery;
- urology; and
- vascular surgery.

You may locate Aexcel<sup>SM</sup> physicians by calling Aetna or by using Aetna Navigator™ DocFind® at the KingCare<sup>SM</sup> member Web site—[www.kingcare.com](http://www.kingcare.com)—where Aexcel<sup>SM</sup> physicians are identified with a blue star. (See *Contact Information*.)

### Disease Management

If you're a patient with coronary artery disease, chronic heart failure or diabetes, you may receive:

- information on and education about your disease;
- access to a case management nurse;
- help following your physician's treatment plan;
- help managing illness-related depression;

- assistance getting some medical equipment; and
- tools, programs and resources to improve your quality of life.

You may enroll for disease management services by calling Aetna or using Aetna Navigator™ at the KingCare<sup>SM</sup> member Web site: [www.kingcare.com](http://www.kingcare.com). You may also enroll by being referred by a physician or an Enhanced Member Outreach nurse. Aetna has a contract with LifeMasters to provide disease management services. (See *Contact Information*.)

### Enhanced Member Outreach

You may receive additional support for health conditions through Aetna's Enhanced Member Outreach. 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 that you have access to up-to-date treatment;
- help you follow your treatment plan;
- address emerging health issues early and effectively; and
- provide coaching and education about your benefit plan, available programs and tools.

### MedQuery®

MedQuery® keeps your physician informed of the best practice treatments for a wide variety of conditions such as diabetes, coronary artery disease and influenza. As a result, your physician may update your treatment to ensure that you're getting the best care.

## Knowing What's Covered and What's Not

It's possible that some medical treatments may not be covered under KingCare<sup>SM</sup>. To make decisions about the health care you receive, you should know which treatments are covered and which are not. Ultimately, the claims administrator will be responsible for informing you if a medical service or supply isn't covered. The following provides guidelines of what is considered a "covered expense" and an "uncovered expense."

#### IMPORTANT

There is no preexisting condition limit for medical or prescription drug services. However, there is a waiting period for transplants. (For more information, see "Transplants" on page 106.)

If you end employment with King County, refer to "Certificate of Coverage" for information on how your participation in KingCare<sup>SM</sup> can be credited against other plans with preexisting condition limits.

#### WHAT KINGCARE<sup>SM</sup> PAYS FOR CARE

For specific coinsurance and copays for the covered expenses described in this section, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.

## IMPORTANT!

See "Glossary" on page 191 for the definition of "medically necessary."

## Covered Expenses

Only medically necessary services, supplies and prescription drugs are covered.

### Alternative Care

Covered services, which must be medically necessary and/or prescribed by a health care provider, include:

- acupuncture;
- hypnotherapy services performed by a covered mental health provider specified under "Mental Health Care"; and
- massage therapy prescribed by a physician.

You're eligible to receive a total of 60 covered alternative care visits/year. This may include any combination of acupuncture, hypnotherapy and/or massage therapy visits.

(For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

### Ambulance Services

KingCare<sup>SM</sup> covers medically necessary emergency ground or air ambulance services to a network facility or the nearest facility where appropriate care is covered. (For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

### Chemical Dependency Treatment

Covered inpatient and outpatient chemical dependency treatment includes:

- detoxification services;
- diagnostic evaluation and education;
- organized individual and group counseling; and
- prescription drugs.

Aetna network providers obtain preauthorization for chemical dependency treatment as necessary. If you see an out-of-network provider, you must obtain preauthorization from Aetna for inpatient chemical dependency treatment. (For details, see "Preauthorization" on page 89.) Chemical dependency benefits are covered up to the maximum described in "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.

For additional counseling and referral services, you may also contact the Making Life Easier Program. (For more information, see *Contact Information*.)

Aetna processes claims for prescription drugs used during inpatient hospitalization. Express Scripts processes claims for outpatient retail pharmacy and mail-order drugs. (For details about prescription drug coverage, see "Using Your Prescription Drug Plan" on page 114 and "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

## Chiropractic Care and Manipulative Therapy

KingCare<sup>SM</sup> covers the services of licensed chiropractors for the diagnosis and treatment of musculoskeletal disorders, including:

- diagnostic lab services directly related to the spinal care treatment you're receiving;
- full spinal X-rays; and
- non-invasive spinal manipulations.

(For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

## Diabetes Care Training

KingCare<sup>SM</sup> covers diabetes care training when prescribed by and supervised by your physician as part of a self-care program. The program must consist of services recognized by health care professionals and be designed to educate you about specific conditions and any lifestyle changes necessary as a result of your diabetes condition. Reasonable charges include individual or group educational services, tuition, supplies and appropriate diagnostic services. (For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

## Durable Medical Equipment, Prosthetics and Orthopedic Appliances

Durable medical equipment is covered if it:

- is designed for prolonged use;
- has a specific therapeutic purpose in treating an illness or injury;
- is prescribed by your physician; and
- is primarily and customarily used for medical purposes only.

Network providers will obtain preauthorization for your care as necessary. If you see an out-of-network provider, you must obtain preauthorization from Aetna. (For details, see "Preauthorization" on page 89. For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

**Medical Services.** KingCare<sup>SM</sup> covers the following durable medical equipment:

- artificial limbs or eyes, including implant lenses prescribed by your physician and required as the result of cataract surgery or to replace a missing portion of the eye;
- casts, splints, crutches, trusses and braces;
- diabetes equipment, excluding batteries, for home testing and insulin administration not covered under the prescription drug benefit (For details about prescription drug coverage, see "Using Your Prescription Drug Plan" on page 114);

### IMPORTANT!

Some chiropractic services aren't covered. (For details, see "Expenses Not Covered" on page 108.)

- initial external prosthesis and bra necessitated by breast surgery and replacement of these items when required by normal wear, a change in medical condition or additional surgery;
- oxygen and rental equipment for its administration;
- penile prosthesis, with a lifetime maximum of two prostheses, when impotence is caused by a covered medical condition, a complication directly resulting from a covered surgery, or an injury to the genitalia or spinal cord, and other accepted treatment has been unsuccessful;
- rental or purchase, as decided by Aetna, of durable medical equipment such as wheelchairs, hospital beds and respiratory equipment (combined rental fees may not exceed full purchase price); and
- wig or hairpiece to replace hair lost due to radiation therapy or chemotherapy for a covered condition, up to a lifetime maximum of \$100.

**Prescription Drug Services.** Some durable medical equipment is covered through Express Scripts. (For more information, see “Using Your Prescription Drug Plan” on page 114.)

### Emergency Room Care

Emergency room treatment is covered only for medical conditions that threaten loss of life or limb or may cause serious harm to the patient’s health if not done immediately. Examples of conditions that might require emergency room care include, but are not limited to:

- chest pain;
- convulsions;
- major burns;
- severe breathing problems;
- unconsciousness or confusion, especially after a head injury; and
- uncontrollable bleeding.

If you need emergency room care, follow these steps:

- Call 911 or go to the nearest hospital emergency room immediately.
- When you arrive, show your medical plan ID card.
- If possible, call Aetna within 48 hours using the phone number printed on the front of your ID card; otherwise, you may receive a reduced benefit.
- If you’re incapable of calling Aetna, ask a friend, relative or hospital staff member to call for you.

If you have a medical emergency as determined by KingCare<sup>SM</sup>, you’ll receive the network level of benefits whether you receive network or out-of-network care. (For plan benefits, see “KingCare<sup>SM</sup> Benefits at a Glance” on page 75.) If your condition doesn’t qualify as a medical emergency but care is urgently needed, see “Urgent Care” on page 108 for a description of coverage.

## Family Planning

**Medical Services.** KingCare<sup>SM</sup> covers the following family planning services:

- insertion of intrauterine birth control devices (IUDs);
- tubal ligation;
- vasectomy; and
- voluntary termination of pregnancy (abortion).

(For plan benefits, see “KingCare<sup>SM</sup> Benefits at a Glance” on page 75.)

**Prescription Drug Services.** Birth control pills and devices requiring a prescription are covered and processed by Express Scripts. (For plan benefits, see “KingCare<sup>SM</sup> Benefits at a Glance” on page 75.)

## Growth Hormones

Growth hormones are covered for certain medical conditions and must be preauthorized whether you receive network or out-of-network care. If you receive this drug from your physician, he/she will bill Aetna for the drug and its administration. If you obtain the drug from a retail pharmacy or mail-order service, Express Scripts pays for the drug and Aetna pays for administration by your physician, if needed. (For plan benefits, see “KingCare<sup>SM</sup> Benefits at a Glance” on page 75.)

## Hearing Aids

Hearing aids, including fitting, rental and repair, are covered. (For plan benefits, see “KingCare<sup>SM</sup> Benefits at a Glance” on page 75.)

## Home Health Care

Home health care services are covered if care:

- takes the place of a hospital stay;
- is part of a home health care plan; and
- is provided and billed by an organization licensed as a home health care agency by the state of Washington.

Network providers obtain preauthorization for your care as necessary. If you see an out-of-network provider for home health care, you must obtain preauthorization from Aetna. (For details, see “Preauthorization” on page 89.)

Covered services include:

- nursing care;
- occupational therapy;
- physical therapy;
- respiratory therapy;

### IMPORTANT!

**Some family planning services aren't covered. (For details, see “Expenses Not Covered” on page 108.)**

### IMPORTANT!

**Some home health care services aren't covered. (For details, see “Expenses Not Covered” on page 108.)**

- restorative therapy; and
- speech therapy (restorative only).

Services and prescription drugs provided and billed by a home infusion therapy company are also covered if the company is licensed by the state as a home health care agency. The prescription drug claims are processed by Express Scripts when they're filled at a retail pharmacy or through the mail-order service. (For details, see "Using Your Prescription Drug Plan" on page 114.)

(For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

### Hospice Care

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

Hospice care services are covered up to six months if care:

- takes the place of a hospital stay;
- is part of a hospice care treatment plan; and
- is provided and billed by an organization licensed as a hospice by the state of Washington.

Network providers obtain preauthorization for your care as necessary. If you see an out-of-network provider for hospice care, you must obtain preauthorization from Aetna. (For details, see "Preauthorization" on page 89.)

Covered services include:

- drugs and medications (Aetna processes claims for prescription drugs provided by the hospice during the course of medical treatment, and Express Scripts processes claims for retail pharmacy and mail-order drugs. For details, see "Using Your Prescription Drug Plan" on page 114);
- emotional support services;
- family bereavement services;
- home health services;
- homemaker services, if appropriate to patient's direct care;
- inpatient hospice care;
- physician services; and
- respite care for dependents providing care for the patient.

An extension of these benefits beyond the six-month lifetime maximum may be granted if Aetna receives a written request from your physician. (For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

#### IMPORTANT!

**Some hospice care services aren't covered. (For details, see "Expenses Not Covered" on page 108.)**

## Hospital Care

**Inpatient Care.** Covered inpatient hospital care includes:

- hospital services such as:
  - anesthesia and related supplies administered by hospital staff;
  - artificial kidney treatment;
  - blood, blood plasma and blood derivatives;
  - drugs provided by the hospital in the course of medical treatment;
  - electrocardiograms;
  - operating rooms, recovery rooms, isolation rooms and cast rooms;
  - oxygen and its administration;
  - physiotherapy and hydrotherapy;
  - splints, casts and dressings;
  - X-ray, radium and radioactive isotope therapy; and
  - X-ray and lab exams;
- intensive care or coronary care units;
- newborn nursery care after covered childbirth, including circumcision; and
- semi-private room, patient meals and general nursing care (private room charges are covered only up to the hospital's semi-private room rate).

Network providers obtain preauthorization for your care as necessary. If you see an out-of-network provider, you must obtain preauthorization from Aetna for inpatient care other than that necessary for up to 48 hours following a vaginal childbirth or 96 hours following a cesarean section. (For details, see "Preauthorization" on page 89.)

If a hospital stay continues from one calendar year to the next, a second deductible isn't required for further treatment before discharge. Coverage continues at 100% until discharge, if the out-of-pocket maximum is met for the year in which hospitalization began.

(For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

**Outpatient Care.** Covered outpatient care includes:

- diagnostic and therapeutic nuclear medicine in a hospital setting;
- hospital outpatient chemotherapy to treat malignancies;
- outpatient surgery; and
- surgery in an ambulatory surgical center in place of inpatient hospital care.

(For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

### IMPORTANT!

Some inpatient care services aren't covered. (For details, see "Expenses Not Covered" on page 108.)

## IMPORTANT!

Some infertility-related expenses aren't covered. (For details, see "Expenses Not Covered" on page 108.)

### Infertility

Covered infertility expenses include:

- embryo transfer;
- intrauterine and intravaginal artificial insemination; and
- in vitro fertilization.

(For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

### Injury to Teeth

The services of a licensed dentist are covered for repair of accidental injury to sound, natural teeth. Injuries caused by biting or chewing are not covered. Treatment must begin within 30 days of the accident, and all services must be provided within 12 months of the date of injury. (For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

### Inpatient Care Alternatives

Your physician may develop a written treatment plan for care in an equally or more cost-effective setting than a hospital or skilled nursing facility. If the alternative setting plan is approved by Aetna, all hospital or skilled nursing facility benefit terms, maximums and limits apply to the inpatient care alternatives, depending on the kind of care the alternative is intended to replace. (For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

### Jaw Abnormalities

Surgical corrections of jaw abnormalities, or malocclusions, are covered when medically necessary. (For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

### Lab, X-ray and Other Diagnostic Testing

Covered services include:

- lab or X-ray services such as ultrasound, nuclear medicine and allergy testing;
- screening and diagnostic procedures during pregnancy, as well as related genetic counseling when medically necessary for prenatal diagnosis of congenital disorders; and
- services provided by a physician or licensed optometrist to diagnose or treat medical conditions of the eye (eyewear and routine vision exams and tests for vision sharpness are covered under your vision plan).

(For routine screenings, such as hearing tests and mammograms, see "Preventive Care" on page 104. For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

## Maternity Care

Maternity care is covered if provided by:

- a physician or registered nurse whose specialty is midwifery; or
- a midwife licensed by the State of Washington.

Covered maternity care includes:

- complications of pregnancy or delivery;
- hospitalization and delivery, including home births and licensed birthing centers for low-risk pregnancies;
- postpartum care;
- pregnancy care;
- related genetic counseling when medically necessary for prenatal diagnosis of congenital disorders; and
- screening and diagnostic procedures during pregnancy.

(For plan benefits, see “KingCare<sup>SM</sup> Benefits at a Glance” on page 75.)

### HOSPITAL STAYS AND FEDERAL LAW

Group medical plans and health insurers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally doesn't prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or newborn earlier than 48 hours or 96 hours, as applicable. In any case, plans and insurers may not require a provider to obtain authorization for prescribing a stay that doesn't exceed 48 hours or 96 hours, as applicable.

You don't need to preauthorize the length of stay unless it exceeds the 48- or 96-hour rule.

## Mental Health Care

Mental health care services are covered at the same coinsurance rates as other medical care.

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.

### IMPORTANT!

**Some maternity-related expenses aren't covered. (For details, see “Expenses Not Covered” on page 108.)**

### IMPORTANT!

**Some mental health services aren't covered. (For details, see “Expenses Not Covered” on page 108.)**

For additional counseling and referral services, you may also call the Making Life Easier Program. (See *Contact Information*.)

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; and
- psychological testing.

(For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

Depending on individual medical needs, other benefit options may be available under the KingCare<sup>SM</sup> case management program. (For more information, see "Case Management" on page 91.)

Network providers obtain preauthorization for your care as necessary. If you see an out-of-network provider, you must obtain preauthorization from Aetna for inpatient mental health care. (For details, see "Preauthorization" on page 89.)

### **Naturopathy**

KingCare<sup>SM</sup> covers the following services:

- immunization agents or biological sera, such as allergy serum;
- medical care in the provider's office;
- nutritional counseling by a licensed nutritionist or dietitian when medically necessary for disease management;
- physician services for surgery and anesthesia, and home, office, hospital and skilled nursing facility visits; and
- second opinions obtained before treatment (the provider giving the second opinion must be qualified, either through experience or specialist training); a second opinion may be required to confirm the medical necessity of a proposed surgery or treatment plan.

### **Neurodevelopmental Therapy**

KingCare<sup>SM</sup> covers inpatient and outpatient neurodevelopmental therapy for covered dependents age six and younger.

Neurodevelopmental therapy services are covered only if the care is:

- furnished by providers authorized to deliver occupational therapy, speech therapy and physical therapy;

- prescribed by the patient's physician, and
- provided because significant deterioration in the child's condition would result without such services, or to restore and improve the child's ability to function.

Network providers obtain preauthorization for your care as necessary. If you see an out-of-network provider you must obtain preauthorization for inpatient neurodevelopmental therapy. (For details, see "Preauthorization" on page 89. For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

### Newborn Care

KingCare<sup>SM</sup> covers newborns under the mother's health plan for the first three weeks, as required by Washington State law. (For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.) To continue the newborn's coverage after three weeks, the newborn must be eligible and enrolled within 60 days of birth. (For information about enrolling newborns, see "Adding Eligible Dependents" on page 55.)

### Obesity Surgery

Obesity surgery or other procedures, treatment or services such as gastric intestinal bypass surgery are covered only if proven medically necessary per the Aetna Policy Coverage Bulletin. You must obtain preauthorization for this coverage. (For details, see "Preauthorization" on page 89.) However, successful completion of a physician-supervised weight management and exercise program is required before you can obtain preauthorization. (For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

### Phenylketonuria (PKU) Formula

KingCare<sup>SM</sup> covers the medical dietary formula that treats PKU. Claims are processed through Aetna. (For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

### Physician and Other Medical/Surgical Services

KingCare<sup>SM</sup> covers the following services:

- immunization agents or biological sera, such as allergy serum;
- medical care in the provider's office;
- nutritional counseling by a licensed nutritionist or dietitian when medically necessary for disease management;
- physician services for surgery and anesthesia, and home, office, hospital and skilled nursing facility visits; and
- second opinions obtained before treatment (the provider giving the second opinion must be qualified, either through experience or specialist training); a second opinion may be required to confirm the medical necessity of a proposed surgery or treatment plan.

(For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

#### IMPORTANT!

**You must successfully complete a physician-supervised weight management and exercise program before you can obtain preauthorization for obesity surgery.**

## Prescription Drugs

Information about your prescription drug coverage is available under “Using Your Prescription Drug Plan” on page 114.

## Preventive Care

KingCare<sup>SM</sup> covers the following preventive care services:

- breast exams, pelvic exams and Pap tests every year for women;
- mammograms every year for women over 40, or as determined by a provider for high-risk patients;
- cervical screening every year;
- diagnostic screening for prostate cancer as recommended by a physician, registered nurse or physician assistant; annual exams are recommended at age 40 and older;
- cholesterol screening every 5 years for men 35 and older, and every 5 years for women 45 and older;
- immunizations, including annual flu shots (immunizations for travel are not covered); and
- routine physicals and hearing tests.

Immunizations, 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. Before scheduling a routine physical, confirm with Aetna that your physical will be covered.

Age	Preventive Care
<b>Birth to 1 year</b>	Routine newborn care plus 7 well-baby office exams
<b>1-2 years</b>	2 well-child exams
<b>2- 5 years</b>	3 well-child exams, with 1 exam in each of these age groups: 2–3, 3–4, 4–5
<b>6 - 12 years</b>	7 well-child exams, with 1 exam per year
<b>13 - 17 years</b>	5 well-teen exams, with 1 exam per year
<b>18 - 25 years</b>	1 well-adult exam every 2 years
<b>26 - 49 years</b>	1 well-adult exam every 2 years
<b>50–64 years</b>	1 well-adult exam every 2 years
<b>65 years and older</b>	1 well-adult exam every year

(For plan benefits, see “KingCare<sup>SM</sup> Benefits at a Glance” on page 75.)

## Radiation Therapy, Chemotherapy and Respiratory Therapy

Inpatient and outpatient services are covered for medically necessary radiation, chemotherapy and respiratory therapy when prescribed by your physician. (For plan benefits, see “KingCare<sup>SM</sup> Benefits at a Glance” on page 75.)

## Reconstructive Services

Reconstructive surgery to improve or restore bodily function is covered, subject to Aetna’s review and approval. KingCare<sup>SM</sup> covers cosmetic surgery to improve physical appearance only if it’s medically necessary.

KingCare<sup>SM</sup> covers the following services if the patient is receiving benefits for a mastectomy and elects breast reconstruction in connection with the mastectomy, as determined in consultation with the attending physician:

- prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas;
- reconstruction of the breast on which the mastectomy has been performed; and
- surgery and reconstruction of the healthy breast to produce a symmetrical appearance.

These reconstructive benefits are subject to the same annual deductible and coinsurance provisions as other medical and surgical benefits. (For plan benefits, see “KingCare<sup>SM</sup> Benefits at a Glance” on page 75.)

## Rehabilitative Services

KingCare<sup>SM</sup> covers 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. (For plan benefits, see “KingCare<sup>SM</sup> Benefits at a Glance” on page 75.)

## Skilled Nursing Facility

Skilled nursing facility services are covered if:

- they’re provided and billed by an organization licensed as a skilled nursing facility by the state of Washington; and
- the care takes the place of a hospital stay.

Let your provider know a written plan of treatment is required for these services to be covered. Network providers obtain preauthorization for your care as necessary. If you see an out-of-network provider for skilled nursing facility care, you must obtain preauthorization from Aetna. (For details, see “Preauthorization” on page 89.)

### IMPORTANT!

**Some rehabilitative services aren’t covered. (For details, see “Expenses Not Covered” on page 108.)**

### IMPORTANT!

**Some skilled nursing facility services aren’t covered. (For details, see “Expenses Not Covered” on page 108.)**

## IMPORTANT!

**Some smoking cessation expenses aren't covered. (For details, see "Expenses Not Covered" on page 108.)**

## IMPORTANT!

**Some transplant-related expenses aren't covered. (For details, see "Expenses Not Covered" on page 108.)**

Prescription drugs are covered through Aetna when provided by the skilled nursing facility and used by the patient during a period of covered skilled nursing facility care. Outpatient, retail pharmacy and mail-order drugs are covered through Express Scripts. (For details, see "Using Your Prescription Drug Plan" on page 114.)

(For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

### Smoking Cessation

KingCare<sup>SM</sup> covers:

- acupuncture to ease nicotine withdrawal;
- hypnotherapy to ease nicotine withdrawal;
- non-prescription nicotine patches, lozenges and gum, which are covered at 100% through Aetna;
- prescription drugs to ease nicotine withdrawal, inhalers and sprays, which are covered at 100% through Express Scripts; and
- smoking cessation programs, including a Tobacco Quit Line, which are covered at 100% through Harris HealthTrends (other smoking cessation programs are covered at the out-of-network rate, but to receive benefits for out-of-network smoking cessation programs, you must complete the full course of treatment).

(For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

### Temporomandibular Joint (TMJ) Disorders

Diagnosis and treatment of TMJ and myofascial pain, including night guards when prescribed by a medical doctor due to a TMJ diagnosis, are covered as a medical condition. Out-of-network services must be preauthorized and in general use and acceptance by the medical/dental community to relieve symptoms, promote healing, modify behavior and stabilize the condition. (For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

Additional benefits are available through the Dental Plan.

### Transplants

KingCare<sup>SM</sup> covers professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery and follow-up care, as well as certain donor expenses, related to transplants. Benefits may include travel and accommodations for a recipient's dependent or parent and up to \$100 a day for the dependent's food and lodging if the care is provided out of state. These benefits are payable only until the dependent's presence is no longer necessary, as determined by Aetna.

Network providers obtain preauthorization for your care as necessary. If you see an out-of-network provider for transplants, you must obtain preauthorization from Aetna. (For details, see "Preauthorization" on page 89.)

You're not eligible for organ transplant benefits until the first day of the 13<sup>th</sup> month of continuous coverage under KingCare<sup>SM</sup> before a transplant will be covered.

If your physician recommends a transplant, even if it's not listed in this section, call Aetna immediately to discuss your situation and determine if the transplant is covered. If it is covered, make the necessary arrangements.

The following human transplants are covered:

- bone marrow, including peripheral stem cell rescue;
- cornea;
- heart;
- heart-lung;
- kidney;
- liver;
- lung, single or double; and
- pancreas with kidney.

(For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

***Transplant Recipients.*** If you're a transplant recipient, all of your services and supplies, including transportation to and from designated facilities, are covered. Designated facilities are specific facilities identified by Aetna and authorized to perform certain transplant procedures for plan members. You must be accepted into the facility's transplant program and continue to follow that program's protocol.

***Transplant Donor.*** Transplant donor expenses are covered if the recipient is a plan member. Covered services include:

- bone marrow testing and typing of the brothers, sisters, parents and children of the patient who needs the transplant (testing and typing of any other potential donor are not covered);
- evaluation of the donor organ or bone marrow, its removal and transport of both the surgical/harvesting team and donor organ or bone marrow, if used for a covered transplant; and
- locating a donor, such as tissue typing of dependents and other donor procurement costs.

## Urgent Care

KingCare<sup>SM</sup> covers treatment for conditions that aren't considered a medical emergency but may need immediate medical attention. Examples of urgent conditions include:

- ear infections;
- high fevers; and
- minor burns.

If you need urgent care during office hours, call your physician's office for assistance. After office hours, call your physician's office and contact the on-call physician. Depending on your situation, the physician may provide instructions over the phone, ask you to come into the office or advise you to go to the nearest emergency room.

If you see a network provider for urgent care, you'll receive network-level benefits. If you see an out-of-network provider for urgent care, you'll receive out-of-network benefits. However, if you need emergency care, it will be covered at network levels whether you see a network or out-of-network provider. (For plan benefits, see "KingCare<sup>SM</sup> Benefits at a Glance" on page 75.)

## Expenses Not Covered

KingCare<sup>SM</sup> doesn't cover:

- alternative care (including acupuncture, hypnotherapy and massage therapy) if it's not medically necessary and/or not prescribed by a health care provider;
- benefits covered by the following agencies or programs or benefits that would be covered by these agencies or programs if KingCare<sup>SM</sup> didn't cover them, except as required by law:
  - any federal, state or government program (except for facilities in Aetna's list of network providers);
  - government facilities outside the service area;
  - Medicare; and
  - workers' compensation or state industrial coverage;
- benefits payable under any automobile, medical personal injury protection, homeowner, commercial premises coverage or similar contract (reimbursement to Aetna is made without reduction for any attorney's fees, except as specified in the contract);
- biofeedback;
- charges exceeding reasonable and customary (R&C) rates;
- charges that, without this plan, would not have to be paid, such as services performed by a dependent;

- chiropractic spinal manipulations under anesthesia;
- cosmetic surgery except:
  - for a dependent child’s congenital anomalies;
  - for all stages of reconstruction on a non-diseased breast to make it equal in size to the reconstructed diseased breast following mastectomy;
  - for reconstructive breast surgery on the diseased breast necessary because of a mastectomy; and
  - when related to a disfiguring injury;
- court-ordered services or programs not judged medically necessary by the plan;
- custodial care solely to assist with normal daily activities (such as dressing, feeding and ambulation) or any other treatment that doesn’t require the services of a registered nurse or licensed practical nurse;
- dental charges, except for natural teeth injured in an accident while covered by the plan (this treatment must be within one year of the accident);
- exams, tests or shots required for work, insurance, marriage, adoption, immigration, camp, volunteering, travel, licensing, certification, registration, sports or recreational activities;
- experimental or investigational services, supplies or settings determined to be experimental or investigational because:
  - there are insufficient outcomes data available from controlled clinical trials published in peer-reviewed literature to substantiate its safety and effectiveness for the disease or injury involved;
  - FDA approval, if required, hasn’t been granted for marketing;
  - a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental, investigational or for research purposes; or
  - the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment, or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is experimental, investigational or for research purposes;
- fertility services, such as:
  - any fees related to donors, donor sperm and banking services;
  - drugs to treat infertility—for example, menotropins such as Pergonal;
  - procedures to reverse voluntary sterilization;

- fertility services for dependent children;
- sexual dysfunction treatment or related diagnostic testing;
- some assisted reproductive technology (ART) methods;
- surrogate parenting fees; and
- voluntary removal of birth control devices implanted under the skin— for example, Norplant;
- foot care considered routine, such as:
  - arch supports or orthotics unless needed for diabetes or other covered conditions;
  - corrective orthopedic shoes;
  - hygienic care;
  - removal of corns or calluses; and
  - treatment for flat feet;
- home health care services involving:
  - custodial care, except by home health aides as ordered in the approved plan of treatment;
  - housecleaning;
  - services or supplies not included in the written plan of treatment;
  - services provided by a person who resides in your home or is a dependent; and
  - travel costs or transportation services;
- hospice care services involving:
  - any services provided by members of the patient's family;
  - financial or legal counseling, such as estate planning or the drafting of a will;
  - funeral arrangements;
  - homemaker, caretaker or other services not solely related to the patient, such as:
    - housecleaning or upkeep;
    - sitter or companion services for either the plan member who is ill or for other dependents; and
    - transportation; and
  - more than 120 hours of respite care in any three months of hospice care;
- hospital inpatient convalescent, custodial or domiciliary care;

- hospitalization solely for diagnostic purposes when not medically necessary;
- injuries to teeth caused by biting or chewing;
- injuries sustained:
  - by an intentional overdose of a legal prescription, over-the-counter drug, illegal drug or other chemical substance;
  - from suicide or attempted suicide (unless the patient was being treated by a mental health professional immediately before or after the attempt);
  - while engaged in any activity that results in a felony conviction; or
  - while performing any acts of violence or physical force;
- maternity treatment, services or drugs for a dependent child;
- maternity-related services such as home pregnancy tests, Lamaze classes and maternity care for children;
- mental health services involving:
  - biofeedback;
  - custodial care;
  - specialty programs for mental health therapy not provided by KingCare<sup>SM</sup>; and
  - treatment of sexual disorders;
- non-approved drugs and substances (those the FDA has not approved for general use and labeled “Caution—Limited by federal law to investigational use”);
- services and supplies not medically necessary to treat illness or injury, except for newborns and unless otherwise specified;
- services of a provider related to you by blood, marriage, adoption or legal dependency;
- 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;
- sexual dysfunction or transsexualism surgery, treatment or prescriptions;
- skilled nursing facility services involving:
  - custodial care;
  - services or supplies not included in your physician’s written plan of treatment;
  - services provided by a person who resides in your home or is a dependent;

- skilled nursing facility confinement for developmental disability, mental conditions or primarily domiciliary, convalescent or custodial care; and
- travel costs;
- smoking cessation-related inpatient services, books or tapes, or vitamins, minerals or other supplements;
- third-party required treatment or evaluations such as those for school, employment, flight clearance, summer camp, insurance or court;
- treatment (inpatient or outpatient) of chronic mental health conditions such as mental retardation, mental deficiency or forms of senile deterioration resulting from service in the armed forces, declared or undeclared war or voluntary participation in a riot, insurrection or act of terrorism;
- transplant costs and services involving:
  - donor costs for a transplant not covered under the plan, or for a recipient who isn't a plan member (however, complications and unforeseen effects from a plan member's organ or bone marrow donation are covered);
  - donor costs for which benefits are available under other group coverage;
  - non-human or mechanical organs unless deemed non-experimental and non-investigational by the plan; and
  - organ or bone marrow search or selection costs, including registry charges, unless described as covered;
- vision tests unless due to illness or injury. The plan also doesn't cover:
  - contact lenses (except for cataract surgery);
  - eyeglasses or their fittings;
  - orthoptics;
  - radial keratotomy or similar surgery for treating myopia; and
  - visual analysis, therapy or training.

## Filing a Claim

If you receive care from Aetna network providers, they submit claims for you.

If you receive care from an out-of-network provider, your provider may submit a claim for you. However, if your out-of-network provider doesn't submit a claim for you, it is your responsibility to pay the provider in full and submit a claim to Aetna for reimbursement of reasonable and customary (R&C) charges. Claim forms are available from Aetna at the KingCare<sup>SM</sup> member Web site: [www.kingcare.com](http://www.kingcare.com).

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

- patient's name;
- provider's tax ID number;
- diagnosis or ICD-9 code;
- date of service/supply; and
- itemized charges from the provider for the services/supplies received.

You also need to provide:

- your name (if you're not the patient);
- your unique identifier number on your ID card; and
- group number 725069.

For prompt payment, submit all claims as soon as possible. Generally, KingCare<sup>SM</sup> will not pay a claim submitted more than 27 months after the date of service or the date expenses were incurred. If you can't meet the 27-month deadline because of circumstances beyond your control, such as being legally incapacitated, the claim will be considered for payment when accompanied by a written explanation of the circumstances. However, to be considered, the claim must have been submitted by you or Aetna within the 27-month period for submitting a claim.

## How Aetna Reviews Claims

Aetna will review your claim and notify you or your provider in writing within the following time frames:

- **Within 72 hours for urgent claims.** Urgent claims are those where your provider believes a delay in treatment could seriously jeopardize your life, health or ability to regain maximum function, or cause severe pain that can't be controlled adequately without the care being considered. Urgent claims can be submitted by phone. (See *Contact Information*.) You'll be notified of the claim review decision by phone and later by a written notice.
- **Within 15 days for pre-service claims (within 30 days if an extension is filed).** Pre-service claims are those where KingCare<sup>SM</sup> requires you to obtain approval of the benefit before receiving the care. KingCare<sup>SM</sup> may ask for a one-time extension of 15 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.
- **Within 24 hours for concurrent claims.** Concurrent claims are those for continuation of services previously approved by the claims administrator as an ongoing course of treatment or to be provided over a certain period.

- **Within 30 days for post-service claims (within 60 days if an extension is filed).** Post-service claims are claims that aren't urgent, pre-service or concurrent. KingCare<sup>SM</sup> may ask for a one-time extension of 30 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.

The claims administrator reviews your claim, applying plan provisions and discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above.

## If Aetna Approves the Claim

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

Reimbursement to out-of-network providers is for the maximum allowable fees paid by KingCare<sup>SM</sup>.

## If Aetna Denies the Claim

If the claim is denied, you'll be notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that were reviewed in making the determination. (For information about appeals, see "KingCare<sup>SM</sup>" in "Claims Review and Appeals Procedures" in *Rules, Regulations and Administrative Information*.)

The claims administrator reviews your claim, applying plan provisions and discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above.

## Using Your Prescription Drug Plan

Prescription drug services for KingCare<sup>SM</sup> members are provided by Express Scripts, a pharmacy benefit manager that isn't affiliated with Aetna. Express Scripts contracts with pharmacies that participate in its nationwide network. The network includes all major chain pharmacies and most independent pharmacies, as well as a mail-order service, which have agreed to dispense covered prescription drugs to plan members at a discounted cost and not to bill plan members for any amounts over the copays.

Express Scripts issues a separate prescription card to KingCare<sup>SM</sup> members to use when filling prescriptions at network pharmacies or through the Express Scripts mail-order pharmacy. If you don't show your prescription card, the network pharmacy cannot confirm that you're covered through Express Scripts. In this case, you'll need to pay the pharmacy in full and submit a claim to Express Scripts for reimbursement.

### WHO'S IN THE EXPRESS SCRIPTS NETWORK?

For a list of participating network pharmacies, contact Express Scripts. (See *Contact Information*.)

You may receive up to a 30-day supply from a retail network pharmacy. You may receive a 30-day, 60-day or 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 even if your prescription is written for less than a 90-day supply. (For plan benefits, see “KingCare<sup>SM</sup> Benefits at a Glance” on page 75.)

## Accessing Care

You may receive network benefits or out-of-network benefits, but the level of coverage depends on the pharmacy you use.

### Retail Pharmacy Purchases

To fill a prescription at a network pharmacy and receive network benefits:

- you must choose an Express Scripts network pharmacy;
- show your Express Scripts prescription card to the network pharmacist each time you fill or refill a prescription (your Aetna medical card isn't valid when you purchase prescription drugs); and
- pay the copay for each covered new prescription or refill. There are no claim forms to submit because the network pharmacy bills the plan directly.

For certain prescription drugs and quantities, your physician will need to obtain preauthorization from Express Scripts.

If you fill a prescription at an out-of-network pharmacy, you must pay the cost of the prescription and submit a claim to Express Scripts for reimbursement. Express Scripts reimburses you at the rate it would pay a network pharmacy, less the appropriate copay. **Any amount in excess of this rate is your responsibility.**

### Mail-Order Purchases

You may purchase maintenance drugs through the mail-order service. “Maintenance drugs” are 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 Express Scripts. This form also includes options for payment. You need to complete this questionnaire only once.

Each time you order a new prescription, you can either:

- send the order form and prescription, together with your payment, directly to the address on the form; or
- have your physician fax the prescription directly from his/her office or call Express Scripts directly.

Once you've submitted the order form, you may obtain refills through the Express Scripts Web site, mail in your refill slip or call Express Scripts. (See *Contact Information*.)

### IMPORTANT!

**If an out-of-network provider charges more than the rates Express Scripts pays its network providers, you're responsible for paying the extra amount.**

All prescriptions are processed promptly and usually arrive within 14 days. If you don't receive your medicine within 14 days or if you have questions, contact Express Scripts customer 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. There's no out-of-network mail-order service.

#### **SPECIALTY PHARMACY/CARELOGIC**

If you take specialty injectable/biotech prescription drugs, you may fill your specialty prescriptions at a local retail pharmacy one time only. For all subsequent prescriptions of your medication, you'll be directed to fill your prescriptions through CareLogic, Express Scripts' specialty pharmacy. After your first retail fill, CareLogic will send you a letter that details how to have your prescription transferred to CareLogic. If you want to contact CareLogic directly to receive your supply of specialty medication(s), call Express Scripts (See *Contact Information*):

- Monday through Friday, 8 a.m. to 9 p.m. Eastern Time; or
- Saturday, 9 a.m. to 1 p.m., Eastern Time.

Express Scripts is closed Sundays and holidays, including New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving and Christmas.

A patient care coordinator will contact your doctor and work with you to schedule a delivery time for your medication.

## **Preauthorization**

Express Scripts doesn't determine the maximum number of refills or period when a prescription is valid because these requirements are mandated by federal and state laws regulating pharmacy practices. To promote proper use of medications, preauthorization and quantity level limits have been implemented for certain prescriptions under your KingCare<sup>SM</sup> pharmacy benefit.

You or your prescribing physician can find out if preauthorization is required by contacting Express Scripts before you have a prescription filled. For you and your physician's convenience, Express Scripts customer service assistance is available 24 hours a day, 7 days a week at 1-800-417-8164. Otherwise, your pharmacist or the Express Scripts mail-order service will advise you of the preauthorization procedures required to fill the prescription.

Express Scripts routinely reviews prescribing guidelines to ensure that drugs are clinically appropriate, and may limit the quantities of certain drugs to ensure proper utilization. The list of drugs requiring preauthorization is subject to change. (For the most current list of these drugs, go to the Express Scripts Web site. See *Contact Information*.)

### **IMPORTANT!**

**You or your prescribing physician can find out if preauthorization is required by contacting Express Scripts before you have a prescription filled.**

To preauthorize a prescription, your prescribing physician or his/her representative must initiate the process with a phone call to Express Scripts. Information required to complete the review includes but isn't limited to:

- member name;
- member ID number (located on your Express Scripts prescription drug card);
- birth date;
- name of drug;
- quantity and days' supply;
- diagnosis;
- previous therapies utilized; and
- prescribing physician information.

During the course of the review process, your eligibility will be confirmed and your prescription records checked to see if the prescription meets the established criteria.

Preauthorization requests are evaluated using criteria approved by KingCare<sup>SM</sup>. The request is then approved, denied or held for further information. If more information is required, Express Scripts will notify the requestor. Once the information is provided to your physician, your request will be approved or denied.

If the request is approved, Express Scripts will notify your physician and immediately update its database so you can fill the prescription.

If the request is denied, an Express Scripts clinical pharmacist will verify that the denial is valid according to plan criteria; Express Scripts will then notify:

- your physician verbally if the request was received by phone call; or
- you and your physician in writing if the request was received by mail.

When you receive a written denial, you may appeal that decision.

## ABOUT FORMULARY DRUGS

Your copay for a particular prescription is based on a list of drugs called a formulary, which sets the copay for that particular prescription based on its inclusion or exclusion in the formulary. For a copy of the formulary, including formulary alternatives, contact Express Scripts.

## What's Covered and What's Not

### Covered Expenses

Express Scripts covers:

- contraceptives (including oral, injectable, vaginal, topical and implantable);
- DESI drugs;
- emergency allergic reaction kits;
- emergency contraceptives;
- erectile dysfunction drugs, if used to treat impotency or penile dysfunction and preauthorized;
- glucagon emergency kit;
- injectable prescription drugs purchased at a retail pharmacy or through mail-order as a specialty drug (for some, preauthorization may be required; some injectables may be covered under medical services for a patient at a hospital);
- insulin and diabetic supplies, including
  - alcohol swabs;
  - blood glucose testing strips;
  - injection devices (such as Novopen);
  - insulin administered by pen/cartridge or other special injection devices;
  - insulin needles and syringes;
  - insulin/pre-drawn syringes;
  - ketone testing strips;
  - lancets;
  - lancet devices;
  - monitors; and
  - urine glucose testing strips;
- legend drugs (i.e., drugs requiring a written prescription unless specified otherwise);
- ostomy supplies;
- prenatal vitamins;

- smoking cessation drugs, inhalers and nasal sprays requiring a prescription (claims for non-prescription nicotine patches are covered through Aetna and reimbursed at network rates—for plan benefits, see “KingCare<sup>SM</sup> Benefits at a Glance” on page 75); and
- topical smoking cessation patches whether prescription or over-the-counter.

***Mental Health Prescriptions.*** Prescription drugs intended to treat any mental health disorder are covered the same as other prescription drugs as the result of the Washington State Mental Health Parity Law.

### Expenses Not Covered

The following items are not covered by Express Scripts:

- anorexiant/weight-loss medications;
- any over-the-counter medication unless otherwise noted;
- blood products;
- cosmetic/hair loss medications;
- experimental medications that have not been approved by the FDA;
- 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; and
- vitamins (except prenatal).

In addition to the exclusions or limits described in other sections of this guide, KingCare<sup>SM</sup> doesn't cover:

- charges that exceed the amounts Express Scripts pays its network pharmacies;
- drugs for a dependent child's maternity care;
- infertility drugs, including Viagra (unless preauthorized);
- non-approved drugs and substances (those the FDA hasn't approved for general use and labeled “Caution—Limited by federal law to investigational use”); and
- sexual dysfunction or transsexualism drugs.

## Managing Your Medications

Through a program called Medication Therapy Management Services, you may receive personal consultation on managing the interactions and potential complications of the multiple medications you're taking. Without additional cost to you, you may ask certified pharmacists to:

- review your entire list of medications, including prescription, herbal and over-the-counter medications, to make sure you're not taking medications that conflict with each other;
- answer your questions about correct dosage and frequency of dosage;
- answer your questions about risks and side effects from multiple prescriptions (certified pharmacists make one follow-up call to make sure you're not experiencing complications);
- find a less expensive medication covered under KingCare<sup>SM</sup>; and
- answer questions about over-the-counter medications.

Outcomes Pharmaceutical Health Care administers the Medication Therapy Management Services program. A list of participating pharmacies is available on the county's Web site. (See *Contact Information*.)

## Filing a Claim

When you go to a network pharmacy, there's no claim to file. However, if you fill a prescription at an out-of-network pharmacy, you're responsible for paying the pharmacy in full and submitting a claim to Express Scripts. To obtain a claim form, contact Express Scripts. (See *Contact Information*.)

When submitting a pharmacy claim, you need to include a completed claim form, together with the original prescription receipt, containing the following information:

- patient's name;
- NCPDP number (pharmacy's number) if listed on label;
- prescription number;
- date filled;
- dollar amount;
- quantity;
- days' supply; and
- NDC number (drug code); for compounds, the ingredients and the NDC number of the highest-priced legend drug used (listed on label).

After your claim is processed, you'll receive written notice describing the approval (amount submitted, amount covered/allowed and amount of reimbursement) or the reason for denial. Payment for covered prescriptions is made directly to you. Reimbursement typically takes about 14 days. Generally, KingCare<sup>SM</sup> will not pay a claim submitted more than 12 months after the date of service or the date expenses were incurred. If you can't meet the 12-month deadline because of circumstances beyond your control, such as being legally incapacitated, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

If your claim is denied, you may appeal. (For information about appeals, see "KingCare<sup>SM</sup>" in "Claims Review and Appeals Procedures" in *Rules, Regulations and Administrative Information*.)

## GROUP HEALTH

To make the most of the benefits available under Group Health, you need to understand how the plan works.

### Accessing Care

When you're enrolled in Group Health, you'll receive benefits if you see your primary care physician (PCP) or another provider within the network. You'll pay a copay when you receive care. After the copay, Group Health pays 100% for most covered services and handles all forms and paperwork for you.

If you see a provider who isn't part of the network, you'll receive benefits **only** if:

- you need emergency care; or
- your network provider referred you to an out-of-network provider.

### Network Providers

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

### Out-of-Area Coverage

Group Health doesn't 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.

### Your Primary Care Physician (PCP)

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

You're strongly encouraged to select a PCP from the Group Health network provider directory when you enroll. Each family member may have a different PCP. The provider directory is updated periodically. For current information about providers, contact Group Health. (See *Contact Information*.)

#### WHAT GROUP HEALTH PAYS FOR CARE

For details on what Group Health pays for care, see "Group Health Benefits at a Glance" on page 81.

#### IMPORTANT!

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

## Specialists

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

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

You may see a participating general and family practitioner, physician's assistant, gynecologist, certified nurse midwife, licensed midwife, doctor of osteopathy, pediatrician, obstetrician or advanced registered nurse practitioner who is contracted by Group Health to provide women's health care services directly, without a referral from your PCP, for medically necessary maternity care, covered reproductive health services, preventive care (well care) and general examinations, gynecological care and follow-up visits for these services. If your women's health care provider diagnoses a condition that requires a referral to other specialists or hospitalization, you or your provider must obtain preauthorization.

If you see an out-of-network provider without a referral, benefits won't be payable.

## If You Live Outside the Network Service Area

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're 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 ID card).
- If you live in an area served by Kaiser Permanente, you won't be able to access care through the Kaiser network. Group Health's reciprocity agreement with Kaiser covers members only during short-term travel.

## If Your Dependent Lives Away from Home

If your dependent lives away from home, he/she may be eligible for Group Health benefits as long as he/she uses a Group Health-approved HMO or Kaiser Permanente. Otherwise, only emergency care will be covered.

## Paying for Your Care

When you receive medical care, you pay:

- required copays at the time of the service;
- coinsurance amounts not covered by Group Health; and
- expenses for services or supplies not covered by Group Health.

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

See “Covered Expenses” on page 126 for details on copays and coinsurance; also see the latest new hire guides and annual open enrollment materials for details about monthly premiums you must pay (if any) for coverage.

### Copay

You pay copays for medical care and prescription drugs at the time you receive service. (For details, see “Covered Expenses” on page 126.)

### Coinsurance

“Coinsurance” is the amount you and Group Health share toward covered expenses.

### Annual Out-of-Pocket Maximum

The “annual out-of-pocket maximum” is the most you pay in copays for covered medical expenses each year. Once you reach the annual out-of-pocket maximum, Group Health pays 100% for most covered expenses for the rest of that year. If you have three or more dependents (including yourself), each dependent’s covered expenses accumulate toward the family out-of-pocket maximum.

The following expenses don’t apply to the annual out-of-pocket maximum:

- expenses not covered under your Group Health plan;
- health education;
- hearing aids;
- inpatient mental health;
- outpatient mental health;
- prescription drug copays; and
- residential day treatment.

### Lifetime Maximum Benefit

There's no lifetime maximum benefit under Group Health.

## Other Features of Group Health

It's important to understand other features of Group Health, such as disease management and second opinions. Having a better understanding of how the plan works will enable you to use the plan wisely and take advantage of all the benefits that the plan has to offer.

### Disease Management

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, 7 days a week, to get information on a variety of health and wellness topics, including advice on when to seek emergency care.

You can speak with a registered nurse by calling 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 on to MyGroupHealth at [www.ghc.org](http://www.ghc.org) or by calling 1-800-992-2279.

### Second Opinions

On occasion, you may want a second opinion from another physician regarding a medical diagnosis or treatment plan. To receive benefits, you must obtain the second opinion from a network provider.

### IMPORTANT!

For specific coinsurance and copays for the covered expenses described in this section, see “Group Health Benefits at a Glance” on page 81.

### IMPORTANT!

Some alternative care services aren’t covered. (For details, see “Expenses Not Covered” on page 138.)

## Knowing What’s Covered and What’s Not

It’s possible that some medical treatments may not be covered under Group Health. To make decisions about the health care you receive, you should know which treatments are covered and which are not. Ultimately, the claims administrator will be responsible for informing you if a medical service or supply isn’t covered. The following are guidelines for what is considered a “covered expense.”

### IMPORTANT

There is no preexisting condition limit for medical or prescription drug services. However, there is a waiting period for growth hormones and transplants. (For more information, see “Growth Hormones” on page 130 and “Transplants” on page 137.)

If you end employment with King County, refer to “Certificates of Coverage” for information on how your participation in Group Health can be credited against other plans with preexisting condition limits.

## Covered Expenses

Only medically necessary services, supplies and prescription drugs are covered.

### Alternative Care

Covered services, when medically necessary, include:

- acupuncture (certain limits apply);
- home births for low-risk pregnancies (see any Group Health network midwife for covered prenatal and home birth services);
- massage therapy, as part of a formal rehabilitation program; and
- naturopathy (certain limits apply).

(For plan benefits, see “Group Health Benefits at a Glance” on page 81.)

You can self-refer for acupuncture and naturopathy care, but referral by a PCP is required for home births and massage therapy.

### Ambulance Services

Group Health covers ambulance services if:

- ordered or approved by a network provider;
- other transportation would endanger your health; and
- the transportation isn’t for personal or convenience reasons.

(For plan benefits, see “Group Health Benefits at a Glance” on page 81.)

## Chemical Dependency Treatment

Chemical dependency is a physiological and/or psychological dependency on a controlled substance and/or alcohol which substantially impairs or endangers your health, or substantially disrupts your ability to function socially or to work.

Your PCP can arrange chemical dependency treatment, or for outpatient care, you may call Group Health Behavioral Health. For additional counseling and referral services, you may also call the Making Life Easier Program. (See *Contact Information*.)

Treatment may include the following inpatient or outpatient services:

- covered prescription drugs and medicines;
- diagnostic evaluation and education; and
- organized individual and group counseling.

Detoxification services are covered as any other medical condition and aren't subject to the chemical dependency limit. (For plan benefits, see "Group Health Benefits at a Glance" on page 81.)

## Chiropractic Care and Manipulative Therapy

Group Health covers medically necessary manipulative therapy of the spine and extremities. You don't need a referral from your PCP before you see a network chiropractor or osteopath—you may self-refer. Associated X-rays are covered when provided at a Group Health radiology facility. (For plan benefits, see "Group Health Benefits at a Glance" on page 81.)

## Diabetes Care Training and Supplies

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

Group Health covers the following supplies under either the prescription drug or durable medical equipment benefit:

- blood glucose monitoring reagents;
- diabetic monitoring equipment;
- external insulin pumps;
- insulin syringes;
- lancets; and
- urine testing reagents.

(For plan benefits, see "Group Health Benefits at a Glance" on page 81.)

## Durable Medical Equipment, Devices and Supplies

Group Health covers durable medical equipment if it:

- is designed for prolonged use;

### IMPORTANT!

**Some chiropractic services aren't covered. (For details, see "Expenses Not Covered" on page 138.)**

- has a specific therapeutic purpose in treating an illness or injury;
- is prescribed by your Group Health physician and is part of the Group Health formulary, and
- is 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 the result of cataract surgery or to replace a missing portion of the eye);
- diabetic equipment for home testing and insulin administration (excluding batteries) not covered under the prescription benefit (For details about prescription drug coverage, see “Prescription Drugs” on page 134);
- external breast prosthesis and bra following mastectomy; 1 external breast prosthesis per diseased breast every 2 years and 2 post-mastectomy bras every 6 months (up to 4 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 if you are covered by Group Health Gold or 50% if you are enrolled in Silver or Bronze);
- rental or purchase (decided by Group Health) of durable medical equipment such as wheelchairs, hospital beds and respiratory equipment (combined rental fees may not exceed full purchase price); and
- splints, crutches, trusses or braces.

(For plan benefits, see “Group Health Benefits at a Glance” on page 81.)

### **Emergency Room Care**

Emergency room care is for medical conditions that threaten loss of life or limb or may cause serious harm to the patient’s health if not treated immediately. You don’t need a referral from your PCP before you receive emergency room care. Examples of conditions that might require emergency room care include:

- an apparent heart attack (chest pain, sweating, nausea);
- convulsions;

- major burns;
- severe breathing problems;
- unconsciousness or confusion, especially after a head injury; and
- uncontrollable bleeding.

If you need emergency room care, follow these steps:

- Call 911 or go to the nearest hospital emergency room immediately. In cases when you can choose an emergency location, go to the Eastside Hospital in Redmond —this will allow Group Health to coordinate your care efficiently and perhaps reduce your expenses.
- When you arrive, show your Group Health ID card.
- If you're admitted to an out-of-network facility, you must call 1-888-457-9516 within 24 hours; otherwise, you may be responsible for all costs incurred before you call. If you're unable to call, ask a friend, relative or hospital staff person to call for you. Group Health's phone number is printed on the back of your ID card.
- If you're admitted to a health care facility, you must notify Group Health within 24 hours. You may be required to transfer your care to a network provider and/or Group Health facility. If you refuse to transfer to a Group Health facility, all further costs incurred during the hospitalization will be your responsibility.

(For plan benefits, see "Group Health Benefits at a Glance" on page 81.)

In general, follow-up care that is the direct result of the emergency must be received through Group Health. Non-emergency use of an emergency facility isn't covered.

### Family Planning

Group Health covers the following family planning expenses:

- family planning counseling;
- services to insert intrauterine birth control devices (IUDs);
- sterilization procedures; and
- voluntary termination of pregnancy (abortion).

(For plan benefits, see "Group Health Benefits at a Glance" on page 81.)

Birth control drugs are covered under the prescription drug benefit. (For details about prescription drug coverage, see "Prescription Drugs" on page 134.)

#### IMPORTANT!

**Some family planning services aren't covered. (For details, see "Expenses Not Covered" on page 138.)**

#### **IMPORTANT!**

**Some hearing aid services aren't covered. (For details, see "Expenses Not Covered" on page 138.)**

#### **IMPORTANT!**

**Some home health care services aren't covered. (For details, see "Expenses Not Covered" on page 138.)**

#### **IMPORTANT!**

**Some hospice care services aren't covered. (For details, see "Expenses Not Covered" on page 138.)**

### **Growth Hormones**

Group Health covers growth hormones. You or your family member won't be eligible for any growth hormone benefits until the first day of the 13<sup>th</sup> month of continuous coverage under Group Health, whether or not the growth disorder existed before coverage began. (For plan benefits, see "Group Health Benefits at a Glance" on page 81.)

### **Hearing Aids**

Group Health covers hearing examinations, hearing aids and fittings. (For plan benefits, see "Group Health Benefits at a Glance" on page 81.)

### **Home Health Care**

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

- medical social worker and limited home health aide services;
- nursing care;
- occupational therapy;
- physical therapy;
- respiratory therapy; and
- restorative speech therapy.

(For plan benefits, see "Group Health Benefits at a Glance" on page 81.)

### **Hospice Care**

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

Group Health covers hospice services if:

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

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

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

Other covered hospice services may include:

- counseling services for the patient and the primary caregiver(s);
- drugs and biologicals used primarily for the relief of pain and symptom management;
- medical appliances and supplies primarily for the relief of pain and symptom management; and
- bereavement counseling services for the family.

(For plan benefits, see “Group Health Benefits at a Glance” on page 81.)

### Hospital Care

Group health covers the following hospital care expenses:

- drugs and medications administered during confinement;
- hospital services;
- room and board; and
- special duty nursing.

(For plan benefits, see “Group Health Benefits at a Glance” on page 81.)

### Inpatient Care Alternatives

Information about inpatient care alternatives is available under “Home Health Care” on page 130 and “Skilled Nursing Facility” on page 136.

### Lab, X-ray and Other Diagnostic Testing

Group Health covers diagnostic X-ray, nuclear medicine, ultrasound and laboratory services. (For plan benefits, see “Group Health Benefits at a Glance” on page 81. For more information on routine diagnostic testing such as a mammogram, see “Preventive Care” on page 134.)

### Maternity Care

Group Health covers maternity care if provided by a:

- physician; or
- midwife licensed by the State of Washington.

Covered maternity care includes:

- complications of pregnancy or delivery;

#### IMPORTANT!

Some maternity-related expenses aren't covered. (For details, see “Expenses Not Covered” on page 138.)

- hospitalization and delivery, including home births and certain birthing centers for low-risk pregnancies;
- postpartum care;
- pregnancy care;
- related genetic counseling when medically necessary for prenatal diagnosis of an unborn child's congenital disorders; and
- screening and diagnostic procedures during pregnancy.

(For plan benefits, see "Group Health Benefits at a Glance" on page 81.)

#### HOSPITAL STAYS AND FEDERAL LAW

Group medical plans and health insurers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally doesn't prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or newborn earlier than 48 hours or 96 hours, as applicable. In any case, plans and insurers may not require a provider to obtain authorization for prescribing a stay that doesn't exceed 48 hours or 96 hours, as applicable.

You don't need to preauthorize the length of stay unless it exceeds the 48- or 96-hour rule.

#### Mental Health Care

Group Health covers inpatient and outpatient mental health services. These services, which place priority on restoring social and occupational functioning, include:

- consultations;
- crisis intervention;
- evaluation;
- intermittent care;
- managed psychotherapy; and
- psychological testing.

Your PCP can arrange for mental health services, or you may contact Group Health Behavioral Health directly. Counseling and referral services are also available through the Making Life Easier Program. (See *Contact Information*.) Group Health also covers services authorized by Group Health's medical director which can be expected to improve or stabilize a condition.

(For plan benefits, see "Group Health Benefits at a Glance" on page 81.)

#### IMPORTANT!

**Some mental health services aren't covered.**  
(For details, see "Expenses Not Covered" on page 138.)

## Neurodevelopmental Therapy

Group Health covers neurodevelopmental therapy for covered family members age six and younger, including:

- hospital care;
- maintenance of the patient when his or her condition would significantly worsen without such services;
- occupational, speech and physical therapy (if ordered and periodically reviewed by a physician);
- physician services; and
- services to restore and improve function.

(For plan benefits, see “Group Health Benefits at a Glance” on page 81.)

## Newborn Care

Group Health covers newborns under the mother’s health plan for the first three weeks, as required by Washington State law. (For plan benefits, see “Group Health Benefits at a Glance” on page 81.) To continue the newborn’s coverage after three weeks, the newborn must be eligible and enrolled within 60 days of birth. (For information about enrolling newborns, see “Adding Eligible Dependents” on page 55.)

## Phenylketonuria (PKU) Formula

Group Health covers the medical dietary formula that treats PKU. (For plan benefits, see “Group Health Benefits at a Glance” on page 81.)

## Physician and Other Medical/Surgical Services

Group Health covers other medical and surgical services, including:

- bariatric surgery and related hospitalizations when Group Health criteria are met;
- blood and blood derivatives and their administration;
- circumcision;
- general anesthesia services and related facility charges for dental procedures for patients who are under age 7, who are physically or developmentally disabled or who have a medical condition where the patient’s health would be put at risk if the dental procedure were performed in the dentist’s office. These services must be authorized in advance by Group Health and performed at a Group Health hospital or ambulatory surgery facility;
- non-experimental implants limited to cardiac devices, artificial joints and intraocular lenses;
- outpatient diagnostic radiology and lab services;
- outpatient radiation therapy and chemotherapy;
- outpatient surgical services;

### IMPORTANT!

Some neurodevelopmental therapy-related services aren’t covered. (For details, see “Expenses Not Covered” on page 138.)

### IMPORTANT!

Some medical and surgical services aren’t covered. (For details, see “Expenses Not Covered” on page 138.)

## IMPORTANT!

**Some prescription drugs aren't covered. (For details, see "Expenses Not Covered" on page 138.)**

- outpatient total parenteral nutrition therapy;
- procedures performed by a network provider or oral surgeon (reduction of a fracture or dislocation of the jaw or facial bones; excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof or floor of the mouth; incision of salivary glands and ducts; accidental injury to teeth not covered);
- services of a podiatrist;
- sterilization procedures; and
- treatment of growth disorders by growth hormones subject to certain limits. (See "Growth Hormones" on page 130 for details.)

(For plan benefits, see "Group Health Benefits at a Glance" on page 81.)

### Prescription Drugs

Benefits are provided for legend drugs and other covered items, including insulin, injectables and contraceptive drugs and devices when you use a network pharmacy or mail-order service, including off-label use of FDA-approved drugs. To be covered, prescriptions must be:

- prescribed by a network provider for covered conditions; and
- filled through a network pharmacy or the mail-order service.

To fill your prescription through a network pharmacy, show the pharmacist your Group Health ID card. For mail-order prescriptions, your provider will first prescribe a 30-day "trial" supply, which you'll fill through a network pharmacy. If the trial supply is effective, you can order a 90-day supply by contacting the mail-order service through the Group Health Web site. (See *Contact Information*.) Your prescription will be mailed to your home.

If you need a refill, check the label on the prescription container; some may be refilled without consulting your physician. The number of refills is indicated on the label. If you need your physician's approval to reorder your medication, call your pharmacy or the mail-order service at least two weeks before you run out of medication. The pharmacy/mail-order service will need time to order your medicine and contact your physician for approval. (For plan benefits, see "Group Health Benefits at a Glance" on page 81.)

Generic drugs are used whenever available. Brand-name drugs are used if there is no generic equivalent. You may choose to buy specific brand-name drugs by paying the higher copay if they're available at the network pharmacy.

### Preventive Care

Group Health covers the following preventive care services:

- most immunizations and vaccinations for adults and children (except immunizations for travel);
- routine hearing exams (once in 12 consecutive months);

- routine mammograms (age and risk factor determine frequency);
- routine physicals for adults and children (age and risk factor determine frequency); and
- routine vision exams (once in 12 consecutive months).

Preventive care is provided according to the following schedule. The schedule is a guideline; benefits may be available for more frequent care depending on the situation. Before scheduling a routine physical, confirm with Group Health that your physical will be covered.

Age	Preventive Care
<b>Birth to 1 year</b>	Routine newborn care, plus 7 well-baby office exams
<b>1-2 years</b>	2 well-child exams
<b>2- 5 years</b>	4 well-child exams, with 1 exam in each of these age groups: 2, 3, 4, 5
<b>6 - 12 years</b>	4 well-child exams, with 1 exam in each of these age groups: 6, 7–8, 9–10, 11–12
<b>13 - 17 years</b>	2 well-teen exams, with 1 exam for ages 13–15 and 1 exam for ages 15–17
<b>18 - 19 years</b>	1 well-adult exam
<b>20–39 years</b>	1 well-adult exam every 4-5 years
<b>40 - 49 years</b>	1 well-adult exam every 4-5 years
<b>50 years and older</b>	1 well-adult exam every 2 years

(For plan benefits, see “Group Health Benefits at a Glance” on page 81.)

### Radiation Therapy, Chemotherapy and Respiratory Therapy

Group Health covers radiation therapy, high-dose chemotherapy and stem cell support, and respiratory therapy services. (For plan benefits, see “Group Health Benefits at a Glance” on page 81.)

### Reconstructive Services

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

Group Health covers the following services if the patient is receiving benefits for a mastectomy and elects breast reconstruction in connection with the mastectomy, as determined in consultation with the attending physician:

- prosthesis and treatment of physical complications of all stages of mastectomy, including lymphedemas;

#### IMPORTANT!

**Some rehabilitative services aren't covered. (For details, see "Expenses Not Covered" on page 138.)**

#### IMPORTANT!

**You don't need a PCP referral to a network provider to take advantage of these smoking cessation benefits.**

#### IMPORTANT!

**Some TMJ-related services aren't covered. (For details, see "Expenses Not Covered" on page 138.)**

- reconstruction of the breast on which the mastectomy has been performed; and
- surgery and reconstruction of the healthy breast to produce a symmetrical appearance.

These reconstructive benefits are subject to the same annual deductible and coinsurance provisions as other medical and surgical benefits. (For plan benefits, see "Group Health Benefits at a Glance" on page 81.)

#### Rehabilitative Services

Group Health covers inpatient and outpatient rehabilitative services only for physical, occupational and speech therapy to restore function after illness, injury or surgery. Rehabilitative services are covered only when Group Health determines that they're expected to result in significant, measurable improvement within 60 days. (For plan benefits, see "Group Health Benefits at a Glance" on page 81.)

#### Skilled Nursing Facility

Group Health covers skilled nursing facility services when the patient is referred by a network provider. (For plan benefits, see "Group Health Benefits at a Glance" on page 81.)

#### Smoking Cessation

Group Health covers the following, without a lifetime limit:

- one course of nicotine replacement therapy a year if you're actively participating in the Group Health-designated tobacco cessation program, Free & Clear<sup>®</sup> Quit for Life<sup>™</sup> Program (For more information, visit [www.ghc.org/products/freeclr.jhtml](http://www.ghc.org/products/freeclr.jhtml));
- educational materials; and
- participation in one program a year from a network provider.

For approved smoking cessation products, such as gum, patches or prescription medication, you need to purchase the product from a Group Health pharmacy or a contracted community pharmacy and pay the prescription drug copay. (For plan benefits, see "Group Health Benefits at a Glance" on page 81.)

#### Temporomandibular Joint (TMJ) Disorders

Group Health covers:

- medical and surgical services and related hospitalizations to treat TMJ disorders when medically necessary;
- orthognathic (jaw) surgery;
- radiology services; and
- TMJ specialist services, including the fitting and adjustment of splints.

(For plan benefits, see “Group Health Benefits at a Glance” on page 81.)

TMJ appliances are covered under the orthopedic appliances benefit. (See “Durable Medical Equipment, Devices and Supplies” on page 127.)

Additional benefits are available through the Dental Plan.

### Transplants

Group Health covers professional and facility fees for inpatient accommodation, diagnostic tests and exams, surgery and follow-up care, as well as certain donor expenses, related to transplants.

You and your covered dependents aren't eligible for organ transplant benefits until the first day of the 13<sup>th</sup> month of continuous coverage under Group Health, regardless of whether the condition necessitating the transplant existed before coverage began (unless the patient was continuously covered under this plan since birth or he/she requires a transplant as the result of a condition that had a sudden unexpected onset after the patient's effective date of coverage).

The following transplants are covered:

- bone marrow;
- cornea;
- heart;
- heart-lung;
- intestinal/multi-visceral;
- kidney;
- liver;
- lung (single or double);
- pancreas;
- kidney; and
- stem cell support (obtained from allogeneic or autologous peripheral blood or marrow) with associated high dose chemotherapy.

Transplant services must be received at a facility designated by Group Health and are limited to:

- evaluation testing to determine recipient candidacy;
- follow-up services for specialty visits, re-hospitalization and maintenance medication; and
- transplantation (limited to costs for surgery and hospitalization related to the transplant, as well as medications).

### IMPORTANT!

**Some transplanted-related services aren't covered. (For details, see “Expenses Not Covered” on page 138.)**

Group Health covers the following donor expenses for a covered organ recipient:

- excision fees;
- matching tests;
- procurement center fees; and
- travel costs for a surgical team.

(For plan benefits, see “Group Health Benefits at a Glance” on page 81.)

### **Urgent Care**

Group Health covers treatment for conditions that aren’t considered a medical emergency but may need immediate medical attention. Examples of urgent conditions include:

- ear infections;
- high fevers; and
- minor burns.

If you need urgent care during office hours, call your PCP’s office for assistance. After office hours, call Group Health’s Consulting Nurse Service at 1-800-297-6877. Depending on your situation, the consulting nurse may provide instructions over the phone for self-care, instruct you to make an appointment with your PCP for the next day or advise you to go to the nearest urgent care or emergency room.

Urgent care is covered the same as other care. (For plan benefits, see “Group Health Benefits at a Glance” on page 81.)

### **Vision Exams**

Group Health covers routine vision exams only. (For plan benefits, see “Group Health Benefits at a Glance” on page 81.) The Vision Plan provides benefits for eye exams and for prescription lenses and frames.

## **Expenses Not Covered**

Group Health doesn’t cover:

- artificial or mechanical hearts;
- cardiac or pulmonary rehabilitation
- chiropractic expense involving:
  - care performed on a non-acute, asymptomatic basis;
  - care primarily for your convenience;
  - office visits other than for the initial evaluation;

- supportive care performed primarily to maintain the level of correction already achieved; and
- other services that don't meet Group Health clinical criteria for being medically necessary;
- complications of non-covered surgical services;
- conditions resulting from service in the armed forces during a declared or undeclared war or voluntary participation in a riot, insurrection or act of terrorism;
- convalescent or custodial care;
- corrective appliances or artificial aids, including eyeglasses, contact lenses or services related to their fitting, except as described under "Hearing Aids";
- cosmetic services, including treatment of complications from cosmetic surgery that is elective or not covered;
- court-ordered services or programs not judged medically necessary by the network provider;
- dental care, oral surgery, and dental services and appliances, except as described under "Physician and Other Medical/Surgical Services";
- diabetic meals and some diabetes education materials;
- evaluations and surgical procedures to correct refractions not related to eye pathology;
- exams, tests or shots required for work, insurance, marriage, adoption, immigration, camp, volunteering, travel, licensing, certification, registration, sports, recreational or school activities;
- experimental or investigational treatment;
- gambling addiction or other specialty treatment programs;
- genetic testing and related services unless determined medically necessary by Group Health's medical director;
- hearing aid replacement parts, batteries and maintenance costs;
- herbal supplements;
- home health care services involving:
  - any care provided by a member of the patient's family;
  - any other services rendered in the home that aren't specifically listed as covered under "Home Health Care" on page 130;
  - care in a nursing home or convalescent facility;
  - custodial care or maintenance care;

- housekeeping or meal services; and
- private duty or continuous nursing care in the patient's home;
- home pregnancy tests;
- hospice services involving:
  - any services provided by members of the patient's family;
  - custodial care or maintenance care;
  - financial or legal counseling (e.g., estate planning or will preparation);
  - funeral arrangements; and
  - homemaker, caretaker or other services not solely related to the patient, such as:
    - housecleaning or upkeep;
    - meal services;
    - sitter or companion services for either the patient or other family members; and
    - transportation;
- hypnotherapy or any related services;
- infertility treatment; sterility; or sexual dysfunction diagnostic testing or treatment, including Viagra; penile implants; vascular or artificial reconstruction; and procedures to reverse voluntary sterilization;
- injury to teeth;
- jaw abnormalities or malocclusions;
- medicine or injections for anticipated illness while traveling;
- mental health services involving:
  - custodial care;
  - day treatment;
  - marital and family counseling;
  - specialty programs for mental health therapy not provided by Group Health; and
  - treatment of sexual disorders;
- neurodevelopmental and rehabilitation services involving:
  - implementation of home maintenance programs;
  - long-term rehabilitation programs;
  - physical, occupational or speech therapy services when available through programs offered by public school districts;

- programs for the treatment of learning problems;
- recreational, life-enhancing, relaxation or palliative therapy;
- specialty rehabilitation programs not provided by Group Health; and
- therapy for degenerative or static conditions when the expected outcome is primarily to maintain the patient's level of functioning;
- non-emergency use of an emergency facility;
- organ transplant costs involving donor costs reimbursable by the organ donor's insurance plan, and living expenses and transportation expenses not listed under "Transplants";
- orthopedic shoes not attached to an orthopedic appliance or arch supports (including custom shoe inserts or their fitting, except for therapeutic shoes and shoe inserts for severe diabetic foot disease);
- orthoptic (i.e., eye training) therapy;
- out-of-network expenses exceeding usual, customary and reasonable (UCR) charges;
- over-the-counter drugs (i.e., medicines and devices not requiring a prescription), except for tobacco cessation drugs;
- personal comfort items, such as phones or television;
- physical exams, immunizations or evaluations primarily for the protection and convenience of third parties, including for obtaining or continuing employment or insurance or government licensure;
- pre- and post-surgical nutritional counseling and related weight-loss programs;
- prescribing and monitoring of drugs;
- prescription drugs, specifically:
  - dietary drugs;
  - drugs for cosmetic uses;
  - drugs for treatment of sexual dysfunction;
  - drugs not approved by the FDA and in general use as of March 1 of the previous year;
  - over-the-counter drugs; and
  - vitamins, including prescription vitamins;
- preventive care visits to acupuncturists and naturopaths, and services not within the scope of their license;
- rehabilitative services involving:
  - chronic conditions;

- implementation of home maintenance programs;
- physical, occupational or speech therapy services when available through programs offered by public school districts;
- programs for the treatment of learning problems;
- recreational, life-enhancing, relaxation or palliative therapy;
- specialty treatment programs not provided by Group Health; and
- therapy for degenerative or static conditions when the expected outcome is primarily to maintain the patient's level of functioning;
- routine foot care;
- services and supplies covered by other insurance policies, including any vehicle, homeowner's, property or other insurance policy whether or not a claim is made pursuant to:
  - medical coverage, medical "no fault" coverage, personal injury protection coverage or similar medical coverage contained in the policy; and/or
  - uninsured motorist or underinsured motorist coverage contained in the policy;
- services and supplies resulting from the loss or willful damage to covered appliances, devices, supplies or materials provided by Group Health;
- services performed by a network provider or oral surgeon involving:
  - reduction of a fracture or dislocation of the jaw or facial bones;
  - excision of tumors or cysts of the jaw, cheeks, lips, tongue, gums, roof or floor of the mouth; and
  - incision of salivary glands and ducts, and accidental injury to teeth;
- services covered by the national health plan of any other country;
- services provided by government agencies, except as required by federal or state law;
- sexual disorder treatment;
- TMJ-related expenses involving:
  - all dental services (except as noted under "Temporomandibular Joint (TMJ) Disorders" on page 136), including orthodontic therapy;
  - orthognathic (jaw) surgery in the absence of a TMJ diagnosis or severe obstructive sleep apnea diagnosis, except for newborn infants with congenital anomalies; and
  - treatment for cosmetic purposes;
- transplant costs and services involving:
  - donor costs reimbursable by the organ donor's insurance plan;

- living expenses;
- transportation expenses (except as listed under “Transplants” on page 137); and
- treatment of donor complications;
- weight reduction programs and/or exercise programs and specialized nutritional counseling; and
- work-incurred injury, illness or condition treatment.

## Filing a Claim

If you receive care from a network provider, the provider submits claims for you.

If you receive emergency services from an out-of-network provider, you pay the provider in full, and it's your responsibility to submit a claim form to Group Health or have the provider submit one for you. Claim forms are available from Group Health. (See *Contact Information*.)

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

- patient's name;
- provider's tax ID number;
- diagnosis or ICD-9 code;
- date of service/supply; and
- itemized charges from the provider for the services/supplies received.

You also need to provide:

- your name (if you're not the patient);
- your Social Security number (or unique ID number if assigned one by Group Health); and
- group number (shown on your Group Health ID card and available from Benefits and Retirement Operations).

For prompt payment, submit all claims as soon as possible. Group Health will not pay a claim submitted more than 12 months after the date of service/supply. If you can't meet the 12-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

## How Group Health Reviews Claims

Group Health will review your claim and notify you or your provider in writing within the following time frames:

- **Within 72 hours for urgent claims.** Urgent claims are those where your provider believes a delay in treatment could seriously jeopardize your life, health or ability to regain maximum function or cause severe pain that can't be controlled adequately without the care being considered. Urgent claims can be submitted by phone. (See *Contact Information*.) You'll be notified of the claim review decision by phone and later by a written notice.
- **Within 15 days for pre-service claims (within 30 days if an extension is filed).** Pre-service claims are those where Group Health requires you to obtain approval of the benefit before receiving the care. Group Health may ask for a one-time extension of 15 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.
- **Within 24 hours for concurrent claims.** Concurrent claims are those for continuation of services previously approved by the claim administrator as an ongoing course of treatment or to be provided over a certain period.
- **Within 30 days for post-service claims (within 60 days if an extension is filed).** Post-service claims are claims that aren't urgent, pre-service or concurrent. Group Health may ask for a one-time extension of 30 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.

The claim administrator reviews your claim, applying plan provisions and discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above.

### If Group Health Approves the Claim

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

### If Group Health Denies the Claim

If the claim is denied, you'll be notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that Group Health reviewed in making the determination. (For information about appeals, see "Group Health" in "Claims Review and Appeals Procedures" in *Rules, Regulations and Administrative Information*.)

The claims administrator reviews your claim, applying plan provisions and discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above.

## DENTAL PLAN

Dental care is an important part of your overall health and well-being. That's why the county offers you dental coverage that encourages regular preventive care, helps you maintain healthy teeth and gums, and helps you pay for a broad range of other dental services when treatment is needed.

As a benefit-eligible employee, you receive dental benefits through Washington Dental Service (WDS), a member of the Delta Dental Plans Association.

Although WDS administers the payment of claims for this plan, the dental benefits are "self-funded" by King County. This means that the county is financially responsible for and pays all allowable claims and administrative costs associated with the dental plan.

### How the Dental Plan Works

With the dental plan, you can use any dentist you want, but your out-of-pocket expenses are usually lower when you use a WDS/Delta Dental participating dentist. (For information about participating dentists, see "Participating Dentists" on page 147.)

Any WDS/Delta Dental participating dentist will automatically file your claims for you. Most dentists in Washington are participants in one or more of the WDS/Delta Dental networks.

The dental plan increases what it pays for most services through an incentive program, as long as you see a dentist each year for a covered service:

- for diagnostic and preventive services, as well as basic services, the dental plan begins paying at 70% and increases 10% in January of each year until the dental plan pays 100%; and
- for major services (excluding prosthodontics), the dental plan begins paying at 70%, then increases to 80%, and then again to 85%.

(For more information on the incentive program, see "Incentive Program" on page 150.)

### Your Dental Benefits at a Glance

The following table shows what the dental plan pays for covered services and supplies under the dental plan and identifies related deductibles, coinsurance and maximums. (For additional details, see "Knowing What's Covered and What's Not" on page 153.)

#### DEFINED TERMS

Be sure you understand the meaning of the terms used in this summary, such as "deductible" and "coinsurance." (See "Glossary" on page 191.)

Plan Feature	
<b>Annual deductible</b> (doesn't apply to diagnostic and preventive services, orthodontic services or accidental injuries)	\$25/person; \$75/family
<b>Annual maximum benefit</b> (doesn't apply to orthodontic or TMJ services)	\$2,000/person
Covered Expenses	Dental Plan Pays
<b>Diagnostic and preventive services</b> <ul style="list-style-type: none"> <li>• Exam and cleaning, twice/calendar year</li> <li>• Oral health assessment</li> <li>• Periodontal cleaning and maintenance up to 4 times/calendar year (under certain oral health conditions)</li> <li>• Complete X-rays every 3 years</li> <li>• Supplementary bitewing X-rays, twice/calendar year</li> </ul>	70%–100% based on patient's incentive level (deductible doesn't apply)
<b>Basic services</b> <ul style="list-style-type: none"> <li>• Crowns (stainless steel)</li> <li>• Extractions</li> <li>• Fillings</li> <li>• Periodontics</li> <li>• Root canals</li> </ul>	70%–100% based on patient's incentive level
<b>Major services</b> <ul style="list-style-type: none"> <li>• Crowns (gold, porcelain)</li> <li>• Onlays</li> <li>• Periodontics—occlusal (night) guard</li> </ul>	70%–85% based on patient's incentive level 50% occlusal guard (incentive levels don't apply). Your medical plan may provide additional coverage. (See "Medical Plans" on page 73.)
<b>Major services—Prosthodontics</b> <ul style="list-style-type: none"> <li>• Dentures</li> <li>• Fixed bridges</li> <li>• Implants</li> </ul>	70% (incentive levels don't apply)
<b>Orthodontic services for adults and children</b>	50% up to a \$2,500 lifetime maximum (deductible, incentive levels and annual maximums don't apply) Not more than \$1,250 will be paid during the initial stage of treatment; the remaining plan benefit is paid seven months after the initial stage if the covered participant still meets eligibility requirements. (See "Medical Plans" on page 73.)

<b>Temporomandibular joint (TMJ) disorders</b>	50% up to a \$500 lifetime maximum for non-surgical treatment and appliances (deductible, incentive levels and annual maximums don't apply). Your medical plan may provide additional coverage. (See "Medical Plans" on page 73.)
<b>Accidental injury</b>	100% for covered expenses incurred within 180 days of accident (deductible doesn't apply)

## Using the Dental Plan

When you make an appointment, tell your dentist that you're covered by the WDS dental plan and provide your Social Security number (or alternate ID if you've requested one) and your dental plan group number, which is 00152.

## Participating Dentists

To receive the full benefits of the dental plan, you must choose a WDS/Delta Dental participating dentist. When you see a WDS/Delta Dental participating dentist:

- your participating dentist obtains predetermination from WDS for certain procedures and services;
- your participating dentist files your claims, and WDS reimburses your dentist;
- you won't be charged for more than the approved fee or the fee that the participating dentist has filed with WDS;
- you receive an explanation of benefits (EOB) from WDS, informing you of applicable deductibles and coinsurance, and indicating your share of the cost; and
- you receive a bill from your participating dentist, and you pay the dentist the amount indicated on the EOB.

### Choosing a Participating Dentist

Participating dentists in the dental plan include WDS/Delta Dental Premier dentists and WDS/Delta Dental PPO dentists. The PPO dentists are Premier dentists who have negotiated lower fees. While your coinsurance, deductible and annual maximums are the same whether you see a Premier dentist or a PPO dentist, your out-of-pocket expenses are usually lower when you see a PPO dentist, because of lower negotiated fees.

Let's take a look at an example. Beth needs a crown. The following table shows the possible difference in cost if Beth goes to a WDS/Delta Dental Premier dentist rather than choosing a WDS/Delta Dental PPO dentist. The sample fee for each dentist is shown, with payment at the 80% incentive level.

	WDS/Delta Dental PPO Dentist	WDS/Delta Dental Premier Dentist
Dentist's fee for crown	\$1,000	\$1,200
What the dental plan pays (80%)	<u>- 800</u>	<u>- 960</u>
What Beth pays (20%)	<b>\$200</b>	<b>\$240</b>

Beth would pay \$40 less if she were to see a WDS/Delta Dental PPO dentist.

To choose a WDS/Delta Dental PPO dentist, visit the WDS Web site or call WDS. (See *Contact Information*.)

### Choosing Non-Participating Dentists

When you see a dentist who doesn't participate in the WDS/Delta Dental PPO or Premier network:

- you must obtain a predetermination of benefits from WDS for certain procedures and services (For more information, see "Predetermination of Benefits" on page 151);
- you may be required to pay the bill in full and file a claim for reimbursement from WDS (some non-participating dentists will file your claim for you);
- WDS reimburses you based on the maximum allowable fees for non-participating dentists or the actual charges, whichever is less, and you're responsible for paying any remaining amount.

WDS accepts any American Dental Association-approved claim form that your dentist may provide you. You can also download WDS claim forms from the WDS Web site. (See *Contact Information*.) It's your responsibility to ensure that the claim is sent to WDS.

### Out-of-State Dentists

You have the option to select a WDS/Delta Dental participating dentist outside the State of Washington. There are no WDS/Delta Dental participating dentists outside the United States.

## Paying for Your Care

Because you don't receive an ID card for your dental plan, you'll need to tell your dentist you're covered by the King County WDS dental plan (group number 00152). You must provide either your Social Security number or an alternative ID (if you've requested one) to your dentist for verification of your benefit eligibility. From there, your dentist (if a WDS/Delta Dental participating dentist) will handle all your claims and predetermination of benefits.

### Deductible

The "annual deductible" is the amount you must pay each year toward covered services before the dental plan begins paying. The dental plan deductible is \$25 per covered person, up to \$75 per family per year, for claims involving crowns, extractions, fillings, periodontics, root canals, onlays, dentures, fixed bridges, implants, occlusal (night) guards and temporomandibular joint disorder (TMJ) treatments. The deductible doesn't apply to diagnostic and preventive services, orthodontic services or treatment for accidental injuries.

### Coinsurance

After you've paid the deductible, if applicable, you begin paying a percentage—the coinsurance—of the cost of your dental care based on the incentive level you've earned and the type of service you're receiving. (For specific coinsurance rates, see "Your Dental Benefits at a Glance" on page 145.)

### Benefit Maximums

The "benefit maximum" is the most the dental plan will pay for most covered services each calendar year. The dental plan's annual benefit maximum is \$2,000 per covered person.

Two services have lifetime maximums, which don't apply to the calendar-year benefit maximum:

- orthodontic treatment at \$2,500 per person; and
- TMJ treatment at \$500 per person.

Your benefit maximum is calculated based on the services completed in a calendar year. Charges for dental procedures such as crowns and bridgework that require multiple treatment dates are considered incurred on the date the service is completed even if it began in the previous calendar year.

## IMPORTANT!

Payment levels for major prosthodontic services, orthodontia, TMJ treatment, occlusal (night) guards and accidental injury aren't determined by the incentive program.

## Incentive Program

WDS increases the payment levels for your benefits through an incentive program. As long as you see your dentist for a covered service each year:

- for diagnostic and preventive services, as well as basic services, the dental plan begins paying at 70% and increases 10% in January of each year until the dental plan pays 100%; and
- for major services (excluding prosthodontics), the dental plan begins paying at 70%, then increases to 80%, and then again to 85%.

If you don't see a dentist for a covered service during the year, your payment level is reduced to the next lower payment level under which your last claim was paid, but never below 70%—for example, if you saw your dentist for a covered service in 2005 and your payment level was 80%, but you didn't see your dentist for a covered service in 2006, your payment level in 2007 would be reduced from 80% to 70%.

If you're a new employee, coverage begins at the 70% incentive level—**levels "earned" under another group plan don't apply to the county's dental plan.** However, incentive levels are adjusted based on previous participation in the county's dental plan if you're a:

- covered spouse/domestic partner of a King County employee and become employed by the county;
- recalled or reinstated employee; or
- rehired employee who has continued county coverage uninterrupted under COBRA between your previous county employment and the date of your rehire (if county coverage has been interrupted, new employee incentive levels apply).

The following table summarizes how the incentive program works.

If you receive...	The dental plan pays ...
<b>Diagnostic and preventive services</b> <b>Basic services</b>	<ul style="list-style-type: none"><li>• 70% in the first year</li><li>• 80% in the second year</li><li>• 90% in the third year</li><li>• 100% in the fourth year and each year thereafter</li></ul>
<b>Major services</b>	<ul style="list-style-type: none"><li>• 70% in the first year</li><li>• 80% in the second year</li><li>• 85% in the third year and each year thereafter</li></ul>

### Up Close and Personal

The following examples help illustrate how the dental plan payment levels work.

#### Meet Heather

Heather is in her second year of plan participation. She visits her participating dentist for her annual exam, which is a covered diagnostic and preventive service. Since she visited the dentist last year, her payment level for this year increased from 70% to 80%. The annual deductible doesn't apply to the preventive care Heather received.

Here's how much Heather pays:

The total expense is...	Dental plan pays...	Heather pays...
\$50 for the exam	\$40 (80% of \$50)	\$10 (20% of \$50)
		+ 0 deductible
		\$10

#### Meet Jim

Jim has been in the dental plan for three years, but he hasn't been to his dentist during any of those years—as a result, his payment level is 70%. This year, Jim needs a root canal. The annual deductible applies to this type of basic service and is met once Jim has the root canal.

Here's how much Jim pays:

The total expense is...	Dental plan pays...	Jim pays...
\$600 for the root canal	\$402.50 (70% of \$575)	\$172.50 (30% of \$575)
- 25 deductible		+ 25.00 deductible
\$575		\$197.50

## Other Features of the Dental Plan

It's important to understand other features of the dental plan such as preauthorization and the oral health assessment program. Having a better understanding of how the dental plan works will enable you to use the plan wisely and take advantage of all the benefits that the plan has to offer.

### Predetermination of Benefits

If you think your dental care will exceed \$200, or you need orthodontic or TMJ services, ask your dentist to submit a standard WDS claim form for predetermination of benefits. By doing this, you'll learn in advance exactly what procedures are covered, the amount the dental plan will pay toward the treatment, and the amount you'll be required to pay.

#### IMPORTANT!

**A predetermination of benefits is not a guarantee of payment.**

WDS conducts professional clinical reviews of basic and major services. If professional dental standards indicate that a condition can be treated by a less costly alternative to the service proposed by your dentist, WDS limits benefits to the less costly alternative, unless otherwise noted or restricted in “Knowing What’s Covered and What’s Not” on page 153. You’re responsible for any treatment costs exceeding the allowable amounts paid by the dental plan.

Predetermination of benefits requires notification or approval before you receive dental care. WDS will provide notice of the claim decision within 15 days after receiving your claim form. If a predetermination is filed improperly, WDS will provide notice of the improper filing and how to correct it within 5 days after receiving the predetermination filing. If more information is required, WDS will notify you of what is needed within 15 days of receiving the claim. **A predetermination of benefits is not a guarantee of payment.**

WDS may request a one-time extension not longer than 15 days and hold your claim until all information is received. Once notified of the extension, you have 45 days to submit this information, and WDS will make a determination within 15 days. If the information isn’t submitted within 45 days, the claim will be denied. A denial notice will explain the reason for denial, refer to the part of the plan it’s based on, and describe the claim appeal procedures. (For more information, see “Health Care Plans” in “Claims Review and Appeals Procedures” in *Rules, Regulations and Administrative Information*.)

For an emergency, immediate treatment is allowed without predetermination of benefits, and the claim is evaluated after treatment has begun.

## Oral Health Assessment Program

The dental plan includes an oral health assessment program, which helps determine the most appropriate treatment for you based on your oral and overall health. If you see a Preshent dentist—that is, a WDS/Delta Dental dentist specially trained to provide oral health care with a preventive focus—you may receive an oral health assessment.

Depending on the results of your oral health assessment, you may be eligible for remineralization of your teeth to halt or reverse tooth decay, which is caused by a combination of sugars and acid. Remineralization is a process in which calcium, fluoride and an antimicrobial mouth rinse are combined to reduce bacteria and bond with a tooth to strengthen and rebuild the enamel. This treatment helps heal the tooth and make it more resistant to acid. Be sure to consult your dentist about whether remineralization is right for you.

To find a specially trained Preshent dentist, visit the WDS Web site and log on to the subscriber home page with your user name and secure password. That will give you access to the WDS MySmile® personal benefits center, where you can use the Find a Dentist directory to locate a Preshent dentist in your area. (See *Contact Information*.)

## Knowing What's Covered and What's Not

It's possible that some dental treatments may not be covered under the dental plan, or that they may have certain limitations. To make decisions about the dental care you receive, you should know which treatments are covered and which are not. Ultimately, WDS will be responsible for informing you if a dental service or supply isn't covered. The following provides guidelines about what is considered a "covered expense" and what expenses aren't covered.

If professional dental standards indicate the condition can be treated by a less costly alternative to the service proposed by your dentist, the dental plan will limit benefits to the less costly alternative, as determined by WDS on a case-by-case basis. You're responsible for any treatment costs exceeding the allowable amounts paid by the dental plan. (For more information, see "Predetermination of Benefits" on page 151.)

### Covered Expenses

To be covered, expenses must be medically necessary for treatment, diagnosis or prevention of a dental condition.

The dental plan covers expenses for the following services:

- Class I: preventive and diagnostic services;
- Class II: basic services; and
- Class III: major services.

#### Class I: Preventive and Diagnostic Services

##### *Diagnostic Services*

The dental plan covers the following diagnostic services:

- routine examination (periodic oral evaluation), twice per calendar year;
- oral health assessment if the claim is accompanied by an assessment risk code provided by a Preshent network provider;
- comprehensive oral evaluation once in a three-year period as one of the two covered annual routine examinations per dental office. Additional comprehensive oral evaluations will be allowed as routine examinations. You won't be responsible for any difference in cost between a comprehensive oral evaluation and routine examination when services are provided by a WDS/Delta Dental participating dentist;
- X-rays, as follows:
  - a complete series of X-rays (including any number or combination of intraoral and/or extraoral X-rays, billed on the same date of service, that equals or exceeds the allowed fee for a complete series) or panorex X-rays, once in a three-year period; and
  - supplementary bitewing X-rays, twice per calendar year;

#### WHAT THE DENTAL PLAN PAYS

For specific coinsurance amounts for the covered expenses described in this section, see "Your Dental Benefits at a Glance" on page 145.

#### IMPORTANT!

Some preventive and diagnostic services aren't covered. (For details, see "Expenses Not Covered" on page 161.)

## IMPORTANT!

**Under certain conditions, prophylaxis or periodontal maintenance (but not both) may be covered up to four times per calendar year.**

- emergency examination;
- palliative treatment for pain;
- examination performed by a specialist in an American Dental Association recognized specialty; and
- WDS-approved caries (decay) and periodontal susceptibility/risk tests.

X-rays related to temporomandibular joint (TMJ) disorders are covered under the TMJ benefit. (See “Temporomandibular Joint Treatment” in “Other Benefits” in “Class III: Major Services” on page 157.)

### *Preventive Services*

The dental plan covers the following preventive services:

- prophylaxis (cleaning) and/or periodontal maintenance, twice per calendar year;
- fissure sealants for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface, once per tooth in a two-year period;
- remineralization (if performed by a Preshent provider), up to four times per calendar year;
- topical application of fluoride or preventive therapies—for example, fluoridated varnishes. Either service, but not both, is covered twice per calendar year;
- space maintainers when used to maintain space for eruption of permanent teeth.

### *Periodontics*

The dental plan covers the following periodontic services:

- prescription strength fluoride toothpaste; and
- antimicrobial mouth rinse, once per periodontal treatment.

Prescription strength fluoride toothpaste and antimicrobial mouth rinse are covered following periodontal surgery or other covered periodontal procedures when dispensed in a dental office. Proof of a periodontal procedure must accompany the claim or your WDS history must show a periodontal procedure within the previous 180 days. However, antimicrobial mouth rinse is covered for pregnant women whether or not a periodontal procedure has been performed.

## Class II: Basic Services

### *General Anesthesia*

The dental plan covers general anesthesia when administered by a licensed dentist or other WDS-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington or as determined by the state in which the services are rendered. General anesthesia is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS, or when medically necessary, for children through age 6 or a physically or developmentally disabled person, when in conjunction with other covered dental procedures. Either general anesthesia or intravenous sedation (but not both) is covered when performed on the same day.

### *Intravenous Sedation*

The dental plan covers intravenous sedation when administered by a licensed dentist or other WDS-approved licensed professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the State of Washington or as determined by the state in which the services are rendered. Intravenous sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS. Either general anesthesia or intravenous sedation (but not both) is covered when performed on the same day.

### *Restorations*

The dental plan covers the following restorations:

- amalgam restorations and, in anterior teeth, resin-based composite or glass ionomer restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp). Restorations on the same surface(s) of the same tooth are covered once in a two-year period;
- resin-based composite or glass ionomer restorations placed in the buccal (facial) surface of bicuspid. If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except on bicuspid as noted above), it will be considered as a cosmetic procedure and an amalgam allowance will be made, and any difference in cost will be your responsibility; and
- stainless steel crowns, once in a two-year period.

(If teeth are restored with crowns, veneers, inlays or onlays, see "Restorations" in "Class III: Major Services" on page 157.)

### IMPORTANT!

**Some basic services aren't covered. (For details, see "Expenses Not Covered" on page 161.)**

### IMPORTANT!

**You may be responsible for a portion of the cost of some resin-based composite and glass ionomer restorations.**

### *Oral Surgery*

The dental plan covers the following oral surgery services:

- removal of teeth;
- preparation of the mouth for insertion of dentures; and
- treatment of pathological conditions and traumatic injuries of the mouth.

(For more information, see “General Anesthesia” and “Intravenous Sedation” in “Class II: Basic Services” on page 155.)

### *Periodontics*

The dental plan covers the following periodontic services:

- surgical and non-surgical procedures for treatment of the tissues supporting the natural teeth; services covered include periodontal scaling/root planing and periodontal surgery;
  - periodontal scaling/root planing is covered once in a 12-month period;
  - periodontal surgery (per site) is covered once in a three-year period; and
  - soft tissue grafts (per site) are covered once in a three-year period;
- limited adjustments to occlusion (8 teeth or less), once in a 12-month period; and
- WDS-approved localized delivery of antimicrobial agents, up to two teeth per quadrant and up to twice per tooth per calendar year.

Periodontal surgery and localized delivery of antimicrobial agents must be preceded by scaling and root planing at least six weeks but not more than six months—or you must have been in active supportive periodontal therapy—before such treatment begins.

(For information about periodontal maintenance benefits, see “Class I: Preventive and Diagnostic Services” on page 153. For information about complete occlusal equilibration and occlusal (night) guards, see “Periodontics” in “Class III: Major Services” on page 157.)

### *Endodontics*

The dental plan covers the following endodontic services:

- procedures for pulpal and root canal treatment. Root canal treatment on the same tooth is covered once in a two-year period; and
- pulp exposure treatment, pulpotomy and apicoectomy.

Re-treatment of the same tooth is allowed when performed by a different dental office.

(For details relating to root canals that are placed in conjunction with a prosthetic appliance, see “Prosthodontics” in “Class III: Major Services” on page 157.)

## Class III: Major Services

### *Periodontics*

Under certain conditions, the dental plan covers occlusal (night) guards, repair and relines of occlusal (night) guards, and complete occlusal equilibration. Keep in mind that:

- occlusal (night) guards are covered once in a three-year period;
- repairs and relines done more than six months after the initial placement are covered; and
- complete occlusal equilibration is covered once in a lifetime.

### *Restorations*

The dental plan covers the following restorations:

- crowns, veneers, inlays (as a single tooth restoration—with limitations) or onlays (whether gold, porcelain, WDS-approved gold substitute castings, except laboratory-processed resin, or combinations thereof) for the treatment of carious lesions (that is, visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp), when teeth cannot reasonably be restored with filling materials, such as amalgam or resin-based composites;
- crown buildups, once in a two-year period when more than 50% of the natural coronal tooth structure is missing or there is less than 2mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology; and
- cast post and core, once in a five-year period on the same tooth in keeping with the policy for all cast restorations.

While the dental plan covers the restoration services listed above, there are a number of limitations to that coverage:

- crowns, veneers, inlays (as a single tooth restoration—with limitations) or onlays on the same teeth are covered once in a five-year period;
- if a tooth can be restored with a filling material such as amalgam or resin-based composites, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided;
- WDS will allow the appropriate amount for an amalgam restoration (posterior tooth) or resin-based composite restoration (anterior tooth) toward the cost of a laboratory processed resin inlay (as a single tooth restoration—with limitations), onlay, veneer or crown;

### IMPORTANT!

**Some major services aren't covered. (For details, see "Expenses Not Covered" on page 161.)**

- payment for crowns, veneers, inlays (as a single tooth restoration—with limitations) or onlays will be paid on the date they're permanently cemented into place on the tooth; and
- inlays (as a single tooth restoration) will be considered a cosmetic procedure and an amalgam allowance will be made, and any difference in cost will be your responsibility.

### *Prosthodontics*

The dental plan covers the following prosthodontic services:

- dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge), removable partial dentures and the adjustment or repair of an existing prosthetic device; and
- surgical placement or removal of implants or attachments to implants.

While the dental plan covers the prosthodontic services listed above, there are a number of limitations to that coverage:

- replacement of an existing prosthetic device is covered once every five years and only if it is unserviceable and cannot be made serviceable;
- inlays are covered on the same teeth once every five years only when used as an abutment for a fixed bridge;
- payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge) and removable partial dentures will be made on the delivery date;
- replacement of implants and superstructures is covered only after five years have elapsed from any prior provision of the implant;
- WDS will allow the appropriate amount for a full, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment;
- WDS will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be covered after six months;
- root canal treatment performed in conjunction with overdentures is limited to two teeth per arch and is paid at the Class III payment level (For coverage details, see "Your Dental Benefits at a Glance" on page 145);
- if a more elaborate or precision device is used to restore the cast of a partial denture, WDS will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided; and
- denture adjustments and relines done more than six months after the initial placement are covered. Subsequent relines or rebases (but not both) will be covered once in a 12-month period.

## Other Benefits

### *Orthodontic Services*

The dental plan covers the following orthodontic services for adults and children:

- treatment of malalignment of teeth and/or jaws;
- exams (initial, periodic, comprehensive, detailed and extensive);
- X-rays (intraoral, extraoral, diagnostic radiographs, panoramic);
- diagnostic photographs;
- diagnostic casts (study models);
- cephalometric films; and
- orthodontic records.

Payment is limited to:

- completion, or through limiting age, whichever occurs first;
- treatment received after coverage begins (claims must be submitted to WDS within six months of the start of coverage); and
- termination of the treatment plan before completion of the case or termination of this contract.

(For coverage amounts, see “Your Dental Benefits at a Glance” on page 145.)

#### **BEFORE TREATMENT BEGINS**

It is strongly suggested that an orthodontic treatment plan be submitted to WDS, together with a predetermination of benefits request, before treatment begins. Predetermination of benefits is not a guarantee of payment.

### *Temporomandibular Joint Treatment*

The dental plan covers certain treatments for temporomandibular joint (TMJ) disorders that have one or more of the following characteristics:

- pain in the musculature associated with the temporomandibular joint;
- internal derangements of the temporomandibular joint;
- arthritic problems with the temporomandibular joint; or
- an abnormal range of motion or limitation of motion of the temporomandibular joint.

Covered services include, but aren't limited to, the following non-surgical procedures:

- TMJ examination;
- X-rays (including TMJ film and arthrogram);
- temporary repositioning splint;

- occlusal orthotic device;
- removable metal overlay stabilizing appliance;
- stabilizing appliance;
- occlusal equilibration;
- arthrocentesis; and
- manipulation under anesthesia.

To be covered, these services must be:

- appropriate, as determined by WDS for the treatment of a disorder of the temporomandibular joint under all the factual circumstances of the case;
- effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint:
  - pain;
  - infection;
  - disease;
  - difficulty speaking; or
  - difficulty chewing or swallowing food;
- recognized as effective, according to the professional standards of good dental practice; and
- not experimental or primarily for cosmetic purposes.

(For coverage amounts, see “Your Dental Benefits at a Glance” on page 145.)

Any procedure defined as a TMJ service above but that may otherwise be a service covered under another class of coverage will be considered covered by that class of coverage and not covered under TMJ treatment.

#### **BEFORE TREATMENT BEGINS**

It is strongly recommended that a TMJ treatment plan be submitted to WDS, together with a predetermination of benefits request, before treatment begins. Predetermination of benefits is not a guarantee of payment.

#### *Accidental Injury*

The dental plan pays 100% of covered expenses directly resulting from an accidental bodily injury, up to the annual maximum, if the diagnosis and treatment is performed/incurred within 180 days after the accident. (A bodily injury doesn't include teeth broken or damaged while chewing or biting on foreign objects.)

The accidental bodily injury and treatment must have occurred while you were covered under this plan. Payment for accidental injury claims will not exceed the maximum.

## Expenses Not Covered

The dental plan doesn't cover the following dental services and supplies:

- any treatment for which you failed to obtain a required examination from a WDS-appointed consultant dentist;
- application of desensitizing agents;
- analgesics, such as nitrous oxide, conscious sedation, or euphoric drugs, injections or prescription drugs;
- bleaching of teeth;
- broken appointments;
- certain diagnostic services and supplies—specifically:
  - consultations or elective second opinions;
- certain periodontic services—specifically:
  - periodontal splinting;
  - crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances;
  - gingival curettage; and
  - localized delivery of antimicrobial agents when used for the purpose of maintaining non-covered dental procedures or implants;
- certain preventive services and supplies—specifically:
  - plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits); and
  - replacement of a space maintainer previously paid for by the dental plan;
- certain prosthodontic services and supplies—specifically:
  - cleaning of prosthetic appliances;
  - duplicate dentures;
  - personalized dentures;
  - copings; and
  - crowns in conjunction with overdentures;
- certain oral surgery services and supplies—specifically:
  - bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of natural teeth;
  - materials placed in tooth extraction sockets for the purpose of generating osseous filling; and
  - tooth transplants;

- certain orthodontic services and supplies—specifically:
  - replacement or repair of an appliance;
  - orthognathic surgery; and
  - services considered inappropriate and unnecessary, as determined by WDS;
- certain restorative services and supplies—specifically:
  - crown buildups within two years of a restoration on the same tooth;
  - crown buildups for the purpose of improving tooth form, filling in undercuts or reducing bulk in castings;
  - a crown used for purposes of recontouring or repositioning a tooth to provide additional retention for a removable partial denture, unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment;
  - crowns or onlays when used to repair microfractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there are existing restorations with defective margins when there is no decay or other significant pathology present;
  - crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology;
  - crowns and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances;
  - overhang removal, copings, recontouring or polishing of a restoration; and
  - restorations or appliances necessary to correct vertical dimension, alter the morphology (shape) or restore the occlusion, including:
    - restoration of tooth structure lost from attrition, abrasion or erosion; and
    - restorations for malalignment of teeth;
- completing claim forms;
- dentistry for cosmetic reasons;
- experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation or observation. In determining whether services are experimental, WDS, in conjunction with the American Dental Association, will consider if the services:
  - are in general use in the dental community in the State of Washington;
  - are under continued scientific testing and research;

- show a demonstrable benefit for a particular dental condition; and
- are proven to be safe and effective.

Any denial of benefits by WDS on the grounds that a given procedure is deemed experimental may be appealed to WDS. WDS must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with your written consent;

- general anesthesia/intravenous (deep) sedation for routine post-operative procedures and except as specified by WDS for certain oral, periodontal or endodontic surgical procedures. General anesthesia isn't covered except when medically necessary, for children through age 6 or a physically or developmentally disabled person, when in conjunction with covered dental procedures;
- habit-breaking appliances;
- hospitalization charges and any additional fees charged by a dentist for hospital treatment;
- patient management problems;
- services for injuries or conditions that are compensable under workers' compensation or employers' liability laws, and services that are provided to you by any federal or state or provincial government agency or provided without cost to you by any municipality, county or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, Section 1902 of the Social Security Act; and
- services or supplies to the extent that benefits are payable under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection, commercial liability, homeowner's policy or other similar type of coverage.

## Filing a Claim

If you receive care from a WDS/Delta Dental participating dentist, the dentist will submit a claim for you.

If you receive services from a non-participating dentist, you may be required to pay the dentist in full, and it's your responsibility to submit a claim form to WDS or have the provider submit one for you. Claim forms are available from WDS. (See *Contact Information*.)

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

- patient's name;
- provider's tax ID number;
- diagnosis or CDT-7 code;

- date of service/supply; and
- itemized charges from the provider for the services and/or supplies received.

You also need to provide:

- your name (if you're not the patient);
- your Social Security number (or unique identifier number if you've requested one); and
- group number 00152.

For prompt payment, submit all claims as soon as possible. The dental plan won't pay a claim submitted more than six months after the date of service and/or supply. If you can't meet the six-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

## How the Claim Is Reviewed

WDS will review your claim and notify you or your provider in writing within the following time frames:

- **Within 72 hours for urgent claims.** Urgent claims are claims for services where your provider believes a delay in treatment could seriously jeopardize your life, health or ability to regain maximum function, or cause severe pain that can't be controlled adequately without the care being considered. Urgent claims can be submitted by phone. (See *Contact Information*.) You'll be notified of the claim review decision by phone and later by a written notice.
- **Within 15 days for pre-service claims (within 30 days if an extension is filed).** Pre-service claims are those where WDS requires you to obtain approval of the benefit before receiving the care. The dental plan may ask for a one-time extension of 15 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.
- **Within 30 days for post-service claims (within 60 days if an extension is filed).** Post-service claims are claims that aren't urgent or pre-service. The dental plan may ask for a one-time extension of 30 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.

The claim administrator reviews your claim, applying plan provisions and discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above.

## **If WDS Approves the Claim**

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

## **If WDS Denies the Claim**

If the claim is denied, you'll be notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that were reviewed in making the determination. (For more information about appeals, see "Dental" in "Health Care Plans" in "Claims Review and Appeals Procedures" in *Rules, Regulations and Administrative Information*.)

## VISION PLAN

### DEFINED TERMS

Be sure you understand the meaning of the terms used in this summary, such as “copay.” (See “Glossary” on page 191.)

Routine eye exams and affordable eyeglasses and contact lenses are another part of your total health care program. That’s why the county offers a vision plan that makes it easy for you to get the eye care you need.

As a benefit-eligible employee, you receive vision benefits through Vision Service Plan (VSP).

Although VSP administers the payment of claims for this plan, the vision benefits are “self-funded” by King County. This means that the county is financially responsible for and pays all allowable claims and administrative costs associated with the vision plan.

### How the Vision Plan Works

With the vision plan, you can use any eye care provider you want, but your out-of-pocket expenses are usually lower if you see a VSP provider. Plus, a VSP provider automatically files your claims for you.

Your benefits with the vision plan are based on a 12-month cycle rather than a calendar year—for example, if you have your first eye exam in June, you’ll be eligible for your next eye exam the following June.

Group Health provides routine vision exams under its medical plan, but none of the other vision benefits shown in “Your Vision Benefits at a Glance” on page 166. Those benefits are provided by VSP. In addition, VSP providers may not accept a Group Health prescription for lenses. (For more information, see “Group Health Benefits at a Glance” on page 81 in “Medical Plans.”)

### Your Vision Benefits at a Glance

The following table shows what the vision plan pays for covered eye care services and eyewear and identifies related limits. (For more information, see “Knowing What’s Covered and What’s Not” on page 171.)

Vision Plan		
Covered Expenses	If you see a VSP provider, you pay a \$10 copay and the plan pays the amount listed below	If you see a non-VSP provider, you pay the bill in full and the plan reimburses you the amounts listed below, minus a \$10 copay
<i>Exam (once every 12 months)</i>	100%	Up to \$40
<i>Eyeglass lenses (one pair every 12 months)</i>		
• Single vision	100%	Up to \$40
• Lined bifocal	100%	Up to \$60

Vision Plan		
• Lined trifocal	100%	Up to \$80
• Progressive lenses	100%	Up to trifocal allowance of \$80
• Lenticular	100%	Up to \$125
• Polycarbonate lenses for children	100%	Not covered
• Anti-reflective coating	100%	Not covered
• Color/mirror coating	100%	Not covered
• Scratch coating	100%	Not covered
• Tints/photochromic lenses	100%	Up to \$5
• UV lenses	100%	Not covered
<b><i>Eyeglass frames (once every 24 months)</i></b>	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 cost	Up to \$45
<b><i>Contact lenses (once every 12 months in place of eyeglass lenses and frames)</i></b>		
• 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 contact lens fees apply to the \$105 maximum paid by the plan)	Up to \$105	Up to \$105
• Medically necessary (See "Knowing What's Covered and What's Not" on page 171.)	100% (Preauthorization required)	Up to \$210 (Preauthorization required)
• Low-vision benefit	75% up to \$1,000 (Preauthorization required)	75% up to \$1,000 (Preauthorization required)

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 a faster turnaround, your provider may be able to accommodate you, depending on its arrangements with the lab. Because the cost and arrangements vary by provider, contact your VSP provider for details.

Each time you receive contact lenses under the vision plan, you must wait 12 months before you're eligible for lenses (eyeglass or contact) and 24 months before you're eligible for frames.

#### HELPFUL HINT

If you're interested in getting both glasses and contacts, purchase the glasses first—then you can replace lenses (either eyeglass or contact) each year.

## Using the Vision Plan

When you enroll in the vision plan, you may receive benefits from a VSP or a non-VSP provider. However, when you use a VSP provider:

- your out-of-pocket expenses are usually lower than if you had used a non-VSP provider;
- your VSP provider automatically files claims for you; and
- VSP guarantees patient satisfaction.

To receive VSP-level benefits:

- Make an appointment with a VSP provider. Be sure to identify yourself as a VSP member and give the employee's Social Security number (or alternate ID if one has been requested). This is how VSP identifies all dependents under the employee's plan. The VSP provider will notify you if any services you're requesting aren't covered.
- Pay a \$10 copay when you receive eye care services from the provider (you pay only once during any 12-month period). The plan pays 100% for most covered services.

You don't need to file claims when you see a VSP provider. Your provider handles the rest by verifying your benefits and eligibility for VSP services.

To receive non-VSP-level benefits:

- make an appointment with any licensed eye care provider. If you want to verify if the care you'll receive is covered, contact VSP (See *Contact Information*);
- pay the bill in full; and
- file a claim with VSP for reimbursement.

## The VSP Network

VSP has an extensive nationwide network of private-practice optometrists and ophthalmologists. To locate a VSP provider or find out if your provider is part of the VSP network, visit the VSP Web site or call VSP. (See *Contact Information*.) VSP keeps its list of participating eye care providers current and has search tools you can use for locating a provider near you.

### VSP Providers

The VSP network of eye care providers offers some services for your eye care that out-of-network providers usually don't, including:

- direct verification of your benefits and eligibility for services;
- direct filing of your claims; and
- patient satisfaction with the VSP guarantee. If you're not satisfied with the services you receive from a VSP provider, contact VSP. (See *Contact Information*.)

### Non-VSP Providers

You may choose to go to a licensed ophthalmologist, optometrist or optician who isn't a VSP provider. Non-VSP providers may offer the same level of eye care as VSP providers, but they don't necessarily offer the additional services that VSP eye care professionals provide. In most cases, your out-of-pocket expenses will be higher, and you'll need to verify your eligibility for services and file a claim for reimbursement yourself.

### If Your Dependent Lives Away from Home

If your dependent lives away from home temporarily or permanently, he/she can still receive vision coverage through either a VSP (if available) or a non-VSP provider. Benefits depend on whether he/she chooses a VSP or non-VSP provider and are paid at the level shown in "Your Vision Benefits at a Glance" on page 166.

## Paying for Your Care

Since you don't receive an ID card for the vision plan, you'll need to tell your eye care provider that you're covered by the VSP vision plan for King County (group number 12029826). You must provide the employee's Social Security number (or alternate ID if one has been requested) to your provider for verification of your eligibility. From there, your provider (if he/she is a VSP provider) will handle your claims for you.

### Copay

When you receive eye care services from a VSP provider, you'll pay a \$10 copay. Most of your eye care expenses are covered at 100% after your copay when you see a VSP provider. When you see a non-VSP provider, you'll need to pay a \$10 copay, which applies to the total charges, and you'll pay any amount not covered by or exceeding the plan's benefits.

### Up Close and Personal

The following examples help illustrate how the vision plan works.

#### Meet Jamal

Jamal is in his second year of plan participation. He visits his VSP provider for an annual exam. It's been 12 months since his last exam, at which time he purchased new eyeglass frames and lenses. This year, knowing that he can't replace his frames, he wants to replace his scratched progressive lenses. He also wants to add a tint to the lenses in addition to anti-reflective and anti-scratch coatings. Here's how much Jamal pays for his visit to his VSP provider and for the new lenses, which he purchased from his provider:

The total expense is...	Vision plan pays...	Jamal pays...
\$100 for the exam	\$ 90 (\$100 minus \$10 copay)	\$10 copay
\$350 for progressive lenses, anti-reflective coating, anti-scratch coating, tinting	+ 350 \$440	+ 0 \$10

Jamal must now wait 12 months before the vision plan will pay benefits for another exam and for replacing his eyeglass frames and lenses.

#### Meet Maria

Maria is also in her second year of plan participation, but she has chosen to visit a non-VSP provider. Like Jamal, she also wants to replace her scratched progressive lenses and add a tint to anti-reflective and anti-scratch coatings. Here's what Maria pays for her visit to a non-VSP provider:

The total expense is...	Vision plan pays...	Maria pays...
\$100 for the exam	\$ 40	\$ 60
\$350 for progressive lenses, anti-reflective coating, anti-scratch coating, tinting	+ 85 (\$80 for progressive lenses and \$5 for tinted lenses) \$125	+ 265 \$325

Maria must now wait 12 months before the vision plan will pay benefits for another exam and for replacing her eyeglass frames and lenses.

## Knowing What's Covered and What's Not

It's possible that some eye care services may not be covered under the vision plan, or that they may have certain limitations. To make decisions about the eye care you receive, you should know what is covered and what is not. Ultimately, VSP will be responsible for informing you if an eye care service or supply isn't covered. The following provides guidelines about what is considered a "covered expense" and what expenses aren't covered.

### Covered Expenses

The vision plan covers expenses for the following services (For additional information on the benefits you receive, see "Your Vision Benefits at a Glance" on page 166):

- contact lenses—elective;
- contact lenses—medically necessary contact lenses when preauthorized by VSP and prescribed by an eye care provider for your visual welfare due to specific medical conditions such as:
  - cataract surgery;
  - conditions of anisometropia;
  - extreme visual acuity problems that cannot be corrected with eyeglasses; and
  - keratoconus;
- exam—a complete analysis of the eye and related structures to determine the presence of vision problems or abnormalities;
- eyeglass lenses—single vision, bifocal, trifocal, progressive and lenticular, including polycarbonate lenses for children, anti-reflective/scratch coatings and tinted/photochromic lenses; and
- eyeglass frames.

#### IMPORTANT!

Keep in mind that some eye care services aren't covered. (For details, see "Expenses Not Covered" on page 172.)

### Low-Vision Benefit

If you have severe visual problems that aren't correctable with regular lenses, you may be eligible for the low-vision benefit. To receive this benefit, you may see either a VSP or non-VSP provider, and you must:

- obtain authorization from VSP before you receive services; and
- pay a copay equal to 25% of the cost of services.

#### WHAT THE VISION PLAN PAYS

For specific copays or out-of-pocket expenses for the covered expenses described in this section, see "Your Vision Benefits at a Glance" on page 166.

After you pay the copay, the vision plan pays 100% for analysis and diagnosis, including a comprehensive exam of visual functions, with a prescription for corrective eyewear or vision aids where indicated. The low-vision benefit maximum is \$1,000 (excluding the copay) every two years.

If you see a non-VSP provider, you must pay the provider in full and file a claim with VSP for reimbursement. The benefit won't be more than the amount payable had you seen a VSP provider.

### Discounts

The vision plan provides discounts for a number of services.

- **Extra frames and prescription lenses.** You may purchase an additional pair of frames and prescription lenses from your VSP provider at a 20% discount. To receive this discount, you must make the additional purchase within 12 months of your initial exam and from the same VSP provider.
- **Exam for prescription contact lenses.** If you see a VSP provider for a contact lens exam for the purpose of fitting you for prescription contact lenses, you'll receive a 15% discount toward the exam and any follow-up services.
- **Laser vision correction.** VSP has arranged for plan members to receive laser vision correction from VSP-approved surgeons and laser centers for a discounted fee. Discounts vary by location but average 15% to 20%. The laser centers may offer an additional price reduction, where VSP members receive 5% off the advertised price if it's less than the usual discounted price. Post-procedure care is coordinated between your VSP provider (optometrist or ophthalmologist) and your VSP surgeon and laser center. To obtain laser vision services:
  - call your VSP provider to check if he/she participates in the program, or contact VSP to locate a participating provider (See *Contact Information*); and
  - schedule a free screening and consultation on the advantages and risks of laser vision correction. Your VSP provider will give preoperative care and make arrangements with the VSP-approved surgeon and laser center. While the screening and consultation are complimentary, your VSP provider may charge a discounted exam fee of up to \$100 if you have a preoperative exam and don't proceed with the surgery.

### Expenses Not Covered

The vision plan doesn't cover:

- costs that exceed plan allowances;
- exams or eyewear required as a condition of employment;

- extra-cost items. The vision plan is designed to pay the cost of visual rather than cosmetic needs. A VSP provider can tell you the additional charges that you'll pay for:
  - amounts over the low-vision benefit maximum;
  - frames above the plan allowance; and
  - optional cosmetic services, procedures and eyewear;
- lenses—blended;
- medical or surgical treatment of the eye (For information on coverage for these expenses, see "KingCare<sup>SM</sup>" on page 86 or "Group Health" on page 122 in "Medical Plans");
- orthoptics or vision training and any associated supplemental testing;
- oversized lenses (61 mm or larger);
- plano (non-prescription) lenses;
- replacement of lost or broken lenses and frames, except at scheduled intervals—once every 12 months for lenses (eyeglass or contact) and once every 24 months for frames. If frames are broken as new lenses are being inserted, VSP may cover the cost, depending on the age and condition of the broken frames; contact VSP for details (See *Contact Information*);
- services or materials provided as the result of workers' compensation law or similar legislation, or obtained through or required by any government agency or program; and
- two pairs of glasses in place of bifocals.

## Filing a Claim

If you receive care from a VSP provider, the provider submits claims for you. If you receive services from a non-VSP provider, you pay the provider in full, and it's your responsibility to submit a claim to VSP for reimbursement. You may submit a claim without a form, but if you would like one, claim forms are available from VSP by phone or at the VSP Web site. (See *Contact Information*.)

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

- patient's name;
- provider's tax ID number;
- date of service and/or supply; and
- itemized charges from the provider for the services and/or supplies received.

You also need to provide:

- the employee's name (if different from the patient's); and
- the employee's Social Security number (or alternate ID if one has been requested).

For prompt payment, submit all claims as soon as possible. The vision plan will not pay a claim submitted more than 12 months after the date of service and/or supply. If you can't meet the 12-month deadline because of circumstances beyond your control, the claim will be considered for payment when accompanied by a written explanation of the circumstances.

## How VSP Reviews the Claim

VSP will review your claim and notify you or your provider in writing within the following time frames:

- **Within 15 days for pre-service claims (within 30 days if an extension is filed).** Pre-service claims are those where VSP requires you to obtain approval of the benefit before receiving the care. VSP may ask for a one-time extension of 15 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.
- **Within 30 days for post-service claims (within 60 days if an extension is filed).** Post-service claims are claims that aren't pre-service. VSP may ask for a one-time extension of 30 days to request additional information. Once notified of the extension, you have 45 days to provide any missing information.

The claim administrator reviews your claim, applying plan provisions and discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above.

### If VSP Approves the Claim

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

### If VSP Denies the Claim

If the claim is denied, you'll be notified in writing of the reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim that VSP reviewed in making the determination. (For information about appeals, see "Vision" in "Health Care Plans" in "Claims Review and Appeals Procedures" in *Rules, Regulations and Administrative Information*.)

## CONTINUING COVERAGE UNDER COBRA

If you and/or your covered dependents lose your health care plan coverage through the county, the federal Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) gives you and/or your covered dependents the right to continue coverage.

COBRA coverage is available in certain instances (called “qualifying events”) where coverage under the following county health care plans would otherwise end:

- KingCare<sup>SM</sup>;
- Group Health;
- dental plan; and
- vision plan.

This section of *Your King County Benefits* provides you with important information about your COBRA rights and how they apply to you and your covered dependents.

### How COBRA Works

COBRA coverage is a continuation of health care plan coverage when coverage ends because of a life event known as a “qualifying event.” When a qualifying event occurs, COBRA coverage must be offered to each “qualified beneficiary.” You, your covered spouse/domestic partner and your covered children could become qualified beneficiaries if coverage under your county health care plan ends because of a qualifying event.

A notice describing COBRA rights will be mailed to your home within 30 days after the time you first enroll for county coverage. When you become eligible for COBRA coverage, Benefits and Retirement Operations will notify the Fringe Benefits Management Company (FBMC) of your status, and FBMC will contact you with information about your COBRA options. FBMC is the COBRA administrator for the county.

### Who’s Eligible for COBRA Coverage and Why

A qualified beneficiary is an employee, a spouse/domestic partner or a child who is covered by a county health care plan and who loses coverage because of a qualifying event.

#### Employee

As a benefit-eligible employee, you become a qualified beneficiary when you lose coverage under your county health care plan because of any of these qualifying events:

- a change in your job status, such as a reduction in hours;

- an unpaid leave of absence for more than 31 days; or
- your employment ends for retirement or any reason other than your gross misconduct.

### Spouse/Domestic Partner

Your covered spouse/domestic partner becomes a qualified beneficiary when he/she loses coverage under your county health care plan because of any of these qualifying events:

- you die;
- there's a change in your job status, such as a reduction in hours;
- your employment ends for retirement or any reason other than your gross misconduct; or
- you and your spouse divorce, or you end your domestic partnership (legal separation isn't a qualifying event).

If you drop your spouse from coverage in anticipation of a divorce and a divorce later occurs, the divorce is considered the qualifying event even though your spouse lost coverage earlier.

You must complete the Discontinue Dependent Coverage form online as soon as possible, preferably within 30 days but no later than 60 days after your divorce is final. If King County isn't notified within 60 days, your former spouse won't be eligible for continuation of coverage. Your former spouse will have 60 days from the date his/her county coverage ends or from the date that FBMC sends your former spouse notification of his/her COBRA eligibility, whichever is later, to enroll in COBRA. COBRA eligibility begins on the first day of the month following the divorce as long as enrollment and payment of premium have been timely.

#### HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits and Retirement Web site at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits). At the Web site, click "My Benefits" in the left navigation menu and follow the directions. Most non-county forms are available on the Benefits and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

### Children

Your covered child becomes a qualified beneficiary when he/she loses coverage under your county health care plan because of any of these qualifying events:

- you die;
- there's a change in your job status, such as a reduction in hours;
- your employment ends for retirement or any reason other than your gross misconduct;

- you and your spouse divorce, or you end your domestic partnership (legal separation isn't a qualifying event); or
- your child becomes ineligible for coverage as a dependent under your health care plan. (For more information on dependent eligibility, see "Dependent Children" on page 47 in "Who Is Eligible" in "Participating in the Health Care Plans.")

For your dependent to be eligible for COBRA, you must complete the Discontinue Dependent Coverage form online as soon as possible, preferably within 30 days but no later than 60 days of the date he/she becomes ineligible. If King County isn't notified within 60 days, your dependent won't be eligible for continuation of coverage.

#### HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits and Retirement Web site at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits). At the Web site, click "My Benefits" in the left navigation menu and follow the directions. Most non-county forms are available on the Benefits and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

## How to Enroll for COBRA Coverage

When you qualify for COBRA coverage because you have a change in job status, leave county employment or retire, your qualifying event is reported to Benefits and Retirement Operations through your Termination Notice, which you need to complete, or the county payroll report.

#### FORMS

Forms are available at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits) or from Benefits and Retirement Operations. (See *Contact Information*.)

If you die while actively employed by the county, Benefits and Retirement Operations will notify your eligible dependents of their COBRA rights.

For other qualifying events, such as divorce, dissolution of a domestic partnership or a child's loss of eligibility for coverage as a dependent, you must complete the Discontinue Dependent Coverage form online as soon as possible, preferably within 30 days but no later than 60 days of the qualifying event.

#### HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits and Retirement Web site at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits). At the Web site, click "My Benefits" in the left navigation menu and follow the directions. Most non-county forms are available on the Benefits and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

If these procedures aren't followed or if the online Discontinue Dependent Coverage form isn't completed by the last day of the 60-day notice period, any covered spouse/domestic partner or child who loses coverage will **not** be offered the option to elect COBRA coverage.

### COBRA Enrollment Process

When Benefits and Retirement Operations receives COBRA-qualifying information, it notifies FBMC so that FBMC can offer COBRA coverage to each qualified beneficiary and explain COBRA plan options and cost. Each qualified beneficiary has an independent right to elect COBRA coverage. As the covered employee, you may elect COBRA coverage on behalf of your spouse/domestic partner. Parents may elect COBRA coverage on behalf of their covered children.

You have 60 days from the date your county coverage ends or from the date that FBMC sends you notification of your COBRA eligibility, whichever is later, to elect COBRA coverage. If you elect COBRA coverage, it will pick up where your county coverage left off as long as enrollment and payment of premium have been timely.

You can only continue COBRA coverage for the county benefits you have on your last day of work. When enrolling in COBRA, you may choose any health care plan for which you were eligible on your last day of work. However, if you don't have medical coverage on your last day because you opted out of medical coverage, for example, you cannot enroll in medical coverage under COBRA.

This applies to KingCare<sup>SM</sup>, Group Health, your dental plan and your vision plan. You also must pay for COBRA coverage. (For details about what COBRA coverage costs, see "How Much COBRA Coverage Costs" on page 179.)

You and/or your qualified dependents may continue coverage under Medicare or another group health care plan if the effective date of coverage under the other plan is before the COBRA election date.

### OTHER COBRA BENEFITS

**If you are continuing your health care plan coverage under COBRA, you may continue to use the county's Making Life Easier benefit. For more information about this benefit, contact Making Life Easier. (See *Contact Information*.)**

### COBRA AND FSAS

If you're participating in a health care flexible spending account (FSA) when you elect COBRA, you may continue to contribute to your FSA on an after-tax basis through the end of the calendar year as long as you continue your COBRA benefits. This allows you to receive reimbursements for expenses incurred during the remainder of the year.

However, if you don't elect COBRA and don't elect to continue your FSA contributions, you will be able to file claims for reimbursement only against the contributions you made to your FSA through your last day with the county. Claims may be filed through March 31 of the following year.

To continue your FSA, you need to contact FBMC. (For more information, see *Flexible Spending Accounts*.)

## How Much COBRA Coverage Costs

Under the county health care plans, qualified beneficiaries who elect COBRA coverage must pay for it. Your plan options and their cost are explained in information you receive from FBMC when you qualify for COBRA.

If you elect COBRA coverage, you must make the initial premium payment within 45 days of your COBRA enrollment. **If you don't make the initial premium payment within those 45 days, your coverage will be terminated.** To expedite COBRA coverage, you may attach your initial payment to the COBRA election form and return them both to FBMC.

All other premiums are due on the first of the month. Coverage automatically ends if payment isn't made within 30 days. FBMC will provide you with more detailed payment information when it first contacts you.

Once you've elected COBRA coverage and paid the initial premium within the 45-day time frame, COBRA coverage is retroactive to the first day of the month following your loss of coverage. There's no lapse in coverage—COBRA benefits begin when county-paid benefits end, even if retroactive processing and payments are required. Your initial payment must include all applicable back premiums. Any covered out-of-pocket expenses incurred before you enrolled for COBRA coverage may be reimbursable once you've enrolled.

## How Long COBRA Coverage Lasts

COBRA coverage is a *temporary* continuation of coverage. When the qualifying event is your death, divorce, dissolution of a domestic partnership or a covered child's losing eligibility as a dependent, COBRA coverage for your dependents may continue for up to a total of 36 months.

If you're the covered employee and your Medicare entitlement precedes a reduction in hours of employment or the end of employment, your spouse/domestic partner and covered children are entitled to COBRA coverage for up to 18 months from the end of employment or 36 months from the earlier Medicare entitlement date, whichever is greater. For example, if you become entitled to Medicare 8 months before the date on which your employment ends, COBRA coverage for your spouse/domestic partner and covered children can continue for up to 28 months after the date of the qualifying event (that is, 36 months minus 8 months).

However, when the qualifying event is loss of coverage due to the end of your employment or a change in your job status, COBRA coverage continues only up to a total of 18 months.

## Additional Qualifying Events

The 18-month period of COBRA coverage can be extended as the result of:

- a disability; or
- a second qualifying event.

### COBRA COST

COBRA cost information is available from Benefits and Retirement Operations and its Web site. (See *Contact Information*.)

## Special Rules for Disability

An 11-month extension of COBRA coverage may be available if any qualified beneficiaries under your county health care plan are disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of COBRA coverage, and you must provide FBMC with written notice and a copy of the SSA award letter within 60 days of the SSA determination and before the end of the first 18 months of COBRA coverage.

All qualified beneficiaries who have elected COBRA coverage will be entitled to the 11-month disability extension if any covered family member qualifies for the extension. If the SSA determines that the disabled beneficiary is no longer disabled, you must notify FBMC in writing of that fact within 30 days of the SSA determination.

### DISABILITY EXTENSION UNDER KINGCARE<sup>SM</sup>

Under KingCare<sup>SM</sup>, if you or a covered family member is totally disabled and coverage ends for any reason other than plan termination, medical coverage *only* for the disabling condition may be extended for 12 months at no cost. The disabled person may choose either the medical extension coverage under KingCare<sup>SM</sup> or COBRA coverage; however, electing the extension means forfeiting the right to elect COBRA coverage and to convert to an individual policy. Other family members may be able to elect coverage through COBRA.

Medical extension coverage will end when you or your family members experience any of the following:

- reach any lifetime maximum;
- are no longer disabled;
- become eligible for benefits under another group policy;
- reach the end of the 12-month extension; or
- your group plan ends.

## Second Qualifying Event

If you or a covered family member experiences another qualifying event while receiving 18 or 29 months of COBRA coverage, your spouse/domestic partner and covered children may receive additional months of COBRA coverage, up to a maximum of 36 months from the date that COBRA coverage began. To receive this extension, you must inform FBMC of the qualifying event. This extension may be available to your spouse/domestic partner and covered children receiving COBRA coverage when:

- you die, divorce or end a domestic partnership; or
- a covered child is no longer eligible for coverage.

However, the extension is available only if the event would have caused your spouse/domestic partner or covered child to lose coverage under the plan if the first qualifying event had not occurred.

**TRADE ACT OF 2002**

The Trade Act of 2002 created a second COBRA election for workers displaced by the impact of foreign trade and who are determined to be eligible for trade adjustment assistance (TAA). TAA-eligible individuals who declined COBRA when they were first eligible can elect COBRA within the 60 days after the first day of the month in which they become TAA-eligible individuals. However, this election may not be made more than six months after the date the TAA individual's group health care plan coverage ended.

TAA-eligible individuals are also eligible for a health insurance tax credit of up to 65% of qualified health insurance premiums, including for COBRA coverage. If you're in this situation, you'll be notified.

If you have questions about your extended ability to elect COBRA coverage or this new tax credit, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. More information about the Trade Act of 2002 is also available at [www.doleta.gov/tradeact/2002act\\_index.cfm](http://www.doleta.gov/tradeact/2002act_index.cfm).

**COBRA and Unpaid Leaves of Absence**

You're eligible for COBRA coverage if your medical coverage ends because:

- you're no longer receiving coverage through federal or county job-protected family and medical leave;
- you're on workers' compensation for an injury, are no longer receiving coverage through federal or county job-protected family and medical leave, and are no longer receiving a payroll check from the county; or
- you're on an unpaid leave of absence.

As long as your payroll or human resources representative has informed Benefits and Retirement Operations of your leave of absence, Benefits and Retirement Operations will contact you about your COBRA rights. If you're on an unpaid leave of absence for 31 or more days and haven't received a COBRA enrollment packet, contact Benefits and Retirement Operations immediately.

**When You Can Make Changes Under COBRA**

As long as you notify FBMC, you may:

- discontinue county medical coverage at any time, and retain your county dental and vision coverage (FBMC must receive your notification the month before you want the change to become effective);
- discontinue county dental and vision coverage at any time, and retain county medical coverage (FBMC must receive your notification the month before you want the change to become effective);
- discontinue coverage for yourself and your family members at any time (FBMC must receive your notification the month before you want the change to become effective);

- add eligible family members to your health care coverage when a qualifying life event occurs (see “Changes You May Make After Qualifying Life Events” on page 54 in “Participating in the Health Care Plans.”);
- change medical plans during annual open enrollment; and
- change medical plans between annual open enrollments if:
  - you have a change in family status;
  - you or a covered dependent exhaust the lifetime maximum of your medical plan;
  - you move out of your current plan’s coverage area and another county plan offers coverage in your new location.

## When COBRA Coverage Ends

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

- any required premium isn’t paid on time;
- a qualified beneficiary becomes covered under another group health care plan that doesn’t impose any exclusion for a preexisting condition on the qualified beneficiary;
- a covered employee enrolls in Medicare (dependent COBRA coverage may continue through the end of the original COBRA period, independent of the employee’s enrollment in Medicare);
- the county no longer provides any group health care plan for its employees;
- the plan would terminate coverage of a participant or qualified beneficiary not receiving continued coverage for any reason (such as fraud); and
- the plan terminates (whether by contract or county bankruptcy).

If you die while on COBRA, your death is considered a second qualifying event and your covered family members may extend their COBRA coverage up to 36 months from the date of your death.

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

- If you become covered under another group health care plan and that plan contains a preexisting condition limit that affects you, your COBRA coverage cannot be terminated. However, if the other plan’s preexisting rule doesn’t affect you, your original COBRA coverage will be terminated.
- You don’t have to show that you’re insurable to elect COBRA coverage. However, COBRA coverage is subject to your eligibility for coverage, and the county reserves the right to terminate your coverage retroactively if you’re determined to be ineligible.

When you're no longer covered under COBRA, you may be entitled to purchase an individual conversion policy. If you're interested in learning about converting to an individual health care policy when your COBRA coverage ends, contact your health care plan (for example, KingCare<sup>SM</sup> or Group Health) or the Statewide Health Insurance Benefits Advisors (SHIBA) for more information. (See *Contact Information*.)

## HIPAA Certificate of Creditable Coverage

When your COBRA coverage ends, you automatically receive a HIPAA certificate of creditable coverage that:

- confirms you had whatever medical coverage you continued through COBRA; and
- states how long you were covered.

If you become eligible for other medical coverage that excludes or delays coverage for certain preexisting conditions, you can use this certificate to reduce the waiting period of the new plan's preexisting condition limit for the time you were covered by COBRA.

If you're interested in learning about your right to convert to an individual policy when your COBRA coverage ends, contact FMBC or your medical plan for more information. An individual conversion policy usually provides different coverage from your county group coverage; some benefits you have now may not be available. A conversion policy may also cost more than your current coverage.

## How to Contact the COBRA Administrator

You may obtain more information regarding your rights to COBRA coverage from FMBC or Benefits and Retirement Operations. (See *Contact Information*.)

For more information about COBRA, HIPAA and other laws affecting group health care plans, you may contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefits Security Administration. Addresses and phone numbers for the nearest regional or district offices are available at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

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

**TWO ADDITIONAL  
OPTIONS YOU CAN  
CONSIDER**

You can also continue coverage through private insurance and Medicare. For information about private insurance, you'll need to contact the insurance companies directly or ask the Statewide Health Insurance Benefits Advisors (SHIBA) for assistance. For information about Medicare, contact Medicare. (See *Contact Information*.)

## CONTINUING COVERAGE WHEN YOU RETIRE

Retiree medical benefits are an alternative to COBRA. When you retire, you can continue your health care coverage through COBRA or your county retiree medical benefits. You may choose one or the other. **Once you make an election, you may not change it.** In addition:

- if you elect to continue health care coverage through your county retiree medical benefits, you forfeit your rights to elect COBRA later on; and
- if you elect COBRA, you forfeit your rights to elect retiree medical benefits later on.

This section explains retiree medical benefits and how they differ from COBRA. (For more information about COBRA, see “Continuing Coverage Under COBRA” on page 175.)

### DEFINITION OF RETIREMENT

It's important to know what “retirement” means. K.C.C.3.12.320 states that “retirement from county employment shall be in accordance with the provisions set forth in state law, RCW Chapter 41.40,” which defines retirement as “withdrawal from active service with a retirement allowance as provided by this chapter.” The code and statutory definition of retirement confirms that the intended interpretation of “retire” in K.C.C.3.12.220(F) (the section that allows a cash-out of 35% of unused, accrued sick leave for employees with more than five years of county service) is as follows:

“Retire as a result of length of service” means an employee who is eligible, applies for and begins drawing a pension benefit from PERS, LEOFF or the City of Seattle (for county employees who were formally grandfathered and continued participation in that plan) immediately upon terminating county employment.

## How Retiree Medical Benefits and COBRA Compare

Consider these differences when choosing between retiree medical benefits and COBRA benefits when you retire:

Comparison of Retiree Medical Benefits and COBRA		
	Retiree Medical Benefits	COBRA
<i>Health care coverage available</i>	Continuation of your county medical and vision coverage Opportunity to elect a different retiree dental plan offered through Washington Dental Service	Continuation of your county medical, dental and vision coverage
<i>Length of time coverage is available</i>	Medical and vision—until you become eligible for Medicare Retiree dental plan—no time limit	Up to 18 months (29 months if you leave employment because of a disability as determined by Social Security)

<b>Allowed to change medical plans between annual open enrollments</b>	Yes (See “How to Make Changes Under Retiree Medical Benefits” on page 187.)	Yes (See “When You Can Make Changes Under COBRA” on page 181.)
<b>Eligibility</b>	<p>You must:</p> <ul style="list-style-type: none"> <li>• be covered under a county health care plan and lose county coverage because of retirement;</li> <li>• have worked at least five consecutive years at King County before retirement;</li> <li>• not be eligible for Medicare;</li> <li>• not be covered under another medical group plan; and</li> <li>• meet the requirements for formal service or disability retirement.</li> </ul>	You must be covered under a county health care plan and lose county coverage for a qualifying reason (retirement is a qualifying reason).
<b>Enrollment</b>	Same requirements and time periods	

(For more information about COBRA, see “Continuing Coverage Under COBRA” on page 175.)

## Who’s Eligible for Retiree Medical Benefits

County-paid coverage ends the last day of the month you retire. You may pay to continue county medical and vision coverage and elect a different retiree dental plan offered through Washington Dental Service 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;
- aren’t eligible for Medicare (if you’re Medicare-eligible, you may not continue medical and vision coverage, but you may purchase a retiree dental plan when you retire);
- aren’t covered under another medical group plan; and
- meet the requirements for formal service or disability retirement under a Washington State Department of Retirement Systems pension plan 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).

However, there is an exception. You're **not** eligible to participate in retiree medical benefits if:

- you've opted out of your own coverage in order to be covered under your spouse/domestic partner's county coverage; and
- you retire before your spouse/domestic partner does.

Your county health care coverage must be in your name at the time you retire for you to be eligible for retiree medical benefits. However, you may continue coverage under your spouse/domestic partner's county health care benefits. If you choose to continue coverage under your spouse/domestic partner's county health care benefits, at the time of your retirement, you must notify Fringe Benefits Management Company (FBMC), the county's COBRA and retiree medical benefit administrator, that you're deferring your enrollment in retiree medical benefits until your spouse/domestic partner is no longer covered under the county plan. (See *Contact Information*.)

Covered dependents are eligible for continued coverage under your retiree medical benefits if they're not eligible for Medicare and meet the same eligibility requirements in effect when you were an active employee. **Retiree medical benefits don't include life, AD&D and LTD coverage.**

If you're participating in a health care flexible spending account (FSA) when you become eligible for retiree medical benefits or COBRA, you may continue participating through the end of the calendar year. (For more information, see *Flexible Spending Accounts*.)

## How to Enroll for Retiree Medical Benefits

Your retirement is reported to Benefits and Retirement Operations through your Termination Notice, which you need to complete, or payroll report.

### FORMS

Forms are available at [www.metrokc.gov/employees/benefits](http://www.metrokc.gov/employees/benefits) or from Benefits and Retirement Operations. (See *Contact Information*.)

Benefits and Retirement Operations confirms your retirement status and notifies FBMC, who contacts you regarding benefit plan options.

You'll need to elect retiree medical benefits within 60 days after your coverage ends or within 60 days from the date of the FBMC letter notifying you of your options, whichever occurs later. If you elect retiree medical benefits, you must make the initial premium payment within 45 days of your election. **If you don't make the initial premium payment within those 45 days, your coverage will be terminated.** To expedite retiree medical coverage, you may attach your initial payment to the election form and return them both to FBMC.

All other premiums are due on the first of the month. Coverage automatically ends if payment isn't made within 30 days. FBMC will provide you with more detailed payment information when it first contacts you.

Because retiree medical benefits take effect on the first day after your county coverage ends, there's 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.

## What Your Coverage Options Are

If you elect retiree medical benefits, you pay to continue the health care coverage you had on your last day of employment. You may elect a different plan than you had on your last day of employment. Your options include:

- medical coverage;
- dental coverage (as a different retiree dental plan);
- vision coverage; or
- any combination of medical, dental and vision coverage.

The dental plan available to you is the King County Retiree Dental Plan, offered through Washington Dental Service. Unlike your other retiree medical benefits, you can continue these retiree dental benefits when you become eligible for Medicare. You must elect the retiree dental plan when you enroll for retiree medical benefits—you cannot enroll later on. If you choose to discontinue your retiree dental plan after you've elected it, you won't be able to sign up again.

When you elect retiree medical benefits, you waive your COBRA rights, but you may continue covering the same eligible dependents who were covered on the last day of your employment. If you don't continue covering the same dependents, they have their own COBRA rights. If you continue covering the same dependents under your retiree medical benefits and they cease to be eligible for retiree medical benefits, they'll have COBRA rights only if there is a qualifying event. (For more information, see "Who's Eligible for COBRA Coverage and Why" on page 175.)

## How to Make Changes Under Retiree Medical Benefits

If you notify FBMC, you may:

- drop vision coverage and retain medical coverage anytime (FBMC must receive notice in the month before you want the change to take effect);
- drop coverage for yourself and your dependents (FBMC must receive notice in the month before you want the change to take effect);
- add newly eligible dependents to your health care coverage;

- change medical plans during annual open enrollment; and
- change medical plans between annual open enrollments if:
  - you add an eligible dependent;
  - you have a qualifying life event or a covered dependent exhausts the lifetime maximum of your medical plan; or
  - you move out of your current plan's coverage area and another county plan offers coverage in your new location.

## When Retiree Medical Benefits End

Retiree medical benefits end:

- on the last day of the month you fail to make the required payments within 30 days of the due date;
- when you become entitled to Medicare after electing retiree medical benefits; or
- on the day the plan terminates, you die or you first become covered under another group health care plan after the date of your retiree medical benefit election (unless the new plan limits or excludes coverage for a preexisting condition).

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

- If you become covered under another group health care plan and that plan contains a preexisting condition limit that affects you, your retiree medical benefits cannot be terminated. However, if the other plan's preexisting rule doesn't affect you, your retiree medical benefits will be terminated. In addition, if your original retiree medical benefits are better than the coverage under the new group health care plan, you may continue your retiree medical benefits until they expire.
- You don't have to show that you're insurable to choose retiree medical benefits. However, retiree medical benefits are subject to your eligibility for coverage, and King County reserves the right to end your coverage retroactively if you're determined to be ineligible.

## If You Return to Work

Your Washington State Department of Retirement Systems (DRS) plan may allow you to return to work at King County while you're drawing your pension benefits during retirement. Because certain restrictions apply, contact DRS before returning to work. (See *Contact Information*.)

If you return from retirement to work in a benefit-eligible position, you'll receive the same coverage that a part-time transit operator in the same position receives. During this return-to-work period, the premiums you pay for retiree medical benefits are suspended. When the work period ends, you can resume your retiree medical benefits, as long as you're not Medicare-eligible. As a part-time transit operator in the Partial Benefits Plan, you must pay a portion of your monthly premiums while you're working. (For more information, see "Who Is Eligible" on page 45 in "Participating in the Health Care Plans.")

Anytime you fail to meet eligibility requirements for benefits or when you leave post-retirement employment, you resume paying the full cost of your retiree medical benefits.

You must contact FBMC to resume your retiree medical benefits.

## If You Lose Eligibility Because You're Medicare-Eligible

If you elect retiree medical benefits for yourself and your qualified dependents before you're Medicare-eligible, retiree medical benefits end for everyone once you become Medicare-eligible. When this occurs:

- You may apply for Medicare supplemental insurance for yourself through FBMC. The supplemental insurance is provided through the PacifiCare Secure Horizons plan within specific counties. To qualify, you must contact FBMC and apply within 30 days after your retiree medical benefits end.
- Your dependents may continue their county coverage under COBRA for up to 36 months from the date you become Medicare-eligible. FBMC will notify your dependents of this option by sending a COBRA qualifying event notice with an election form to be returned to FBMC. Based on the date you retire and the date you become Medicare-eligible, COBRA may provide a longer period of continuation coverage for qualified dependents than retiree medical benefits will. For more information, contact Benefits and Retirement Operations. (See *Contact Information*.)
- You and your qualified dependents may continue the retiree dental plan you elected when you were first eligible.

If you retire once you become Medicare-eligible or afterward, you and your dependents won't be eligible for retiree medical benefits. However:

- you may apply for Medicare supplemental insurance for yourself through FBMC, as described above;

- your qualified dependents may continue county benefits under COBRA for up to 18 months from your loss of coverage due to retirement or 36 months from the earlier Medicare entitlement date, whichever is greater; and
- you can elect the retiree dental plan for you and your qualified dependents.

For information on Medicare supplemental insurance options, contact the Statewide Health Insurance Benefits Advisors (SHIBA). (See *Contact Information*.)

## GLOSSARY

---

### Accident

An “accident” is a sudden and unforeseen event that occurs at a specific time and place, and results in bodily injury. It is independent of illness other than infection of a cut or wound received in an accident.

---

### Aetna

“Aetna” is the organization contracted by the county to administer medical services for KingCare<sup>SM</sup>, its self-insured medical plan, and for the life insurance plan. (Aetna isn’t affiliated with Express Scripts.)

---

### Aexcel Designated Preferred Care Specialists

“Aexcel Designated Preferred Care Specialists” are Aetna Preferred Care Providers who have met designation criteria for thresholds for performance and effectiveness, as established by Aetna. They’re listed in the provider directory and on DocFind as Aexcel Designated Preferred Care Specialists for the specialty care involved for the class of employees who are plan members.

---

### Alveolar ridge

An “alveolar ridge” is one of the two jaw ridges either on the roof of the mouth or on the bottom of the mouth containing the sockets (alveoli) of the teeth.

---

### Amalgam

An “amalgam” is a silver filling.

---

### Amblyopia

“Amblyopia,” commonly known as lazy eye, is a disorder of the eye characterized by poor or blurry vision in an eye that is otherwise physically normal without an apparent change in eye structure.

---

### Anisometropia

“Anisometropia” is unequal refractive power in the two eyes.

---

### Annual deductible

An “annual deductible” is the amount you pay each calendar year before the plan (other than Group Health) pays benefits. The annual deductible doesn’t apply to any out-of-pocket maximums.

---

### Annual open enrollment

An “annual open enrollment” is the annual period when benefit-eligible employees may join a plan, change plans, add or increase accidental death and dismemberment (AD&D) insurance coverage, and add family members for coverage within the limits of each benefit plan. The annual open enrollment also gives benefit-eligible employees the opportunity to enroll or re-enroll in a flexible spending account (FSA).

---

### Anti-reflective coating

An “anti-reflective coating” is a coating that goes on both sides of an eyeglass lens, and on the backside of a sunglass lens, to allow light to pass more freely through the lens.

---

### Apicoectomy

“Apicoectomy” is the amputation of the tip or end of the root of a tooth.

---

### Bifocal lens

A “bifocal lens” is a single lens divided by a visible line into two viewing areas, each with a different prescription. The lower section is for reading and for viewing objects up close, and the upper section is for viewing objects in the distance.

---

### Bitewing X-ray

A “bitewing X-ray” is an X-ray taken of the crowns of teeth to check for decay.

---

### Blended lens

A “blended lens” is a multifocal lens without the usual dividing line that exists with normal multifocal lenses.

---

### Body Mass Index

“Body Mass Index” is a practical marker that is used to assess the degree of obesity. It’s calculated by dividing the weight in kilograms by the height in meters squared.

---

### Brand-name drug

A “brand-name drug” is a trademarked drug patented for a limited period by a single pharmaceutical company.

---

### Bridge

A “bridge” is a non-removable tooth replacement attached to adjoining natural teeth when one or a few teeth are missing.

---

### Caries

“Caries” is tooth decay, which leads to a cavity.

---

### Caries susceptibility test

A “caries susceptibility test” is performed, usually by measuring the concentration of certain bacteria in the mouth, to determine how likely someone is to develop tooth decay.

---

### Carrier

A “carrier” is a licensed insurance company or health maintenance organization that operates as a health care plan or a third-party administrator that processes claims on behalf of a self-insured organization.

---

---

### Cast restoration

“Cast restoration” is a procedure that uses a model of the tooth (an impression) to make a casting that replaces a missing part. A crown is an example of a casting restoration.

---

### Chemical dependency

“Chemical dependency” is a psychological and/or physical dependence on alcohol or a state-controlled substance. The pattern of use must be so frequent or intense that the user loses self-control over the amount and circumstances of use, develops symptoms of tolerance and, if use is reduced or discontinued, shows symptoms of physical and/or psychological withdrawal. The result is that health is substantially impaired or endangered, or social or economic function is substantially disrupted.

---

### Chiropractic care

“Chiropractic care” is the manipulation of the spine or extremities to correct a subluxation (that is, incomplete or partial dislocation) identified on an X-ray. The subluxation must be consistent with the patient’s neuromusculoskeletal symptoms, and treatment must be within the limits of a specific documented treatment plan. Services must be provided by a state-licensed chiropractor or osteopath. (Chiropractors are restricted by law to manipulation of the spine; osteopaths are licensed to perform manipulative therapy to all parts of the body.)

---

### Coating

A “coating” is one of a variety of compounds that can be applied to the exterior of a lens or absorbed by a lens.

---

### COBRA

“COBRA” stands for the Consolidated Omnibus Budget Reconciliation Act of 1986. COBRA allows plan members to continue health care coverage on a self-pay basis under certain circumstances for a limited time. The county offers all required COBRA rights to employees, their spouses/domestic partners and their children covered at the time coverage is lost.

---

### Coinsurance

After you’ve met your annual deductible, you begin paying a percentage—“coinsurance”—of the allowed amount for most medical services and supplies until you reach the annual out-of-pocket maximum. Coinsurance doesn’t apply to prescription drugs.

---

### Companion

A “companion” is a person whose presence as a companion or caregiver is necessary to enable an NME patient:

- to receive services in connection with an NME procedure or treatment on an inpatient or outpatient basis; or
- to travel to and from the facility where treatment is given.

---

### Composite

A “composite” is a tooth-colored filling made of plastic resin or porcelain.

---

### Contracted professional/contracted specialist—Group Health

A “contracted professional/contracted specialist” is a network provider who is under contract to Group Health.

---

### Copay

A “copay” is the fixed amount you pay at the time a covered service is received.

---

### Coping

A “coping” is a thin thimble of a crown with no anatomic features. It is placed on teeth before placement of either an overdenture or a large span bridge to allow for the removal and modification (if the tooth is lost) of the bridge without requiring a major remake of the bridgework.

---

### Crown

A “crown” is an artificial covering for a tooth with metal, porcelain or porcelain fused to metal. A crown, sometimes referred to as a cap, covers a tooth weakened by decay or severely damaged or chipped.

---

### Curettage

“Curettage” is a deep scaling of the portion of the tooth below the gum line to remove calculus and infected gum tissue.

---

### Custodial or convalescent care

“Custodial or convalescent care” is care that primarily assists the patient in activities of daily living, including inpatient care mainly to support self-care and provide room and board. Examples are helping the participant to walk, get in and out of bed, bathe, get dressed, eat or prepare special diets or take medication that is normally self-administered.

---

### Dental care

“Dental care” is care of, or related to, the mouth, gums, teeth, mouth tissues, upper or lower jaw bones or attached muscle, upper or lower jaw augmentation or reduction procedures, orthodontic appliances, dentures and any care generally recognized as dental. This also includes related supplies and devices, but not prescription drugs.

---

### Denture

A “denture” is a removable set of artificial teeth in a plastic base that rests directly on the gums. A denture may be partial or complete depending on the number of missing natural teeth.

---

## Dependent

A “dependent” is a member of your immediate family who is eligible for medical, dental and vision benefits through your county plans. The following family members are considered dependents:

- your spouse/domestic partner;
- your or your spouse/domestic partner’s unmarried children if they’re under age 23 and chiefly dependent on you for support and maintenance. This means you may claim them on your federal tax return. These children may be your:
  - biological children;
  - adopted children (or children legally placed with you for adoption or for whom you assume total or partial legal obligation for support in anticipation of adoption);
  - stepchildren; or
  - legally designated wards (legally placed foster children, children placed with you as legal guardian or children named in a Qualified Medical Child Support Order).

Parents and other relatives are not considered “dependents.”

---

## DESI drugs

“DESI (Drug Efficacy Study Implementation) drugs” are drugs that lack substantial evidence of effectiveness according to the FDA; but since they’ve been used and accepted for many years without significant safety problems, they continue to be used today. Examples include Donnatal, Naldec Syrup and Tigan suppositories.

---

## Disability—Medical Plans

A “disability” is a condition determined to be disabling by the Social Security Administration, Washington State Department of Retirement Systems or the county-sponsored long-term disability plan.

---

## Domestic partner

A “domestic partner” is an individual who is in an established domestic partnership in which both individuals:

- share the same regular and permanent residence;
- have a close personal relationship;
- are jointly responsible for basic living expenses (a “basic living expense” is the cost of basic food, shelter and any other expenses of a domestic partner paid at least in part by a program or benefit for which the partner qualified because of the domestic partnership; individuals need not contribute equally or jointly to the cost of these expenses, as long as they both agree they’re responsible for the cost);
- aren’t married to anyone;
- are both 18 years of age or older;

- aren't related by blood closer than would bar marriage in the State of Washington;
- were mentally competent to consent to contract when the domestic partnership began; and
- are each other's sole domestic partners and are responsible for each other's common welfare.

---

#### Durable medical equipment

"Durable medical equipment" is mechanical equipment that:

- is prescribed by a physician;
- can stand repeated use and multiple users;
- is primarily and customarily used to serve a medical purpose; and
- is generally not useful to a person in the absence of illness or injury.

---

#### Emergency—Medical Plans

An "emergency" is the sudden, unexpected onset of a medical condition that threatens loss of life or limb, or may cause serious harm to the patient's health if not treated immediately.

---

#### Evidence of Insurability (EOI)

"Evidence of insurability (EOI)" is any statement or proof of a person's physical condition, occupation or other factor affecting his/her acceptance for insurance.

---

#### Exclusion

An "exclusion" is a service or supply not covered under a plan.

---

#### Experimental or investigational service/supply

An "experimental or investigational service/supply" is any treatment, procedure, facility, equipment, drug, drug usage, medical device or supply that meets any of the following criteria at the time it is or will be provided to the plan member:

- cannot be legally marketed in the United States without FDS approval and such approval hasn't been granted;
- is the subject of a current new drug or new device application on file with the FDA;
- is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner intended to evaluate the service or supply's safety, toxicity or efficacy;
- is provided under written protocol or other document that lists an evaluation of the service's or supply's safety, toxicity or efficacy among its objectives;
- is under continued scientific testing and research concerning safety, toxicity or efficacy;

- is provided under informed consent documents that describe the service or supply as experimental or investigational, or in other terms that indicate it is being evaluated for safety, toxicity or efficacy; and
- is of the prevailing opinion among experts as expressed in the published authoritative medical or scientific literature that:
  - use should be substantially confined to research settings; or
  - further research is necessary to determine safety, toxicity or efficacy.

In determining whether a service or supply is experimental or investigational, the following sources of information are relied upon exclusively:

- the plan member's medical records;
- written protocols or other documents under which the service or supply has been or will be provided;
- any consent documents the plan member or plan member's representative has executed or will be asked to execute to receive the service or supply;
- the files and records of the Institutional Review Board (IRB) or similar body that approves or reviews research at the institution where the service or supply has been or will be provided, and other information concerning the authority or actions of the IRB or similar body;
- the published authoritative medical or scientific literature regarding the service or supply, as applied to the plan member's illness or injury; and
- regulations, records, applications and any other documents or actions issued by, filed with or taken by the FDA, the Office of Technology Assessment or other agencies within the U.S. Department of Health and Human Services, or any state agency performing similar functions.

If two or more services or supplies are part of the same plan of treatment or diagnosis, all are excluded if one is experimental or investigational. KingCare<sup>SM</sup> or Group Health should consult the appropriate professional staff and then use the previously specified criteria to decide if a particular service or supply is experimental or investigational.

---

### Express Scripts

"Express Scripts" is Express Scripts, Inc., the organization contracted by the county to administer prescription benefits for KingCare<sup>SM</sup>, its self-insured medical plan. (Express Scripts isn't affiliated with Aetna.)

---

### FDA

"FDA" stands for the U.S. Food and Drug Administration, which enforces laws regulating the manufacture and distribution of food, drugs and cosmetics.

---

### Filling

A "filling" is the material used to fill a cavity or replace part of a tooth.

---

### Fissure

A "fissure" is a break in the tooth enamel.

---

### Fluoride

“Fluoride” is a chemical agent used to strengthen teeth to prevent cavities.

---

### Fluoride varnish

A “fluoride varnish” is a fluoride treatment contained in a varnish base, which is applied to the teeth to reduce acid damage from the bacteria that cause tooth decay. It remains on the teeth longer than regular fluoride and is considered more effective than other fluoride delivery systems.

---

### FMLA

“FMLA” stands for the Family and Medical Leave Act of 1993. FMLA allows you to take up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons if you meet eligibility requirements.

---

### Formulary

A “formulary” is an authorized list of generic and brand-name prescription drugs approved for use by the FDA.

---

### Fringe Benefits Management Company (FBMC)

“Fringe Benefits Management Company (FBMC)” is the organization contracted by the county to administer its flexible spending accounts, COBRA benefits and retiree medical benefits.

---

### General anesthesia

“General anesthesia” is a drug or gas that produces unconsciousness and insensibility to pain.

---

### Generic drug

A “generic drug” is a medication that isn’t a trademarked drug but is chemically equivalent to the brand-name drug.

---

### Gingivitis

“Gingivitis” is an inflammation or infection of the gingiva (gum tissue)—the initial stage of gum disease.

---

### Group Health

“Group Health” is Group Health Cooperative, the organization contracted by the county to provide employees with its HMO medical plan option.

---

### HIPAA

“HIPAA” stands for the Health Insurance Portability and Accountability Act of 1996. HIPAA restricts the extent to which group health plans may impose preexisting condition limits and protects the personal health information of plan members.

---

---

## HMO

“HMO” stands for health maintenance organization. HMO members usually pay a specified fee for comprehensive care, including inpatient and outpatient care, through a network of physicians and hospitals. Group Health is the county’s HMO, with the county in effect paying the membership fee for employee and dependent coverage.

---

## Home health care agency

A “home health care agency” is an agency that:

- mainly provides skilled nursing and other therapeutic services;
- is associated with a professional group which makes policy; this group must have at least one physician and one registered nurse;
- has full-time supervision by a physician or a registered nurse;
- keeps complete medical records on each person;
- has a full-time administrator; and
- meets licensing standards.

---

## Home health care plan

A “home health care plan” is a plan that provides for care and treatment of a disease or injury. The care and treatment must be:

- prescribed in writing by the attending physician; and
- an alternative to confinement in a hospital or convalescent facility.

---

## Hospice

A “hospice” is a private or public agency or organization with a hospice agency license which administers or provides hospice care.

---

## Hospice care

“Hospice care” is a coordinated program of supportive care provided by a team of professionals and volunteers for a dying person.

---

## Hospital

A “hospital” is an institution licensed by the state and primarily engaged in providing diagnostic and therapeutic facilities for surgical and/or medical diagnosis, as well as treatment and care of injured or ill persons by or under the supervision of staff physicians. The institution also continuously provides 24-hour nursing service by or under the supervision of registered nurses, or is any other licensed institution with which the medical plans have an agreement to provide hospital services. Skilled nursing facilities, nursing homes, convalescent homes, custodial homes, health resorts, hospices or places for rest, for the aged or for the treatment of pulmonary tuberculosis are not hospitals.

---

## Implant

An “implant” is a support for a bridge or denture that has been surgically placed into bone.

---

### Inlay

An “inlay” is a solid filling cast to fit the missing portion of a tooth and cemented into place. An inlay covers one or more teeth.

---

### Inpatient services

“Inpatient services” refers to the care provided to a patient who is hospitalized or in hospice.

---

### Intravenous sedation

“Intravenous sedation” is a form of sedation where the patient experiences a lowered level of consciousness but is still awake and can respond.

---

### Ionomer

An “ionomer” is a filling made of a mixture of glass and an organic acid, sometimes called glass ionomer concrete.

---

### KCFML

“KCFML” stands for King County Family and Medical Leave. Passed by King County Ordinance 13377 in 1998 and adopted by most, but not all, labor unions representing county employees, it allows you to take up to 18 weeks of unpaid, job-protected leave with medical benefits for certain family and medical reasons if you meet certain eligibility requirements.

---

### Keratoconus

“Keratoconus” is an hereditary, degenerative corneal disease affecting vision, characterized by generalized thinning and cone-shaped protrusion of the central cornea, usually in both eyes.

---

### KingCare<sup>SM</sup>

“KingCare<sup>SM</sup>” is the county’s self-insured medical plan. Medical services are provided by Aetna, and prescription services are provided by Express Scripts.

---

### Lenticular lens

A “lenticular lens” is a single convex lens that magnifies light through a prism effect.

---

### Lifetime maximum

A “lifetime maximum” is the maximum benefit amount you may receive from your medical plan or for a given benefit during your lifetime.

---

### Limitations

“Limitations” are restricting conditions such as age, time covered and waiting periods, which affect the level of benefits.

---

### Low vision

“Low vision” is a term usually used to indicate vision of less than 20/200 and requiring special lenses.

---

---

### Malocclusion

“Malocclusion” is the improper alignment of biting or chewing surfaces of upper and lower teeth.

---

### Medically necessary

“Medically necessary” refers to health care services, supplies, treatments or settings considered appropriate and necessary according to generally accepted principles of good medical practice to diagnose or treat a medical condition. Services, supplies, treatments or settings must meet all of these requirements:

- are not solely for the convenience of the patient, his/her family or the provider of the services or supplies;
- are the most appropriate level of service or supply that can be safely provided to the patient;
- are for the diagnosis or treatment of an actual or existing illness or injury unless being provided for preventive services;
- are not for recreational, life-enhancing, relaxation or palliative therapy, except to treat terminal conditions;
- are not primarily for research and data accumulation;
- are appropriate and consistent with the diagnosis and, in accordance with accepted medical standards in the State of Washington, couldn't have been omitted without adversely affecting the patient's condition or the quality of health services rendered;
- as to inpatient care, couldn't have been received in a provider's office, the outpatient department of a hospital or a nonresidential facility without affecting the patient's condition or quality of health services; and
- are not experimental or investigational.

The plan member is responsible for the cost of services and supplies that aren't medically necessary.

KingCare<sup>SM</sup> and Group Health reserve the right to determine whether a service, supply, treatment or setting is medically necessary. The fact that a physician or other provider has prescribed, ordered, recommended or approved a service, supply, treatment or setting doesn't, in itself, make it medically necessary.

---

### Mental condition

A “mental condition” is a condition classified as such by the most current edition of the Diagnostic and Statistical Manual of Mental Disorders.

---

### Mental disorder

A “mental disorder” is any mental, emotional, behavioral, psychological, personality, cognitive, mood or stress-related abnormality, disorder, disturbance, dysfunction or syndrome, regardless of cause, including any biological or biochemical disorder or imbalance of the brain. Mental disorder includes, but is not limited to, bipolar affective disorder, organic brain syndrome, schizophrenia, psychotic illness, manic depressive illness, depression and depressive disorders, and anxiety and anxiety disorders.

---

### Multifocal lens

A “multifocal lens” is a lens with multiple lens corrections so you can see objects at varying distances through the same lens. A bifocal lens offers two different viewing fields (near and far). Progressive and trifocal lenses offer three different viewing fields (near, intermediate and far).

---

### Mutual aid agreement

A “mutual aid agreement” is an agreement that allows certain benefits to continue while you’re away from the county if you’re needed to work temporarily for another agency.

---

### Network benefits

“Network benefits” refers to the level of benefits you receive when you see a network provider. Network benefits are generally higher than out-of-network benefits.

---

### Network provider

A “network provider” is a person, group, organization or facility under contract with a benefit plan to furnish covered services to plan members.

---

### NME patient

An “NME patient” is a person who:

- requires any of the NME procedure and treatment types for which the charges are a covered expense;
- contacts Aetna and is approved by Aetna as an NME patient; and
- agrees to have the procedure or treatment performed in a hospital designated by Aetna as the most appropriate facility.

“NME” stands for the symptom of necrolytic migratory erythema observed in patients with glucagonoma.

---

### Non-preferred brand

A “non-preferred brand” is a brand-name prescription drug that isn’t on the formulary list because it’s considered no more effective than preferred brands and generic drugs, but in general costs more.

---

### Occlusal adjustment

An “occlusal adjustment” is a modification of the surfaces of opposing teeth to improve how the teeth interact with each other.

---

### Occlusal guard

An “occlusal guard,” usually worn at night, is a device that lessens the impact of biting, chewing or grinding on the surfaces of the upper and lower teeth.

---

### Onlay

An “onlay” is a cast gold or porcelain filling that covers one or all of a tooth’s cusps.

---

### Ophthalmologist

An “ophthalmologist” is a medical doctor specializing in vision care, who can perform vision examinations and recommend lens options, fit contact lenses, prescribe medications, test for and treat eye diseases, treat eye injuries and perform eye surgery.

---

### Optometrist

An “optometrist” is a doctor of optometry specializing in vision examinations and recommending lens options. An optometrist can test for eye diseases, fit contact lenses and, in many states, diagnose and treat certain eye conditions with medication.

---

### Oral health assessment

An “oral health assessment” helps determine the most appropriate dental treatment for you based on your oral health, as well as your overall health.

---

### Orthodontics

“Orthodontics” is a specialized branch of dentistry that corrects malocclusion and restores teeth to proper alignment and function. There are several different types of appliances used in orthodontics, one of which is commonly referred to as braces.

---

### Orthoptics

“Orthoptics” is a discipline dealing with the diagnosis and treatment of defective eye coordination, binocular vision and functional amblyopia by non-medical and non-surgical methods, such as glasses, prisms and exercises.

---

### Out-of-network benefits

“Out-of-network benefits” refers to the level of benefits you receive when you see an out-of-network provider.

---

### Out-of-network provider

An “out-of-network provider” is a person, group, organization or facility not under contract with a plan to furnish covered services to plan members. Though some benefit plans allow use of out-of-network providers, they still must be licensed, registered or certified to provide covered services by the state in which they operate.

---

### Outpatient services

“Outpatient services” refers to the care provided to a patient who isn’t hospitalized but who receives treatment, including surgery, at a licensed medical facility.

---

### Overbite

An “overbite” is a condition in which the upper teeth excessively overlap the lower teeth when the jaw is closed. This condition can be corrected with orthodontics.

---

### Overdenture

An “overdenture” is a prosthetic device supported by implants or the roots of at least two natural teeth to provide better stability for the denture.

---

### Palliative

“Palliative” refers to treatment that relieves pain but is not curative.

---

### Partial denture

A “partial denture” is a removable appliance used to replace one or more lost teeth.

---

### Periodontal

“Periodontal” refers to the treatment of the gums, tissue and bone that support the teeth.

---

### Periodontal scaling/root planing

“Periodontal scaling/root planing” is treatment of periodontal disease that involves scraping and planing the exposed root surfaces of a tooth to remove all calculus, plaque and infected tissue.

---

### Physician

A “physician” is a provider licensed by the State of Washington in which he/she practices as a:

- doctor of medicine or surgery;
- doctor of osteopathy;
- doctor of ophthalmology;
- doctor of podiatry;
- registered nurse;
- chiropractor;
- dentist (DDS or DMD); or
- psychologist (if licensed by the state to practice psychology and in private practice).

KingCare<sup>SM</sup> and Group Health also cover eligible services provided by providers licensed as a physician or osteopath's assistant, certified as a nursing assistant, or licensed as a practical nurse or registered nurse's assistant, when that provider works with or is supervised by one of the above physicians.

---

#### Plano lens

A "plano lens" is an eyeglass lens with no prescription.

---

#### Pontic

A "pontic" is an artificial tooth used in a bridge to replace a missing tooth.

---

#### Preauthorization—Medical Plans

"Preauthorization" is medical plan approval for services or supplies before the patient receives them.

---

#### Preferred brand

A "preferred brand" is a brand-name prescription drug that is on the formulary list because of its clinical and economic value to the plan and its members. Preferred-brand drugs are considered equally effective as non-preferred brands, but cost less.

---

#### Preferred provider organization

A "preferred provider organization" (PPO), sometimes referred to as a participating provider organization, is a managed care organization of medical doctors, hospitals and other health care providers who have contracted with an insurer or a third-party administrator to provide health care at reduced rates to the insurer's or administrator's clients.

---

#### Prescription drug

A "prescription drug" is any medical substance that, under the Federal Food, Drug and Cosmetic Act (as amended), must be labeled with "Caution—Federal law prohibits dispensing without a prescription."

---

#### Primary care physician (PCP)

A "primary care physician (PCP)" is a physician who provides or coordinates care for plan members.

---

#### Progressive lens

A "progressive lens" is a trifocal lens without visible lines separating near vision, mid-range vision and distance vision, with smooth transitions and no trifocal demarcation lines.

---

#### Prophylaxis

"Prophylaxis" is a professional cleaning to remove plaque, calculus and stains to help prevent dental disease.

---

#### Prosthesis

A "prosthesis" is an artificial substitute to replace a missing natural body part.

---

### Prosthodontics

“Prosthodontics” is the replacement of missing teeth with artificial materials, such as a bridge or denture.

---

### Provider

A “provider” is a person, group, organization or facility licensed to provide health care services, equipment, supplies or drugs. For KingCare<sup>SM</sup> and Group Health, this includes, but is not limited to, naturopaths, acupuncturists and massage therapists. The provider must be practicing within the scope of his/her license.

---

### Pulpotomy

“Pulpotomy” is the removal of a portion of the tooth’s pulp (the soft interior of the tooth).

---

### Qualified Medical Child Support Order (QMCSO)

A “Qualified Medical Child Support Order (QMCSO)” is a decree, judgment or order, including approval of a settlement agreement, from a state court or an administrative order that requires benefit plans to include a child in the employee’s coverage and make any applicable payroll deductions.

---

### Reasonable and customary (R&C) charges—KingCare<sup>SM</sup>

“Reasonable and customary (R&C) charges” are rates that are consistent with those normally charged by the provider for the same services or supplies and within the general range of charges by other providers in the same geographic area for the same services or supplies.

---

### Reline

“Reline” is the process of resurfacing the tissue side of a denture with a base material.

---

### Remineralization

“Remineralization” is a process in which calcium, fluoride and an antimicrobial mouth rinse are combined to reduce bacteria and bond with a tooth to strengthen and rebuild the enamel.

---

### Resin-based composite

A “resin-based composite” is a tooth-colored filling material used primarily for cosmetic purposes on front teeth.

---

### Respite care

“Respite care” is time off or a break for someone who is the main caregiver for an aged, ill or disabled adult or child.

---

### Root canal

A “root canal” is the removal of the pulp tissue of a tooth due to decay or injury.

---

---

### Root planing

“Root planing” is a procedure performed to smooth roughened root surfaces.

---

### Scratch-resistant coating

A “scratch-resistant coating” is material used to coat a plastic lens, which is relatively soft and easily scratched, to help reduce the lens’ susceptibility to being scratched.

---

### Sealant

A “sealant” is a thin plastic material used to cover the biting surface of a tooth to prevent tooth decay.

---

### Service area

A “service area” is the geographic area where a plan has arranged for covered services through agreements with various providers.

---

### Single vision lens

A “single vision lens” is a lens with only one use, either to see objects in the distance or for reading.

---

### Skilled nursing facility

A “skilled nursing facility” is a facility that provides room and board, as well as skilled nursing care, 24 hours a day and is accredited as an extended care facility or is Medicare-certified as a skilled nursing facility. It is not a hotel, motel or place for rest or domiciliary care for the aged.

---

### Space maintainer

A “space maintainer” is a dental appliance that fills the space of a lost tooth or teeth and prevents the other teeth from moving into the space, primarily used in orthodontic and pediatric treatment.

---

### Staff member/staff specialist—Group Health

A “staff member/staff specialist” is a network provider who is part of the Group Health staff.

---

### Stainless steel crown

A “stainless steel crown” is a pre-made metal crown, shaped like a tooth, primarily used to temporarily cover a seriously decayed or broken down tooth in children.

---

### Temporomandibular joint (TMJ) disorders

“Temporomandibular joint (TMJ) disorders” are disorders affecting the temporomandibular joint (which is just ahead of the ear and connects the mandible, or jawbone, to the temporal bone of the skull) and exhibiting any of the following characteristics:

- pain in the musculature associated with the TMJ;
- internal derangements of the TMJ;

- arthritic problems with the TMJ; or
- abnormal range of motion or limited range of motion of the TMJ.

---

### Tint

A “tint” is a coating added to or absorbed by a lens in almost any shade or color density.

---

### Urgent care

“Urgent care” refers to medical service for someone whose condition doesn’t constitute a medical emergency but who needs immediate medical attention.

---

### USERRA

“USERRA” stands for the Uniformed Services Employment and Reemployment Rights Act of 1994.

---

### Usual, customary and reasonable (UCR) charges—Group Health

“Usual, customary and reasonable (UCR) charges” are the levels of benefits payable when expenses are incurred from an out-of-network provider. Expenses are considered usual, customary and reasonable if the charges are consistent with those normally charged to others by the provider or organization for the same services or supplies, and the charges are within the general range of charges made by other providers in the same geographical area for the same services or supplies.

---

### Veneer

A “veneer” is an artificial filling material, usually plastic, composite or porcelain, that is used to provide an aesthetic covering over the visible surface of a tooth. It is primarily used on front teeth.

---

### Women’s health care services

“Women’s health care services” are health care services related to:

- general exams and preventive care;
- gynecological care;
- reproductive health services; and
- maternity care.