Welcome to Your King County Benefits for Deputy Sheriffs 2012

***Your King County Benefits* is the first place to turn when you want to know more about your county benefits or if you just have a benefit question.**

This guide contains information related to your county:

- **medical plans;**
- **dental and vision plans;**
- **flexible spending accounts (FSAs); and**
- **life and accident insurance.**

Using This Guide

The individual sections of this guide provide you with the information you need to understand each of your plans. As you dig deeper into a section, you will find more and more details about that plan. For example, in *Health Care,* you can find:

- "Participating in the Health Care Plans," with information about eligibility, enrollment and more;
- "Medical Plans," with detailed information about the Deputy Sheriff Plan, administered by Aetna, and Group Health; and
- "Continuing Coverage Under COBRA," with information about how you and/or your eligible dependents may continue medical coverage at group rates.

For information about the things you need to do when events such as marriage or retirement occur, be sure to look at *What Happens If . . . .*

If you can't find what you're looking for, refer to *Contact Information* for phone numbers, e-mail addresses and Web sites.

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About This Guide

As a King County employee, you receive a comprehensive benefit package for you and your eligible dependents.

How to Use This Guide

Your King County Benefits has a number of features that will help you find information easily. Each benefit section tells you who is eligible for coverage, what coverage is available and when coverage is effective.

When you find a word or phrase you don't understand, refer to the "Glossary" at the end of each section. The guide is intended to help you use your benefits most effectively for your particular situation, which means it sometimes describes things that could limit your benefits.

Although the benefit descriptions in this guide contain certain key features and brief summaries of the county's benefit plans, they're not detailed descriptions. If you have questions about specific plan details, contact the plan's third-party administrator or Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

We've made every attempt to ensure the accuracy of the information in this guide. However, if there's any discrepancy between the benefit descriptions in this guide and the insurance contracts, the insurance contracts will always govern. In addition, no person has the authority to make any oral or written statements of any kind that would conflict with the insurance contracts or would alter the insurance contracts maintained in conjunction with the plans.

The county intends to continue its benefit plans indefinitely, but reserves the right to amend or terminate them at any time, in whole or in part, for any reason, according to the amendment and termination procedures described in the legal documents.

About the Benefit Plans

For the medical benefits under the Deputy Sheriff Plan, King County has the sole discretionary authority to determine who is eligible to enroll in the plan, and to resolve appeals based on eligibility. In its role as plan fiduciary, the county has designated Aetna as the medical claims fiduciary for the Deputy Sheriff Plan with discretionary authority to apply the terms of the plan for the purpose of paying claims and resolving claims appeals under the plan.

For the pharmacy benefits under the Deputy Sheriff Plan and for the benefits under the dental and vision plans, the county has the sole discretionary authority to determine who is eligible to enroll in the plans, and to resolve appeals based on eligibility. All of the plans have discretionary authority to apply the terms of their respective plans for the purpose of paying claims and resolving claims appeals under the plans.

For benefits provided by the health maintenance organization and by the life and accidental death and dismemberment (AD&D) insurance, the county administers eligibility as outlined in the insurance contracts. Group Health, Aetna Life Insurance and CIGNA Group Insurance have the sole discretionary authority to apply the terms of their respective plans for the purpose of determining eligibility for claims payment and resolving claims appeals under the plans.

About Your Employment

The information in this guide does not create a contract of employment between the county and any employee.

If You Have Questions

If you would like to review any of the insurance contracts, you may contact Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

WHAT HAPPENS IF...

This section of *Your King County Benefits* tells you what you need to know and do when any of the following events occur while you're employed with King County.

You Get Married/Establish a Domestic Partnership

When you get married or establish a domestic partnership, you must enroll your spouse/domestic partner by completing a Marriage/Domestic Partnership form online within 30 days of the date this qualifying life event occurs if you want to add your spouse/domestic partner to your county benefits.

When you add your spouse/domestic partner, you have three health care options:

- add your spouse/domestic partner and eligible dependent children to your current medical, dental and vision coverage;
- change your medical plan and add your spouse/domestic partner and eligible dependent children to your new medical plan, and include them in your current dental and vision coverage; or
- opt out of your medical coverage to be covered under your spouse/domestic partner's coverage, and add your spouse/domestic partner and eligible dependent children to your current dental and vision coverage.

Within 30 days of this qualifying life event, you may also:

- begin, change or discontinue participation in a flexible spending account (FSA); and
- add or discontinue supplemental life insurance for yourself.

However, if you're in a domestic partnership and later marry your domestic partner, your ability to add or change coverage depends on whether you were covering your domestic partner under county benefits at the time you were married:

- If you were covering your domestic partner at the time of marriage, you may not make changes to your benefits—you had the opportunity to add or change coverage when you first enrolled your domestic partner;
- If you weren't covering your domestic partner at the time of marriage, you are allowed to add or change coverage because your new spouse has not previously been covered under county benefits.

You make these changes by completing the appropriate forms online.

LOSS OF COVERAGE

If your spouse/domestic partner loses coverage elsewhere and isn't covered under the county's health care plans, you must enroll your spouse/domestic partner by completing a Spouse/Domestic Partner Lost Medical Coverage form online within 30 days of his/her loss of coverage if you want your spouse/domestic partner to have county health care coverage. Coverage will begin on the first day of the month following his/her loss of coverage. (See *Contact Information*.)

HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits, Payroll and Retirement Web site at www.kingcounty.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, Payroll and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

Coverage begins on the first day of the month following the date of your marriage or the establishment of your domestic partnership. If this qualifying life event occurs on the first day of the month, however, coverage begins on that day.

If you add a domestic partner or your domestic partner's children for coverage, the county pays for the coverage, but you're taxed on the value of the coverage. Taxable values are available from Benefits, Payroll and Retirement Operations and its Web site. (See *Contact Information*.)

When you get married or establish a domestic partnership, you may also want to update your beneficiary designations with Aetna Life Insurance for life insurance, with CIGNA Group Insurance for AD&D insurance, with the Washington State Department of Retirement Systems (DRS) or the Seattle City Employees' Retirement System (if you remained in the city retirement system when you became a county employee) for your retirement plan, and with the King County Employees Deferred Compensation Plan for your deferred compensation plan. (See *Contact Information*.)

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

You Divorce/End a Domestic Partnership

IMPORTANT

If you discontinue county coverage for your spouse in anticipation of divorce, your spouse will not be eligible for COBRA benefits until after your divorce is final.

When you divorce or end a domestic partnership, you must inform Benefits, Payroll and Retirement Operations of this qualifying life event online as soon as possible but no later than 60 days from the date of its occurrence. Your covered spouse/domestic partner will then have 60 days from the date he/she is notified of his/her COBRA election rights to enroll in COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage.

The county has an obligation to discontinue benefit coverage for your former spouse/domestic partner and to notify FBMC, the county's COBRA administrator, of your spouse/domestic partner's eligibility for continuing health care coverage, if applicable. Your failure to notify the county within 60 days will lead to denial of COBRA rights for your former spouse/domestic partner. (For information about continuing health care coverage, see "Continuing Coverage Under COBRA" in *Health Care*.)

While your former spouse/domestic partner has 60 days to enroll in COBRA coverage, you must complete the county's Discontinue Dependent Coverage form online within 30 days of the date your divorce occurs or your domestic partnership ends. *(On the online form, you'll need to elect either "Divorce" or "Dissolution of Domestic Partnership" as your "Reason for Event," and complete the remainder of the form.)* Otherwise, you may have to reimburse the county for expenses incurred following the date your spouse/domestic partner became ineligible for county coverage.

HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits, Payroll and Retirement Web site at www.kingcounty.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, Payroll and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

Coverage for your spouse/domestic partner under county benefits ends at the end of the month in which you discontinue coverage for him/her.

COBRA coverage begins on the first day of the month following the final divorce decree or the end of your domestic partnership as long as:

- your former spouse/domestic partner enrolls in COBRA coverage within 60 days of being notified of his/her COBRA election rights; and
- your former spouse/domestic partner's payment of premium is timely.

If you're ending a domestic partnership, your federal withholding on the value of your former domestic partner's county health care coverage will be discontinued after you've completed the online Discontinue Dependent Coverage form and your spouse/domestic partner's coverage ends.

When you divorce or end a domestic partnership, you may also want to update your beneficiary designations with Aetna Life Insurance for life insurance, with CIGNA Group Insurance for accidental death and dismemberment (AD&D) insurance, with the Washington State Department of Retirement Systems (DRS) or the Seattle City Employees' Retirement System (if you remained in the city retirement system when you became a county employee) for your retirement plan, and with the King County Employees Deferred Compensation Plan for your deferred compensation plan. (See *Contact Information*.)

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

You Become a Parent

When you become a parent, you have up to 60 days from the birth of your child or placement for adoption of your child (up to 30 days from placement of a legally designated ward) to add your eligible child to your benefits online. However, you're encouraged to notify the county of this qualifying life event within 30 days so you can take advantage of other changes that must be made within 30 days of this qualifying life event.

Within 60 days, you may add your new child or child placed for adoption to your medical, dental and vision coverage. When you add your eligible child, you have two health care options:

- add your child to your current medical, dental and vision coverage; or
- change your medical plan and add your child to your new medical plan, and include him/her in your current dental and vision coverage.

Within 30 days of this qualifying event, you may:

- begin or change a flexible spending account (FSA);
- add a legally designated ward (legally placed foster child, a child placed with you as legal guardian or a child named in a Qualified Medical Child Support Order) to your medical, dental and vision coverage; and
- add or discontinue supplemental life insurance for yourself.

You make these changes by completing the appropriate forms online.

HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits, Payroll and Retirement Web site at www.kingcounty.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, Payroll and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

Medical, dental and vision coverage begins from birth for a newborn and from date of placement for an adopted child. Coverage of a child in legal custody begins on the first day of the month following placement.

When you add a child to your benefits, you may also want to update your beneficiary designations with Aetna Life Insurance for life insurance, with CIGNA Group Insurance for AD&D insurance, with the Washington State Department of Retirement Systems (DRS) or the Seattle City Employees' Retirement System (if you remained in the city retirement system when you became a county employee) for your retirement plan, and with the King County Employees Deferred Compensation Plan for your deferred compensation plan. (See *Contact Information*.)

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

Your Child Is No Longer Eligible

Your covered child is no longer eligible for:

- health care coverage upon reaching age 26; and
- life insurance coverage upon reaching age 19 (age 25 if he/she is unmarried and dependent on you for more than 50% support and maintenance).

When your child is no longer eligible for county benefits, you must inform Benefits, Payroll and Retirement Operations of this qualifying life event online as soon as possible but no later than 60 days from the date of its occurrence. Your covered child will then have 60 days from the date he/she is notified of his/her COBRA election rights to enroll in COBRA (Consolidated Omnibus Budget Reconciliation Act) coverage.

The county has an obligation to discontinue county coverage for your child and to notify FBMC, the county's COBRA administrator, of his/her eligibility for COBRA coverage, if applicable. Your failure to notify the county within 60 days could lead to denial of COBRA rights for your child. (For information about continuing health care coverage, see "Continuing Coverage Under COBRA" in *Health Care*.)

While your child has 60 days to enroll in COBRA coverage, you must complete the county's Discontinue Dependent Coverage form online within 30 days of the date this qualifying life event occurs. *(On the online form, you'll need to elect "Child no longer dependent" as your "Reason for Event" and complete the remainder of the form.)* Otherwise, you may have to reimburse the county for expenses incurred following the date your child became ineligible for county coverage.

HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits, Payroll and Retirement Web site at www.kingcounty.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, Payroll and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

Coverage for your child under county benefits ends at the end of the month in which you discontinue your child's coverage.

COBRA coverage begins on the first day of the month following the loss of your child's eligibility for county coverage as long as:

- your child has enrolled in COBRA coverage within 60 days of the date he/she is notified of his/her COBRA election rights; and
- your child's payment of premium is timely.

When your child becomes ineligible for coverage, you may also want to update your beneficiary designations with Aetna Life Insurance for life insurance, with CIGNA Group Insurance for accidental death and dismemberment (AD&D) insurance, with the Washington State Department of Retirement Systems (DRS) or the Seattle City Employees' Retirement System (if you remained in the city retirement system when you became a county employee) for your retirement plan, and with the King County Employees Deferred Compensation Plan for your deferred compensation plan. (See *Contact Information*.)

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

You may continue medical, dental and vision coverage for a child reaching age 26 and supplemental life insurance for a child reaching age 25 if the child:

- was incapacitated and covered under your plans before reaching the age limit;
- continues to be incapacitated due to developmental or physical disability; and
- is dependent on you for more than 50% support and maintenance.

To continue coverage, you need to submit a Continue Coverage for Disabled Adult Child form to Benefits, Payroll and Retirement Operations six months before the child reaches the age limit or no later than 30 days after the child reaches the age limit.

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

You Have an Emergency

IMPORTANT!

If you have a medical, dental or vision emergency, seek immediate treatment.

If you have a medical, dental or vision emergency, seek immediate treatment. If possible, go to a network provider. Except for Group Health, nationwide networks are available for medical, prescription drug, dental and vision care. Therefore, even if you're out of the area, you may use network providers and pharmacies to receive network coverage.

If you're enrolled in the Deputy Sheriff Plan and you have a medical emergency as determined by the plan, you'll receive the network-level of benefits regardless of whether you receive network or out-of-network services. (For more information on how your Deputy Sheriff Plan emergency room care is covered, see "Knowing What's Covered and What's Not" under "Deputy Sheriff Plan" in *Health Care*.)

However, if you do not have an emergency and go to an out-of-network provider, you'll need to file a claim for reimbursement, and you'll be reimbursed at reasonable and customary rates. For prescription drug claims, you'll be reimbursed at the rates Express Scripts pays its network pharmacies, and you'll pay the amounts that out-of-network providers or pharmacies charge in excess of these rates.

If you're enrolled in Group Health and you have a medical emergency, the plan provides out-of-network medical and prescription drug coverage for emergency or urgent care nationwide. If you're outside the Group Health service area and you're able to obtain medical care from Kaiser Permanente, you pay the same copay you would have paid had you obtained care from Group Health.

You Need Care While Traveling

If you're traveling within the United States, you may use network and out-of-network providers as discussed in "You Have an Emergency" on page 16.

If you're traveling outside the United States and you're enrolled in the Deputy Sheriff Plan, any medical, prescription drug, dental and/or vision care you receive will be treated as an out-of-network service, and you'll need to file a claim for reimbursement.

Before traveling outside the United States, however, you can notify Express Scripts in advance of your travel and obtain up to a three-month supply of your medications from a network pharmacy at the regular copay rate. Express Scripts will allow you and your dependents to obtain an advance three-month supply of medications for foreign travel up to two times a year per person.

Before traveling abroad, contact Aetna, which administers the Deputy Sheriff Plan, to learn what type of information and documentation you may need for filing a claim. At a minimum, you'll need:

- the name and address of your provider;
- a complete description of the services provided;
- a copy of your receipt of payment for services; and
- your provider's signature.

If you're traveling outside the United States and you're enrolled in Group Health, the plan provides out-of-network medical and prescription drug coverage for emergency or urgent care.

You Take a Family/Medical Leave of Absence

You may be eligible to take leave for certain family and medical reasons under the Family and Medical Leave Act (FMLA) and King County Family and Medical Leave (KCFML). While on leave under FMLA/KCFML, you receive the same county-paid health benefits (medical, dental and vision) you had when on paid status immediately before you began leave.

LEAVE AND YOUR RETIREMENT PLAN

When you return from leave, you may be eligible to purchase retirement service credits. For more information, contact the Washington State Department of Retirement Systems. (See *Contact Information*.)

To request leave under FMLA/KCFML, you'll need to submit a Protected Family and Medical Leave Request Form to your supervisor, and your supervisor will need to notify Benefits, Payroll and Retirement Operations of your leave start date. For more complete information, be sure to consult with your supervisor and, if needed, your human resources representative.

If you've requested leave to care for yourself or a family member, you'll be asked to submit the appropriate medical certification form, which has been completed by an approved health care provider certifying the need for family/medical leave and for periodic medical evaluations during family/medical leave. If you've requested leave to bond with a newborn, adopted child or foster child, you will be asked to submit documentation of the birth or placement of your child.

Your supervisor or other leave-granting authority will respond to your family/medical leave request by providing you and Benefits, Payroll and Retirement Operations with a completed Protected Family and Medical Leave Response Form.

If you continue on leave past your FMLA/KCFML period on unpaid status, your medical, dental and vision coverage ends. However, you may be eligible to pay to continue your coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act). (For more information, see "Continuing Coverage Under COBRA" in *Health Care*.)

When you're on an approved FMLA/KCFML unpaid leave, your basic and supplemental life insurance and your basic accidental death and dismemberment (AD&D) insurance also ends. You may pay to continue your life insurance for up to 12 months and your AD&D insurance for up to 18 weeks so you'll have coverage while you're on unpaid status. However, even if you don't pay for this insurance while on unpaid leave, it will be reinstated once you return to work in a benefit-eligible position working enough hours to maintain benefit coverage.

When you return from FMLA/KCFML or unpaid leave, you and your supervisor or other leave-granting authority will need to notify Benefits, Payroll and Retirement Operations of your return date so that your benefits can be reinstated and your status in the Healthy Incentives℠ program can be updated. (For more information on the Healthy Incentives℠ program, see "How the Healthy Incentives℠ Program Works" in "Medical Plans" in *Health Care*.

Because a number of family and medical leave policies are based on federal, state and county laws, discuss your leave options with your supervisor or human resources representative.

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

FMLA Leave and Military Service

You may be eligible for two types of FMLA leave related to military service: active duty leave and caregiver leave.

Active Duty Leave

FMLA allows you to take up to 12 weeks of leave if a situation arises because your spouse, son, daughter or parent is on active military duty or to help make preparations when your spouse, son, daughter or parent receives a military order to report for active duty in support of a contingency operation. Your leave may begin as soon as your relative receives his/her military order.

Caregiver Leave

FMLA allows you to take up to 26 weeks of FMLA leave during a single 12-month period to care for a recovering service member if you are the spouse, son, daughter, parent or nearest blood relative of the service member.

A recovering service member is a member of the armed forces who, while on active duty, suffered an injury or illness that may render him/her unable to perform the duties of his/her office, grade, rank or rating.

LEAVE AND YOUR RETIREMENT PLAN

When you return from leave, you may be eligible to purchase retirement service credits. For more information, contact the Washington State Department of Retirement Systems. (See *Contact Information*.)

You're on Uniformed Services Leave

If you take a uniformed services leave, you need to provide your supervisor, your human resources representative, your military leave coordinator and Benefits, Payroll and Retirement Operations with written notice and a copy of your orders both when you leave employment to perform uniformed service (as in the military) and when you return to employment after performing uniformed service.

While you're performing uniformed service, your health care (medical, dental and vision) coverage may be continued until your active duty ends, depending on the circumstances, and your basic life insurance may be continued for up to 12 months. When the Benefits, Payroll and Retirement Operations staff receives notice that you've begun active duty or active duty training, the staff contacts you about:

- continuation of benefit coverage;
- arrangements for paying any benefit premiums you currently pay through payroll deduction; and
- options for you to continue supplemental life insurance.

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

LEAVE AND YOUR RETIREMENT PLAN

When you return from leave, you may be eligible to purchase retirement service credits. For more information, contact the Washington State Department of Retirement Systems. (See *Contact Information*.)

You Take an Authorized Unpaid Leave of Absence

LEAVE AND YOUR RETIREMENT PLAN

When you return from leave, you may be eligible to purchase retirement service credits. For more information, contact the Washington State Department of Retirement Systems. (See *Contact Information*.)

If you don't qualify for leave under any federal, state or county family and medical leave policies, you may take an approved leave of absence without pay. When you do, your benefit coverage for medical, dental and vision:

- continues uninterrupted if your unpaid leave is 30 consecutive days or less; or
- may be continued under COBRA if your unpaid leave is 31 consecutive days or more. In this case, your county coverage will end on the last day of the month in which you work before the leave begins. (For more information, see "Continuing Coverage Under COBRA" in *Health Care*.)

If your unpaid leave is 31 days or more, you'll need to pay for basic and supplemental life insurance and basic accidental death and dismemberment (AD&D) insurance if you want to continue coverage while you're on leave. You may pay to continue your life insurance for up to 12 months and your AD&D insurance for up to 6 months. However, even if you don't pay for your insurance while on unpaid leave, it will be reinstated when you return to paid status.

You may take a leave of absence without pay from 31 days up to one year with the approval of the county's Human Resources Director. To request leave without pay, you'll need to submit a Leave of Absence Without Pay Request form to your supervisor, and your supervisor will need to notify Benefits, Payroll and Retirement Operations of your leave start date. However, if your leave of absence is for your own medical condition, your leave must also be approved by the county's Disability Services Section.

When you return from your leave, you and your supervisor or other leave-granting authority will need to notify Benefits, Payroll and Retirement Operations of your return date so your benefit coverage can be reinstated and your status in the Healthy Incentives℠ program can be updated. (For more information on the Healthy Incentives℠ program, see "How the Healthy Incentives℠ Program Works" in "Medical Plans" in *Health Care*.)

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

You Become Disabled

If you become disabled while employed by the county, you may be able to continue your health care and life insurance coverage.

DEFINITION OF DISABLED

You're "disabled" if, because of injury or sickness:

- you're unable to perform all the material duties of your **regular occupation**, and if solely due to injury or sickness, you're unable to earn more than 80% of your indexed covered earnings from working in your regular occupation; and

- after disability payments have been payable for 24 months, you're unable to perform all the material duties of **any occupation** for which you may reasonably become qualified based on education, training or experience, and if solely due to injury or sickness, you're unable to earn more than 80% of your indexed covered earnings.

Health Care Coverage

If your disability qualifies you for leave under the Family and Medical Leave Act (FMLA), King County Family and Medical Leave (KCFML) or both, your medical, dental and vision coverage will continue for the length of your FMLA and/or KCFML leave. (For more information, see "You Take a Family/Medical Leave of Absence" on page 17.)

If you don't qualify for leave under FMLA or KCFML or if you continue on unpaid leave after your FMLA/KCFML leave ends, your medical, dental and vision coverage ends. However, you may be eligible to continue coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act). (For more information, see "Continuing Coverage Under COBRA" in *Health Care*.)

Under the Deputy Sheriff Plan, if you or your covered dependent is totally disabled and your coverage ends for any reason other than plan termination, medical 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 covered dependents may be able to elect COBRA coverage.

Extended medical coverage will end when you experience any of the following:

- you reach the end of the 12-month medical extension;
- you become eligible for benefits under another group policy (For more information, see "Definition of Disabled" on page 20.); or
- you're no longer disabled.

Life Insurance Coverage

In addition to continuing health care coverage, you may be eligible to continue receiving county-paid basic and/or self-paid supplemental life insurance coverage when you become disabled.

IMPORTANT

To be eligible to receive county-paid basic and/or self-paid supplemental life insurance coverage when you become disabled, you must pay the premiums to continue your basic and/or supplemental life insurance until Aetna approves your disability claim.

If you become disabled before age 60, the county-paid basic life insurance and self-paid supplemental life insurance you had on the last day you worked will be continued at no cost to you as long as you pay the premiums to continue your basic life and/or supplemental life insurance until Aetna approves your disability claim.

If you become disabled after age 60 and before you retire or end county employment, you may pay to continue the basic life and supplemental life insurance you had on the last day you worked until age 65 if Aetna approves your disability claim.

In either case, you must notify Benefits, Payroll and Retirement Operations of your disability within 30 days of the last day you worked.

To determine your eligibility for continuation of your county life insurance coverage, you will need to submit a group disability application to Aetna between 8 and 12 months after the last day you worked. (Group disability applications received 12 months after the last day you worked may be denied.)

You must meet all of these general requirements to be eligible for a continuation of your county life insurance coverage:

- your life insurance must be in force when you become permanently and totally disabled (this means that if you want to retain your life insurance coverage, you must pay the premiums until Aetna approves your disability claim);
- you have been disabled for at least 9 months, and no more than 12 months have passed since the last day you were physically present at work;
- you are unable to work at any reasonable job for pay or profit (For more information, see “Definition of Disabled” on page 20; and
- you furnish all proof when requested (Aetna may ask you to have an exam, at its expense, before accepting the proof).

If you convert coverage to an individual policy when you end employment rather than pay the premiums to continue the county’s life insurance coverage and if your group disability application is subsequently approved, Aetna will honor your disability application, cancel your individual policy and refund the premiums you have paid. (See “Converting to Individual Whole Life Insurance” in “How to Continue or Convert Coverage” in *Life and Accident Protection*.)

Continuation of your county life insurance coverage ends when the first of these circumstances occurs:

- Aetna sends you a request for an exam but you don’t have the exam within 31 days of that date, or Aetna requests proof that you’re still permanently and totally disabled and you don’t provide the proof within 31 days of that date;
- you’re well enough to work in any reasonable job;
- you start to work in any job for pay or profit;
- you reach age 65; or

- you discontinue payment of your premiums (if you became disabled after age 60).

If you became disabled before age 60 and your coverage has been extended continuously for two years, Aetna will not request an exam or proof more often than once in 12 months. When the extended coverage period ends, you may be eligible to convert to an individual life insurance policy.

If you die while disabled and before you submit a group disability application, Aetna pays your beneficiaries the life insurance benefit they would have received, provided that:

- your premium payments cease while you're totally disabled from disease or injury that keeps you from working in a reasonable job;
- your total disability has continued without interruption;
- your death occurs within 12 months after the last day you worked and your county-paid life insurance payments ended; and
- you would have qualified for extended insurance coverage, except that:
  - your disability had not lasted at least 9 months; or
  - Aetna had not yet approved your disability claim or received proof that your disability was permanent and total.

You're on a Mutual Aid Assignment

Occasionally—for example, in the case of a natural disaster—you may be asked to work temporarily for another agency that needs additional assistance. When you're being asked to provide assistance outside the country, your assignment—salary, benefits, per diem and other matters—will be arranged on a case-by-case basis between the county and the contracting agency.

There's a Declared Emergency

If there's a declared emergency, such as an earthquake or pandemic flu, there could be delays in processing claims and providing assistance. Every effort will be made to communicate any changes or delays resulting from a declared emergency.

You Enter Into a Labor Dispute

If you enter into a labor dispute, your county benefits—health care, FSA, life insurance and accidental death and dismemberment (AD&D) insurance—will end on the last day of the last month during which you work. If your pay is suspended directly or indirectly as the result of a strike, lockout or other labor dispute, you may be able to continue your health care coverage temporarily for up to 18 months by paying for it through COBRA (Consolidated Omnibus Budget Reconciliation Act). (See "Continuing Coverage Under COBRA" in *Health Care*.) You may also continue your life insurance coverage temporarily by paying the full cost for up to six months.

When your COBRA coverage ends, you may be able to continue health care coverage if you convert from county group coverage to an individual plan. Check with your plans for details. (See *Contact Information*.)

You Retire

When you decide to retire from the county, you should notify the Washington State Department of Retirement Systems (DRS) or the Seattle City Employees' Retirement System (if you remained in the city retirement system when you became a county employee) of your intentions as early as six months before retirement. Because you'll need to make some decisions, early notification will allow time for you and DRS to set up your retirement account for a smooth transition. (See *Contact Information.*)

To notify the county of your retirement plans, you need to submit a Termination Notice to your supervisor, payroll or human resources representative, and Benefits, Payroll and Retirement Operations. (See *Contact Information.*) Your payroll or human resources representative will help you make arrangements for your last paycheck from the county.

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

If you participate in the county's deferred compensation plan, you'll need to contact T. Rowe Price, the current deferred compensation plan administrator, for information on withdrawing funds from your account during retirement. Unlike your DRS plan, your deferred compensation plan doesn't require that you begin making withdrawals immediately—you're not required to take distributions until you reach age 70-1/2. You may contact the deferred compensation plan coordinator in Benefits, Payroll and Retirement Operations for assistance. (See *Contact Information.*)

When you retire, county-paid health care coverage ends on the last day of the month you retire. You may continue the medical and vision coverage you had if you pay the full cost of coverage and:

- you're covered under the county's health care plans on your last day of employment;
- you've worked for King County for at least five consecutive years before you retire;
- you're not eligible for Medicare;
- you're not covered under another group medical plan; and
- you meet the requirements for formal service or disability retirement under the Washington State Public Employees Retirement Act or the Seattle City Employees' Retirement System, in which you elected to remain according to a formal agreement between King County and the City of Seattle.

When you retire, you cannot continue the dental plan you have with the county; however, you may purchase an alternative retiree dental plan. You may also continue the alternative dental plan coverage after you become eligible for Medicare and are no longer eligible for COBRA (Consolidated Omnibus Budget Reconciliation Act) or retiree medical coverage.

If you choose COBRA benefits instead of retiree medical coverage, your covered dependents are eligible for the same coverage they had when you were an active employee.

If you choose retiree medical coverage, you may cover your dependents under retiree medical or your dependents may elect COBRA coverage instead. When you choose retiree medical coverage, however, you waive your COBRA rights. (For more information, see "Continuing Coverage Under COBRA" in *Health Care*.

If you're a member of a group that voted to participate in the HRA Voluntary Employees Benefits Association (VEBA), you must submit an HRA VEBA Membership Enrollment Form to Benefits, Payroll and Retirement Operations within 12 months of your retirement date so that your 35% sick leave cash-out can be transferred to the VEBA. If you do not submit the form within 12 months, your cash-out will be forfeited.

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

When you leave county employment, you may pay to continue your existing life insurance (for reasons other than disability) or convert it to a whole life policy with Aetna Life Insurance. You also may be eligible to purchase accidental death and dismemberment (AD&D) conversion insurance with CIGNA Group Insurance. (For more information, see "How to Continue or Convert Coverage" in *Life and Accident Protection*.)

You Leave Employment with the County

If you decide to leave county employment, you need to submit a Termination Notice to your supervisor, your payroll or human resources representative, and Benefits, Payroll and Retirement Operations. (See *Contact Information*.) Your payroll or human resources representative will help you make arrangements for your last paycheck from the county.

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

If you leave employment, you may continue county health care coverage for up to 18 months under COBRA (Consolidated Omnibus Budget Reconciliation Act), but you must pay the full cost of coverage. (For more information, see "Continuing Coverage Under COBRA" in *Health Care*.) Your monthly rates are based on what the county pays to provide the same coverage for you as an active employee, plus a maximum 2% administrative fee.

You may also pay to take a wellness assessment and receive the benefits of health coaching telephone calls throughout the year, but it is not a requirement for continuing your health care coverage. (For more information about the county's wellness assessment and health coaching calls, see "How the Healthy Incentives℠ Program Works" in "Medical Plans" in *Health Care*.)

When you leave the county for any reason other than gross misconduct, Benefits, Payroll and Retirement Operations notifies FBMC, the county's COBRA administrator, of your eligibility for COBRA health care coverage. If you have a covered spouse/domestic partner or dependent children, they're also eligible for COBRA health care coverage. County-paid coverage ends the last day of the month you leave the county.

COBRA coverage begins on the first day of the month after you leave the county if:

- you have enrolled in COBRA coverage within 60 days of the date you were notified of your COBRA election rights; and
- your payment of premium is timely.

When you leave county employment, you may pay to continue your existing life insurance (for reasons other than disability) or convert it to a whole life policy with Aetna Life Insurance. You also may be eligible to purchase accidental death and dismemberment (AD&D) conversion insurance with CIGNA Group Insurance. (For more information, see "How to Continue or Convert Coverage" in *Life and Accident Protection*.)

You may leave your contributions in your Washington State Department of Retirement Systems (DRS) plan account, you may withdraw your contributions and the interest earned, or you may roll your contributions and interest into another tax-deferred investment. When you withdraw your contributions, you pay federal taxes on them, and you may also pay a penalty, unless you roll your contributions into another tax-deferred investment. You may not withdraw any King County contributions to your retirement plan. (See *Contact Information.*)

If you participate in the county's deferred compensation plan, you may leave your funds in the plan or you may withdraw your funds without a penalty. However, if you withdraw your funds, you pay federal taxes on the amount withdrawn. (See *Contact Information.*)

You Leave the County and Are Rehired

If you leave the county for 30 days or less and are rehired, your previous benefit coverage may be reinstated and you won't have to re-enroll. Your human resources representative will need to formally ask Benefits, Payroll and Retirement Operations to reinstate your benefits.

If you leave the county for more than 30 days and are rehired, you must re-enroll in benefits as a new employee. (For more information, see "Enrolling When First Eligible" in "Participating in the Health Care Plans" in *Health Care.*)

You Die

If you die while covered under the county's benefit plans, your family and beneficiaries will receive a letter from Benefits, Payroll and Retirement Operations with instructions on how to:

- continue county health care coverage through COBRA (Consolidated Omnibus Budget Reconciliation Act) and other options; and
- submit claims for reimbursement under a flexible spending account (FSA), if you were enrolled.

Benefits, Payroll and Retirement Operations will also help your family and beneficiaries:

- complete a claim for any accidental death insurance they're entitled to receive;
- contact:
  - Aetna Life Insurance to file a life insurance claim;
  - the King County Employees Deferred Compensation Plan coordinator; and
  - Washington State Department of Retirement Systems (DRS);
- receive your final paycheck; and
- contact the Making Life Easier Program for bereavement counseling, if they're interested.

If Your Spouse/Domestic Partner or Dependent Child Dies

If your spouse/domestic partner or dependent child dies while you're covered under the county's benefit plans, contact Benefits, Payroll and Retirement Operations for assistance with:

- making benefit changes as appropriate;
- completing a claim for any life insurance benefit you're entitled to receive;
- completing other benefit forms as required; and
- arranging counseling and referral through the Making Life Easier Program.

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.

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

You're eligible for county-paid medical, dental and vision coverage for yourself and the eligible dependents (spouse/domestic partner and children) you enroll if you're:

- a part-time or full-time deputy sheriff; or
- employee deputy sheriff in a provisional or term-limited temporary position (your hiring authority can tell you if your position is benefit-eligible).

A part-time deputy sheriff is someone who works at least half-time but less than full-time in a calendar year.

You're not eligible for these benefits if:

- you work less than half-time in a calendar year;
- you're a temporary or seasonal employee; or
- you work in a capacity that, at the discretion of human resources, is considered contract work or independent contracting.

Spouse / Domestic Partner

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.

Your spouse/domestic partner is eligible for county-paid medical, dental and vision coverage.

However, when a spouse/domestic partner is in active full-time military service, he/she isn't eligible for medical, dental and vision coverage.

When you enroll your spouse/domestic partner, you must complete the online Marriage/Domestic Partnership form, which contains an Affidavit of Marriage/Domestic Partnership. 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 31 for details.)

HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits, Payroll and Retirement Web site at www.kingcounty.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, Payroll and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

Domestic Partners

While the county pays for your domestic partner's medical, dental and vision coverage, the IRS taxes you on the value of that 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.

Children

Children are eligible for county-paid medical, dental and vision coverage.

However, when a child is in active full-time military service, he/she isn't eligible for medical, dental and vision coverage.

Eligible children include:

- Your children or your spouse/domestic partner's children:
  - Your children are eligible for medical, dental and vision coverage up to age 26 as long as they do not have access to employer-sponsored coverage other than a parent's plan. Your adult children may be covered even if they are not dependent on you for support and even if they are married, though you may not cover their spouses or their children;

  "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;
    - 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 33);
- a child (as defined above) age 26 or older if the child:
  - was incapacitated and covered under your plans before age 26;
  - continues to be incapacitated due to a developmental or physical disability;
  - is incapable of self-sustaining employment; and
  - is dependent on you for more than 50% support and maintenance. (For more information, see "Disabled Dependent Children" on page 32.)

For children ages 23, 24 and 25 who are not disabled dependent children, you pay the premium for dental and vision coverage, but not medical coverage. Benefits, Payroll and Retirement Operations notifies you 60 days in advance of your child's 23rd birthday so you can elect to continue your child's coverage with premium payments. (For information about disabled dependent children ages 23, 24 and 25, see "Disabled Dependent Children" on page 32.)

If you don't notify Benefits, Payroll and Retirement Operations that you want to continue your child's coverage before your child turns 23, coverage for your child is automatically discontinued, and you will only be able to reinstate your child's coverage during open enrollment or within 30 days after a qualifying life event.

SPECIAL ENROLLMENT RIGHTS UNDER THE 2009 CHILDREN'S HEALTH INSURANCE PROGRAM

An expansion of the former State Children's Health Insurance Program, now called Children's Health Insurance Program, allows you and your eligible dependents to enroll in a group health plan when:

- You or your dependent loses Medicaid coverage or coverage under the Children's Health Insurance Program because you are no longer eligible (this provision was effective April 1, 2009), or
- You or your dependent qualifies for state assistance in paying your employer group medical plan premiums (pending action by the State of Washington, this provision allows states to provide premium assistance to children whose family earns less than 200% of the federal poverty level).

If you qualify for special enrollment rights under the Children's Health Insurance Program and want to enroll in a King County medical plan, you must notify Benefits, Payroll and Retirement Operations within 60 days following the event. (See *Contact Information*.) For all other special enrollment events, notification must occur within 30 days following the event. Otherwise, you must wait until the next open enrollment period to enroll in coverage.

Domestic Partner's Children

While the county pays for the medical, dental and vision coverage of your domestic partner's children, the IRS taxes you on the value of the coverage. 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 so you don't have to pay the premium when he/she is 23, 24 and 25 years of age, you must submit a Continue Coverage for Disabled Adult Child form, along with a certification of disability and incapability of self-sustaining employment, to Benefits, Payroll and Retirement Operations within 30 days of the child's 23rd birthday. You also must provide certification of the child's continued disability and incapability of self-sustaining employment annually thereafter.

If your dependent child becomes disabled between ages 23 and 25 while covered under your county benefits, you can follow the same process described above to avoid paying premiums.

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll 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, Payroll 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, Payroll 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 benefit enrollment forms in your Deputy Sheriff New Hire Guide as well as wellness assessments for you and your spouse/domestic partner when you attend a new employee orientation after you first report to work.

On your benefit enrollment forms, you have two medical plans to choose from: the Deputy Sheriff Plan and Group Health. All deputy sheriffs receive the same dental coverage with Washington Dental Service and the same vision coverage with Vision Service Plan.

The medical plan you elect for yourself is the medical plan your eligible dependents receive if you enroll them. When enrolling, you may elect different combinations of medical, dental and vision coverage for you and your eligible dependents. For example, you may elect medical, dental and vision coverage for you and your eligible children while electing only dental and vision coverage for your spouse.

If you and your spouse/domestic partner are both deputy sheriffs, you may cover each other as a dependent under your medical, dental and vision coverage. However, if one of you is a deputy sheriff and one of you is a regular county employee or part-time transit operator, you may not cover each other as a dependent.

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 35.)

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

Enrolling in the Health Care Plans

To enroll in your health care plans, you must return the benefit enrollment forms in your Deputy Sheriff New Hire Guide to Benefits, Payroll and Retirement Operations **within one week of your hire date**, which is the first day you report to work. If you don't meet this deadline:

- you'll be assigned the Deputy Sheriff Plan as your default medical coverage at the out-of-pocket expense level you achieve by taking or not taking the wellness assessment within 14 days of your new employee orientation (See "Taking the Wellness Assessment" on page 35);
- you won't be able to enroll your eligible dependents for any health care coverage—medical, dental or vision—until you have a qualifying life event or enroll them during the next annual open enrollment; and
- you won't be able to change your medical plan until the next annual open enrollment.

Taking the Wellness Assessment

In addition to returning your benefit enrollment forms, you and your spouse/domestic partner must each decide whether to take a wellness assessment as part of the county's Healthy Incentives℠ program. You and your spouse/domestic partner have **14 days from the day you attend your new employee orientation** to take the wellness assessment and return it to Benefits, Payroll and Retirement Operations:

- If you and your spouse/domestic partner complete and return the wellness assessment within 14 days, you'll receive the gold (lower) out-of-pocket expense level for your medical benefits for the current year and the following year.
- If your spouse/domestic partner doesn't complete and return the wellness assessment within 14 days, he/she will lose medical coverage for the current year and the following year (your coverage and coverage for your children will not be affected).
- If you don't complete and return the wellness assessment within 14 days, your employment may be discountinued, as your continued employment is dependent on taking the wellness assessment annually. (See "How the Healthy Incentives℠ Program Works" on page 55 in "Medical Plans.")

Each year, your out-of-pocket expense level is determined by your participation in the Healthy Incentives℠ program, which is required by your collective bargaining agreement—**please read your collective bargaining agreement to fully understand the requirements for your participation as a deputy sheriff.** By completing a wellness assessment by January 31 and completing an individual action plan by June 30 each year, you receive the gold out-of-pocket expense level for your medical benefits in the following year. If you only complete the wellness assessment by June 30, you receive the silver out-of-pocket expense level.

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.

The medical plan you elect for yourself is the medical plan your eligible dependents receive if you enroll them. When enrolling, you may elect different combinations of medical, dental and vision coverage for you and your eligible dependents. For example, you may elect medical, dental and vision coverage for you and your eligible children while electing only dental and vision coverage for your spouse.

IMPORTANT!

You and your spouse/domestic partner must each take a wellness assessment and return it to Benefits, Payroll and Retirement Operations within 14 days of attending your new employee orientation if you want to receive the gold (lowest) level of out-of-pocket expenses for your medical coverage.

HEALTHY INCENTIVES℠ IN BRIEF

The Healthy Incentives℠ 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[SM] Program Works" on page 55 in "Medical Plans.")

Opting Out of Medical Coverage

OPTING OUT

Only employees may opt out of medical coverage.

You may opt out of medical coverage only when you're first eligible for benefits 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.

As a newly benefit-eligible employee, you have a unique opportunity that your eligible 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. When you opt out of medical, it doesn't affect other health coverage; you and your covered dependents continue to receive county-paid dental and vision benefits.

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 complete the online Employee Lost Medical Coverage form within 30 days of losing that 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 to receive coverage, which will take effect January 1 of the following year.

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

Enrolling During the Annual Open Enrollment

DISCONTINUING COVERAGE FOR DEPENDENTS

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

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 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;
- 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 36 in "Enrolling When First Eligible.")

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 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*.)

If You're on a Leave of Absence

If you're on a paid leave of absence or on a leave of absence under the Family Medical Leave Act (FMLA) or King County Family Medical Leave (KCFML) during the annual open enrollment, you'll need to go online to:

- enroll or re-enroll in a flexible spending account; and
- make any other changes to your benefits.

If you're on an unpaid leave of absence other than FMLA or KCFML leave and are continuing your health benefits under COBRA (Consolidated Omnibus Budget Reconciliation Act), you will not go online to make any benefit elections. Instead, you will receive a COBRA enrollment packet with forms you must return to FBMC, the COBRA administrator. However, if you're not continuing your health benefits under COBRA, you will be given the opportunity to make open enrollment elections when you return to benefit-eligible status.

If you're unsure of your leave status, contact Benefits, Payroll and Retirement Operations to find out what you need to do during the annual open enrollment. (See *Contact Information*.)

(For more information about leaves of absence, see *What Happens If . . . .*)

When and How to Make Changes

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.

You may make certain changes to your health care coverage only 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 with Aetna Life Insurance for life insurance and with CIGNA Group Insurance for accidental death and dismemberment (AD&D) 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 eligibility or loss of eligibility under the terms of the plan;
- death of a covered dependent; and
- 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).

(For more information on leaves of absence, see *What Happens If . . . .*)

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, Payroll and Retirement Web site at www.kingcounty.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, Payroll 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 online Marriage/Domestic Partnership form, which contains an Affidavit of Marriage/Domestic Partnership. If you want, you may also submit a copy of your marriage certificate.

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 occurred. 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, Payroll and Retirement Web site at www.kingcounty.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, Payroll 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, Payroll and Retirement Web site at www.kingcounty.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, Payroll 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, Payroll 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 and lose coverage elsewhere, you must complete the online Employee Lost Medical Coverage form within 30 days of losing coverage if you want to opt back into the county's health care plans. If you don't complete the form within 30 days, you may not opt back in until the next annual open enrollment.

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll 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 of a spouse/domestic partner.

Requesting Continuation of Coverage for a Disabled Adult Child

You may continue medical, dental and vision coverage for a child past age 26 if the child:

- was incapacitated and covered under your plans before reaching age 26;
- continues to be incapacitated due to developmental or physical disability;
- is incapable of self-sustaining employment; and
- is dependent on you for more than 50% support and maintenance. (For more information, see "Disabled Dependent Children" on page 32.)

To continue coverage, you need to submit a Continue Coverage for Disabled Adult Child form, along with a certification of disability and incapability of self-sustaining employment, six months before the child turns age 26 or no later than 30 days after the child turns age 26.

If you want to continue coverage for a disabled child when he/she turns 23 so you don't have to pay the premium when he/she is 23, 24 and 25 years of age, you must submit a Continue Coverage for Disabled Adult Child form, along with a certification of disability and incapability of self-sustaining employment, to Benefits, Payroll and Retirement Operations within 30 days of the child's 23rd birthday. You also must provide certification of the child's continued disability and incapability of self-sustaining employment annually thereafter.

If your dependent child becomes disabled between ages 23 and 25 while covered under your county benefits, you can follow the same process described above to avoid paying premiums.

If you should leave county employment while covering a disabled adult child, your adult child's health care coverage can be continued under COBRA. Should you later return to work at the county (or should your spouse/domestic partner begin a job with the county), you can reinstate your adult child's health coverage under the county health care plans as long as COBRA coverage has not lapsed. If COBRA coverage has lapsed, you will not be able to continue your adult child's coverage under the county health care plans.

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

Requesting Coverage for Someone under a State Program

If the Washington State Department of Social and Health Services determines that it's more cost-effective for a person under a state medical assistance program or a children's health insurance program to enroll in an employer-sponsored health care plan, you may add that person to your county health care plan at any time during the year as long as he/she meets the county's eligibility requirements.

To do so, contact Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

Changes You May Make at Any Time

There is one change 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.

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 lower out-of-pocket expense level and your spouse/domestic partner has earned the higher out-of-pocket expense level for a given year, for example, your family coverage is at the higher out-of-pocket expense level. Your family coverage remains at the higher 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℠ program and how participation affects the cost of medical coverage, see "How the Healthy Incentives℠ Program Works" on page 55 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 coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act). (For more information, see "Continuing Coverage Under COBRA" on page 165.) 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, Payroll and Retirement Web site at www.kingcounty.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, Payroll 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 eligible dependents until the next annual open enrollment or after a qualifying life event occurs. (For more information, see "Changes You May Make After Qualifying Life Events" on page 38.)

Changes You Must Make

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

Discontinuing Coverage for Ineligible Dependents

You must discontinue dependent health 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 eligible children but not your spouse/domestic partner unless you are both deputy sheriffs); or
- your child turns age 26, unless he/she depends on you because he/she is incapacitated due to a developmental or physical disability.

When you discontinue coverage for a dependent, your dependent has 60 days from the date he/she loses coverage to enroll in coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act). (For information about COBRA coverage, see "Continuing Coverage Under COBRA" on page 165.) 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.

INELIGIBLE DEPENDENTS

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

HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits, Payroll and Retirement Web site at www.kingcounty.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, Payroll 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.

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.

Change Forms

Use the following forms to make these changes online:

- Marriage/Domestic Partnership, which includes an Affidavit of Marriage/Domestic Partnership;
- Spouse/Domestic Partner Lost Medical Coverage;

- Employee Lost Medical Coverage;
- Change Benefit Access Fee;
- Birth/Adoption;
- Add/Change Children Coverage; or
- Discontinue Dependent Coverage.

HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits, Payroll and Retirement Web site at www.kingcounty.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, Payroll and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

Use the following form to make this change on paper:

- Continue Coverage for Disabled Adult Child.

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

What Coverage Costs

Because you're a benefit-eligible deputy sheriff or a benefit-eligible deputy sheriff in a provisional or term-limited temporary position (your hiring authority can tell you if your position is benefit-eligible), the county pays the entire premium for medical, dental and vision coverage for you and the eligible dependents you enroll.

When Coverage Begins

ID CARDS

When you enroll for medical coverage, which includes prescription drug coverage, you receive an ID card or 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 135 in "Dental Plan" and "Using the Vision Plan" on page 155 in "Vision Plan."

Coverage begins on the first day of the month following your hire date, which is the first day you report to work, unless modified by your collective bargaining agreement. If your hire date is the first day of the month, your coverage begins the same day.

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.

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 38.)

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 39.)

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 Deputy Sheriff 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 the Deputy Sheriff Plan, 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 unless you are both deputy sheriffs. 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 eligible children under your plan. (For more information on opting out, see "Enrolling When First Eligible" on page 33.)

While the plan covering an individual as an employee is primary and pays first, the following guidelines determine which plan is primary for eligible 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 have the same birthday, in which case the plan that has covered one of the parents the longest is primary. 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 eligible 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 eligible 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 the Deputy Sheriff Plan, Group Health, the dental plan and the vision plan.

Deputy Sheriff Plan

When you or your covered dependent is injured or becomes ill because of the actions or inactions of a third party, the Deputy Sheriff Plan 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 Deputy Sheriff Plan procedures with respect to subrogation and right of recovery.

“Subrogation” means that if an injury or illness is someone else’s fault, the Deputy Sheriff Plan 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 the Deputy Sheriff Plan:

- 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 the Deputy Sheriff Plan 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 the Deputy Sheriff Plan 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 the Deputy Sheriff Plan 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 the Deputy Sheriff Plan 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, the Deputy Sheriff Plan 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 the Deputy Sheriff Plan, 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.

The Deputy Sheriff Plan 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 covered 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 covered 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 the Deputy Sheriff Plan 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 covered 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 covered dependent becomes eligible for Medicare.

If you or your eligible dependent is covered under the Deputy Sheriff Plan while totally disabled and coverage ends for any reason other than plan termination, the Deputy Sheriff Plan 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 coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act). However, electing the extension means forfeiting the right to elect COBRA coverage and convert to an individual policy. Other covered dependents may be able to elect coverage through COBRA. (For more information, see "Continuing Coverage Under COBRA" on page 165.)

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 or die;
- the day you submit a claim that exceeds the lifetime limit for benefits under the plan; or
- the day the plan terminates.

(For information about extending coverage, see "When Coverage Ends" on page 52. For information about continuing coverage under COBRA, the Consolidated Omnibus Budget Reconciliation Act, see "Continuing Coverage Under COBRA" on page 165.)

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 or they die;
- the day your covered dependent submits a claim that exceeds the lifetime limit for benefits under the plan; or
- the day the plan terminates.

(For information about extending coverage, see "When Coverage Ends" on page 52. For information about continuing coverage under COBRA, the Consolidated Omnibus Budget Reconciliation Act, see "Continuing Coverage Under COBRA" on page 165.)

Certificates of Coverage

When you, your spouse/qualified domestic partner and/or your dependents lose coverage under your medical plan, you must receive a certificate of your coverage, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). You may need this certificate of coverage when you become covered by a new plan under a different employer or by a new individual policy.

You, your spouse/qualified domestic partner and/or your dependents will receive a certificate of coverage at any of the following times:

- when your medical plan coverage ends;
- when COBRA coverage ends (provided you elected COBRA); and
- upon request (provided you made your request within 24 months following the end of either medical plan coverage or COBRA coverage).

Keep a copy of your certificate of coverage in case you need it to prove you had previous coverage when you join a new medical plan. For example, your certification of coverage could be helpful if you enroll in a new employer's medical plan that has a preexisting condition limitation, which delays coverage for conditions treated before you were eligible for the new plan. With proof of previous coverage, the employer may be required to reduce the duration of the preexisting condition limitation on your coverage by one day for each day you had previous coverage, subject to certain requirements. The same applies to a new individual policy.

Certificates of coverage aren't available for dental and vision coverage.

To request a certificate of coverage, contact your medical plan. (See *Contact Information*.)

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 (Consolidated Omnibus Budget Reconciliation Act). 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 165.)

How to Convert Coverage

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

Deputy Sheriff Plan

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.

If you're no longer eligible for the Deputy Sheriff Plan 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 Deputy Sheriff Plan 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.

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

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.

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.

For a quick overview of your medical benefits, see either "Deputy Sheriff Plan Benefits at a Glance" on page 57 or "Group Health Benefits at a Glance" on page 63.

DEFINED TERMS

Be sure you understand the meaning of the terms used in this summary, such as "copay" and "coinsurance." (See "Glossary" on page 185.)

Your Medical Plan Choices

As a benefit-eligible employee, you may be covered by one of two medical plans: the Deputy Sheriff Plan (administered by Aetna) and Group Health.

Deputy Sheriff Plan

Medical benefits under the Deputy Sheriff Plan are administered by Aetna; prescription benefits under the plan are administered by Express Scripts, Inc.

The medical and prescription drug benefits of the Deputy Sheriff Plan 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 the Deputy Sheriff Plan.

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℠ Program Works

The Healthy Incentives℠ 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, you and your spouse/domestic partner have the opportunity to take a wellness assessment. The wellness assessment provides a snapshot of your current health risks that are affected by behavior and identifies the potential for future health problems. You and your spouse/domestic partner also can participate in an individual action plan, which supports you in making healthy lifestyle behavior changes.

Participation in the Healthy Incentives℠ program is a requirement of your collective bargaining agreement—**please read your collective bargaining agreement to fully understand the requirements for your participation as a deputy sheriff.**

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

Out-of-Pocket Expense Levels

Under the Healthy Incentives℠ program, there are two out-of-pocket expense levels in the Deputy Sheriff Plan and Group Health plans:

- gold—the lower out-of-pocket expense level; and
- silver—the higher out-of-pocket expense level.

By taking the wellness assessment by January 31 and completing an individual action plan by June 30 each year, you receive the gold out-of-pocket expense level for your medical benefits in the following year. If you only complete the wellness assessment by June 30, you receive the silver out-of-pocket expense level.

If your spouse/domestic partner doesn't take the wellness assessment by June 30, he/she will lose medical coverage for the following year (your coverage and coverage for your children will not be affected).

If you don't take the wellness assessment by June 30, your employment may be discontinued, as your continued employment is dependent on taking the wellness assessment annually.

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. 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 deputy sheriffs and their spouse/domestic partners are given 14 days to take the wellness assessment after attending their new employee orientation to earn the gold out-of-pocket expense level for the current year and the following year. If a new deputy sheriff doesn't take the wellness assessment within 14 days, his/her employment may be discontinued, as continued employment is dependent on taking the wellness assessment annually. If the spouse/domestic partner doesn't take the wellness assessment, he/she will lose medical coverage for that year and the following year.

For details on how the three out-of-pocket expense levels affect your medical benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57 or "Group Health Benefits at a Glance" on page 63. For more information about the Healthy Incentives℠ program, visit the benefits Web site or contact Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

Your Medical Benefits at a Glance

This section provides a quick overview of your Deputy Sheriff Plan and Group Health benefits. (See "Deputy Sheriff Plan" on page **Error! Bookmark not defined.** and "Group Health" on page 107 for more details about each plan.)

Deputy Sheriff Plan Benefits at a Glance

The following tables show what the Deputy Sheriff Plan 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℠ Program Works" on page 55 and "Knowing What's Covered and What's Not" on page 76.)

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	Deputy Sheriff Plan Gold	Deputy Sheriff Plan Silver
Provider choice	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.	
Annual deductible	$50/person; $150/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. **The deductible doesn't apply to prescription drugs, preventive care or hearing aids.**	$600/person; $1,800/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. **The deductible doesn't apply to prescription drugs, preventive care or hearing aids.**
Copays	Applicable only to emergency room care and prescription drugs	
After the deductible/copays, the plan pays most covered services at these levels until you reach the annual out-of-pocket maximum	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)
Annual out-of-pocket maximum for medical services	Network: $375/person or $1,125/family, plus deductible Out-of-network: $1,600/person or $3,200/family, plus deductible Doesn't apply to prescriptions	Network: $1,000/person or $2,000/family, plus deductible Out-of-network: $2,800/person or $3,600/ family, plus deductible Doesn't apply to prescriptions
Annual out-of-pocket maximum for prescription drugs	$1,500/person or $3,000/family	

Plan Feature	Deputy Sheriff Plan Gold	Deputy Sheriff Plan Silver
After you reach the out-of-pocket maximum for medical services, most benefits are paid for the rest of the calendar year at this level	Network: 100% Out-of-network: 100% of R&C charges	
Lifetime maximum	No limit	

Covered Expenses

The following table summarizes covered services and supplies under the Deputy Sheriff Plan (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 76.)

Aetna processes medical claims and inpatient prescription drug 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.

IMPORTANT!

Before you receive out-of-network care, be sure you understand how covered out-of-network expenses are paid. 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 R&C charges, see "Reasonable and Customary (R&C) Charges" on page 72.)

Covered Expenses	Deputy Sheriff Plan Gold	Deputy Sheriff Plan Silver
Allergy testing and treatment (including injections separate from office visit)	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Alternative care (including medically necessary acupuncture, hypnotherapy and massage therapy)	Network: 90% Out-of-network: 70% Massage therapy 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 therapy 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)
Ambulance services	Network: 90% Out-of-network: 90%	Network: 80% Out-of-network: 80%
Chemical dependency treatment (requires preauthorization)	Network: 100% Out-of-network: 70%	Network: 100% Out-of-network: 60%
Chiropractic care and manipulative therapy (like all services, must be medically necessary)	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

Covered Expenses	Deputy Sheriff Plan Gold	Deputy Sheriff Plan Silver
Diabetes care training	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
Diabetes supplies (insulin, needles, syringes, lancets, etc.)	Covered under prescription drugs	
Durable medical equipment, prosthetics and orthopedic appliances	Network: 90% Out-of-network: 70% Preauthorization required for expense of $1,000 or more	Network: 80% Out-of-network: 60% Preauthorization required for expense of $1,000 or more
Emergency room care (Also see "Urgent Care")	Emergency care, network and out-of-network: 90% after $25 copay/visit (waived if admitted) Non-emergency care, network and out-of-network: 90% after $25 copay/visit	Emergency care, network and out-of-network: 80% after $100 copay/visit (waived if admitted) Non-emergency care, network and out-of-network: 80% after $100 copay/visit
Family planning	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Growth hormones	Network: 90% when preauthorized Out-of-network: 70% when preauthorized May also be covered under the prescription drug benefit	Network: 80% when preauthorized Out-of-network: 60% when preauthorized May also be covered under the prescription drug benefit
Hearing aids	100%, up to $500 in 36 months for combined network and out-of-network services Deductible doesn't apply.	
Hearing exam	Network: 100%, no deductible (included as part of routine physical exam) Out-of-network: 70%, after deductible (included as part of routine physical exam)	Network: 100%, no deductible (included as part of routine physical exam) Out-of-network: 60%, after deductible (included as part of routine physical exam)
Home health care	100% when preauthorized, up to 130 visits/year for combined network and out-of-network services	
Hospice care	100% when preauthorized 12-month lifetime maximum 120-hour maximum for respite care in any 3-month period 12-month maximum for bereavement services	
Hospital care (both inpatient and outpatient, including outpatient surgery)	Network: 90% when preauthorized Out-of-network: 70% when preauthorized	Network: 80% when preauthorized Out-of-network: 60% when preauthorized
Infertility	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

Covered Expenses	Deputy Sheriff Plan Gold	Deputy Sheriff Plan Silver
Injury to teeth	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
Inpatient care alternatives	Network: 90% when preauthorized Out-of-network: 70% when preauthorized	Network: 80% when preauthorized Out-of-network: 60% when preauthorized
Jaw abnormalities, or malocclusions (covered when medically necessary)	Network: 90% when preauthorized Out-of-network: 70% when preauthorized	Network: 80% when preauthorized Out-of-network: 60% when preauthorized
Lab, X-ray and other diagnostic testing	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Maternity care	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Mental health care	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Naturopathy	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Neurodevelopmental therapy for covered dependents age 6 and under	Network: 90% when preauthorized Out-of-network: 70% when preauthorized Limited to 60 visits/year and $2,000/year for combined network and out-of-network services	Network: 80% when preauthorized Out-of-network: 60% when preauthorized Limited to 60 visits/year and $2,000/year for combined network and out-of-network services
Obesity surgery or other procedures, treatment or services, such as gastric intestinal bypass surgery	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 is 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 is required before preauthorization.
Out-of-area coverage—for example, while traveling or for your covered children away at school	Same coverage as when home, through Aetna and Express Scripts national provider networks	
Phenylketonuria (PKU) formula	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Physician and other medical/surgical services	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%

Covered Expenses	Deputy Sheriff Plan Gold	Deputy Sheriff Plan Silver
Prescription drugs—Up to a 30-day supply through network pharmacies	Generic: 100% after $7 copay Preferred brand: 100% after $12 copay ($20 if generic is available; but if you're unable to take it for medical reasons, the $12 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.	Generic: 100% after $7 copay Preferred brand: 100% after $30 copay (if a generic is available and your physician obtains preauthorization for use of the brand, you may only pay a $22 copay—see "Preventive Care" under "What's Covered and What's Not" for more information) Non-preferred brand: 100% after $60 copay (if a generic is available and your physician obtains preauthorization for use of the brand, you may only pay a $45 copay—see "Preventive Care" under "What's Covered and What's Not" for more information) Prescriptions filled at out-of-network pharmacies are reimbursed at the rate Express Scripts pays to network pharmacies, less your copay.
Prescription drugs—Up to a 90-day supply through mail-order network only	Generic: 100% after $14 copay Preferred brand: 100% after $24 copay ($40 if generic is available; but if you're unable to take it for medical reasons, the $24 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)	Generic: 100% after $14 copay Preferred brand: 100% after $60 copay (if a generic is available and your physician obtains preauthorization for use of the brand, you may only pay a $44 copay—see "Preventive Care" under "What's Covered and What's Not" for more information) Non-preferred brand: 100% after $120 copay (if a generic is available and your physician obtains preauthorization for use of the brand, you may only pay a $90 copay—see "Preventive Care" under "What's Covered and What's Not" for more information)
Preventive care (well-child check-ups, immunizations, routine health and hearing exams, etc.)	Network: 100% Out-of-network: 70% Deductible doesn't apply, but coverage is based on specific schedules.	Network: 100% Out-of-network: 60% Deductible doesn't apply, but coverage is based on specific schedules.
Radiation therapy, chemotherapy and respiratory therapy	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%

Covered Expenses	Deputy Sheriff Plan Gold	Deputy Sheriff Plan Silver
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.	Network: 90% Out-of-network: 70%	Network: 80% Out-of-network: 60%
Rehabilitative services—Inpatient and outpatient	Network: 90% Out-of-network: 70% *Inpatient:* Up to 60 days/year *Outpatient:* Up to 60 visits/all therapies combined (progress review every 20 visits for out-of-network outpatient)	Network: 80% Out-of-network: 60% *Inpatient:* Up to 60 days/year *Outpatient:* Up to 60 visits/all therapies combined (progress review every 20 visits for out-of-network outpatient)
Skilled nursing facility	Network: 90% when preauthorized Out-of-network: 70% when preauthorized	Network: 80% when preauthorized Out-of-network: 60% when preauthorized
Smoking cessation	100%, no deductible 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%.	
Temporomandibular joint (TMJ) disorders	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
Transplants (certain services only)	Network: 100% when preauthorized Out-of-network: 70% when preauthorized Medical coverage must have been continuous for more than 12 months under KingCare℠ before a transplant will be covered. No lifetime maximum	Network: 100% when preauthorized Out-of-network: 70% when preauthorized Medical coverage must have been continuous for more than 12 months under KingCare℠ before a transplant will be covered. No lifetime maximum
Urgent care (ear infections, high fevers, minor burns, etc.)	Network: 90% Out-of-network: 70%	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℠ Program Works" on page 55 and "Knowing What's Covered and What's Not" on page 112.)

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
Provider choice	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.	
Annual deductible	None	
Copay, unless otherwise indicated	You pay $7	You pay $20
After copays, the plan pays most covered services at these levels until you reach the annual out-of-pocket maximum	Network: 100% Out-of-network: Limited emergency/out-of-area care	
Annual out-of-pocket maximum	Network: $1,000/person or $2,000/family Out-of-network: Limited emergency/out-of-area care Pharmacy copays do not apply to annual out-of-pocket maximum.	Network: $1,500/person or $3,000/family Out-of-network: Limited emergency/out-of-area care Pharmacy copays do not apply to annual out-of-pocket maximum.
After you reach the annual out-of-pocket maximum, most benefits are paid for the rest of the calendar year at this level	Network only: 100%	
Lifetime maximum	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 112.)

Covered Expenses	Group Health Gold	Group Health Silver
Alternative care (including medically necessary acupuncture, massage therapy and naturopathy)	Self-referrals to a network provider: $7 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 requires PCP referral.	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 requires PCP referral.
Ambulance services	80% (except hospital-to-hospital ground transfers, which are covered at 100% when initiated by Group Health)	
Chemical dependency treatment (requires preauthorization)	*For inpatient care:* 100% *For outpatient care:* 100% after $7 copay/visit	*For inpatient care:* 100% *For outpatient care:* 100% after $20 copay/visit
Chiropractic care and manipulative therapy (like all services, must be medically necessary)	100% after $7 copay/visit	100% after $20 copay/visit
Diabetes care training	100% after $7 copay/visit	100% after $20 copay/visit
Diabetes supplies (insulin, needles, syringes, lancets, etc.)	Covered under prescription drugs	Covered under prescription drugs
Durable medical equipment, prosthetics and orthopedic appliances	80% when preauthorized	80% when preauthorized
Emergency room care	Network: 100% after $75 copay/visit ($75 copay is waived if admitted) Out-of-network: 100% of reasonable and customary expenses after $125 copay/visit ($125 copay is waived if admitted) **Non-emergency care is not covered.**	Network: 100% after $100 copay/visit ($100 copay is waived if admitted) Out-of-network: 100% of reasonable and customary expenses after $150 copay/visit ($150 copay is waived if admitted) **Non-emergency care is not covered.**
Family planning	100% after $7 copay/visit **Infertility treatment is not covered.**	100% after $20 copay/visit **Infertility treatment is not covered.**
Growth hormones	100%, covered under prescription drugs	
Hearing aids	Not covered	
Hearing exam (routine)	100% after $7 copay	100% after $20 copay
Home health care	100%	

Covered Expenses	Group Health Gold	Group Health Silver
Hospice care	100% when preauthorized Certain limits apply; call plan for details.	
Hospital care	Inpatient: 100% Outpatient surgery: 100% after $7 copay/surgery	Inpatient: 100% Outpatient surgery: 100% after $20 copay/surgery
Infertility services	Not covered	
Inpatient care alternatives	100% when preauthorized	
Lab, X-ray and other diagnostic testing	100%	
Maternity care	*For delivery and related hospital care:* 100% *For prenatal and postpartum care:* 100% after $7 copay/visit	*For delivery and related hospital care:* 100% *For prenatal and postpartum care:* 100% after $20 copay/visit
Mental health care	*For inpatient care:* 100% *For outpatient care:* 100% after $7 copay/individual, family, couple or group session	*For inpatient care:* 100% *For outpatient care:* 100% after $20 copay/individual, family, couple or group session
Neurodevelopmental therapy for covered dependents age 6 and under	*For inpatient care:* 100%, up to 60 days/year (combined with rehabilitative services) *For outpatient care:* 100% after $7 copay/visit, up to 60 visits/year (combined with rehabilitative services)	*For inpatient care:* 100%, up to 60 days/year (combined with rehabilitative services) *For outpatient care:* 100% after $20 copay/visit, up to 60 visits/year (combined with rehabilitative services)
Out-of-area coverage—for example, while traveling or for your covered children away at school	Reciprocal benefits are available through Kaiser Permanente and affiliated HMOs; otherwise, only emergency services are covered out of area.	
Phenylketonuria (PKU) formula	100%	
Physician and other medical/surgical services	*For inpatient care:* 100% after $7 copay *For outpatient care:* 100% after $7 copay/office visit	*For inpatient care:* 100% after $20 copay *For outpatient care:* 100% after $20 copay/office visit
Prescription drugs—Up to a 30-day supply through network pharmacies	Generic: 100% after $5 copay Preferred brand: 100% after $5 copay Non-preferred brand: Not covered Growth hormones: 100% There's no reimbursement for prescriptions filled at out-of-network or out-of-area pharmacies.	Generic: 100% after $10 copay Preferred brand: 100% after $15 copay Non-preferred brand: Not covered Growth hormones: 100% There's no reimbursement for prescriptions filled at out-of-network or out-of-area pharmacies.
Prescription drug—Up to a 90-day supply through mail-order network only	Generic: 100% after $10 copay Preferred brand: 100% after $10 copay Non-preferred brand: Not covered	Generic: 100% after $20 copay Preferred brand: 100% after $30 copay Non-preferred brand: Not covered

Covered Expenses	Group Health Gold	Group Health Silver
Preventive care (well-child check-ups, immunizations, routine health and hearing exams. etc.)	100% (according to well-child/adult preventive schedule)	100% (according to well-child/adult preventive schedule)
Radiation therapy, chemotherapy and respiratory therapy	100% after $7 copay/visit	100% after $20 copay/visit
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.	100% depending on services provided; copays may apply	100% depending on services provided; copays may apply
Rehabilitative services—Inpatient and outpatient	*For inpatient care:* 100%, up to 60 days/calendar year (combined with neurodevelopmental therapy) *For outpatient care:* 100% after $7 copay/visit, up to 60 visits/calendar year (combined with neurodevelopmental therapy)	*For inpatient care:* 100%, up to 60 days/calendar year (combined with neurodevelopmental therapy) *For outpatient care:* 100% after $20 copay/visit, up to 60 visits/calendar year (combined with neurodevelopmental therapy)
Skilled nursing facility	100% up to 60 days/calendar year at a Group Health-approved nursing facility	
Smoking cessation	100% for nicotine replacement therapy (including gum, patches or prescription medication) through the Group Health-designated tobacco cessation program, Free & Clear® Quit for Life™ Program, when prescribed by Group Health PCP No annual or lifetime limit	
Sterilization (tubal ligation or vasectomy)	100% after $7 copay	100% after $20 copay
Temporomandibular joint (TMJ) disorders	*For inpatient care:* 100% *For outpatient care:* 100% after $7 copay/visit Up to $1,000/calendar year and a $5,000 lifetime maximum	*For inpatient care:* 100% *For outpatient care:* 100% after $20 copay/visit Up to $1,000/calendar year and a $5,000 lifetime maximum
Transplants (certain services only)	Inpatient: 100% Outpatient: 100% after $7 copay Medical coverage must have been continuous for more than 6 months under this plan before a transplant will be covered.	Inpatient: 100% Outpatient: 100% after $20 copay Medical coverage must have been continuous for more than 6 months under this plan before a transplant will be covered.
Urgent care (ear infections, high fevers, minor burns)	100% after $7 copay/visit	100% after $20 copay/visit

Covered Expenses	Group Health Gold	Group Health Silver
Vision exams	100% after $7 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 $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)

Deputy Sheriff Plan

To make the most out of the benefits available under the Deputy Sheriff Plan, you need to understand how the plan works.

For a quick overview of your medical benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.

Accessing Care

When you're enrolled in the Deputy Sheriff Plan, 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 73);
- 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 (R&C) charges (For important details about R&C charges, see "Reasonable and Customary (R&C) Charges" on page 72); and
- you're responsible for paying any remaining charges.

IMPORTANT!

There are some situations, such as surgery, for which you may receive services from both network and out-of-network providers. In these situations, you may be responsible for paying out-of-network costs beyond what is considered "reasonable and customary."

Whenever possible, anticipate the unexpected by asking in advance whether you are receiving network or out-of-network services.

(For important details about reasonable and customary charges, see "Reasonable and Customary (R&C) Charges" on page 72.)

Network Providers

WHAT THE DEPUTY SHERIFF PLAN PAYS FOR NETWORK CARE

For details on what the Deputy Sheriff Plan pays when you see network providers, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.

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

Aetna 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, and malpractice and state sanction histories.

You may select a network provider by contacting Aetna or visiting 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

WHAT THE DEPUTY SHERIFF PLAN PAYS FOR OUT-OF-NETWORK CARE

For details on what the Deputy Sheriff Plan pays for out-of-network care, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.

Although Aetna's network of health care providers is nationwide, you may also use out-of-network providers. However, when you choose out-of-network providers, you must file your own claims.

- For out-of-network medical claims, you're reimbursed based on reasonable and customary charges. (For important details about reasonable and customary charges, see "Reasonable and Customary (R&C) Charges" on page 72.)
- 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.

(For the group number to use when filing a claim, see *Contact Information*.)

If Your Dependent Lives Away from Home

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

- For out-of-network medical claims, you're reimbursed based on reasonable and customary charges. (For important details about reasonable and customary charges, see "Reasonable and Customary (R&C) Charges" on page 72.)
- 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.

(For the group number to use when filing a claim, see *Contact Information*.)

If You Go on Active Military Leave

If you should go on active military leave while employed with the county, you'll continue to receive medical coverage under your Deputy Sheriff Plan insurance for the length of your military leave. For more information, contact Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

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 the Deputy Sheriff Plan with respect to how benefits are paid.

Deductible

The "annual deductible" is the amount you must pay each year toward covered expenses before Aetna begins paying. The Deputy Sheriff Plan annual deductibles are as follows:

- Deputy Sheriff Plan Gold: $300/person, $900/family; and
- Deputy Sheriff Plan Silver: $600/person, $1,800/family.

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

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.

Family Deductible

If three or more covered 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 covered dependent for the rest of that year.

If you and your covered 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 more detailed information, see "Deputy Sheriff Plan Benefits at a Glance" on page 57 and "Covered Expenses" on page 76.)

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 more detailed information, see "Deputy Sheriff Plan Benefits at a Glance" on page 57 and "Covered Expenses" on page 76.)

Reasonable and Customary (R&C) Charges

"Reasonable and customary charges" are rates that are consistent with those normally charged by a 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 charges that Aetna has negotiated with the provider. When you use an out-of-network provider, Aetna pays a percentage of the R&C charges, and you pay the remaining amount of the provider's charges.

Annual Out-of-Pocket Maximum

IMPORTANT!

There are some situations, such as surgery or a visit to an emergency room, for which you may receive services from both network and out-of-network providers. In these situations, you may be responsible for paying out-of-network costs beyond what is considered "reasonable and customary."

Whenever possible, anticipate the unexpected by asking in advance whether you are receiving network or out-of-network services.

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, the Deputy Sheriff Plan pays 100% for most covered expenses for the rest of that year. If you have three or more covered 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 the Deputy Sheriff Plan.

Lifetime Maximum

There's no lifetime maximum benefit under the Deputy Sheriff Plan. However, some expenses are also subject to annual or lifetime benefit limits. (For more information, see "Covered Expenses" on page 76.)

Up Close and Personal

The following example helps illustrate how the Deputy Sheriff Plan medical plan works.

Meet Ken

Ken was playing volleyball one weekend in January when he felt a sharp pain in his left foot. He could still walk on it, so he thought it might just be a strained muscle or stressed tendon. He decided not to go to the emergency room but to self-refer himself during the workweek to an orthopedic surgeon instead. Ken knows he has the lowest level of out-of-pocket expenses because he earned "gold" by taking the wellness assessment and completing an individual action plan in the Healthy Incentives℠ program in the previous year.

The orthopedic surgeon, who is a network provider, quickly works Ken into her schedule, examines his foot and orders a set of X-rays. The X-rays show that Ken has developed a stress fracture in his fifth metatarsal. The orthopedic surgeon gives him a walking boot to prevent movement in his foot so that his stress fracture can heal. She also arranges a follow-up appointment for Ken in four weeks to check on his progress.

Here's how much Ken pays for this visit:

The total expense is...	Deputy Sheriff Plan pays...	Ken pays...
$150 (allowable charges for the exam)	$0	$150 ($150 toward $300 annual deductible)
$200 (allowable charges for the X-rays)	$42.50 (85% of $50, after remaining $150 of $300 annual deductible is met)	$157.50 ($150 toward remaining amount of $300 annual deductible, plus 15% of $50, or $7.50)
$75 (allowable charges for the walking boot)	$63.75 (85% of $75)	$11.25 (15% of $75, or $11.25)
Total	**$106.25**	**$318.75**

Other Features of the Deputy Sheriff Plan

It's important to understand other features of the Deputy Sheriff Plan 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.

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:

- 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 covered 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 the Deputy Sheriff Plan;
- 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, the Deputy Sheriff Plan 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 99.)

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 the Deputy Sheriff Plan—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.

IMPORTANT!

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

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.

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. When you do, you may also receive a follow-up call from a nurse to make sure you're getting the medical care you need.

IMPORTANT!

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

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 Deputy Sheriff Plan member Web site: www.kingcare.com.

Compassionate Care℠

If your family is facing difficult decisions about advanced illnesses, you may receive support and services through Aetna's Compassionate Care℠ program. The program offers nurse support, information and tools, and enhanced hospice benefits to help:

- remove barriers to needed care;
- promote choice and autonomy; and
- ensure comfort and support for you and your family.

For your covered dependent to be eligible, your physician must certify that your covered dependent is not likely to live longer than 12 months.

Services include palliative care for relieving physical symptoms, curative treatment for a possible cure or prolonging life, and up to 12 months of grief counseling for your family.

(For more information about the Compassionate Care℠ program, visit www.aetnacompassionatecareprogram.com.)

Knowing What's Covered and What's Not

WHAT THE DEPUTY SHERIFF PLAN PAYS FOR CARE

For specific coinsurance and copays for the covered expenses described in this section, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.

It's possible that some medical treatments may not be covered under the Deputy Sheriff Plan. 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 90.)

If you end employment with King County, refer to "Certificate of Coverage" for information on how your participation in the Deputy Sheriff Plan can be credited against other plans with preexisting condition limits.

Covered Expenses

IMPORTANT!

See "Glossary" on page 185 for the definition of "medically necessary."

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 "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Ambulance Services

The Deputy Sheriff Plan 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 "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

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 73.) Chemical dependency benefits are covered up to the maximum described in "Deputy Sheriff Plan Benefits at a Glance" on page 57.

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 99 and "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Chiropractic Care and Manipulative Therapy

The Deputy Sheriff Plan 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 "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

IMPORTANT!

Some chiropractic services aren't covered. (For details, see "Expenses Not Covered" on page 92.)

Diabetes Care Training

The Deputy Sheriff Plan 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 "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

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 73. For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Medical Services. The Deputy Sheriff Plan 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 99);
- phototherapy using a high-intensity light box for the treatment of seasonal affective disorder, bipolar disorder or recurrent major depression when the diagnosis meets Aetna's criteria for coverage;
- 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 99.)

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 the Deputy Sheriff Plan, you receive the network level of benefits—100% with varying levels of copays depending on your out-of-pocket expense level of gold, silver or bronze—regardless of whether you receive network or out-of-network care.

When you visit an emergency room, you may receive some services from network providers and other services from out-of-network providers. For example, you may visit an emergency room in a network hospital that uses some out-of-network providers, such as anesthesiologists, emergency room physicians, assistant surgeons, radiologists and pathologists.

When you receive emergency room care services from network providers, you pay the network level of coinsurance on the charges Aetna has negotiated with the providers. When you receive services from out-of-network providers, you pay the network level of coinsurance on the billed charges, which may be higher than charges negotiated with network providers. However, this coverage is different than most out-of-network care in which Aetna pays a percentage of reasonable and customary (R&C) charges and you're responsible for paying any remaining charges. (For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57. For information about R&C charges, see "Reasonable and Customary (R&C) Charges" on page 72.)

If your condition doesn't qualify as a medical emergency but care is urgently needed, see "Urgent Care" on page 92 for a description of coverage.

Family Planning

IMPORTANT!

Some family planning services aren't covered. (For details, see "Expenses Not Covered" on page 92.)

Medical Services. The Deputy Sheriff Plan covers the following family planning services:

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

(For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Prescription Drug Services. Birth control pills and devices requiring a prescription are covered and processed by Express Scripts. (For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

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 "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Hearing Aids

Hearing aids, including fitting, rental and repair, are covered. (For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Home Health Care

IMPORTANT!

Some home health care services aren't covered. (For details, see "Expenses Not Covered" on page 92.)

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 73.)

Covered services include:

- nursing care;
- occupational therapy;
- physical therapy;
- respiratory therapy;
- 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 99.)

(For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

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.

IMPORTANT!

Some hospice care services aren't covered. (For details, see "Expenses Not Covered" on page 92.)

If a physician certifies that a patient is not likely to live longer than 12 months, hospice care services are covered for up to 12 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 73.)

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 99);
- 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 12-month lifetime maximum may be granted if Aetna receives a written request from your physician. (For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Hospital Care

IMPORTANT!

Some inpatient care services aren't covered. (For details, see "Expenses Not Covered" on page 92.)

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 73.)

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.

If you or your covered dependent is hospitalized and your medical coverage ends, the plan continues to provide hospital care coverage until discharge. Coverage ends on the date of discharge or when you or your covered dependent reaches the plan maximum, whichever comes first.

(For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

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 "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Infertility

Covered infertility expenses include:

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

(For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

IMPORTANT!

Some infertility-related expenses aren't covered. (For details, see "Expenses Not Covered" on page 92.)

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 "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

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 "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Jaw Abnormalities

Covered services include:

- surgical corrections of jaw abnormalities, or malocclusions, when medically necessary; and
- bone grafts for dental implants when medically necessary to provide support to the implants and the jaw (e.g., in cases of osteoporosis).

(For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

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;
- 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); and
- services provided by a physician to diagnose gastrointestinal conditions.

(For routine screenings, such as hearing tests and mammograms, see "Preventive Care" on page 87. For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Maternity Care

IMPORTANT!

Some maternity-related expenses aren't covered. (For details, see "Expenses Not Covered" on page 92.)

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.

The plan covers maternity care for covered dependent children and provides coverage for the newborn of the covered dependent child for three weeks.

(For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

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 heath care services are covered at the same coinsurance rates as other medical care and are applied against your annual out-of-pocket maximum.

Inpatient and outpatient mental health care is covered if provided by a:

- licensed psychiatrist (MD);
- licensed psychologist (PhD);
- licensed master's-level mental health counselor;
- licensed nurse practitioner (ARNP);
- community mental health agency licensed by the Department of Health; or
- licensed state hospital.

For additional counseling and referral services, you may also call the 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 "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Depending on individual medical needs, other benefit options may be available under the Deputy Sheriff Plan case management program. (For more information, see "Case Management" on page 75.)

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 73.)

IMPORTANT!

Some mental health services aren't covered. (For details, see "Expenses Not Covered" on page 92.)

Naturopathy

The Deputy Sheriff Plan covers the following naturopathic 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 "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Neurodevelopmental Therapy

The Deputy Sheriff Plan 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 73. For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Newborn Care

The Deputy Sheriff Plan covers newborns under the mother's health plan for the first three weeks, as required by Washington state law. (For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.) 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 39.)

Obesity Surgery

IMPORTANT!

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

Obesity surgery or other procedures, treatment or services such as gastric intestinal bypass surgery are covered only if proven medically necessary according to the Aetna Policy Coverage Bulletin. You must obtain preauthorization for this coverage. (For details, see "Preauthorization" on page 73.) However, before you can obtain preauthorization, you must successfully complete a physician-supervised weight management and exercise program. (For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Phenylketonuria (PKU) Formula

The Deputy Sheriff Plan covers the medical dietary formula that treats PKU. Claims are processed through Aetna. (For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Physician and Other Medical/Surgical Services

The Deputy Sheriff Plan 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 "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Prescription Drugs

Information about your prescription drug coverage is available under "Using Your Prescription Drug Plan" on page 99. (For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

You may be allowed to pay a lower copay for preferred brands or non-preferred brands if the following criteria are met:

- the brand is available from multiple manufacturers;
- your physician or the pharmacy requests the lower copay;
- you have tried the generic equivalent and it has not been effective; and
- your physician writes a prescription for the brand using the notation, "dispense as written."

Preventive Care

The Deputy Sheriff Plan 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;
- colorectal screening for colon cancer as recommended by a physician for individuals age 50 and older and for younger high-risk individuals; covers:
  - one annual fecal occult blood test;
  - one digital rectal exam and flexible sigmoidoscopy every 5 years;

  - one digital rectal exam and double-contrast barium enema every 5 years;
  - one digital rectal exam and colonoscopy every 10 years;
- cholesterol screening every 5 years for men 35 and older, and every 5 years for women 45 and older;
- immunizations, including annual flu shots or nasal spray (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 more frequently depending on your health care needs. Before scheduling a routine physical, confirm with Aetna that your physical will be covered.

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

Sometimes when you have a preventive care office visit, your provider may identify a condition requiring additional diagnostic services. In these situations when a diagnostic service is performed at the time of a preventive care visit, Aetna will begin covering the additional diagnostic services at only 50% of allowable charges while continuing to cover the preventive care portion of the visit at 100%. This change will not affect you if you see a network provider, because a network provider is not allowed to bill you for amounts over the 50% negotiated fee; however, should you see an out-of-network provider, you can be billed for amounts over 50% of allowable charges.

(For plan benefits, see “Deputy Sheriff Plan Benefits at a Glance” on page 57.)

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 “Deputy Sheriff Plan Benefits at a Glance” on page 57.)

Reconstructive Services

Reconstructive surgery to improve or restore bodily function is covered, subject to Aetna's review and approval. The Deputy Sheriff Plan covers cosmetic surgery to improve physical appearance only if it's medically necessary.

The Deputy Sheriff Plan 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 "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Rehabilitative Services

The Deputy Sheriff Plan covers medically necessary inpatient and outpatient rehabilitative care, including physical, occupational and speech therapy, 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 "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

IMPORTANT!

Some rehabilitative services aren't covered. (For details, see "Expenses Not Covered" on page 92.)

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 73.)

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 99.)

IMPORTANT!

Some skilled nursing facility services aren't covered. (For details, see "Expenses Not Covered" on page 92.)

(For plan benefits, see “Deputy Sheriff Plan Benefits at a Glance” on page 57.)

Smoking Cessation

IMPORTANT!

Some smoking cessation expenses aren’t covered. (For details, see “Expenses Not Covered” on page 92.)

The Deputy Sheriff Plan covers the following smoking cessation services:

- 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 (network only).

(For plan benefits, see “Deputy Sheriff Plan Benefits at a Glance” on page 57.)

Additional help for smoking cessation is available through:

- Tobacco Quit Line, a smoking cessation program covered at 100% through Healthways (For more information about the Tobacco Quit Line, contact Healthways at 1-877-279-0624); and
- Quit Net, a county-sponsored program through which you can gain access to a number of online support options, such as downloading educational materials and joining an online support group (For more information about QuitNet, visit www.quitnet.com/KingCounty).

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 “Deputy Sheriff Plan Benefits at a Glance” on page 57.)

Additional benefits are available through the dental plan. (For more information, see “Dental Plan” on page 133.)

Transplants

IMPORTANT!

Some transplant-related expenses aren’t covered. (For details, see “Expenses Not Covered” on page 92.)

The Deputy Sheriff Plan 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 (food costs are not covered) for someone to accompany a transplant recipient (the recipient’s companion can be anyone of the recipient’s choosing) and up to $100 a day for the companion’s lodging (food costs are not covered) if the care is provided at an Institutes of Excellence facility more than 100 miles from the recipient’s residence. If the recipient is 18 years or younger, he/she may be accompanied by two parents or guardians.

The companion's lodging expenses are covered when the companion's presence is required to enable the recipient to receive services from an Institutes of Excellence facility on either an inpatient or an outpatient basis. Institutes of Excellence facilities are part of Aetna's National Medical Excellence (NME) program for transplants and other specialized diseases.

Transplant benefits are paid at 100% when the transplant takes place at an Institutes of Excellence facility. If the transplant takes place at a network or out-of-network facility that is not an Institutes of Excellence facility, benefits are only paid at the out-of-network level.

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 73.)

You're not covered for organ transplant benefits until the first day of the 13th month of continuous coverage under the Deputy Sheriff Plan.

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, you may make the necessary arrangements.

The following human transplants are covered:

- heart;
- lung;
- heart/lung;
- pancreas;
- kidney;
- simultaneous pancreas and kidney (SPK);
- liver;
- intestine;
- bone marrow/stem cell transplant;
- tandem transplants (stem cell);
- multiple organs replaced during one transplant surgery;
- sequential transplants;
- re-transplant of the same organ type within 180 days of the first transplant;
- any other single organ transplant, unless otherwise excluded under the plan.

(For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Transplant Recipients. If you're a transplant recipient, all of your services and supplies, including transportation to and from Institutes of Excellence facilities, are covered. Institutes of Excellence 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 spouse, 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
- activation of the donor search process for donors in the registry, HLA-DR sample procurement and typing, donor physical examinations and laboratory tests, and bone marrow/stem cell procurement.

Urgent Care

The Deputy Sheriff Plan 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. (For information about emergency room care coverage, see "Emergency Room Care" on page 79.)

(For plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

Expenses Not Covered

The Deputy Sheriff Plan doesn't cover the following services:

- alternative care (including acupuncture, hypnotherapy and massage therapy) if it's not medically necessary;
- benefits covered by the following agencies or programs, or benefits that would be covered by these agencies or programs if the Deputy Sheriff Plan 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 attorneys' 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 family member;
- chiropractic spinal manipulations under anesthesia;
- cosmetic surgery except:
  - for a covered 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 covered 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 family member; 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;
- mental health services involving:
  - biofeedback;
  - custodial care;
  - specialty programs for mental health therapy not provided by the Deputy Sheriff Plan; and
  - treatment of sexual disorders;
- non-approved drugs and substances (those the FDA has not approved for general use and has 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 family member;
  - skilled nursing facility confinement for developmental disability 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
  - the cost of food for the transplant recipient and the recipient's companion;
- 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 Aetna's portion of the claim. Claim forms are available from Aetna at the Deputy Sheriff Plan member Web site: 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
- one of these group numbers:
  - 725069-10-011 for gold out-of-pocket expense level coverage;
  - 725069-10-012 for silver out-of-pocket expense level coverage; and
  - 725069-10-013 for bronze out-of-pocket expense level coverage.

For prompt payment, submit all claims as soon as possible to:

Aetna, Inc.
P.O. Box 14079
Lexington, KY 40512-4079.

Generally, the Deputy Sheriff Plan 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 the Deputy Sheriff Plan requires you to obtain approval of the benefit before receiving the care. The Deputy Sheriff 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 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. The Deputy Sheriff 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 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 the Deputy Sheriff Plan.

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 "Deputy Sheriff Plan" 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 Deputy Sheriff Plan 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.

WHO'S IN THE EXPRESS SCRIPTS NETWORK?

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

Express Scripts issues a separate prescription card to Deputy Sheriff Plan members to use when filling prescriptions at network pharmacies or through the Express Scripts mail-order service. 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.

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 "Deputy Sheriff Plan Benefits at a Glance" on page 57.)

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.

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.

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*.)

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/CURASCRIPT

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 Curascript, Express Scripts' specialty pharmacy. After your first retail fill, Curascript will send you a letter that details how to have your prescription transferred to the specialty pharmacy. If you want to contact Curascript 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.

Coverage While Traveling Outside the U.S.

If you will be traveling outside the United States, you can notify Express Scripts in advance of your travel and obtain up to a three-month supply of your prescription drugs from a network pharmacy at the regular copay rate. Express Scripts will allow you and your covered dependents to obtain an advance three-month supply of medications for foreign travel up to two times a year per person.

If you will be traveling abroad for longer than three months, be prepared to purchase your prescription drugs at the retail rate in those other countries after your supply runs out. When you return to the United States, you will need to submit a claim for reimbursement of prescription drug purchases you made in those other countries. Your purchase of prescription drugs in other countries will be treated as an out-of-network expense and will be reimbursed at the out-of-network rate. For purposes of claim reimbursement, Puerto Rico, Guam and the U.S. Virgin Islands are not considered foreign countries, but cruise ships are.

For more information about filing a claim for prescription drugs purchased outside the U.S., contact Express Scripts before you travel. (See *Contact Information*.)

Coverage during a Natural Disaster

When a natural disaster occurs, prescriptions drugs may be lost or destroyed, and home delivery may not be feasible. Under certain circumstances resulting from a natural disaster, Express Scripts may choose to allow members living in affected areas to obtain prescription drugs ahead of the regular refill schedule. For more information about obtaining prescriptions during a natural disaster, contact Express Scripts. (See *Contact Information.*)

Progressive Medication Management

To ensure you receive safe and effective prescription drugs at the lowest cost, Express Scripts evaluates the use of 12 classes of medications for certain conditions through a progressive medication management program. Those 12 classes include PPI (stomach acid conditions), statin (high cholesterol), NSIAD (arthritis/pain), hypnotics (sleep disorders), leukotrienes (allergies), ARB/ACE (heart and high blood pressure), bisphosphonates (osteoporosis), nasal steroids (allergies), SSRI and other antidepressants (depression), antivirals (viral infections), non-sedating antihistamines (allergies) and overactive bladder medications (overactive bladder).

If you are prescribed a medication in one of these 12 classes, Express Scripts will first require that the generic drug be used before a preferred brand or non-preferred drug can be used, even if your physician has prescribed a preferred brand or non-preferred drug. If the generic drug is determined to be ineffective, Express Scripts will then allow the use of a preferred brand drug, followed by a non-preferred brand drug, as necessary to treat your condition.

If your pharmacy cannot reach your physician to authorize the generic form of your medication, your pharmancy may contact Express Scripts for authorization to provide you with the generic drug for five days until the physician can be reached.

If you were taking a preferred brand drug or a non-preferred brand drug for any of these conditions 130 days or more before January 1, 2010, Express Scripts exempted you from the progressive medication management for that particular drug.

For more information about progressive medication management, contact Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

Preauthorization

IMPORTANT!

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

Express Scripts doesn't determine the maximum number of refills or period when a prescription is valid because these limitations 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 Deputy Sheriff Plan 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. (The most current list of these drugs is available at the Express Scripts Web site: www.express-scripts.com.)

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 the Deputy Sheriff Plan. 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 by 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.

What's Covered and What's Not

Covered Expenses

Express Scripts covers:

- contraceptives (including oral, injectable, vaginal, topical and implantable);
- DESI drugs (See "Glossary" on page 185);
- 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;
  - keytone testing strips;
  - lancets;
  - lancet devices;
  - monitors; and
  - urine glucose testing strips;
- legend drugs (See "Glossary" on page 185);
- ostomy supplies;
- medically necessary vitamins;

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. (See *Contact Information*.)

- smoking cessation drugs, inhalers and nasal sprays requiring a prescription (claims for non-prescription nicotine patches, lozenges and gum are covered at 100% through Aetna—for plan benefits, see "Deputy Sheriff Plan Benefits at a Glance" on page 57); and
- topical smoking cessation patches whether prescription or over-the-counter.

Expenses Not Covered

The following items are not covered by Express Scripts:

- anorexiants/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, the Deputy Sheriff Plan doesn't cover:

- charges that exceed the amounts Express Scripts pays its network pharmacies;
- drugs for a covered 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 has 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 the Deputy Sheriff Plan; and
- answer questions about over-the-counter medications.

Outcomes Pharmaceutical Health Care administers the Medication Therapy Management Services program. You can find a participating pharmacy by using the "Pharmacist Finder" at the Outcomes Pharmaceutical Health Care Web site: www.getoutcomes.com.

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, which will reimburse you at the negotiated rate within its network. To obtain a claim form, contact Express Scripts. For the group number to use when filing a claim, 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.

For prompt payment, submit all claims as soon as possible to:

Express Scripts, Inc.
Member Reimbursements
P.O. Box 66583
St. Louis, MO 63166.

Generally, Express Scripts 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 "Deputy Sheriff Plan" 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.

For a quick overview of your medical benefits, see "Group Health Benefits at a Glance" on page 63.

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 refers you to an out-of-network provider.

Medical and prescription drug benefits under Group Health are administered by Group Health. You receive a single ID card from Group Health for both your medical and prescription drug coverage. (For your group number, see *Contact Information*.)

Network Providers

Network providers may be either staff members of Group Health or contracted providers. Services of contracted providers must be preauthorized.

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, and malpractice and state sanction histories. For a list of network 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 63.

Out-of-Area Coverage

Group Health doesn't provide out-of-area benefits except for emergency care. If you or a covered dependent is away from home, you may be able to access urgent or emergency care at network benefit levels in health maintenance organizations (HMOs) associated with Group Health. You or your covered dependent 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)

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.

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 covered dependent may have a different PCP. The provider directory is updated periodically. For current information about providers, contact Group Health. (See *Contact Information*.)

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 only 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.

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, 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. 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. Services of a contracted provider must be preauthorized.

- 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 covered 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.

If You Go on Active Military Leave

If you should go on active military leave while employed with the county, you'll continue to receive medical coverage under your Group Health insurance for the length of your military leave. For more information, contact Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

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.

Medical and prescription drug benefits under Group Health are administered by Group Health. You receive a single ID card from Group Health for both your medical and prescription drug coverage.

(For more detailed information on copays and coinsurance, see "Group Health Benefits at a Glance" on page 63 and "Covered Expenses" on page 112.)

Copay

You pay copays for medical care and prescription drugs at the time you receive service.

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 covered 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;
- prescription drug copays.

Lifetime Maximum Benefit

There’s no lifetime maximum benefit under Group Health.

Up Close and Personal

The following example helps illustrate how the Group Health medical plan works.

Meet Caroline

Caroline was playing volleyball one weekend in January when she felt a sharp pain in her left foot. She could still walk on it, so she thought it might just be a strained muscle or stressed tendon. She decided not to go to the emergency room but to contact her Group Health primary care physician (PCP) during the workweek instead. Caroline knows she has the lowest level of out-of-pocket expenses because she earned “gold” by taking the wellness assessment and completing an individual action plan in the Healthy Incentives℠ program in the previous year.

Caroline’s PCP examines her foot and refers her to a Group Health orthopedic surgeon, who quickly works Caroline into his schedule, examines her foot and orders a set of X-rays. The X-rays show that Caroline has developed a stress fracture in her fifth metatarsal. The orthopedic surgeon gives her a walking boot to prevent movement in her foot so that her stress fracture can heal. He also arranges a follow-up appointment for Caroline in four weeks to check on her progress.

Here's how much Caroline pays for this visit:

The total expense is...	Group Health pays...	Caroline pays...
$150 (charges for the exam)	$130 ($150 – $20 copay)	$20 copay
$200 (charges for the X-rays)	$200	$0 copay
$70 (charges for the walking boot, which is durable equipment)	$56 (80% of $70)	$14 (20% of $70)
Total	**$386**	**$34**

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.

Health Care 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.

Personal Health Record

You can stay up-to-date with your medical history and other personal information. After signing in at www.ghc.org, you can manage your appointments and medications, check e-mail messages from your health care providers, and view after-visit summaries, lab results and more.

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 or by calling 1-888-901-4636.

(For additional services available to members, visit www.ghc.org.)

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.

Knowing What's Covered and What's Not

IMPORTANT!

For specific copays and coinsurance for the covered expenses described in this section, see "Group Health Benefits at a Glance" on page 63.

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 transplants. (For more information, see "Transplants" on page 124.)

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

IMPORTANT!

Some alternative care services aren't covered. (For details, see "Expenses Not Covered" on page 125.)

Covered alternative care 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 63.)

You can self-refer for acupuncture and naturopathy care, but referral by a PCP is required for home births and massage therapy. You must use a network provider for these services.

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 63.)

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. (For plan benefits, see "Group Health Benefits at a Glance" on page 63.)

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 63.)

IMPORTANT!

Some chiropractic services aren't covered. (For details, see "Expenses Not Covered" on page 125.)

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 63.)

Durable Medical Equipment, Devices and Supplies

Group Health covers durable medical equipment if it:

- is designed for prolonged use;
- 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.

For durable medical equipment, you pay a coinsurance amount rather than a copay amount.

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 120);
- 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 coinsurance on both the rental and purchase cost);
- 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 63.)

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 non-Group Health 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 63.)

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 63.)

IMPORTANT!

Some family planning services aren't covered. (For details, see "Expenses Not Covered" on page 125.)

Birth control drugs are covered under the prescription drug benefit. (For details about prescription drug coverage, see “Prescription Drugs” on page 120.)

Growth Hormones

Group Health covers growth hormones without a waiting period, which until 2009 had been 12 months. (For plan benefits, see “Group Health Benefits at a Glance” on page 63.)

Hearing Aids

IMPORTANT!

Some hearing aid services aren’t covered. (For details, see “Expenses Not Covered” on page 125.)

Group Health covers hearing examinations, hearing aids and fittings. (For plan benefits, see “Group Health Benefits at a Glance” on page 63.)

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:

IMPORTANT!

Some home health care services aren’t covered. (For details, see “Expenses Not Covered” on page 125.)

- 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 63.)

Hospice Care

IMPORTANT!

Some hospice care services aren’t covered. (For details, see “Expenses Not Covered” on page 125.)

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 or 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 63.)

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.

If you or your covered dependent is hospitalized and your medical coverage ends, the plan continues to provide coverage until:

- it is no longer medically necessary for you to be an inpatient at the facility, according to GHC clinical criteria;
- the remaining benefits for the hospitalization are exhausted, regardless of whether a new calendar year begins;
- you become covered under another agreement with a group health plan that provides benefits for the hospitalization;
- you become enrolled under an agreement with another health plan carrier that would provide benefits for the hospitalization if you weren’t covered by this plan; or
- you become eligible for Medicare.

(For plan benefits, see “Group Health Benefits at a Glance” on page 63.)

Inpatient Care Alternatives

Information about inpatient care alternatives is available under "Home Health Care" on page 116 and "Skilled Nursing Facility" on page 123.

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 63. For more information on routine diagnostic testing such as a mammogram, see "Preventive Care" on page 121.)

Maternity Care

IMPORTANT!

Some maternity-related expenses aren't covered. (For details, see "Expenses Not Covered" on page 125.)

Group Health covers maternity care if provided by a:

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

Covered maternity care includes:

- prenatal care (outpatient copay waived unless specialized treatment is required);
- complications of pregnancy or delivery;
- hospitalization and delivery, including home births and certain birthing centers for low-risk pregnancies;
- postpartum care (outpatient copay waived unless specialized treatment is required);
- 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 63.)

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, which are covered at the same copay rates as other medical care and are applied against your annual out-of-pocket maximum. 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 63.)

IMPORTANT!

Some mental health services aren't covered. (For details, see "Expenses Not Covered" on page 125.)

Neurodevelopmental Therapy

Group Health covers neurodevelopmental therapy for covered dependents 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 63.)

IMPORTANT!

Some neurodevelopmental therapy-related services aren't covered. (For details, see "Expenses Not Covered" on page 125.)

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 63.) 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 39.)

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 63.)

Physician and Other Medical/Surgical Services

IMPORTANT!

Some medical and surgical services aren't covered. (For details, see "Expenses Not Covered" on page 125.)

Group Health covers other medical and surgical services, including:

- allergy serum;
- 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;
- outpatient total parenteral nutrition therapy;
- procedures performed by a network provider or oral surgeon for 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 (accidental injury to teeth not covered);
- services of a podiatrist;
- sterilization procedures; and
- treatment of growth disorders by growth hormones. (See "Growth Hormones" on page 116 for details.)

(For plan benefits, see "Group Health Benefits at a Glance" on page 63.)

Prescription Drugs

IMPORTANT!

Some prescription drugs aren't covered. (For details, see "Expenses Not Covered" on page 125.)

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 the 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 63.)

Generic drugs are used whenever available. Brand-name drugs are used if there is no generic equivalent, in which case you pay the generic copay. However, if a generic is available for a brand-name drug and you choose to purchase the brand-name drug without a medical reason for its use, or if you choose to purchase a different brand-name or generic drug than your provider prescribed, you pay the additional amount above the pharmacy's cost.

Preventive Care

Group Health covers the following preventive care services:

- most immunizations and vaccinations for covered adults and children, including annual flu shots (except nasal flu sprays and immunizations for travel);
- routine hearing exams (once in 12 consecutive months);
- routine mammograms (age and risk factor determine frequency);
- diagnostic screening for prostate cancer as recommended by a physician, registered nurse or physician assistant (annual exams are recommended at age 40 and older);
- colorectal diagnostic screening for colon cancer as recommended by a physician for individuals age 50 and older and for younger high-risk individuals;
- routine physicals for covered 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 more frequently depending on your health care needs. Before scheduling a routine physical, confirm with Group Health that your physical will be covered.

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

(For plan benefits, see "Group Health Benefits at a Glance" on page 63.)

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 63.)

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;
- 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 copay and coinsurance provisions as are other medical and surgical benefits. (For plan benefits, see "Group Health Benefits at a Glance" on page 63.)

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 63.)

IMPORTANT!

Some rehabilitative services aren't covered. (For details, see "Expenses Not Covered" on page 125.)

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 63.)

Smoking Cessation

Group Health covers the following, without an annual or lifetime limit:

- nicotine replacement therapy through the Group Health-designated tobacco cessation program, Free & Clear® Quit for Life™ Program (For more information, visit www.ghc.org/products/freeclr.jhtml); and
- educational materials.

IMPORTANT!

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

You may enroll in the tobacco cessation program anytime. Group Health covers approved smoking cessation products, such as gum, patches or prescription medication, in full when prescribed as part of the tobacco cessation program and dispensed through Group Health's mail-order service. Otherwise, you may purchase the products 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 63.)

Additional help for smoking cessation is available through:

- Tobacco Quit Line, a smoking cessation program covered at 100% through Healthways (For more information about the Tobacco Quit Line, contact Healthways at 1-877-279-0624); and
- Quit Net, a county-sponsored program through which you can gain access to a number of online support options, such as downloading educational materials and joining an online support group (For more information about QuitNet, visit www.quitnet.com/KingCounty).

Temporomandibular Joint (TMJ) Disorders

Group Health covers the following services for treating temporomandibular joint (TMJ) disorders:

- 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.

IMPORTANT!

Some TMJ-related services aren't covered. (For details, see "Expenses Not Covered" on page 125.)

(For plan benefits, see “Group Health Benefits at a Glance” on page 63.)

TMJ appliances are covered under the orthopedic appliances benefit. (See “Durable Medical Equipment, Devices and Supplies” on page 114.)

Additional benefits are available through the dental plan. (For more information, see “Dental Plan” on page 133.)

Transplants

IMPORTANT!

Some transplant-related services aren’t covered. (For details, see “Expenses Not Covered” on page 125.)

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, except for transplant-related drugs, until the first day of the 7th 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/multivisceral;
- 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 medications and costs for surgery and hospitalization related to the transplant).

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 63.)

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 63.)

Vision Exams

Group Health covers routine vision exams only. (For plan benefits, see "Group Health Benefits at a Glance" on page 63.) The vision plan provides benefits for eye exams and for prescription lenses and frames. (For more information, see "Vision Plan" on page 153.)

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, or 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 116;
  - 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 therapy (i.e., eye training);
- out-of-network expenses exceeding usual, customary and reasonable (UCR) charges;
- over-the-counter drugs, 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, 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, or 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 123), 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 124); 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, Payroll and Retirement Operations).

For prompt payment, submit all claims as soon as possible to:

Group Health
P.O. Box 34585
Seattle, WA 98124-1585.

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.

DEFINED TERMS

Be sure you understand the meaning of the terms used in this summary, such as "deductible" and "coinsurance." (See "Glossary" on page 185.)

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 135.)

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 137.)

Your Dental Benefits at a Glance

The following table shows what the dental plan pays for covered services and supplies under the dental plan when you use a WDS/Delta Dental participating dentist, and identifies related deductibles, coinsurance and maximums. (For additional details, see "Knowing What's Covered and What's Not" on page 140.)

The following table does not show what the dental plan pays when you use a non-participating dentist. (For more information, see "Choosing Non-Participating Dentists" on page 136.)

Plan Feature	
Annual deductible	None
Annual maximum benefit (doesn't apply to orthodontic or TMJ services)	$2,500/person
Covered Expenses	**Dental Plan Pays**
Diagnostic and preventive services • Exam and cleaning, twice/calendar year • Oral health assessment • Periodontal cleaning and maintenance up to 4 times/calendar year (under certain oral health conditions) • Complete X-rays every 3 years • Supplementary bitewing X-rays, twice/calendar year	70%–100%, based on patient's incentive level
Basic services • Crowns (stainless steel) • Extractions • Fillings • Periodontics • Root canals	70%–100%, based on patient's incentive level
Major services • Crowns (gold, porcelain) • Onlays • Periodontics—occlusal (night) guard	70%–100%, based on patient's incentive level
Major services—Prosthodontics • Dentures • Fixed bridges • Implants	70% (incentive levels don't apply)
Orthodontic services for covered adults and children	60% up to a $2,500 lifetime maximum (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 55.)
Orthognathic surgery	70% up to a $5,000 lifetime maximum benefit Your medical plan may provide additional coverage for temporomandibular joint (TMJ) disorder. (See "Medical Plans" on page 55.)
Accidental injury	100% for covered expenses incurred within 180 days of accident

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 may obtain a 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

The dental plan has an extensive network of participating dentists. To locate a WDS/Delta Dental dentist or find out if your dentist is part of the WDS/Delta Dental network, visit the WDS Web site or call WDS. (See *Contact Information*.) WDS keeps its list of participating dentists current and has search tools you can use for locating a dentist near you.

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%)	– 800	– 960
What Beth pays (20%)	**$200**	**$240**

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 may obtain a predetermination of benefits from WDS for certain procedures and services (For more information, see "Predetermination of Benefits" on page 139);
- 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 usually at a lower rate than if you'd seen a WDS/Delta Dental PPO or Premier dentist (reimbursement is based on the maximum allowable fees that WDS has determined for non-participating dentists or on the actual charges, if they are 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*.)

When filing a claim, use group number 00152. It's your responsibility to ensure that the claim is sent to WDS.

Out-of-State Dentists

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

If You Go on Active Military Leave

If you should go on active military leave while employed with the county, you'll continue to receive dental coverage for the length of your military leave. For more information, contact Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

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 of your claims and any predetermination of benefits you may have requested.

Deductible

The "annual deductible" is the amount you must pay each year toward covered services before the dental plan begins paying. Your dental plan deductible does not have a deductible.

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 133.)

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 $2,500 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
- Orthognathic surgery at $5,000 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.

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, diagnostic and preventive services, as well as basic and major services, are covered initially at 70%, increasing 10% in January of each year until the dental plan pays 100%. However, prosthodontics is only covered at 70% regardless of your incentive level.

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 your payment level was 80% in 2007 but you didn't see your dentist for a covered service that year, your payment level in 2008 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 or dependent of a King County employee and become employed by the county;
- recalled or reinstated employee who returns to work within two years of previous county employment; or

IMPORTANT!

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

- 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 ...
Diagnostic and preventive services **Basic services** **Major services**	• 70% in the first year • 80% in the second year • 90% in the third year • 100% in the fourth year and each year thereafter

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%.

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)

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.

Here's how much Jim pays:

The total expense is...	Dental plan pays...	Jim pays...
$600 for the root canal	$420 (70% of $600)	$180 (30% of $600)

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 what procedures are covered, the amount the dental plan may pay toward the treatment and the amount you'll be expected to pay. Final payment may differ from the estimate based on several factors, such as actual services received, amount of annual deductible outstanding, benefits paid by the primary plan, and applicable plan limits.

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 140. 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 on which it's based, 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 network provider—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 provider, 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

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 133.

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 139.)

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.

(For coverage amounts, see "Your Dental Benefits at a Glance" on page 133.)

Class I: Preventive and Diagnostic Services

IMPORTANT!

Some preventive and diagnostic services aren't covered. (For details, see "Expenses Not Covered" on page 148.)

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 considered 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 of intraoral 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;
- emergency examination;
- 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 144.)

(For coverage amounts, see "Your Dental Benefits at a Glance" on page 133.)

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 network provider), up to four times per calendar year;
- topical application of fluoride or preventive therapies (e.g., fluoridated varnishes), with either service, but not both, covered twice per calendar year;
- space maintainers when used to maintain space for eruption of permanent teeth.

(For coverage amounts, see "Your Dental Benefits at a Glance" on page 133.)

IMPORTANT!

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

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.

(For coverage amounts, see "Your Dental Benefits at a Glance" on page 133.)

Class II: Basic Services

IMPORTANT!

Some basic services aren't covered. (For details, see "Expenses Not Covered" on page 148.)

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 covered children through age 6 or for 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.

Palliative Treatment

The dental plan covers palliative treatment for pain. Palliative treatment is intended to reduce pain before a dental treatment.

IMPORTANT!

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

Restorations

The dental plan covers the following restorations:

- amalgam restorations (fillings) and, in anterior (front) 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);
  - fracture resulting in significant loss of tooth structure (missing cusp);
  - fracture resulting in significant damage to existing restoration;
- Restorations on the same surface(s) of the same tooth are covered once in a two-year period from the date of service;
- resin-based composite or glass ionomer restorations placed in the buccal (facial) surface of bicuspids. If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except on bicuspids 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 from the date of service.

(If teeth are restored with crowns, veneers, inlays or onlays, see "Restorations" in "Class III: Major Services" on page 144.)

(For coverage amounts, see “Your Dental Benefits at a Glance” on page 133.)

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 142.)

(For coverage amounts, see “Your Dental Benefits at a Glance” on page 133.)

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 140. For information about complete occlusal equilibration and occlusal (night) guards, see “Periodontics” in “Class III: Major Services” on page 144.)

(For coverage amounts, see “Your Dental Benefits at a Glance” on page 133.)

Endodontics

The dental plan covers the following endodontic services:

- procedures for pulpal and root canal treatment, with root canal treatment on the same tooth 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 144.)

(For coverage amounts, see “Your Dental Benefits at a Glance” on page 133.)

Class III: Major Services

IMPORTANT!

Some major services aren’t covered. (For details, see “Expenses Not Covered” on page 148.)

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.

(For coverage amounts, see “Your Dental Benefits at a Glance” on page 133.)

Restorations

The dental plan covers the following restorations:

- crowns, veneers, inlays (as a single tooth restoration, with limitations) or onlays (whether gold, porcelain or 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
- post and core, once in a five-year period on the same tooth.

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 from the seat date;
- 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;

- 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, with limitations) will be considered a cosmetic procedure and an amalgam allowance will be made, and any difference in cost will be your responsibility.

(For coverage amounts, see "Your Dental Benefits at a Glance" on page 133.)

Prosthodontics

The dental plan covers the following prosthodontic services:

- dentures, fixed partial dentures (fixed bridges), inlays (only when used as a retainer 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 from the delivery date and only if it is unserviceable and cannot be made serviceable;
- inlays are covered on the same teeth once every five years from the delivery date only when used as a retainer for a fixed bridge;
- payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as a retainer 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 133);
- 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.

(For coverage amounts, see "Your Dental Benefits at a Glance" on page 133.)

Other Benefits

Orthodontic Services

The dental plan covers the following orthodontic services for covered 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, which is based on the date of initial banding); and
- termination of the treatment plan before completion of the case or termination of this contract.

Payment for treatment that begins before the date of initial banding may be prorated and deducted from the lifetime maximum.

(For coverage amounts, see "Your Dental Benefits at a Glance" on page 133.)

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 133.)

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 Class I, Class II and Class III 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;
  - study models;
- 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;
- 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 teeth;
  - bone replacement graft for ridge preservation;

  - 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 whether 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; and
  - WDS must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision; and
  - 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 is covered when medically necessary for covered children through age 6 or for 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 and obtain any necessary predetermination for certain procedures and services.

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 an American Dental Association-approved 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 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 to:

Washington Dental Service
P.O. Box 75983
Seattle, WA 98175-0983.

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 WDS Reviews the Claim

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

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.

DEFINED TERMS

Be sure you understand the meaning of the terms used in this summary, such as "copay." (See "Glossary" on page 185.)

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.

Though Group Health provides routine vision exams under its medical plan, it does not provide any of the other vision benefits shown in "Your Vision Benefits at a Glance" on page 153. 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 63 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 158.)

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**
Exam (once every 12 months)	100%	Up to $40
Eyeglass lenses (one pair every 12 months)		
• Single vision	100%	Up to $40
• Lined bifocal	100%	Up to $60
• Lined trifocal	100%	Up to $80

Vision Plan		
• Progressive lenses	100%	Up to trifocal allowance of $80
• Lenticular	100%	Up to $125
• Polycarbonate lenses for covered 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
Eyeglass frames (once every 24 months)	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
Contact lenses (once every 12 months in place of eyeglass lenses and frames)		
• 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 158)	100% Preauthorization determined by VSP doctor	Up to $210 Preauthorization required
• Low-vision benefit	$125 for exam annually 75% for vision aids up to $1,000 every two years Preauthorization required	$125 for exam annually 75% for vision aids up to $1,000 every two years Preauthorization required
• Vision therapy benefit	$85 for exam annually 75% for vision therapy up to $750 annually	$85 for exam annually 75% for vision therapy up to $750 annually

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). VSP identifies all covered dependents under the employee's plan by using the employee's identification number. 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 verifies your benefits and eligibility for VSP services, and files claims for you.

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 (when filing a claim, use group number 12-029826).

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 covered 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 153.

If You Go on Active Military Leave

If you should go on active military leave while employed with the county, you'll continue to receive vision coverage for the length of your military leave. For more information, contact Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

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 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 pay the bill in full, your $10 copay is deducted from the amount VSP reimburses you up to the plan allowance, and you 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

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 153.

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 153):

- contact lenses—elective;
- contact lenses—medically necessary contact lenses when 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, including optional retinal screening, to determine the presence of vision problems or abnormalities (for more information on optional retinal screening, see "Discounts" later in this section);
- eyeglass lenses—single vision, lined bifocal, lined trifocal, progressive and lenticular, including polycarbonate lenses for covered children, anti-reflective/scratch coatings and tinted/photochromic lenses;
- eyeglass frames; and
- plano sunglasses—only available from a VSP provider when you're eligible for frames and have had PRK, Lasik or Custom Lasik vision correction surgery.

IMPORTANT!

Keep in mind that some eye care services aren't covered. (For details, see "Expenses Not Covered" on page 161.)

Low-Vision Benefit

A low-vision benefit is available if your loss of vision is sufficient enough to prevent you from reading, moving around in unfamiliar surroundings and completing desired tasks. Those with low vision have impaired vision that's not fully treatable by medical or surgical means or by conventional eyewear or contact lenses.

Coverage includes:

- two low-vision supplemental exams every two years (VSP pays up to $125 for this exam); and
- an allowance for low-vision aids, including prescription services and optical/non-optical aids, every two years.

You're responsible for any charges exceeding the amounts that VSP pays.

The maximum benefit per person is $1,000 every two years. If low-vision supplemental testing is approved, VSP will cover the exams up to $125 every two years. If low-vision aids are approved, VSP will pay 75% of the approved amount up to a maximum of $1,000, less any amount paid for supplemental testing, every two years. You're responsible for the remaining 25% of the approved amount, plus any amount over the maximum $1,000 benefit.

If you use a non-VSP provider, you must pay the provider at the time of service and submit a claim to VSP for reimbursement. There is no guarantee of reimbursement or that you'll be reimbursed at the amount you paid. If VSP approves your claim following a post-authorization review, you'll be paid up to the amount that VSP would pay a VSP provider. For example, if you pay $200 for a supplemental evaluation, you'll be reimbursed for only the maximum payable amount of $125.

Vision Therapy Benefit

A vision therapy benefit, called optometric vision therapy, is available to you if you have severe visual problems associated with sensory and/or muscular deficiencies of the visual system.

Optometric vision therapy is a treatment plan used to correct or improve specific dysfunctions of the vision system. It includes, but is not limited to, the treatment of:

- strabismus (turned eye);
- other dysfunctions of binocularity (eye teaming);
- amblyopia (lazy eye);
- accommodation (eye focusing);
- ocular motor function (general eye movement ability); and
- visual-perception-motor abilities.

Optometric vision therapy is based upon a medically necessary plan of treatment designed to improve specific vision dysfunctions determined by standardized diagnostic criteria. Treatment plans encompass lenses, prisms, occlusion (eye patching) and other appropriate materials, modalities and equipment.

VSP pays up to a maximum of $85 annually for one approved supplemental evaluation and up to an additional $750 annually for approved vision therapy. VSP pays 75% of the allowable amount for approved therapy visits, and you are responsible for the remaining 25%. Preauthorization is required.

If you use a non-VSP provider, you must pay the provider at the time of service and submit a claim to VSP for reimbursement. There is no guarantee of reimbursement or that you'll be reimbursed at the amount you paid. If VSP approves your claim following a post-authorization review, you'll be paid up to the amount that VSP would pay a VSP provider. For example, if you pay $200 for a supplemental evaluation, you'll be reimbursed for only the maximum payable amount of $85.

Discounts

The vision plan provides discounts for a number of services.

- **Extra frames and prescription lenses.** You may purchase an unlimited number of additional pairs of prescription glasses and/or non-prescription sunglasses from a VSP provider at a 30% discount when purchased on the same day as your exam by a VSP provider. Otherwise, you may purchase additional pairs of prescription glasses and/or non-prescription sunglasses, including non-covered lens options, from your VSP provider at a 20% discount. To receive the 20% discount, you must make the additional purchase within 12 months after your initial exam by a 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.

  You may qualify for full coverage of a contact lens evaluation and an initial supply of approved lenses, including toric, multifocal and hydrogel lenses, depending on whether you're replacing the same contact lenses or you're a new or refit wearer of contact lenses.

  Ask your eye care provider to explain your options before you receive care.

- **Retinal screening.** If you see a VSP provider for your annual eye exam, you may request retinal screening, for which you pay no more than $39, as an enhancement to dilation in determining the presence of vision problems or abnormalities.

- **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 "Deputy Sheriff Plan" on page **Error! Bookmark not defined.** or "

Group Health" on page 107 in "Medical Plans");

- orthoptics or vision training and any associated supplemental testing;
- oversized lenses (61 mm or larger);
- plano (non-prescription) lenses, except if you have previously had PRK, Lasik or Custom Lasik vision correction surgery;
- polycarbonate lenses for covered adults;
- polycarbonate vision treatment of an experimental nature;
- corrective vision treatment of an experimental nature;
- perceptual training for a learning disability;
- replacement of lost or broken lenses and frames, except at scheduled intervals of 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;
- date of service and/or supply; and
- copy of receipt showing itemized charges from the provider for the services and/or supplies received.

You also need to provide:

- group number 12-029826;
- 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 to:

Vision Service Plan
P.O. Box 997105
Sacramento, CA 95899-7105.

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:

- Deputy Sheriff Plan;
- 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 is mailed to your home within 30 days after the time you first enroll for county coverage. When you become eligible for COBRA coverage, Benefits, Payroll 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 and you were covered by active county benefits at the time of your retirement or separation from county employment.

PREMIUM SUBSIDY IN 2010

Under the American Recovery and Reinvestment Act, which took effect Feb. 17, 2009, the county subsidizes 65 percent of the COBRA premiums for medical coverage for employees who involuntarily lose their job with the county between Sept. 1, 2008, and March 31, 2010. The premium subsidy can continue for up to a maximum of 15 months, but it does not extend the COBRA eligibility period. A refund or credit is applied to normal COBRA premiums paid on or after March 1, 2009.

If you believe you're eligible for the COBRA premium subsidy, contact FBMC. (See *Contact Information.*)

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;
- you become entitled to Medicare (retiree medical coverage only); or
- you and your spouse divorce, or you end your domestic partnership (legal separation isn't a qualifying event).

Under county health coverage, you're allowed to continue covering your spouse even if you are separated so your spouse may have coverage until the divorce is final. However, if you discontinue coverage for your spouse in anticipation of a divorce and a divorce later occurs, your spouse loses coverage and does not become eligible for COBRA until the divorce is final. COBRA eligibility begins on the first day of the month following the divorce as long as enrollment and payment of premium have been timely.

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.

HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits, Payroll and Retirement Web site at www.kingcounty.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, Payroll and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

LEGAL SEPARATION AND COBRA

Legal separation is not a COBRA qualifying event for your spouse. Only when your divorce is final does your spouse become eligible for continuing health coverage under COBRA.

Under county health coverage, you are allowed to continue covering your spouse while you're legally separated so your spouse has coverage until the divorce is final.

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);
- you become entitled to Medicare (retiree medical coverage only); 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 31 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, Payroll and Retirement Web site at www.kingcounty.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, Payroll 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, Payroll and Retirement Operations through your Termination Notice, which you need to complete, or the county payroll report.

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

If you die while actively employed by the county, Benefits, Payroll 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, Payroll and Retirement Web site at www.kingcounty.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, Payroll 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, Payroll 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 qualified spouse/domestic partner. Parents may elect COBRA coverage on behalf of their qualified children.

If you're the covered employee and elect COBRA coverage, you pay the employee rate, your spouse/domestic partner pays the spouse/domestic partner rate and your children pay the children rate. If your spouse/domestic partner does not elect COBRA coverage, your children still pay the children rate.

If you're the covered employee and do not elect COBRA coverage, your qualified spouse/domestic partner and children may continue coverage under COBRA, but the rate that your spouse/domestic partner and children pay depends on who the primary participant is:

- If your spouse/domestic partner is the only participant, he/she pays the employee rate;
- If your spouse/domestic partner and children continue coverage, your spouse pays the employee rate and your children pay the children rate;
- If one of your children is the only participant, he/she pays the employee rate;
- If several of your children are participating without spouse/domestic partner participation, one of your children pays the employee rate and the other children pay the children rate; or
- If your child is no longer an eligible dependent, he/she pays the employee rate.

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 continue COBRA coverage for only the county medical, dental and vision benefits you have on your last day of work. 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.

You also must pay for COBRA coverage. (For details about what COBRA coverage costs, see "How Much COBRA Coverage Costs" on page 170.)

For medical coverage under COBRA, you continue at the out-of-pocket expense level (gold, silver or bronze) you had on your last day of employment. (For more information about the Healthy Incentives℠ program, see "How the Healthy Incentives℠ Program Works" on page 55.)

You and/or your qualified dependents may continue coverage under both COBRA and Medicare or another group health care plan if the effective date of coverage under the other plan is before the COBRA election date.

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.

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.*)

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 up to the full amount of your annual election for expenses incurred through the end of the month in which your employment with the county ended. 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.

COBRA COST

COBRA cost information is available from Benefits, Payroll and Retirement Operations and its Web site. (See *Contact Information*.)

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 so your claims may be paid sooner, 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 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 for you, your spouse/domestic partner and your children. However, 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 qualified dependents may continue for up to a total of 36 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.

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 as long as the disabled qualified beneficiary is determined to be disabled. 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 THE DEPUTY SHERIFF PLAN

Under the Deputy Sheriff Plan, if you or a covered dependent 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 the Deputy Sheriff Plan or COBRA coverage; however, electing the extension means forfeiting the right to elect COBRA coverage and to convert to an individual policy. Other covered dependents may be able to elect coverage through COBRA.

Medical extension coverage will end when you or your covered dependents 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 dependent 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 about 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.

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, state 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, Payroll and Retirement Operations of your leave of absence, Benefits, Payroll 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, Payroll and Retirement Operations immediately.

COBRA and Medicare

If you are enrolled in Medicare and experience a qualifying event that causes you to lose that Medicare coverage, you and your qualifying dependents will become eligible for COBRA coverage. If you became entitled to Medicare benefits less than 18 months before your termination or reduction of hours, COBRA coverage for your qualified dependents who lose coverage as a result of the qualifying event can last until up to a maximum of 36 months after the date of Medicare entitlement.

If you enroll in COBRA coverage before you are entitled to Medicare, you will lose your COBRA coverage when you enroll in Medicare (you typically enroll in Medicare when you apply for Social Security benefits).

FBMC will notify you and your qualified dependents of your options by sending a COBRA enrollment packet. 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 the loss of your county coverage.

Up Close and Personal

The following examples help illustrate how COBRA and Medicare work together.

Meet Brian

Six months before turning 65, Brian decides to retire and elects COBRA coverage for himself and his qualified dependents. When he turns 65, he enrolls in Medicare. As a result, Brian loses his COBRA coverage. However, his qualified dependents may continue their coverage for the remainder of the 18-month COBRA continuation period.

Meet Virginia

Virginia, who is 67, decides to enroll in Medicare 6 months before retiring. When she retires, Virginia decides to enroll herself and her qualified dependents in COBRA coverage. Virginia can continue her COBRA coverage for up 18 months from the end of her coverage. Virginia also remains covered by Medicare while she is covered under COBRA. Virginia's dependents can continue COBRA coverage for up to an additional 30 months from the end of coverage (36 months after the date of Medicare entitlement).

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 one 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 one month before you want the change to become effective);
- discontinue coverage for yourself and your dependents at any time (FBMC must receive your notification one month before you want the change to become effective);
- add eligible dependents to your health care coverage when a qualifying life event occurs (see "Changes You May Make After Qualifying Life Events" on page 38 in "Participating in the Health Care Plans");

- change medical plans and out-of-pocket expense level/related premium you want during annual open enrollment; and
- change medical plans and out-of-pocket expense level/related premium you want between annual open enrollments if:
  - you have a change in family status;
  - you or a covered dependent exhausts 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 qualified beneficiary enrolls in Medicare (COBRA coverage may continue through the end of the original COBRA period for other family members, independent of the qualified beneficiary'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.

Because the Health Insurance Portability and Accountability Act (HIPAA) restricts the extent to which group health care plans may impose preexisting condition limits, there are some restrictions on the termination of COBRA coverage:

- 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. 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.

If you're interested in learning about your right to convert to an individual policy when your COBRA coverage ends, contact your health care plan (for example, the Deputy Sheriff Plan 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 from your medical plan 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.

How to Contact the COBRA Administrator

You may obtain more information regarding your rights to COBRA coverage from FBMC or Benefits, Payroll 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.

To protect your family's rights, you should keep the county and FBMC informed of any changes in the addresses of your covered dependents. You should also keep copies for your records of any address change notices you send to the county or FBMC.

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 165.)

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.*)

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
Health care coverage available	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
Length of time coverage is available	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)

Comparison of Retiree Medical Benefits and COBRA		
Allowed to change medical plans between annual open enrollments	Yes (See "How to Make Changes Under Retiree Medical Benefits" on page 181.)	Yes (See "When You Can Make Changes Under COBRA" on page 173.)
Eligibility	You must: • be covered under a county health care plan and lose county coverage because of retirement; • have worked at least five consecutive years at King County before retirement; • not be eligible for Medicare; • not be covered under another medical group plan; and • meet the requirements for formal service or disability retirement.	You must be covered under a county health care plan and lose county coverage for a qualifying reason (retirement is a qualifying reason).
Enrollment	Same requirements and time periods	

(For more information about COBRA, see "Continuing Coverage Under COBRA" on page 165.)

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 the 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 Seattle City Employees' Retirement System 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 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 insurance, accidental death and dismemberment (AD&D) insurance and long-term disability (LTD) insurance coverage.

If you're participating in a health care flexible spending account (FSA) when you become eligible for retiree medical benefits, 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, Payroll and Retirement Operations through your Termination Notice, which you need to complete, or through the payroll report.

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

Benefits, Payroll 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 so your claims may be paid sooner, 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. Your options include:

- medical coverage;
- dental coverage (as a different retiree dental plan);
- vision coverage; or
- any combination of medical, dental and vision coverage.

You may elect a different medical plan than you had on your last day of employment, and you may elect the out-of-pocket expense level and related premium you want. If you add dependents to your coverage, they receive the same coverage you elect for yourself. (For more information about out-of-pocket expense levels, see "How the Healthy Incentives℠ Program Works" on page 55.)

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. (For more information about the retiree dental plan and its cost, contact Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

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 eligible dependents, they have their own COBRA rights. If you continue covering the same eligible 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 165.)

How to Make Changes Under Retiree Medical Benefits

If you notify FBMC, you may:

- drop medical coverage and retain vision coverage anytime (FBMC must receive notice one month before you want the change to take effect);
- drop vision coverage and retain medical coverage anytime (FBMC must receive notice one month before you want the change to take effect);
- drop coverage for yourself and your dependents (FBMC must receive notice one month before you want the change to take effect);
- add newly eligible dependents to your health care coverage;
- change medical plans and out-of-pocket expense level/related premium you want during annual open enrollment; and
- change medical plans and out-of-pocket expense level/related premium you want 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 (Payments must be made within 30 days of the due date);
- when you become entitled to Medicare after electing retiree medical benefits (Your Medicare coverage begins on the first of the month in which you turn 65); 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).

Because the Health Insurance Portability and Accountability Act (HIPAA) restricts the extent to which group health care plans may impose preexisting condition limits, there are some restrictions on the termination of retiree medical coverage:

- 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.

When you're no longer covered under retiree medical, you may be entitled to purchase an individual conversion policy. 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.

If you're interested in learning about your right to convert to an individual policy when your retiree medical coverage ends, contact your health care plan (for example, the Deputy Sheriff Plan or Group Health) or the Statewide Health Insurance Benefits Advisors (SHIBA) for more information. (See *Contact Information*.)

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 regular employee 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.

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:

- your Medicare coverage typically begins on the first of the month in which you turn 65 if you enroll in a timely fashion;
- 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 qualified dependents may be eligible to continue their county coverage under COBRA for up to 36 months from the date coverage is lost because of your entitlement to Medicare (FBMC will notify your qualified dependents of this option by sending a COBRA enrollment packet); and
- 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 covered 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 for up to 36 months from the earlier Medicare entitlement date if you enrolled in Medicare less than 18 months prior to your retirement; and
- you can elect the retiree dental plan for you and your qualified dependents.

Depending 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 provide. For more information, contact Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

For information on Medicare supplemental insurance options, contact the Statewide Health Insurance Benefits Advisors (SHIBA). (See *Contact Information*.)

Up Close and Personal

The following examples help illustrate how retiree medical and Medicare work together.

Meet Matthew

Six months before turning 65, Matthew decides to retire and elects retiree medical coverage for himself and his qualified dependents. When he turns 65, Matthew enrolls in Medicare. As a result, Matthew loses his retiree medical coverage. His qualified dependents also lose their coverage, but they may enroll in COBRA coverage for up to 36 months because Matthew's enrollment in Medicare is considered to be a COBRA qualifying event.

Meet Sharon

Sharon, who is 67, enrolls in Medicare 6 months before retiring. When she retires, Sharon is not eligible for retiree medical coverage. Sharon's qualified dependents lose their coverage when she retires, but they may enroll in COBRA coverage for up to 30 months (36 months minus 6 months equals 30 months) because Sharon's retirement is a COBRA qualifying event.

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 the Deputy Sheriff Plan, a 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 eligible dependents 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.

"NME" stands for Aetna's National Medical Excellence Program.

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.

Custodial parent

A “custodial parent” is the parent awarded custody of a child by a court decree. In the absence of a court decree, a custodial parent is the parent with whom the child resides more than one-half of the calendar year, excluding any temporary visitation. If the child resides with a third party for part of the year, the parent with whom the child resides the majority of nights is the custodial parent.

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 25 and dependent on you or your spouse/domestic partner for more than 50% support and maintenance. 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."

Deputy Sheriff Plan

"Deputy Sheriff Plan" is a county self-insured medical plan. Medical services are provided by Aetna, and prescription services are provided by Express Scripts.

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 else;
- 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. The Deputy Sheriff Plan 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 the Deputy Sheriff Plan, a 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 and up to 26 weeks of unpaid, job-protected leave to take care of a member of the armed services who was injured during active duty.

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 as a county self-insured plan.

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.

Legend drug

A “legend drug” is a drug requiring a written prescription unless specified otherwise.

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.

The Deputy Sheriff Plan 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.

National Medical Excellence (NME) Program®

Aetna’s “National Medical Excellence Program®” helps eligible plan members access covered treatment for solid organ transplants, bone marrow transplants and certain other rare or complicated conditions at participating facilities experienced in performing these services.

The program has three components:

- National Transplantation Program, designed to help arrange care for solid organ and bone marrow transplants;
- National Special Case Program, developed to coordinate arrangements for treatment of plan members with complex conditions at tertiary care facilities across the country when that care is not available within 100 miles of the plan member’s home;
- Out of Country Program, designed for plan members who require emergency inpatient medical care while temporarily traveling outside the United States.

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 Aetna’s National Medical Excellence Program.

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.

Ostomy

"Ostomy" is an operation (as a colostomy) to create an artificial passage for bodily elimination.

Other plan

"Other plan" is a health plan that does not include accident-only coverage, school accident coverage, Medicaid coverage or coverage under other federal governmental plans, unless permitted by law.

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.

Over-the-counter drugs

"Over-the-counter drugs" are medicines and devices not requiring a prescription.

Palliative

"Palliative" refers to treatment that relieves pain but is not curative.

Parenteral nutrition

"Parenteral nutrition" refers to the administration of nutrition through an intraveneous needle in a vein.

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.

Phenylketonuria

“Phenylketonuria” is a metabolic disorder that is caused by an enzyme deficiency resulting in the accumulation of phenylalanine and its metabolites (as phenylpyruvic acid) in the blood and their excess excretion in the urine. It usually causes severe mental retardation, seizures, eczema and abnormal body odor unless phenylalanine is restricted from the diet beginning at birth.

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).

The Deputy Sheriff Plan 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.

Primary plan

A "primary plan" is a plan whose benefits for a covered person must be determined without taking the existence of any other plan into consideration.

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.

Progressive medication management

"Progressive medication management" is a program for administering the use of medications so that the safest and most effective prescription drugs at the lowest cost are used, beginning with the use of generic drugs and progressing to the use of preferred and non-preferred drugs as medically necessary.

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 the Deputy Sheriff Plan 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—Deputy Sheriff Plan

"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.

Secondary plan

A “secondary plan” is a plan whose benefits for a covered person must be determined by taking the existence of another plan into consideration.

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.

FLEXIBLE SPENDING ACCOUNTS

Flexible spending accounts (FSAs) allow you to set aside before-tax dollars from your paycheck to pay for expenses not covered through your other benefits. When you put money into an FSA, you don't pay federal or Social Security (FICA) taxes on it. As a result, your taxable income is reduced and your taxes are lower.

The county offers two FSAs for all benefit-eligible employees:

- health care FSAs, which allow you to set aside before-tax dollars to pay for certain expenses not covered by your medical, dental and vision plans—for example, copays for office visits and the cost of orthodontia not fully paid by your dental plan; and
- dependent care FSAs, which allow you to set aside before-tax dollars to pay for eligible dependent day care expenses for your child, disabled spouse or dependent parent while you and your spouse work or look for work.

Plan benefits are funded through employee before-tax salary reduction contributions, as permitted by Internal Revenue Code Section 125. The county pays the administrative expenses of the plan to the extent those expenses aren't paid from the plan.

PARTICIPATING IN FSAS

To effectively use your flexible spending accounts (FSAs), you need to know how they work. This section explains who is eligible, how and when to enroll, when participation begins and ends, and how certain life event changes affect your eligibility to participate in FSAs.

FSA PARTICIPATION INFORMATION ONLY

The information about eligibility and changing your coverage in this section applies to FSAs only.

For eligibility and participation information regarding the county's other benefits, see the separate descriptions of each benefit in this handbook.

Who Is Eligible

You're eligible to participate in an FSA when you become a benefit-eligible employee as:

- a regular part-time or full-time employee;
- a full-time Local 587 employee; or
- an employee in a provisional or term-limited temporary position (your hiring authority can tell you if your position is benefit-eligible).

A regular part-time employee is someone who works at least half-time but less than full-time in a calendar year.

You're not eligible to participate in an FSA if:

- you work less than half-time in a calendar year;
- you're a temporary or seasonal employee; or
- you work in a capacity that, at the discretion of human resources, is considered contract work or independent contracting.

When and How to Enroll

IMPORTANT

When you enroll in an FSA, be careful to contribute only what you know you can use by the end of the calendar year. What you don't use will be forfeited. (For more information, see "Estimating Expenses" on page 213 and "Forfeiting Unused Balances" on page 215.)

You may enroll in an FSA when:

- you're first eligible for benefits;
- you experience a qualifying life event; or
- you make your benefit elections during an annual open enrollment.

When you enroll, you enroll for the calendar year (January 1–December 31). You must re-enroll each year during the county's annual open enrollment to continue participating the following year. If you don't enroll during the annual open enrollment, you won't be able to enroll after December 31 unless you have a qualifying life event.

Generally, you may not make changes until the next annual open enrollment period. However, you may have an additional opportunity to make changes if you have a qualifying life event. (For more information, see "Making Changes After a Qualifying Life Event" on page 207.)

Enrolling When First Eligible

You receive FSA information and a Flexible Spending Account Enrollment form when you first become eligible for benefits.

You must return your enrollment form within 30 days of your benefit-eligibility date to Benefits, Payroll and Retirement Operations. (See *Contact Information*.) Your benefit-eligibility date is the day you first report to work as a new employee or the date you meet the eligibility requirements of the plan, if later.

Your FSA information includes an FSA Authorization for Automatic Reimbursement Deposits form so you can have FSA reimbursements deposited directly into a checking or savings account if you choose. (You may opt not to have FSA reimbursements deposited directly when you first enroll, but you may later contact Fringe Benefits Management Company (FBMC), the FSA third-party administrator, to set up direct deposit.)

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

Enrolling During the Annual Open Enrollment

Each year, the county holds an open enrollment. During this period, you have the opportunity to enroll online for the first time or re-enroll in an FSA, and to determine your contribution amount for the upcoming calendar year. Elections made during the annual open enrollment take effect the following January 1 and remain in effect through December 31 of that calendar year.

You must re-enroll online every year if you want to participate in an FSA the next year.

When and How to Make Changes

The election you make when you enroll in an FSA remains in effect for the entire calendar year. The only times you may change your elections—either begin, increase, decrease or stop contributions to an FSA—are:

- during the annual open enrollment for the following calendar year; or
- when you have a qualifying life event in the current calendar year.

CHANGES MUST BE CONSISTENT WITH YOUR QUALIFYING LIFE EVENT

Keep in mind that most of the changes you may make to your FSA participation must be consistent with your qualifying life event—for example, if you get married, you may change your contribution amount to cover your new spouse's eligible health care expenses.

Making Changes After a Qualifying Life Event

Because of the tax advantages available to you when you make FSA contributions on a before-tax basis, Internal Revenue Service (IRS) rules limit when you can enroll and change your contribution amount. That means the enrollment choices you make when you first become eligible or during an annual open enrollment are generally in effect for the entire year for which you enroll.

However, because your needs for benefits typically change when you experience certain "qualifying life events"—such as getting married or having a baby—you're allowed to make changes in some situations, in accordance with federal rules, as long as you make your changes within **30** days following the event.

Changes in Status

Various events may qualify you to enroll in an FSA or to make certain changes to your FSA participation. Generally, the events must affect your or your dependent's eligibility for coverage under an employer plan (including plans of other employers). They also include a change in status that results in an increase or decrease in the number of family members or dependents who may benefit from coverage under the plan. Examples of qualifying life events include:

- a change in your legal marital status due to marriage, legal separation, annulment, divorce or death of a spouse;

- a change in the number of your tax dependents due to birth, adoption or placement for adoption, or death of a dependent;
- a change in employment status for you, your spouse or a dependent due to:
  - termination or commencement of employment;
  - a reduction or increase in work hours;
  - a switch from salaried to hourly paid, from union to non-union, or from part-time to full-time status;
  - a strike or lockout;
  - the beginning of or return from an unpaid leave of absence;
  - any other employment status change that affects FSA eligibility;
- a change in your residence or workplace or the residence or workplace of your spouse or a dependent that affects FSA eligibility;
- a change that causes a dependent to satisfy or cease to satisfy the requirements for coverage due to age, marriage or any similar circumstances provided for in the benefit plans;
- a change due to certain judgments and court orders;
- a change in the cost of dependent care, such as when day care for your dependent child begins or ends or when your dependent care provider increases the monthly fee; and
- a change in dependent care provider, such as from a paid provider to an unpaid neighbor or relative.

To change your FSA election when you have a qualifying life event, you must notify Benefits, Payroll and Retirement Operations of the change online within 30 days following the date of the qualifying life event. The change must be consistent with and as a result of the qualifying life event. The new election begins on the first day of the month following your qualifying life event and continues through the end of the calendar year.

HOW TO MAKE CHANGES ONLINE

To make changes to your FSA, complete the appropriate county form online at the Benefits, Payroll and Retirement Web site at www.kingcounty.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, Payroll and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

You may also submit an FSA Authorization for Automatic Reimbursement Deposits form so you can have FSA reimbursements directly deposited into a checking or savings account if you choose.

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

Health Care Reimbursements After a Qualifying Life Event

If you increase your contribution to a health care FSA after a qualifying life event, there are certain restrictions on how your contributions can be reimbursed. You can use the amount you indicated as your annual contribution at the beginning of the year to pay for any allowable medical expenses throughout the year. However, expenses incurred before the qualifying life event can only be reimbursed by the amount you indicated as your annual contribution amount at the beginning of the year.

For example, you begin contributing toward an annual health care FSA amount of $2,000, but increase your contribution amount to $4,000 after a qualifying life event on May 1. You incurred $2,500 in allowable medical expenses from January 1 through April 30 before your qualifying life event allowed you to increase your FSA contribution amount. Because you can only use your initial annual contribution amount of $2,000 for allowable medical expenses before your qualifying life event, you will only be reimbursed for $2,000 of the $2,500 in medical expenses through April 30. Expenses incurred after April 30 could be reimbursed up to the full $4,000, less any amounts you've already received.

When Participation Begins

The date your FSA begins depends on when you enroll:

- If you enroll in an FSA when you first become eligible for benefits, your FSA begins on the day your benefits begin. You begin making contributions to your account by payroll deduction through the end of the calendar year. If you begin work on the first day of the month, your FSA begins that day. If you begin work on any other day of the month, your FSA begins on the first day of the following month.
- If you enroll in an FSA because of a qualifying life event, your FSA takes effect on the first of the month following your qualifying life event and continues through the end of the calendar year. The amount you contribute to your account is adjusted for the remaining payroll periods in the calendar year.
- When you enroll in an FSA online during the annual open enrollment, your FSA begins on January 1 of the following year and continues through December 31 of that calendar year, during which time you make contributions to your account with every paycheck.

You may be reimbursed only for expenses incurred after your participation begins.

When Participation Ends

Your participation in an FSA ends on the last day of the month when you leave employment with the county and don't continue your benefits coverage under COBRA (Consolidated Omnibus Budget Reconciliation Act) or the retiree medical benefit. (For more information, see "Continuing Coverage Under COBRA" and "Continuing Coverage When You Retire" in *Health Care*.)

However, when you take a leave of absence without pay and don't continue your benefits coverage, your participation is suspended temporarily until you return to work in a paid status, at which time your participation is resumed.

How to Continue Participation

You may be able to continue participation in your health care and/or dependent care FSA when you:

- leave employment with the county and continue health care coverage under COBRA or retiree medical (health care FSA only); or
- go on a leave of absence under the Family and Medical Leave Act (FMLA).

However, when you go on an unpaid leave of absence other than FMLA leave, your participation is temporarily suspended while you're on leave.

Continuing Contributions When You Leave Employment

When you leave employment with the county, you may continue contributing to your health care FSA with after-tax payments through the end of the calendar year as long as you elect to continue the FSA under COBRA or the retiree medical benefit. (For more information, see "Continuing Coverage Under COBRA" and "Continuing Coverage When You Retire" in *Health Care*.) When you continue the FSA under COBRA or the retiree medical benefit, you have until March 31 of the following year to submit reimbursement requests for expenses incurred during the previous calendar year or incurred through the day your COBRA coverage ends, if earlier.

When you leave employment with the county but don't continue your health care FSA under COBRA or the retiree medical benefit, your participation in your FSA ends the day you leave employment. You have until March 31 of the following year to submit reimbursement requests only for expenses incurred through the date you left county employment. Any remaining funds are forfeited.

Your participation in your dependent care FSA ends the day you leave employment with the county. You have until March 31 of the following year to submit reimbursement requests only for expenses incurred through the date you left county employment. Any remaining funds are forfeited.

Continuing Contributions Under FMLA

If you go on a leave of absence under the Family and Medical Leave Act (FMLA), you may continue your participation in your health care and/or dependent care FSA on a before-tax basis through payroll deduction, as long as you're on paid status.

If you're on unpaid status under FMLA, you may continue your participation in your health care FSA with after-tax payments to King County. However, you aren't able to continue your contributions to your dependent care FSA.

For more information, contact Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

Continuing Contributions While on an Unpaid Leave of Absence

If you go on an unpaid leave of absence other than FMLA unpaid leave, your contributions to your health care and/or dependent care FSA are temporarily suspended until you return to work in a paid status.

For more information, contact Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

An Overview of FSAs

When you choose to participate in an FSA, you decide how much you want to contribute through payroll deduction to either a health care or dependent care FSA, or both, and indicate the amount(s) on the:

- Flexible Spending Account Enrollment form you return to Benefits, Payroll and Retirement Operations when you're a newly benefit-eligible employee; or
- one of the online forms when you have a qualifying life event.

When Benefits, Payroll and Retirement Operations receives your submitted information, it verifies your eligibility and transmits the information to Payroll Operations (so deductions can be taken from your paycheck) and to a third-party administrator, Fringe Benefits Management Company (FBMC). FBMC sets up your FSA and administers it for the county.

As you incur eligible expenses, you submit reimbursement request forms, receipts and other required documentation to FBMC, and FBMC reimburses you from your account. Reimbursement requests are processed within five days of receipt. If the reimbursement is approved, a check is issued or a direct deposit transmitted the night your request is processed, and an explanation of reimbursement is mailed to your home.

You may submit reimbursement requests for eligible expenses incurred during the calendar year anytime through March 31 of the following year—requests must be received by FBMC no later than March 31. You may also submit multiple bills or receipts with one reimbursement claim form as long as you list them all on the claim form.

IMPORTANT

When you choose to participate in an FSA, be careful to contribute only what you know you can use by the end of the calendar year. What you don't use will be forfeited. (For more information, see "Estimating Expenses" on page 213 and "Forfeiting Unused Balances" on page 215.)

FBMC's Reimbursement Request form and FSA Authorization for Automatic Reimbursement Deposits form are available through Benefits, Payroll and Retirement Operations and its Web site.

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

Tax Savings

DEFINED TERMS

Be sure you understand the meaning of the terms used in this summary, such as "federal tax credit." (See "Glossary" on page 227.)

Your FSA contributions are automatically deducted from your pay and deposited into your account in equal amounts throughout the year. Contributions are deducted before federal, Social Security (FICA) and, where applicable, state and local income taxes are withheld. In addition, your contributions aren't reported as income on your federal W-2 statement at the end of the year. As a result, an FSA enables you to lower your taxable income and pay less in taxes.

Up Close and Personal

The following examples help illustrate how contributions to an FSA can provide potential tax savings. Because everyone's tax situation is different, these examples may not reflect your particular circumstances. To be sure, you should consult a tax advisor.

Meet Cindy

Anticipating a major surgical procedure in 2006, Cindy elected to make the maximum contribution of $6,000 to her 2006 health care FSA. The $6,000 contribution lowered her taxable salary from $64,532 to $58,532, resulting in a reduced 2006 tax liability for Line 7, "Wages, salaries, tips, etc." on Form 1040. With a filing status of "single," Cindy reduced her tax liability by $1,500.

Salary	Estimated tax on salary without a $6,000 health care FSA contribution	Estimated tax on salary with a $6,000 health care FSA contribution	Estimated tax savings
$64,532	$12,689 Based on $64,532 taxable salary	$11,189 Based on $58,532 taxable salary ($64,532 – $6,000)	$1,500

Meet Marcus

After estimating child care expenses for the coming year, Marcus made the maximum contribution of $5,000 to his 2006 dependent care FSA. The $5,000 contribution lowered his taxable salary from $62,340 to $57,340, resulting in a reduced 2006 tax liability for Line 7, "Wages, salaries, tips, etc." on Form 1040. With a filing status of "single," Marcus reduced his tax liability by $1,250.

Salary	Estimated tax on salary without a $5,000 dependent care FSA contribution	Estimated tax on salary with a $5,000 dependent care FSA contribution	Estimated tax savings
$62,340	$12,139 Based on $62,340 taxable salary	$10,889 Based on $57,340 taxable salary ($62,340 – $5,000)	$1,250

Estimating Expenses

It is very important that you estimate your expenses as accurately as possible when deciding upon your contribution amounts for a health care FSA or a dependent care FSA, or both. (For information about contribution limits, see "Making Contributions" on page 215 in "How the Health Care FSA Works" and "Making Contributions" on page 222 in "How the Dependent Care FSA Works.")

Because dependent care expenses are likely to be more predictable than health care expenses, it is usually easier to estimate the amount you may need to contribute to a dependent care FSA for a calendar year.

Because health care expenses are less predictable and because all eligible expenses for you, your spouse and your eligible dependents are reimbursable from your health care FSA, you may find the following worksheet useful in helping you decide on your contribution amount for a health care FSA. Complete the worksheet to estimate eligible health care expenses not covered by your health care plans. (For some of the other things to keep in mind as you estimate your contribution amounts, see "Forfeiting Unused Balances" on page 215.)

Medical Expenses	Estimated Calendar-Year Expenses
Copays	$
Deductibles	$
Physical exams	$
Prescription drugs	$
Surgical fees	$
X-ray or lab fees	$
Other medical expenses	$
Total Medical Expenses	**$**

Dental Expenses	Estimated Calendar-Year Expenses
Copays	$
Deductibles	$
Dentures	$
Examinations	$
Orthodontia	$
Restorative work (crowns, caps, bridges)	$
Teeth cleaning	$
Other dental expenses	$
Total Dental Expenses	**$**

Vision Expenses	Estimated Calendar-Year Expenses
Copays	$
Deductibles	$
Eye exams	$
Prescription contact lenses	$
Contact lens supplies	$
Prescription eyeglasses or sunglasses	$
Total Vision Expenses	**$**

Other Health Care Expenses	Estimated Calendar-Year Expenses
Acupuncture, chiropractic, naturopathy	$
Hearing aids	$
Immunization fees	$
Psychiatrist, psychologist, counseling (allowed for treatment of specific physical or mental disorder, such as depression, alcohol or drug treatment; diagnosis is necessary for reimbursement)	$
Total Other Health Care Expenses	**$**

Health Care Expenses	Estimated Total Expenses
Total Medical Expenses	$
Total Dental Expenses	$
Total Vision Expenses	$
Total Other Health Care Expenses	$
Total Health Care Expenses	**$**

Impact on Other Benefits

Because you and the county don't pay Social Security (FICA) taxes on the money you contribute to an FSA, your future Social Security benefits may be reduced slightly. However, you may find that the tax savings gained by participating in an FSA outweigh any loss in benefits. To be certain, you should consult a tax advisor.

Forfeiting Unused Balances

The county allows you to be reimbursed only for expenses incurred in the calendar year of your FSA.

You may request reimbursement from an FSA through March 31 of the year following the calendar year in which eligible expenses are incurred. However, if FBMC doesn't receive your request by March 31, any funds remaining in your FSA after March 31 are forfeited, as required by IRS regulations.

How the Health Care FSA Works

The health care flexible spending account (FSA) gives you the opportunity to set aside money from your pay before tax contributions are withheld and then use those non-taxable funds to reimburse yourself for eligible health care expenses you and your eligible family members incur.

Making Contributions

There are two ways you can save money on your taxes when it comes to health care expenses. One is to set aside from $300 up to $6,000 in before-tax dollars to pay for certain eligible health care expenses from a health care FSA. The other is to take a federal income tax deduction for certain eligible health care expenses if they exceed 7.5% of your adjusted gross income. For most people, making contributions to a health care FSA makes the most sense, but you should consult a tax advisor to be sure.

When you enroll in a health care FSA during the annual open enrollment, you begin making contributions to your account:

- twice a month through payroll deduction over the next calendar year if you're paid on the 5th and 20th of the month; or
- every paycheck through payroll deduction over the next calendar year if you're paid every other week.

For example, if you're paid on the 5th and 20th of the month, the amount deducted is calculated by dividing your annual election by 24 pay periods. If you elected to contribute the maximum $6,000 amount to your FSA during the annual open enrollment, you would see a deduction of $250 per paycheck throughout the year.

HEALTH CARE AND DEPENDENT CARE FSAS DON'T MIX

Health care and dependent care FSAs are separate accounts. The funds you allocate for one cannot be used for the other, and you cannot transfer dollars between accounts.

Highly Compensated Employees

IMPORTANT

When you enroll in an FSA, be careful to contribute only what you know you can use by the end of the calendar year. What you don't use will be forfeited. (For more information, see "Estimating Expenses" on page 213 and "Forfeiting Unused Balances" on page 215.)

For plans subject to federal regulations, Internal Revenue Code rules define certain employees as "highly compensated"—that is, their annual salary is $100,000 or greater. Employees determined to be highly compensated may be subject to special rules that affect their FSA reimbursement benefits. If your reimbursement benefits are affected because you're determined to be highly compensated, you'll be notified.

If you're classified as a highly compensated employee as defined by the IRS, your contributions to the health care FSA may be limited, depending on the participation levels of employees who aren't classified as highly compensated. If employee participation doesn't reach certain federal benchmarks, your contributions may be restricted. The county reserves the right to make adjustments to highly compensated employee elections under the health care FSA necessary for the county to pass any required discrimination testing.

Midyear Enrollments

When you enroll in a health care FSA midyear as a newly benefit-eligible employee, you begin making contributions to your health care FSA through payroll deductions for the remainder of the calendar year. When you change your health care FSA as the result of a qualifying life event, the amount of your contribution to your account is adjusted for the remaining payroll periods in the calendar year.

The amount deducted is calculated by dividing your election by the number of remaining pay periods—for example, if you elected to contribute the $6,000 maximum to your health care FSA with 16 pay periods remaining in the calendar year, you would see a deduction of $375 per paycheck for the remainder of the year. (For information about contribution limits, see "Making Contributions" on page 215. For examples of events that allow you to enroll or make coverage changes during the year, see "Making Changes After a Qualifying Life Event" on page 207.)

Knowing What's Covered and What's Not

IMPORTANT!

The rules determining support of your domestic partner and domestic partner's children are complex. You may wish to refer to IRS Publication 17 or consult a tax advisor.

You may use a health care FSA to reimburse expenses for yourself and any dependent who qualifies for coverage under your benefit plans. However, the Internal Revenue Code doesn't allow you to use a health care FSA to reimburse expenses for a domestic partner and his/her children unless they live with you as members of your household and you provide more than half of their support during the calendar year of your FSA.

The Internal Revenue Code allows you to get reimbursed for expenses for:

- any "qualified child" who is related to you and is under age 19 at the end of the calendar year (unless the child is a student, in which case he/she must be 23 years old or younger at the end of the calendar year) and who lives with you for more than half of the year;

- any "qualified relative," such as a parent, stepparent, brother, stepbrother, sister, stepsister, stepchild, grandparent, grandchild, aunt, uncle, niece, nephew, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother-in-law or sister-in-law, who receives more than half of his/her support from you during the calendar year; and
- any person not related to you but who lives with you as a member of your household, receives more than half of his/her support from you during the calendar year and isn't the "qualified child" of another person.

If you get reimbursed for expenses from a health care FSA for any dependents other than your spouse (of opposite gender) or dependent children, you may be required to provide an affidavit certifying that they're eligible dependents based on the criteria described above.

(For detailed information on which expenses qualify for reimbursement, see "Covered Expenses" on page 217 and "Expenses Not Covered" on page 219.)

Covered Expenses

In general, any health care expense that would be deductible on your federal income tax return is eligible for reimbursement, as long as you don't take a tax deduction for the same expense and you're not reimbursed for it in any other way. However, expenses for insurance premiums and long-term care **aren't** eligible for FSA reimbursement, even though long-term care costs are tax-deductible. (For more information on expenses that aren't eligible for reimbursement, see "Expenses Not Covered" on page 219.)

IMPORTANT!

You're responsible for making sure the expenses you submit for reimbursement are considered eligible expenses by the IRS.

Here is a list of health care expenses that generally are eligible for reimbursement through the health care FSA, as long as they're properly documented:

- acupuncture;
- ambulance;
- artificial limbs;
- birth control pills, condoms, spermicides, pregnancy/ovulation kits;
- Braille books and magazines;
- car controls for a disabled person;
- care for a mentally disabled child;
- chiropractor fees;
- Christian Science practitioner fees;
- coinsurance/copays;
- contact lenses and contact cleaning solutions;
- cosmetic procedures to correct a problem arising from a medical condition;
- crutches;
- deductibles for medical, dental and vision plans;

- dental fees;
- dentures;
- diagnostic fees;
- disabled person's cost for special home;
- drug addiction treatment;
- eyeglasses;
- eye exams;
- fertility treatment;
- hearing aids and batteries;
- home improvements for medical reasons;
- hospital bills;
- hypnosis for treatment of an illness;
- insulin;
- laboratory fees;
- learning disability;
- lifetime fee to retirement home for medical care;
- maternity care;
- mileage for medical reasons (according to federal rates and guidelines);
- naturopathic remedies (if prescribed by a physician for a medical condition);
- naturopathic treatment;
- new-baby expenses for medical conditions;
- obstetrical services;
- operations;
- optometrist;
- orthodontics (non-cosmetic purposes);
- orthopedic shoes;
- oxygen;
- physician fees;
- prescription drugs;
- psychiatric care;
- psychologist fees;
- radial keratotomy;

- routine physicals;
- Seeing-Eye dog and its upkeep;
- skilled-nurse fees (including board and Social Security (FICA) taxes you pay);
- smoking cessation;
- spa/pool equipment prescribed by physician and allowed by the IRS;
- special schools for mentally impaired or physically disabled person;
- telephone designed for hearing impaired person;
- television/hearing impaired equipment;
- therapeutic care for drug and alcohol addiction;
- therapy received as medical treatment;
- transportation expenses for medical purposes;
- tuition at special school for disabled person;
- tuition fee portion that goes for medical care;
- vaccines;
- weight loss programs (if prescribed by physician for medical condition);
- well-baby and well-child care;
- wheelchair;
- wigs required for medical purposes; and
- X-rays.

FOR MORE INFORMATION

You can find more examples of eligible expenses by referring to IRS Publication 502, Medical and Dental Expenses. Publication 502 is available at your local IRS office or on the IRS Web site, www.irs.gov. Publication 502 also may include references to medical savings accounts, or MSAs. MSAs aren't the same as FSAs.

If you're not sure whether an expense is eligible, consult a tax advisor or the FAQs (frequently asked questions) at www.myFBMC.com. You may also contact FBMC. (See *Contact Information*.)

Expenses Not Covered

Here is a list of health care expenses that aren't eligible for reimbursement through the health care FSA:

- cosmetic procedures for non-medical reasons;
- diaper services;
- divorce expenses (even if recommended by a physician);
- domestic help fees (for services of a non-medical nature);

- general counseling (for example, family, marital or couple counseling);
- health club programs, including fitness clubs and gyms;
- health insurance premiums;
- lens replacement insurance;
- long-term care insurance premiums and expenses;
- maternity clothes;
- over-the-counter drugs, except insulin;
- parking fees;
- physical therapy treatments for general well-being; and
- vitamins, supplements and remedies taken for general well-being.

(For information on expenses that are eligible for reimbursement, see "Covered Expenses" on page 217.)

FOR MORE INFORMATION

You can find more examples of ineligible expenses by referring to IRS Publication 502, Medical and Dental Expenses. Publication 502 is available at your local IRS office or on the IRS Web site, www.irs.gov. Publication 502 also may include references to medical savings accounts, or MSAs. MSAs aren't the same as FSAs.

If you're not sure whether an expense is eligible, consult a tax advisor or the FAQs (frequently asked questions) at www.myFBMC.com. You may also contact FBMC. (See *Contact Information*.)

Filing a Claim

With a health care FSA, you may begin getting reimbursed from the FSA as soon as you incur eligible expenses after your participation begins during the FSA calendar year and your health care FSA reimbursement request has been received and approved. You don't have to wait until you have sufficient funds in your health care FSA before you can be reimbursed from it.

You're reimbursed for eligible expenses up to the maximum amount you elected, minus any previous reimbursements made during the calendar year. How eligible expenses are reimbursed from a health care FSA depends on the type of expense you have.

Expenses Partially Covered by Health Insurance

For expenses partially covered by health insurance, you file a claim with your health plan. When you receive your Explanation of Benefits (EOB), you see how much the plan paid and the remaining balance due. You then request reimbursement for the remaining balance.

Mail or fax a completed FBMC Reimbursement Request form together with the following:

- an invoice from your health care provider listing the date you received the service, the cost of the service, the specific type of service and the person for whom the service was provided; **or**
- an EOB from your health insurance provider that shows the specific type of service you received, the date and cost of the service, and any uninsured portion of the cost; **and**
- if necessary, because a service could be deemed cosmetic in nature, a signed Letter of Medical Need from your health care provider indicating that the service was medically necessary, accompanied by the invoice or EOB for the service.

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

Expenses Not Covered by Health Insurance

For expenses not covered by health insurance, complete the FBMC Reimbursement Request form and attach your itemized receipt for the expenses. Receipts must show date of service, cost, service performed and provider of service. Canceled checks, credit card receipts or statements showing only “balance due” or “payment on account” cannot be accepted. Fax or mail the information to FBMC. (See *Contact Information*.)

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

Orthodontia Expenses

For orthodontia services, a lump-sum payment to an orthodontist is eligible for full reimbursement. To be reimbursed, you must provide documentation, such as a receipt of payment, claim form or payment coupon, and it must include the patient’s name, provider’s name, date of service and cost of service. An orthodontia worksheet is no longer required, but a copy of your contract is required. Monthly payments will be reimbursed based on the actual amount paid. Orthodontia payments may be reimbursed over multiple plan years.

If Reimbursement Is Denied

If your claim for reimbursement is denied, FBMC will notify you in writing within 30 days of your request, explaining the specific reasons for the denial, your right to appeal and your right to obtain free copies of documentation related to the decision. If matters beyond FBMC's control require more time, the review period may be extended up to 15 days, and you'll be notified of the extension before the initial 30-day period ends. (For information about appeals, see "Flexible Spending Accounts" in "Claims Review and Appeals Procedures" in *Rules, Regulations and Administrative Information*.)

How the Dependent Care FSA Works

The dependent care flexible spending account (FSA) gives you the opportunity to set aside money from your pay before tax contributions are withheld and then use those non-taxable funds to reimburse yourself for eligible dependent care expenses you and eligible family members incur.

To receive reimbursements from a dependent care FSA, you must work full-time or part-time while your child (or children), disabled spouse or other disabled dependents (for example, a disabled parent) receive dependent care services. You also must meet one of the following eligibility requirements:

- you're a single parent;
- you have a working spouse;
- your spouse is a full-time student at least five months during the calendar year while you're working;
- your spouse is mentally or physically unable to care for himself/herself; or
- you're divorced or legally separated and have custody of your child most of the time even though your former spouse may claim the child for income tax purposes.

Making Contributions

The minimum contribution you may make to a dependent care FSA is $300 per calendar year. The maximum contribution depends on your family situation, but that amount may not exceed $5,000. If more than one of the following situations applies to you, your maximum annual contribution is the lesser amount:

- If you're a working single parent, you may contribute up to $5,000 per calendar year.
- If you're married and file a joint income tax return, you may contribute up to $5,000 per calendar year. If your spouse also has access to a dependent care FSA, your combined contribution limit is $5,000.
- If you're married and file separate income tax returns, you may contribute up to $2,500 per calendar year.

DEPENDENT CARE AND HEALTH CARE FSAS DON'T MIX

Dependent care and health care FSAs are separate accounts. The funds you allocate for one cannot be used for the other, and you cannot transfer dollars between accounts.

- If you're married and your spouse earns less than $5,000, you may contribute up to the amount of your spouse's annual income.

Your maximum annual contribution may also be determined by the amount your spouse earns if he/she is either disabled or a full-time student at an educational institution and is deemed to be gainfully employed:

- If you have one dependent requiring care and your spouse has earned more than $250 a month, your maximum contribution is limited to $250 per month, or $3,000 per year.
- If you have two or more dependents requiring care and your spouse has earned more than $500 a month, your maximum contribution is limited to $500 per month, or $5,000 per year.

Alternatively, you may take an income tax credit for your dependent care expenses of up to $3,000 per calendar year for one dependent or up to $6,000 per calendar year for two or more dependents.

To determine whether the dependent care FSA or the federal tax credit, or a combination of both, is best for you, consult a tax advisor to be sure.

When you enroll in a dependent care FSA during an annual open enrollment, you begin making contributions to your account:

- twice a month through payroll deduction over the next calendar year if you are paid on the 5th and 20th of the month; or
- every paycheck through payroll deduction over the next calendar year if you're paid every other week.

For example, if you're paid on the 5th and 20th of the month, the amount deducted is calculated by dividing your annual election by 24 pay periods. If you elected to contribute $4,500 to your FSA during the annual open enrollment, you would see a deduction of $187.50 per paycheck throughout the year.

IMPORTANT

When you enroll in an FSA, be careful to contribute only what you know you can use by the end of the calendar year. What you don't use will be forfeited. (For more information, see "Estimating Expenses" on page 213 and "Forfeiting Unused Balances" on page 215.)

Highly Compensated Employees

For plans subject to federal regulations, Internal Revenue Code rules define certain employees as "highly compensated"—that is, their annual salary is $100,000 or greater. Employees determined to be highly compensated may be subject to special rules that affect their FSA reimbursement benefits. If your reimbursement benefits are affected because you're determined to be highly compensated, you'll be notified.

If you're classified as a highly compensated employee as defined by the IRS, your contributions to the dependent care FSA may be limited, depending on the participation levels of employees who aren't classified as highly compensated. If employee participation doesn't reach certain federal benchmarks, your contributions may be restricted. The county reserves the right to make adjustments to highly compensated employee elections under the dependent care FSA necessary for the county to pass any required discrimination testing.

Midyear Enrollments

When you enroll in a dependent care FSA midyear as a newly benefit-eligible employee, you begin making contributions to your dependent care FSA through payroll deductions for the remainder of the calendar year. When you change your dependent care FSA as the result of a qualifying life event, the amount of your contribution to your account is adjusted for the remaining payroll periods in the calendar year.

The amount deducted is calculated by dividing your election by the number of remaining pay periods—for example, if you elected to contribute the $5,000 maximum to your dependent care FSA with 16 pay periods remaining in the calendar year, you would see a deduction of $312.50 per paycheck for the remainder of the year. (For information about contribution limits, see "Making Contributions" on page 222. For examples of events that allow you to enroll or make coverage changes during the year, see "Making Changes After a Qualifying Life Event" on page 207.)

Knowing What's Covered and What's Not

You may use a dependent care FSA to pay for eligible dependent care expenses for your child (or children), disabled spouse or other disabled dependents, as defined below:

- a child under age 13 with whom you have a "specified relationship" and for whom you're entitled to claim a deduction on your federal tax return. For children of divorced or separated parents, only the parent with whom the child resides for more than half of the calendar year can claim the child as an eligible dependent under the dependent care FSA;
- a disabled parent residing in your household for whom you provide a majority of support and who lives with you for more than half of the calendar year;
- your child of any age who is physically or mentally unable to care for himself/herself and who lives with you for more than half of the calendar year; and
- your spouse who is physically or mentally unable to care for himself/herself and who lives with you for more than half of the calendar year.

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

Under the Working Families Tax Relief Act, you're not required to provide more than half of the cost of maintaining your household in order for your dependents to be eligible for dependent care FSA expenses.

(For detailed information on which expenses qualify for reimbursement, see "Covered Expenses" on page 225 and "Expenses Not Covered" on page 226.)

A NEW TEENAGER IN THE FAMILY?

Once your child turns age 13, expenses incurred for his/her dependent care are no longer eligible for reimbursement under the dependent care FSA (unless your dependent is disabled). Your child's loss of dependent eligibility counts as a qualifying life event and gives you the opportunity to reduce or stop your contributions. (For more information, see "Making Changes After a Qualifying Life Event" on page 207.)

Covered Expenses

Here is a list of dependent care expenses that are eligible for reimbursement through the dependent care FSA:

- care provided inside or outside your home by anyone other than you, your spouse, a person you list as your dependent for income tax purposes, or one of your children under age 19;
- a dependent care center or child care center (if the center cares for more than six children, it must comply with all applicable state and local regulations);
- a housekeeper, au pair or nanny whose services include, in part, providing care for a qualifying dependent;
- deposits and registration fees;
- day camp tuition, including sports camps;
- preschool tuition, such as for a nursery school or day care center that provides meals and educational activities as part of its child care service; and
- adult care for a disabled spouse or parent. This includes only the day care expenses; nursing/medical care doesn't qualify for reimbursement through a dependent care FSA, but may qualify for reimbursement under a health care FSA.

To qualify for reimbursement, you must provide your dependent care provider's tax ID number, Social Security number or license number on your federal tax return. If you fail to do so, your dependent care FSA reimbursements may be reclassified as taxable income by the IRS. You must still complete IRS Form 2441 when reporting taxes at the end of each calendar year.

IMPORTANT!

You're responsible for making sure the expenses you submit for reimbursement are considered eligible expenses by the IRS.

(For information on expenses that aren't eligible for reimbursement, see "Expenses Not Covered" on page 226.)

FOR MORE INFORMATION

Because the expenses that are eligible for reimbursement under the dependent care FSA are the same as those eligible for the federal tax credit, you can get additional examples of eligible expenses by referring to IRS Publication 503, Child and Dependent Care Expenses. Publication 503 is available at your local IRS office or on the IRS Web site, www.irs.gov.

If you're not sure whether an expense is eligible, consult a tax advisor or the FAQs (frequently asked questions) at www.myFBMC.com. You may also contact FBMC. (See *Contact Information*.)

Expenses Not Covered

Here is a list of dependent care expenses that aren't eligible for reimbursement through the dependent care FSA:

- books and supplies;
- child support payments or child care if you are a non-custodial parent;
- health care or educational tuition costs;
- services provided by your dependent, your spouse's dependent or your child who is under age 19; and
- overnight camps and education, including kindergarten (but summer day camps are eligible).

However, if the cost of tuition and dependent care can be separated, the itemized cost of the dependent care is reimbursable. (For more information on expenses that are eligible for reimbursement, see "Covered Expenses" on page 225.)

Filing a Claim

To get reimbursed from a dependent care FSA, complete FBMC's Reimbursement Request form and attach any appropriate receipts or have the dependent care provider sign the claim form instead of a receipt. Fax or mail the information to FBMC. (See *Contact Information*.)

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

If you submit a reimbursement request for an amount that is more than your FSA balance, you're reimbursed up to your current FSA balance. When future contributions are made to your FSA, you automatically receive another reimbursement until your total claim amount has been reimbursed or you reach your election amount for the calendar year.

If Reimbursement Is Denied

If your claim for reimbursement is denied, FBMC will notify you in writing within 30 days of your request, explaining the specific reasons for the denial, your right to appeal and your right to obtain free copies of documentation related to the decision. If matters beyond FBMC's control require more time, the review period may be extended up to 15 days, and you'll be notified of the extension before the initial 30-day period ends. (For information about appeals, see "Flexible Spending Accounts" in "Claims Review and Appeals Procedures" in *Rules, Regulations and Administrative Information.*)

GLOSSARY

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1986 gives plan members the ability to continue health care coverage after leaving employment.

Dependent care FSA expenses

These are expenses for dependent care that are eligible for reimbursement through a flexible spending account.

Family and Medical Leave Act (FMLA)

This federal law allows employees to take unpaid leave because of illness or to care for a sick family member.

Federal tax credit

A federal tax credit is given to an individual or business as credit for a payment already made toward taxes owed.

FICA

The Federal Insurance Contributions Act imposes an employment tax in an equal amount on employees and employers to fund federal programs for retirees, the disabled and children of deceased workers. FICA taxes support Social Security and Medicare.

Health care FSA expenses

These are expenses for health care that are eligible for reimbursement through a flexible spending account.

Internal Revenue Code Section 125

This section of the Internal Revenue Code sets the rules and regulations governing the use of before-tax payments for employer benefit plans, such as flexible spending accounts.

Internal Revenue Code Section 152

This section of the Internal Revenue Code sets the rules and regulations governing the definition and eligibility of dependents for various employer benefit plans, such as flexible spending accounts.

Retiree medical benefit

A retiree medical benefit is offered by King County to its retirees as a self-pay alternative to COBRA for continuing health coverage at the time of retirement up to age 65.

LIFE AND ACCIDENT PROTECTION

These days, it seems we can do almost anything. But there are still some things we can't do, like predict the future. Although King County cannot give you a crystal ball, we can give you the next-best thing: benefits that offer you and your family security and important financial support if you or a covered family member dies or is seriously injured in an accident. By offering both county-provided and supplemental life and accident benefits, the county gives you the flexibility to obtain the financial coverage that meets your personal needs.

As a benefit-eligible employee, you receive county-paid basic life insurance through Aetna Life Insurance and basic accidental death and dismemberment (AD&D) insurance through CIGNA Group Insurance. You also have the option to purchase supplemental life insurance for yourself.

PARTICIPATING IN THE LIFE AND ACCIDENT PLANS

To effectively use your county life and accidental death and dismemberment (AD&D) insurance plans, you need to know how they work. This section about participation in the life and AD&D insurance plans explains who is eligible for life and AD&D insurance, when and how to enroll, when and how to make changes, what coverage costs, when coverage begins and ends, and how to continue or convert coverage.

LIFE AND ACCIDENT PROTECTION PARTICIPATION ONLY

The information about eligibility and changing coverage in this section applies to the county's life insurance and AD&D insurance plans only. For eligibility and participation regarding other benefits, see the separate descriptions of each benefit in this guide.

Who Is Eligible

You are eligible for life and AD&D insurance, and your dependents are eligible for life insurance.

Employee

You're eligible for county-paid basic life and basic AD&D insurance if you're:

- a part-time or full-time deputy sheriff; or
- a deputy sheriff in a provisional or term-limited temporary position (your hiring authority can tell you if your position is benefit-eligible).

A part-time deputy sheriff is someone who works at least half-time but less than full-time in a calendar year.

You're not eligible for basic or supplemental life and basic AD&D insurance if:

- you work less than half-time in a calendar year;
- you're a temporary or seasonal employee; or
- you work in a capacity that, at the discretion of human resources, is considered contract work or independent contracting.

At the time you become a benefit-eligible employee (usually when you first come to work for the county), you're also eligible to purchase supplemental life for yourself. You are eligible to purchase supplemental life insurance at other times as well.

If you go on active military leave while employed with the county, you're eligible to continue receiving county-paid basic life insurance for up to 12 months. You can also pay to continue any supplemental life insurance you have for yourself.

Spouse/Domestic Partner

Your spouse/domestic partner is eligible for basic life insurance, but not supplemental life insurance, under your coverage.

WHAT IS A DOMESTIC PARTNERSHIP?

You and another individual may certify to the county that you're in a domestic partnership if you:

- share the same regular and permanent residence;
- have a close personal relationship;
- are jointly responsible for basic living expenses (See "Basic Living Expenses" on page 231);
- aren't married to anyone;
- are both 18 years of age or older;
- aren't related by blood closer than would bar legal marriage;

- were mentally competent to consent to contract when your domestic partnership began; and
- are each other's sole domestic partner and are responsible for each other's common welfare.

You and your domestic partner must go online to certify that you're in a domestic partnership. You also must notify the county if and when your domestic partnership ends.

Basic Living Expenses

"Basic living expenses" refers to 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 don't need to contribute equally or jointly to the cost of these expenses, as long as they both agree that they're responsible for the cost.

HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits, Payroll and Retirement Web site at www.kingcounty.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, Payroll and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

Children

Your children are eligible for basic life insurance, but not supplemental life insurance, under your coverage. If both you and your spouse/domestic partner work for the county, however, only one of you may cover your eligible children.

Eligible children include:

- your unmarried children or your spouse/domestic partner's unmarried children if they're under age 25 and depend on you or your spouse/domestic partner for more than 50% support and maintenance. "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;
  - stepchildren; and
  - legally designated wards, including 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)" in "Participating in the Health Care Plans" in *Health Care*);
- a child (as defined above) age 25 or older if he/she:
  - was incapacitated and covered under your plan before age 25;

- continues to be incapacitated due to a developmental or physical disability;
- is incapable of self-sustaining employment; and
- is dependent on you for more than 50% support and maintenance. (For more information, see "Disabled Dependent Children" on page 32.)

Disabled Dependent Children

If you want to continue coverage for a disabled child when he/she turns 25, you must submit a Continue Coverage for Disabled Adult Child form to Benefits, Payroll and Retirement Operations within 31 days of the child's 25th birthday. You also must provide proof of the child's continued disability annually thereafter.

FORMS

Forms are available at www.kingcounty.gov/employees/benefits or from Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

When and How to Enroll

While you automatically receive basic life and basic AD&D insurance, you have numerous opportunities to purchase supplemental life insurance. It's important to know when and how to enroll.

Enrolling When First Eligible

BASIC LIFE AND BASIC AD&D INSURANCE

You receive county-paid basic life and basic AD&D insurance when you become eligible for coverage.

When you become eligible for benefits, you receive benefit information and enrollment forms in a Deputy Sheriff New Hire Guide at your new employee orientation. You're automatically enrolled in the basic life and basic AD&D plans.

If you want to purchase supplemental life insurance for yourself, you must return your benefit enrollment forms to Benefits, Payroll and Retirement Operations within 30 days of your hire date. If your hire date, which is the first day you report to work, is the first day of the month, your supplemental coverage begins that day. If your hire date is any other day of the month, your supplemental coverage begins on the first day of the following month.

Supplemental Life Insurance

If you don't purchase supplemental life insurance when you first become eligible for coverage, you have the opportunity to purchase it again:

- when you have a qualifying life event;
- during the annual open enrollment;
- when you leave county employment and return to a benefit-eligible county position; or
- when the county opens supplemental life insurance enrollment to all employees during the annual open enrollment.

Enrolling During the Annual Open Enrollment

During the annual open enrollment, you can purchase or discontinue supplemental life insurance for yourself. However, evidence of insurability is required if you add it during open enrollment.

When and How to Name a Beneficiary

Because you automatically receive basic life and basic AD&D insurance when you first become benefit-eligible, and even if you don't elect supplemental life and supplemental AD&D insurance, you need to name one or more beneficiaries to receive your benefit in the event of your death.

When you first enroll, you receive two beneficiary forms: an Aetna Life Insurance Designation of Beneficiary form for your life insurance, and a CIGNA Beneficiary Designation form for your AD&D insurance. You need to complete and mail these forms directly to Aetna for life insurance and to CIGNA for AD&D insurance. Copies of these forms are available from Benefits, Payroll and Retirement Operations and its Web site. (See *Contact Information*.)

You may name anyone you wish as a beneficiary. There are two types of beneficiaries:

- primary beneficiaries receive your benefit first; and
- contingent beneficiaries receive your benefit if all primary beneficiaries are deceased at the time of your death. If you don't designate beneficiaries as primary or contingent, all beneficiaries are considered primary.

You may designate more than one primary beneficiary and more than one contingent beneficiary. When you do, you must assign a percentage of the benefit you want each beneficiary to receive. Percentages for all primary beneficiaries must total 100%, and percentages for all contingent beneficiaries must total 100%. If you don't assign percentages, beneficiaries receive equal shares.

If you don't name a beneficiary, benefits are paid to your spouse first, then to your children in equal shares if your spouse does not survive you. If none of them survives you, benefits are paid to your estate.

You may change your beneficiaries at any time by completing the Aetna Life Insurance Designation of Beneficiary form and CIGNA Beneficiary Designation form, and mailing the forms to Aetna and CIGNA, respectively. (See *Contact Information*.)

Benefits are paid according to the most recently signed form on file. If you elect supplemental life and/or supplemental AD&D insurance for your eligible dependents and a covered dependent dies, you are the beneficiary. Benefits for dismemberment, paralysis and other losses to you or your covered dependents are paid to you.

IMPORTANT

If you wish to purchase supplemental life and supplemental AD&D insurance, you must return your benefit enrollment forms to Benefits, Payroll and Retirement Operations within 30 days of your hire date, which is the first day you report to work.

When and How to Make Changes

Because things change in life, you may want to make changes to your life and AD&D insurance. It's important to know when and how you can make changes.

Changes You May Make After Qualifying Life Events

When you have a qualifying life event, you may add or discontinue supplemental life insurance for yourself, and you may add basic life insurance for dependents within 31 days of the qualifying life event.

QUALIFYING LIFE EVENTS

Qualifying life events include:

- marriage or establishment of a domestic partnership, except that marriage to a domestic partner already covered under county benefits is not a qualifying life event that allows for a change in supplemental life insurance;
- divorce or dissolution of a domestic partnership;
- birth of a child, adoption of a child or placement of a child as a legal ward;
- death of a dependent; and
- your spouse/domestic partner's loss of employer-sponsored coverage.

(For more information on what to do after qualifying life events, see *What Happens If . . .*.)

Changes You May Make at Any Time

The only change you can make at any time to supplemental life insurance is to discontinue it—that's because you're paying for it. However, you may discontinue basic life insurance for dependents at any time—only you will not be able to re-enroll them in basic life insurance until the annual open enrollment or until a qualifying life event occurs.

Changes You Must Make

You must discontinue basic life insurance for any dependent who is no longer eligible within 31 days of the change in eligibility. You are responsible for any expenses incurred after the date your dependent becomes ineligible.

Change Forms

To add or discontinue supplemental life insurance after a qualifying life event, you must complete the appropriate form online within 31 days after the qualifying life event.

If you wish to discontinue your supplemental life insurance, you need to submit a written request to Benefits, Payroll and Retirement Operations or e-mail your request to kc.benefits@kingcounty.gov. (See *Contact Information*.)

HOW TO MAKE CHANGES ONLINE

To make changes to your benefit coverage, complete the appropriate county form online at the Benefits, Payroll and Retirement Web site at www.kingcounty.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, Payroll and Retirement Web site. For forms not available on the Web site, contact the appropriate company or agency. (See *Contact Information*.)

What Coverage Costs

When you're eligible, the county pays for your basic life and basic AD&D insurance, and you pay for any supplemental insurance you purchase for yourself. (For information on who qualifies as an eligible dependent, see "Spouse/Domestic Partner" on page 230 and "Dependent Children" on page 231.)

If you're on an unpaid leave of absence, you may pay for basic life and basic AD&D insurance as well as any supplemental insurance you already have.

Basic Life and Basic AD&D Insurance

The county pays for your basic life and basic AD&D insurance if you're a deputy sheriff and pays for basic life insurance for eligible dependents you enroll.

Supplemental Life Insurance

The cost you pay for supplemental life insurance for yourself is an amount equal to your base annual salary, less $6,000. The rate for each $1,000 of coverage is $0.321. You pay for supplemental life insurance through payroll deduction.

To estimate your monthly cost for supplemental life insurance, you must estimate your base annual salary. To do so, multiply your hourly rate by the number of hours you work each week, then multiply the answer by 52—for example, if you earn $20.10 per hour and work 40 hours per week, your base annual salary is $20.10 x 40 x 52 = $41,808.

When you've calculated your base annual salary, use it with the following formula to estimate your total monthly cost for supplemental life insurance:

- base annual salary - $6,000 = supplemental insurance amount
- (supplemental insurance amount ÷ 1,000) x $0.321 = monthly amount

For example, if your base annual salary is $50,000, you're eligible to purchase $50,000 - $6,000 = $44,000 of supplemental life insurance. The cost is $0.321 per $1,000 x 44 = $14.12 per month.

When Coverage Begins

Coverage begins on the first day of the month following your hire date, which is the first day you report to work, unless modified by your collective bargaining agreement. If your hire date is the first day of the month, your coverage begins the same day.

If you happen to be ill or injured and away from work on the date coverage begins, your life insurance will take effect when you return to work for one full day, and your AD&D insurance will take effect on the first day of the month following your return to work.

When Coverage Ends

Coverage 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.

Your covered dependent's life insurance also ends on the last day of the month your covered dependent enters into active full-time military service.

How to Continue or Convert Coverage

When you leave county employment, you may want to know your options for continuing and/or converting your life and AD&D insurance coverage.

Life Insurance

When you leave county employment for reasons other than illness, you may continue your existing county life insurance, which is a group term insurance, or convert it to a whole life policy.

Continuing Group Term Life Insurance (For Reasons Other Than Illness)
Your county life insurance, which is group term insurance, is portable. That means that when you leave county employment and you are not ill or injured and away from work on the date your coverage ends, you may continue to pay Aetna directly for the basic and supplemental coverage you had on your last day of employment, up to $500,000, until you reach age 99. The age-specific rates you pay for the continued coverage may be different from the rates paid by active employees.

Your life benefits in excess of the portability maximums may be converted to a whole life policy. (See "Converting to Individual Whole Life Insurance" on page 237.)

Portability coverage reduces to:

- 65% of the original amount on January 1 following the date you reach age 65;
- 40% of the original amount on January 1 following the date you reach age 70; and
- 25% of the original amount on January 1 following the date you reach age 75.

Coverage terminates when you reach age 99 or when you stop premium payments. Continued coverage for your spouse/domestic partner and children ends when they reach the limiting age or when your coverage ends. However, they may convert to an individual whole life insurance policy. (See "Converting to Individual Whole Life Insurance" on page 237.)

To continue coverage, you must request a Portability Application from Aetna and return the completed form with your first premium payment within 31 days after the date your county coverage ends. (See *Contact Information*.) If you die during that 31-day period, your beneficiaries or estate will receive the full amount of your life insurance coverage in force before coverage ended. This payment is made under the group policy, whether or not you actually applied to continue coverage. If you applied, any fees or premiums you paid are refunded.

For information about continuing your life insurance coverage, contact Aetna. (See *Contact Information*.)

Continuing Group Term Life Insurance When You're Disabled

You may be able to continue life insurance if you become disabled. You're considered permanently and totally disabled only if disease or injury stops you from working at your own job or any other job for pay or profit, and it continues to stop you from working at any reasonable job. A "reasonable job" is defined as any job for pay or profit that you are (or may reasonably become) fitted for by education, training or experience.

(For more details, see "Life Insurance Coverage" in "You Become Disabled" in *What Happens If . . . .*)

Converting to Individual Whole Life Insurance

You, your spouse/domestic partner and your children may apply to convert your county life insurance to an individual whole life insurance policy if you:

- leave county employment for any reason; or
- elect to continue your county life insurance when you leave county employment, but discontinue it or lose eligibility for it later.

To convert your county life insurance to an individual whole life insurance policy, you or your covered dependent must apply to Aetna within 31 days after the date your county coverage ends. (See *Contact Information*.) If you die during that 31-day period, your beneficiaries or estate will receive the full amount of your life insurance coverage in force before coverage ended. This payment is made whether or not you actually applied to continue coverage. If you already had applied, any fees or premiums you paid are refunded.

For information about converting your life insurance coverage, contact Aetna. (See *Contact Information*.)

AD&D Insurance

Your AD&D insurance isn't portable. However, you may be eligible to purchase AD&D conversion insurance with CIGNA if your coverage ends because you:

- leave county employment for any reason;
- are no longer eligible (except for age); or
- lose coverage because the CIGNA group policy terminates.

Benefits will differ from the county plan's benefits.

No medical certification is needed, but you must be under age 70.

You must apply in writing within 31 days after the date your county coverage ends.

For information about continuing your AD&D insurance, contact CIGNA. (See *Contact Information*.)

LIFE INSURANCE PLAN

DEFINED TERMS

Be sure you understand the meaning of the terms used in this summary, such as "evidence of insurability." (See "Glossary" on page 250.)

Life insurance offers you and your family financial protection if you or a covered dependent dies. You may also purchase supplemental life insurance for yourself to increase your coverage.

This section tells you important things you need to know about your life insurance. Knowing how the life insurance plan works will help you understand the benefits for which you or your eligible dependents are eligible.

The benefits offered by the life insurance plan are insured by Aetna. This means that Aetna is financially responsible for claim payments and other costs.

How the Life Insurance Plan Works

The life insurance plan includes:

- basic life insurance, which the county provides to benefit-eligible employees and eligible dependents at no cost; and
- supplemental life insurance, which enables you to purchase additional coverage for yourself.

If you elect supplemental life insurance for yourself and you die, your beneficiaries receive a benefit equal to the supplemental amount you've purchased, **plus** your county-paid basic life insurance. If you enroll eligible dependents in basic life insurance, you're the beneficiary of supplemental life insurance if one of your covered dependents dies.

Calculating Life Insurance Benefits

The amount of life insurance benefit you or your beneficiaries receive is calculated from your basic insurance and, if you elected it, your supplemental insurance.

Basic Life Insurance

Your basic life insurance is $6,000.

Supplemental Life Insurance

The supplemental life insurance benefit your beneficiaries receive depends on the level of coverage you purchase.

Supplemental Life Insurance for You

If you purchase supplemental life insurance and you die, your beneficiaries receive the supplemental life insurance amount you purchased—your base annual salary, minus $6,000—in addition to your basic life insurance.

Your supplemental life insurance increases automatically (up to $400,000) as your salary increases. Adjustments to the supplemental life insurance benefit due to a salary change automatically occur the month of the salary change, unless you're on an approved unpaid leave. In that case, the adjustment occurs the month you return to active work. If you happen to be ill or injured and away from work on the date your coverage increases, the increase will take effect when you return to work for one full day.

WHEN YOUR SALARY INCREASES

Because your supplemental life insurance benefit is based on your base annual salary, your benefit amount increases as your salary increases.

Up Close and Personal

The following example helps illustrate how the life insurance plan works.

Meet John

When John became a deputy sheriff for the county in March, he elected supplemental life insurance to supplement his county-paid basic life insurance John unexpectedly died of a heart attack five months later. John had named his spouse, Shirley, as his primary beneficiary, followed by his son and daughter as contingent beneficiaries. Because Shirley is John's only primary beneficiary, she'll receive 100% of both the basic and the supplemental insurance benefit.

Here's how much Shirley receives:

John's base annual salary	Basic life insurance benefit	Supplemental life insurance benefit	Total life insurance benefit
$77,000	$6,000	$71,000 (John's base annual salary - $6,000)	$77,000 ($6,000 + $71,000)

Understanding Evidence of Insurability (EOI)

Evidence of insurability (EOI) is any statement of a person's physical condition, occupation or other factor that provides proof that he/she is insurable. Benefits, Payroll and Retirement Operations provides an EOI application when EOI is required under the policy. The application should be completed and returned directly to Aetna within 30 days of receipt.

Receiving Benefit Payments

It's important for you to know how claims are filed and how benefits are paid.

How to File a Claim

For a death or accelerated claim, you or your beneficiary should contact Aetna to file a claim. When you submit a claim, you'll need to provide your group number: 723832. Benefits, Payroll and Retirement Operations staff will help file the claim with Aetna and provide referrals to counseling and other resources as requested. (See *Contact Information*.)

Aetna processes the claim within 10 business days following receipt of a complete claim. If Aetna needs more time, you or your beneficiary is notified in writing, within the initial 10 days of receipt of the claim, of the need for an extension of up to 90 days.

Aetna may, at its own expense and unless prohibited by law, have an autopsy performed to determine a death benefit.

If the claim is denied, you or your beneficiary is 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 the plan reviewed in making the determination.

How Benefits Are Paid

Life insurance benefits can be paid at your death or the death of a covered dependent, or in the case of a terminal illness.

In Case of Death

Life insurance benefits are payable if you or a dependent dies while covered under the county plan. If you leave the county and die within 31 days after the date your county coverage ends, your beneficiaries or estate will receive the full amount of your life insurance coverage in force before coverage ended, even if you did not apply to continue your coverage through Aetna. (See "How to Continue or Convert Coverage" on page 236.)

Insurance is paid in a lump sum and is not subject to federal income tax. Be sure to consult your tax advisor for more information on taxes and death benefits.

How a Lump Sum Is Paid

When a death benefit of $5,000 or more is payable to you or a beneficiary, it is deposited into an Aetna Benefits Checkbook Account in the person's name. This account will earn competitive money market interest rates. You or the beneficiary receives personalized checks for immediate access to all or part of the funds deposited in the account and may write a check for no less than $250.

In Case of Terminal Illness

If you or your covered spouse/domestic partner has a terminal illness, certain benefits may be paid before death. This is called the "accelerated benefit option." You may elect to receive up to 75% of the life insurance benefit (up to $450,000 for you and up to $1,000 for your spouse/domestic partner) while you or your spouse/domestic partner is living if the following requirements are met:

- life expectancy must be 24 months or less; and
- certification of the terminal illness must be provided by a physician legally licensed to practice medicine, and accepted by Aetna before accelerated benefits are paid.

For the following conditions, you may elect to receive up to 75% of the life insurance benefit (up to $450,000 for you and up to $1,000 for your spouse/domestic partner):

- amyotrophic lateral sclerosis (Lou Gehrig's disease);
- end-stage heart, kidney, liver and/or pancreatic organ failure and you are not a transplant candidate;
- a medical condition requiring artificial life support, without which you would die.
- a permanent neurological deficit resulting from a cerebral vascular accident (stroke) or a traumatic brain injury, both of which are expected to result in life-long confinement in a hospital or skilled nursing facility.

While an accelerated benefit claim is pending, Aetna has the right, as often as reasonably necessary, to have a covered person examined by a health or vocational professional of Aetna's choice and at Aetna's expense.

Accelerated benefits are based on the amount of life insurance in effect according to county payroll records on the date Aetna accepts the physician's certification of terminal illness. Accelerated benefits are payable in a lump sum. The life insurance benefit is reduced by the amount of the accelerated benefit payment, and the remaining benefit is paid to you or your beneficiary after death.

If you have supplemental life insurance and elect the accelerated benefit option, you must continue paying for supplemental life insurance until coverage ends. However, because the accelerated benefit reduces the amount of your supplemental life insurance, the premium you continue to pay is reduced accordingly, based on the remaining amount of insurance.

For more details about the accelerated benefit option, contact Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

IMPORTANT THINGS TO KEEP IN MIND

Here are a few important things to know about the accelerated benefit option:

- accelerated benefits can be used to pay for special nursing requirements or hospice arrangements, needed medical equipment, or custodial care and other expenses;
- accelerated benefits are payable only once for you and once for your spouse/domestic partner;
- your accelerated benefit payment reduces the amount of the life insurance benefit that may be converted to an individual policy;
- you're responsible for any taxes due to an accelerated benefit payment; and
- your spouse/domestic partner must agree with your accelerated benefit option election.

Accidental Death and Dismemberment Insurance Plan

DEFINED TERMS

Be sure you understand the meaning of the terms used in this summary, such as "covered accident." (See "Glossary" on page 250.)

Accidental death and dismemberment (AD&D) insurance offers you and your family financial protection if you suffer a loss as the result of a covered accident. This section tells you important things you need to know about your accidental death and dismemberment (AD&D) insurance. Knowing how the AD&D insurance plan works will help you understand the benefits for which you are eligible.

The benefits offered by this plan are underwritten by Life Insurance Company of North America, a subsidiary of CIGNA Corporation. This means that Life Insurance Company of North America is responsible for claim payments and other costs. CIGNA Group Insurance products and services are provided by underwriting subsidiaries of CIGNA Corporation, including Life Insurance Company of North America. "CIGNA" is used to refer to these subsidiaries and CIGNA Group Insurance, a division of CIGNA Corporation, and is a registered service mark.

How the AD&D Insurance Plan Works

EOI ISN'T REQUIRED

You're not required to provide evidence of insurability (EOI) in order to enroll in AD&D insurance.

The accidental death and dismemberment (AD&D) insurance plan pays benefits if you suffer a specified dismemberment, paralysis or other loss that occurs within 365 days of a covered accident. (For details, see "Schedule of Benefits" on page 243.)

The plan includes basic AD&D insurance, which the county provides to you at no cost. If you die as the result of a covered accident, your beneficiaries receive a benefit equal $6,000.

Calculating AD&D Insurance Benefits

The amount of AD&D insurance benefit you or your beneficiaries receive is based on the amount of your basic AD&D insurance.

Basic AD&D Insurance

Your basic AD&D insurance is $6,000. If you die, your beneficiaries receive a benefit equal to $6,000.

Schedule of Benefits

AD&D insurance protects you against losses due to accidents. Depending on the type of loss or injury, the plan pays up to 100% of the full AD&D benefit amount for you or your spouse/domestic partner, subject to reductions for age, and up to 200% of the full AD&D benefit amount for your covered children. (See "Reduction in Benefits" on page 244.)

To help survivors of severe accidents adjust to new living circumstances, certain benefits are payable for paralysis, dismemberment, and loss of eyesight, speech or hearing according to the following table. Benefits are payable for death, specified dismemberment, paralysis and other losses that occur within 365 days of the covered accident that caused the covered loss.

IMPORTANT!

To receive benefits, you or your covered dependent must be covered under the plan on the date of the accident.

If the covered person suffers loss of…	You or your spouse/ domestic partner receives…	Your children receive…
• Life • Both hands or both feet, or sight in both eyes, or any combination • Speech and hearing in both ears • Quadriplegia (total paralysis of both arms and legs)	Full benefit amount	100% of the full benefit amount for loss of life; 200% of the full benefit amount for other losses listed
• Paraplegia (total paralysis of both legs) • 1 arm or 1 leg	75% of the full benefit amount	150% of the full benefit amount
• 1 hand or 1 foot or sight in 1 eye • Speech • Hearing in both ears • Paralysis of 1 arm and 1 leg	50% of the full benefit amount	100% of the full benefit amount
• Thumb and index finger on the same hand • Paralysis of 1 arm or 1 leg	25% of the full benefit amount	50% of the full benefit amount

Only one amount—the largest you're entitled to receive—is paid for all losses resulting from a single accident.

A "loss" is defined as:

- loss of arm or leg—complete severance at or above the elbow or knee joint;

- loss of hearing—irrecoverable loss of hearing that cannot be corrected by any hearing aid or device;
- loss of hand or foot—complete severance of a limb at or above the wrist or ankle joint;
- loss of sight—total and irrecoverable loss of sight;
- loss of speech—complete inability to communicate audibly in any degree;
- loss of thumb and index finger—complete severance of the thumb and index finger through or above the joint closest to the wrist;
- paralysis of a limb—complete and irreversible loss of use without severance of a limb, which is the complete separation and dismemberment of the limb from the body (this loss must be determined by a physician to be complete and irreversible).

Reduction in Benefits

For you and a covered spouse/domestic partner, supplemental AD&D benefit amounts are reduced to:

- 70% of the benefit amount for ages 70–74;
- 45% of the benefit amount for ages 75–79;
- 30% of the benefit amount for ages 80–84 (applies to you only); and
- 15% of the benefit amount for ages 85 and over (applies to you only).

Additional Benefits

AD&D insurance offers some benefits in addition to AD&D coverage.

Brain Damage Benefit

DEFINITION OF "BRAIN DAMAGE"

"Brain damage" means physical damage to the brain which causes the complete inability to perform all the substantial and material functions and activities normal to everyday life.

The plan pays an additional benefit if you or a covered dependent sustains brain damage as the result of a covered accident. This benefit is payable if:

- brain damage occurs within one year of the accident;
- the covered person is hospitalized for at least seven days within one year of the accident;
- brain damage continues for 12 consecutive months; and
- a physician determines that brain damage is permanent, complete and irreversible at the end of 12 consecutive months.

The plan pays 50% of your AD&D benefit up to $100,000 in one lump sum during the 13th month following the date of the covered accident. The amount payable by this brain damage benefit and any amount the plan paid or owes under the dismemberment, loss of sight, speech or hearing, and paralysis benefit will not exceed the full benefit amount. (See "Schedule of Benefits" on page 243.)

Child Care Benefit

A child care benefit is payable at the time of death or within one year of a covered accident if:

- you elected supplemental AD&D insurance for your child;
- you or your covered spouse/domestic partner dies as the result of a covered accident; and
- you have a surviving child under age 13 in a licensed child care center (or your child is enrolled within one year of the covered accident).

The child care benefit pays an annual sum for each covered child of up to 5% of your supplemental AD&D benefit, up to $5,000 a year, until the child enters first grade or for five straight years, whichever occurs first.

If, at the time of the accident, coverage for a dependent child is in force but no dependent child qualifies for a benefit payment, your designated beneficiary receives an additional benefit payment of $1,500.

Payment is made to the child's surviving custodial parent or legal guardian. Each payment is made at the end of a 12-month period once documented child care center expenses have been provided.

Coma Benefit

The plan pays an additional benefit if you or a covered dependent enters a coma as the result of a covered accident within 31 days of the accident. After the covered person has been comatose for 31 days, the plan makes monthly payments of 1% of the full AD&D benefit—up to 11 monthly payments. If the comatose person recovers, payments stop.

If you or your dependent dies as the result of a covered accident while receiving the monthly coma benefit, the plan pays the full benefit amount (the amount already paid isn't subtracted from the death benefit) minus any amount the plan paid or owes under the dismemberment, loss of sight, speech or hearing, and paralysis benefits.

If the coma continues after the 11 monthly payments, the covered dependent is entitled to a lump sum equal to the full benefit amount, minus any amount the plan paid or owes under the benefit for dismemberment, loss of sight, speech or hearing, and paralysis. No further benefit will be paid from this plan, and coverage will end.

No coma benefit will be paid for any loss excluded from the plan. (See "Understanding Exclusions and Limitations" on page 249.) In addition, the coma benefit isn't payable for a loss resulting from sickness, disease, bodily infirmity, medical or surgical treatment, bacterial infection (unless it results from an accidental external injury or food poisoning) or viral infection.

Education Benefit

If you elect supplemental AD&D insurance for your child and you or your covered spouse/domestic partner dies in a covered accident, the plan pays an education benefit for each covered child enrolled in an accredited school of higher learning (or in the 12th grade and enrolled in an accredited school of higher learning within one year of the accident). To help pay expenses, your benefit amount increases by 5% to up to $5,000 for each qualifying child. This benefit is payable each year for four consecutive years as long as the child continues his/her education.

If you don't have a qualifying child, your beneficiary receives an additional $1,000.

Felonious Assault Benefit

If you're injured or killed as the result of felonious assault while on county property or on county business, the plan pays up to an additional 25% of your basic AD&D benefit, up to $100,000. This felonious assault benefit is available if your injury or death is the result of an actual or attempted robbery or holdup (or kidnapping associated with a holdup). Felonious assaults inflicted by county employees or members of your family or household aren't covered.

Rehabilitation Benefit

If you or a covered dependent experiences a covered loss or injury, the plan pays an additional benefit for covered rehabilitative expenses due to the loss or injury if they're incurred within two years of a covered accident. This benefit maximum is $10,000 in rehabilitative expenses for all losses or injuries caused by the same accident. No rehabilitation benefit will be paid for any loss not covered by the plan. In addition, benefits won't be payable if a covered person is entitled to benefits under any workers' compensation act or similar law.

Seatbelt/Airbag Benefit

The plan pays an additional benefit of 10% of the full AD&D benefit amount, up to $25,000, if a seatbelt fails to protect you or a covered dependent and death results. The accident causing death must occur while the covered person is operating, or riding as a passenger in, an automobile and wearing a properly fastened, original, factory-installed seatbelt. A child restraint—as defined by state law and approved by the National Highway Traffic Safety Administration—properly secured and being used as recommended by its manufacturer for children of like age and weight at the time of the accident also qualifies as a seatbelt.

The plan pays an additional 5% of the full AD&D benefit amount, up to $12,500, if a seatbelt benefit is payable and the covered person is positioned in a seat protected by a properly functioning, original, factory-installed supplemental restraint system that inflates on impact (often called an "airbag").

Verification of actual seatbelt use at the time of the accident and airbag inflation at impact must be part of an official accident report or be certified, in writing, by the investigating officer. If that certification isn't available or if it's unclear whether the covered person was wearing a properly fastened seatbelt or positioned in a seat protected by a properly functioning and properly deployed supplemental restraint system, the designated beneficiary receives a fixed benefit of $1,000.

Secure Travel Benefit

If you or a covered dependent travels 100 or more miles from home, predeparture services and travel and health emergency assistance are available through Worldwide Assistance Services Inc. (See *Contact Information*.)

Predeparture Services

Predeparture services include information on:

- immunization requirements;
- visa and passport regulations;
- foreign exchange rates;
- embassy/consular referrals;
- travel/tourist advisories; and
- climate and cultural issues.

Travel Assistance

When you're traveling, Worldwide Assistance will:

- help you locate and replace luggage, documents and any other lost or stolen possessions;
- arrange aid from local attorneys, embassies and consulates if you need legal assistance, and provide up to $5,000 in bail bond, where permitted by law (you must guarantee reimbursement);
- provide phone translation or local interpreters for all major languages;
- give you a cash advance up to $250 (you must guarantee reimbursement);
- change or make new airline, hotel or car rental reservations in the event of an emergency; and
- relay urgent messages to and from friends, relatives and business associates through the Emergency Message Center.

Health Emergency Assistance

If an unforeseen health emergency arises while you're traveling, Worldwide Assistance will:

- provide referrals to local physicians, dentists and medical treatment facilities;
- help you refill a prescription that has been lost, stolen or depleted;
- arrange for payment of up to $5,000 of your reimbursable medical expenses (as determined by your medical plan);
- pay for your transportation to the nearest medical facility where a medical condition can be properly treated if medically necessary (determined by a Worldwide Assistance–designated physician);
- arrange and pay for the safe return of any dependent children under age 16 if you're hospitalized, and for a traveling companion's return in the event of delays due to your medical emergency;
- arrange and pay for a visit by a family member or friend if you're traveling alone and hospitalized for at least 10 days; and
- arrange all necessary government authorizations and pay for the return of your remains to your place of residence for burial or cremation in the event you die.

Increased Benefit for Children

If you elected supplemental AD&D insurance for your child and he/she has a covered accidental injury, you receive double the AD&D benefit amount, up to $50,000. If your child has two covered losses, only the larger amount payable will be doubled. If, in addition to a covered loss, your child dies because of the accident, only the death benefit is payable.

This benefit can help you cope with the ongoing financial obligations for a child who requires ongoing medical attention, rehabilitation services and a specialized education.

Violent Crime Benefit

This benefit pays up to an additional 25% of your supplemental AD&D benefit amount, up to $100,000, if you or a covered dependent suffers a covered loss due to a violent crime. The plan also pays an additional benefit for hospital confinement as the result of a violent crime—$100 a day up to 10 days (hospital confinement must begin within one year of the crime).

This violent crime benefit applies to:

- actual or attempted robbery or holdup;
- actual or attempted kidnapping; and
- any other type of assault classified as a felony based on governing statute or common law in the state where it occurred.

A copy of a police report containing proof that the loss was a direct result of a covered crime must be provided before any AD&D benefit is paid.

Receiving Benefit Payments

It's important that you know how claims are filed and how benefits are paid.

How to File a Claim

For a death, specified dismemberment or paralysis claim, you or your beneficiary should contact Benefits, Payroll and Retirement Operations. Benefits, Payroll and Retirement Operations staff will help file the claim with CIGNA and provide referrals to counseling and other resources as requested. The claim should be filed within 90 days of the loss or death. The group number for AD&D insurance is OK821586. (See *Contact Information*.)

CIGNA requires proof of loss—for example, a certified copy of the death certificate or accident report—within 90 days of the loss, or as soon as reasonably possible, before benefits are payable. For a death claim, CIGNA may, at its own expense and unless prohibited by law, have an autopsy performed to determine a death benefit. While a dismemberment or paralysis claim is pending, CIGNA may have the covered person examined by a health or vocational professional of his/her own choice at his/her expense, as often as reasonably necessary.

CIGNA processes the claim within 90 days of receipt. If CIGNA needs more time, you or your beneficiary is notified in writing, before the initial 90 days end, of the need for an extension of up to 90 days.

If the claim is denied, you or your beneficiary is notified in writing of reasons for the denial, the right to appeal and the right to obtain copies of all documents related to the claim which the plan reviewed in making the determination.

How Benefits Are Paid

AD&D insurance benefits are payable if you or a covered dependent dies or suffers a covered loss as the result of a covered accident.

Benefits are paid in a lump sum and aren't subject to federal income tax. Be sure to consult your tax advisor for more information on taxes and death benefits.

Understanding Exclusions and Limitations

No AD&D benefits are paid for loss resulting from:

- an accident that occurs while the covered person is engaged in the activities of active duty service in the military, navy or air force of any country or international organization. Accidents that occur while the covered person is engaged in Reserve or National Guard training aren't excluded;
- commission of a felony;
- declared or undeclared war or act of war;

- intentionally self-inflicted injuries, or any attempted self-inflicted injuries, while sane or insane;
- the covered person performing any of the following:
  - piloting, serving as a crew member or taking flying lessons (exclusion doesn't apply if riding as a passenger);
  - hang gliding; and
  - parachuting, except a parachute jump for self-preservation;
- sickness, disease, bodily or mental infirmity, medical or surgical treatment or bacterial or viral infection, regardless of how contracted (except bacterial infection that is the natural and foreseeable result of an accidental external cut or wound, or accidental food poisoning); or
- travel or flight in (including getting in or out, on or off) any aircraft or device that can fly above the earth's surface, if the aircraft or device is being used for any of these purposes:
  - for test or experiment;
  - by or for any military authority (aircraft flown by the U.S. Military Airlift Command or similar service of another country aren't excluded); and
  - for travel beyond the earth's atmosphere.

GLOSSARY

Aetna

"Aetna Life Insurance" is the organization King County contracts with to provide life insurance benefits.

Automobile

An "automobile" is a private-passenger motor vehicle with four or more wheels that is both designed and required to be licensed for use on the highways of any state or country. An "automobile" includes, but isn't limited to, a sedan, station wagon or jeep-type vehicle, or a motor vehicle of the pickup, van, camper or motor-home type. An "automobile" doesn't include a mobile home or any motor vehicle used in mass or public transit.

Base annual salary

"Base annual salary" is your base pay excluding overtime, bonuses, shift differential, premium pay or any other special pay.

Beneficiary

A "beneficiary" is the person or organization you designate to receive any life or AD&D insurance benefits payable at the time of your death.

CIGNA

"CIGNA Group Insurance" is the organization King County contracts with to provide AD&D insurance benefits. CIGNA Group Insurance products and services are provided by underwriting subsidiaries of CIGNA Corporation, including Life Insurance Company of North America. "CIGNA" is used to refer to these subsidiaries and is a registered service mark.

Covered accident—AD&D insurance

A "covered accident" is an event that causes bodily injuries while a person is covered under the AD&D insurance plan. The bodily injury must directly result in a covered loss.

Covered rehabilitative expense

A "covered rehabilitative expense" is an expense that:

- is charged for medically necessary rehabilitative training service of the covered person performed under the care, supervision or order of a physician;
- doesn't exceed the usual level of charges for similar treatment, supplies or services in the locality where the expense is incurred (for a hospital room and board charge, doesn't exceed the most common charge for semiprivate room and board in the hospital where the expense is incurred); and
- doesn't include charges that wouldn't have been made if there were no insurance.

Disabled—Life insurance

You're considered permanently and totally "disabled" only if disease or injury prevents you from working at your own job or any other job for pay or profit, and continues to prevent you from working at any reasonable job. A "reasonable job" is any job for pay or profit that you are (or may reasonably become) fitted for by education, training or experience.

Evidence of insurability (EOI)

"Evidence of insurability (EOI)" is any statement of a person's physical condition, occupation or other factor that provides proof that he/she is insurable.

Hospital

A "hospital" is a facility that:

- is operated according to law for the care and treatment of injured people;
- has organized facilities for diagnosis and surgery on its premises or in facilities available to it on a prearranged basis;
- has 24-hour nursing service by registered nurses; and
- is supervised by one or more physicians.

A "hospital" doesn't include:

- a nursing, convalescent or geriatric unit when a patient is confined there mainly to receive nursing care;

- a facility that is, other than incidentally, a rest home, nursing home, convalescent home or home for the aged, nor does it include any ward, room, wing or other section of the hospital that is used for such purposes; or
- any military or veterans' hospital or soldiers' home or any hospital contracted for or operated by any national government or government agency for the treatment of members or former members of the armed forces.

Licensed child care center

A "licensed child care center" is a facility run according to law, including laws and regulations applicable to child care facilities, and that provides care and supervision for children in a group setting on a regular, daily basis. A child care center doesn't include a hospital, the child's home, or care provided during normal school hours while a child is attending grades 1–12.

Limitation

A "limitation" is any restricting condition, such as age, time covered and waiting periods.

Medically necessary rehabilitative training service

A "medically necessary rehabilitative training service" is any medical service, medical supply, medical treatment or hospital confinement (or part of a hospital confinement) that is essential for physical rehabilitative training due to the injury for which it is prescribed or performed and that meets generally accepted standards of medical practice and is ordered by a doctor.

Supplemental restraint system

A "supplemental restraint system" is an airbag that inflates for added protection to the head and chest area.

Rules, Regulations and Administrative Information

This section of *Your King County Benefits* discusses your legal rights and presents some important administrative information.

Insurance and Administrative Contracts

The benefit descriptions in this guide provide you with most of the information you'll need to know about your King County benefit package. However, they're not detailed descriptions. If you have questions about specific plan details or would like to review any of the insurance and administrative contracts, you may contact the plan's third-party administrator or Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

The county has made every attempt to ensure the accuracy of the information in this guide. However, if there is any discrepancy between the benefit descriptions in this guide and the insurance and administrative contracts, the contracts will always govern. In addition, no person has the authority to make any oral or written statements of any kind that would conflict with the contracts or would alter the contracts maintained in conjunction with the plans.

Your Patient Rights

When you're covered under the county health plans, you have certain rights and responsibilities the county wants you to know about.

Dignity and Respect Under Your Health Plans

You have the right to:

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

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

Knowledge and Information Concerning Your Health Plans

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

- names and titles of all providers involved in your care;
- your health condition and status;
- services and procedures involved in your treatment;
- ongoing health care you need once you're discharged or leave the provider's office;
- how the plans work (see the appropriate plan sections of this guide); and
- any medication prescribed for you—what it is, what it's for, how to take it properly and possible side effects.

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

Medical Plan Participant Accountability and Autonomy

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

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

You're also responsible for:

- identifying yourself and covered dependents to providers when you receive services by showing your plan ID card (if provided by your plan) or providing your complete Social Security number (or unique identifier number if issued by the plan);
- giving your current provider all previous and relevant health care records and submitting accurate, complete health information to all physicians or other providers involved in your care;
- being on time for appointments and letting your provider's office know as far in advance as you can if you need to cancel or reschedule;
- following instructions given by those providing your care;

- sending copies of claim statements or other documents if requested;
- letting your medical plan and primary care provider (if applicable) know within 24 hours, or as soon as reasonably possible, if you receive emergency care or out-of-area urgent care;
- telling the plan and your primary care provider (if applicable) about planned health care treatment, such as a surgery or an inpatient stay; and
- paying all required expenses not covered by the plan.

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

Privacy Protection

To protect your privacy, the county and your plans limit the use of Social Security numbers unless otherwise legally required. Instead, the county and the plans use your PeopleSoft employee ID or a unique identifier number on ID cards, explanations of benefits or any other correspondence sent to you.

Continuous Improvement of Your Health Plans

You have the right to:

- contact Benefits, Payroll and Retirement Operations with any questions or concerns and make suggestions for improving the plans (see *Contact Information*);
- ask your providers to explain or give you more information about any health advice or prescribed treatment; and
- appeal any health care or administrative decisions. (See "Claims Review and Appeals Procedures" on page 257.)

Your HIPAA Privacy Rights

This section of your guide describes how medical information about you may be used and disclosed by King County and how you can get access to this information. Please review all information carefully and, if you have any questions, contact Benefits, Payroll and Retirement Operations. (See *Contact Information*.)

Our Obligations

We treat all protected health information (personally identifiable medical information) that you provide us to administer your health benefits as confidential. In addition, under the Health Insurance Portability and Accountability Act (HIPAA), we must:

- maintain the privacy of any protected health information you provide us when you enroll for benefit coverage, change coverage or ask for our assistance with a health benefit claim;
- inform you if there has been an inadvertent disclosure of your protected health information;
- obtain agreements with all vendors involved with the county's benefit plans to comply with HIPAA rules and regulations; and
- provide you with this information, which advises you of how we handle your protected health information and informs you of our legal obligations and your rights regarding the information.

For a complete summary of King County's obligations, refer to the "HIPAA Notice of Privacy Practices" on the Benefits, Payroll and Retirement Web site under Your King County Benefits. (See *Contact Information*.)

How We May Use and Disclose Protected Health Information

When you enroll for benefit coverage, change coverage or ask for our assistance with a health benefit claim, you provide us with information such as your name and possibly your Social Security number. Sometimes, when you ask for our assistance with a claim, you may also provide us with details about the health treatments you've received and payments for services you've made. This information becomes "protected health information" when used and disclosed in the course of managing our health care operations (administering your health benefits) and facilitating payment of health claims.

We may use and disclose this protected health information to:

- our employees authorized to assist in the administration of county benefit plans; and
- representatives of the plans or any third-party administrators with whom we have agreements to provide your benefit services.

In addition, we may use or disclose protected health information:

- when required by law—for example, in response to a court or administrative order, subpoena or discovery request; and
- when necessary to prevent a serious threat to your health and safety or the health and safety of the public.

For all the reasons explained above, we may use and disclose your personal health information without your written authorization. In all other cases, your written authorization is required.

Your Rights

For any protected health information provided to and maintained by us, you have the right to:

- inspect and copy it;
- request amendments to it if it's incorrect or incomplete (we may deny amendment requests for specific reasons—for example, we deny requests to amend information we didn't create);
- request to know to whom it's been disclosed for non-routine purposes (for disclosures made after April 14, 2003, when these HIPAA privacy practices became effective);
- request restrictions on what is disclosed and to whom (we try to honor restriction requests but are not required to do so); and
- request it be communicated to you in a certain way—for example, that we contact you only by mail or at work (we try to honor these requests but are not required to do so).

HOW TO CONTACT US

To exercise any of these rights, contact us in writing. Mail your request to:

Benefits, Payroll and Retirement Operations
The Chinook Building
CNK-ES-0240
401 Fifth Avenue
Seattle, WA
98104-2333

Or you can e-mail us at kc.benefits@kingcounty.gov.

Changes to Our Privacy Practices

We reserve the right to change our privacy practices and to apply the new practices to protected health information we already have, as well as to any information we receive in the future. We'll announce or notify you of any changes in our privacy practices and when the changes become effective.

Complaints

If you believe your privacy rights have been violated, you may file a complaint in writing with Benefits, Payroll and Retirement Operations or the Office of Civil Rights within the U.S. Department of Health and Human Services. You won't be penalized for filing a complaint.

HOW TO CONTACT US

To file a complaint with Benefits, Payroll and Retirement Operations, mail it to:

Benefits, Payroll and Retirement Operations
The Chinook Building
CNK-ES-0240
401 Fifth Avenue
Seattle, WA
98104-2333

Or you can e-mail us at kc.benefits@kingcounty.gov.

Claims Review and Appeals Procedures

The procedures for filing claims for benefits are summarized in the respective plan overviews. If you're not satisfied with the outcome of your claim, you can ask to have the claim reviewed.

Almost all of the benefit plans described in this guide have a specific amount of time during which benefit claims can be evaluated and responded to. The period of time the plans have to evaluate and respond to a claim begins on the date the claim is first filed. In addition, there are specific timelines and information requirements that you must comply with when filing a claim, or the claim may be denied and the rights you might otherwise have may be forfeited.

As the plan administrator, King County has the authority to control and manage the operation and administration of the plans described in this guide. However, the county can assign specific operational or administrative responsibilities, such as processing claims, to a third-party administrator, which has final responsibility and authority for responding to claims appeals.

Aetna, for example, has responsibility for processing claims and handling claims appeals for the county's Deputy Sheriff Plan. Group Health Cooperative, on the other hand, makes final decisions for benefit appeals for the county's Group Health plan.

Health Care Plans

In most cases, your health care provider will submit claims for health care services on your behalf. However, either you or your authorized representative may file claims for benefits under the county's health care plans (that is, medical, prescription drug, dental and vision). An "authorized representative" means a person you authorize, in writing, to act on your behalf. The plans also will recognize a court order giving a person the authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your authorized representative. All communications from the plans will be directed to your authorized representative unless your written designation provides otherwise.

Deputy Sheriff Plan

If a properly filed medical claim is denied in whole or in part, a Deputy Sheriff Plan service representative will notify you and your provider with an explanation in writing. The Deputy Sheriff Plan may deny a claim on the basis of eligibility or for other reasons.

Claims Denied for Reasons Other Than Eligibility

If you or your representative disagrees with a claim denial, you may try to resolve any misunderstanding by calling Aetna, the appropriate medical claims administrator for the Deputy Sheriff Plan, and providing more information. (See *Contact Information*.)

If you'd rather communicate in writing or the issue isn't resolved with a call, you may file a written appeal.

APPEALS OF AN ADVERSE DECISION

Mail appeals of an adverse decision to:

Aetna
Attn: National Account CRT
P.O. Box 14463
Lexington, KY 40512

You have 180 days after receiving a claim denial notice to file a written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

Aetna will review the written appeal and notify you or your representative of its decision within these time frames:

- within 36 hours for urgent appeals. These pertain to claims that have to be decided more quickly because using the normal time frames for decision-making could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed without the care or treatment that is the subject of the appeal;
- within 15 days for pre-service appeals. These relate to claims for a benefit that must be approved before the patient receives medical care—for example, requests to precertify a hospital stay;
- within 20 days for post-service appeals. These appeals involve the payment or reimbursement of costs for medical care that has already been provided; or
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim. These relate to claims where the plan has previously approved an ongoing course of treatment over a period of time or a specific number of treatments, and either the claims administrator later reduces or terminates coverage for those treatments before the end of that period or the covered person requests an extension of the course of treatment beyond the approved period of time or number of treatments.

Aetna will review your appeal, applying plan provisions and its discretion in interpreting plan provisions, and then will notify you of the decision within the time frames listed above. If the claim appeal is denied, you'll be notified in writing of reasons for the denial. Aetna has sole discretionary authority to determine benefit payment under the Deputy Sheriff Plan, and its decisions are final and binding.

If the appeal is denied and you disagree with the response in the appeal resolution letter, you may request a second-level appeal by sending a request in writing to Aetna within 60 days from the date you receive the resolution letter. If you do not request the second-level appeal within that time, Aetna will consider the decision stated in the appeal resolution letter to be final.

If you do not agree with the final decision, you may pursue legal remedies, but you or your representative must first exhaust this claim appeal process. If legal action is taken, the suit must be filed within two years of the date of service on which the claim is based, or you forfeit your right to legal action.

You must file an appeal within the given time frame or you may forfeit your right to further consideration of your claim.

After you have completed the appeal process with Aetna and before pursuing legal remedies, you may request an external review as long as your appeal meets the following requirements:

- in Aetna's judgment, the requested service or supply is not medically necessary or is experimental or investigational, and

- you would be financially responsible for $500 or more of the cost of the service.

External reviews are conducted by independent physicians with expertise in the area that is the subject of your appeal. Aetna accepts the decision of the external reviewer.

If Aetna determines you are eligible for an external review, you will receive an External Review Request form, which you must submit along with the requested documentation within 60 days of the date you receive the form to the address appearing on the form. You will not have to pay for the external review, nor will your request for an external review affect your rights to any other benefits under the plan, affect your right to representation, affect the process for selecting the external review organization or affect the impartiality of the physician reviewer.

Claims Denied Due to Eligibility Issues

If you have eligibility questions or believe you've had a claim denied because the Deputy Sheriff Plan indicates you or a dependent isn't covered under the plan, call Benefits, Payroll and Retirement Operations. (See *Contact Information*.) A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

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

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

ELIGIBILITY APPEALS

Mail eligibility appeals to:

Benefits, Payroll and Retirement Operations
The Chinook Building, CNK-ES-0240
401 Fifth Avenue
Seattle, WA 98104-2333

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

- within 3 business days for urgent appeals (call 206-684-1556 to file an urgent appeal);
- within 14 days for pre-service appeals (within 30 days if you are notified that an extension is necessary);

- within 20 days for post-service appeals (within 40 days if you are notified that an extension is necessary); and
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

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

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

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

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

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

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

Release of Medical Information

As a condition of receiving benefits under the Deputy Sheriff Plan, you and your family members authorize:

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

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

Prescription Coverage

Claims Denied for Reasons Other Than Eligibility

If you disagree with the decision on your claim for prescription drug coverage, you (or your authorized representative) will have 180 days to file a written appeal after your receipt of the notice of adverse decision. The decision on your appeal will be based on all comments, documents, records and other information you submit, even if they weren't submitted or considered during the initial claim decision.

APPEALS OF AN ADVERSE DECISION

Mail appeals of an adverse decision to:

Express Scripts, Inc.
Attn: Pharmacy Appeals (KCW)
6625 West 78th Street
Mail Route: BL0390
Bloomington, MN 55439

You should include the reasons you believe the claim was improperly denied, and all additional facts and documents you consider relevant in support of your appeal. The following type of information is helpful when submitting your appeal so that it may be handled in a timely manner:

- employee's full name;
- patient's full name;
- your Express Scripts ID Number (located on the front of your prescription card);
- the date(s) services were provided;
- your mailing address;
- your daytime phone number(s);
- your e-mail address (if you would like to provide it);
- relevant information regarding the nature of your appeal; and
- a copy of your Explanation of Benefits, if applicable.

A new decision-maker will review your denied claim—the appeal will not be conducted by the individual who denied the initial claim. The new decision-maker will not give deference to the original decision on your claim. The reviewer will make an independent decision about the claim. If your claim was denied on the basis of medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in your claim.

For appeals of adverse decisions involving urgent care claims, the plan will accept either oral or written requests for appeals for an expedited review. All necessary information may be transmitted between Express Scripts and you or health plan providers by telephone, fax or other available expeditious methods.

Notice of Decision on Appeal

After your appeal is reviewed by Express Scripts, you'll receive a notice of decision on appeal within the time frames specified below. The time frames for providing a notice of decision on appeal generally begin when all necessary information has been received to perform the review. Notice of decision on appeal will be provided in writing. Urgent care decisions may be delivered by telephone, fax or other expeditious methods. The time frames for providing a notice of decision on appeal are as follows:

- urgent care appeals. As soon as possible considering the medical urgency, but no later than 72 hours after Express Scripts receives your appeal and all information necessary to perform review; and
- claim denial appeals. Within a reasonable period of time appropriate to the medical circumstances, but no later than 10 business days after Express Scripts receives your appeal and all information necessary to perform review.

(For a definition of each of these appeals, refer to the descriptions of these appeals under "Claims Denied for Reasons Other Than Eligibility" under "Deputy Sheriff Plan" on page **Error! Bookmark not defined.**.)

If the appeal is denied, legal remedies may be pursued, but you or your representative must first exhaust this claim appeal process. If legal action is taken, the suit must be filed within two years of the date of service on which the claim is based, or you forfeit your right to legal action.

Claims Denied Due to Eligibility Issues

If you have eligibility questions or believe you've had a claim denied because Express Scripts indicates that you or a dependent isn't covered under the plan, call Benefits, Payroll and Retirement Operations. (See *Contact Information*.) A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or if your eligibility issue can't be resolved with a phone call, you or your representative may file a written appeal with Benefits, Payroll and Retirement Operations. You have 180 days after receiving a notice of your eligibility determination from the county or Express Scripts to submit a written appeal. It must include:

- your name and address, as well as each dependent's name and address, if applicable;
- hire letter or job announcement, or retirement determination of eligibility;
- your PeopleSoft employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a dependent); and
- the reason for the appeal.

ELIGIBILITY APPEALS

Mail eligibility appeals to:

Benefits, Payroll and Retirement Operations
The Chinook Building, CNK-ES-0240
401 Fifth Avenue
Seattle, WA 98104-2333

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

- within 3 business days for urgent appeals (call 206-684-1556 to file an urgent appeal);
- within 14 days for pre-service appeals (within 30 days if you are notified that an extension is necessary);
- within 20 days for post-service appeals (within 40 days if you are notified that an extension is necessary); and
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

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

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

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

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

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

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

Group Health

If a properly filed claim is denied in whole or in part, a Group Health Cooperative service representative will notify you and your provider with an explanation in writing. Group Health may deny a claim on the basis of eligibility or medical necessity, or for other reasons.

Group Health has in place certain grievance processes that enable plan members to file a complaint and appeal a denial of benefits:

- the complaint process enables plan members to express dissatisfaction with customer service or the quality or availability of a health service; and
- the appeals process enables plan members to seek reconsideration of a denial of benefits.

Complaint Process

If you wish to file a complaint, you must follow these steps:

Step 1: Contact the provider, and explain your concerns and what you would like done to resolve the problem. Be specific and make your position clear.

Step 2: If you prefer not to talk with the provider or if you're not satisfied with the response, call the department head or the manager of the medical center or department where you're having a problem. That person will investigate your concerns. Most concerns can be resolved in this way.

Step 3: If you're not satisfied with the response, call the Group Health Customer Service Center at 1-888-901-4636 toll-free. Most concerns are handled by phone within a few days. In some cases, you'll be asked to write down your concerns and state what you think would be a fair resolution to the problem. A customer service representative or Member Quality of Care coordinator will investigate your concern by consulting with involved staff and their supervisors, and reviewing pertinent records, relevant plan policies and the Member Rights and Responsibilities statement. This process can take up to 30 days to resolve after receipt of your written statement.

Claims Denied for Reasons Other Than Eligibility

If you wish to appeal a decision denying benefits, you must follow these steps:

Step 1: Submit a request for an appeal either orally or in writing to the Member Appeals Department, specifying why you disagree with the decision. The appeal must be submitted within 180 days of the denial notice you received.

- Send your appeal to:

  Group Health's Member Appeals Department
  P.O. Box 34593
  Seattle, WA 98124-1593

Or, you may call 1-866-458-5479 toll-free.

An Appeals Coordinator will review initial appeal requests. Group Health will then notify you of its determination or need for an extension of time within 30 days of receiving your request for appeal. **Under no circumstances will the review time frame exceed 30 days without your written permission.**

If the appeal request is for an experimental or investigational exclusion or limitation, Group Health will make a determination and notify you in writing within 30 working days of receipt of a fully documented request. If additional time is required to make a determination, Group Health will notify you in writing that an extension in the review time frame is necessary. **Under no circumstances will the review time frame exceed 30 days without your written permission.**

An expedited appeals process is in place for cases that meet criteria or where your provider believes that the standard 30-day appeal review process will seriously jeopardize your life, health or ability to regain maximum function or subject you to severe pain that cannot be managed adequately without the requested care or treatment. You can request an expedited appeal in writing to one of the addresses above. Or, you may call Group Health's Member Appeals Department at 1-866-458-5479 toll-free.

Your request for an expedited appeal will be processed and a decision issued no later than 72 hours after receipt.

Step 2: If you're not satisfied with the decision in Step 1 regarding a denial of benefits, or if Group Health fails to grant or reject your request within the applicable required time frame, you may request a second-level review by an external independent review organization as long as the appeal meets the following requirements:

- in Group Health's judgment, the requested service or supply is not medically necessary or is experimental or investigational, and
- you would be financially responsible for $500 or more of the cost of the service or supply.

An independent review organization isn't legally affiliated with or controlled by Group Health. Once a decision is made through an independent review organization, the decision is final and cannot be appealed through Group Health. You must request a review by an independent review organization within 180 days after the date of the Step 1 decision notice or within 180 days after the date of a Group Health appeals committee decision notice.

Requests can be mailed to the addresses listed under "Claims Denied for Reasons Other Than Eligibility" on page 265.

Claims Denied Due to Eligibility Issues

If you have eligibility questions or believe you've had a claim denied because Group Health indicates you or a dependent isn't covered under the plan, call Benefits, Payroll and Retirement Operations. (See *Contact Information*.) A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

If you'd rather communicate in writing or if your eligibility issue can't be resolved with a phone call, you or your representative may file a written appeal. You have 180 days after receiving a notice of your eligibility determination from the county or Group Health to submit a written appeal. It must include:

- your name and address, as well as each dependent's name and address, if applicable;
- your hire letter or job announcement, or retirement determination of eligibility;
- your PeopleSoft employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a dependent); and
- the reason for the appeal.

ELIGIBILITY APPEALS

Mail eligibility appeals to:

Benefits, Payroll and Retirement Operations
The Chinook Building, CNK-ES-0240
401 Fifth Avenue
Seattle, WA 98104-2333

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

- within 3 business days for urgent appeals (call 206-684-1556 to file an urgent appeal). These pertain to claims that have to be decided more quickly because using the normal time frames for decision-making could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed without the care or treatment that is the subject of the appeal;
- within 14 days for pre-service appeals (within 30 days if you are notified that an extension is necessary). These relate to claims for a benefit that must be approved before the patient receives medical care—for example, requests to precertify a hospital stay;

- within 20 days for post-service appeals (within 40 days if you are notified that an extension is necessary). These appeals involve the payment or reimbursement of costs for medical care that has already been provided; or
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim. These relate to claims where the plan has previously approved an ongoing course of treatment over a period of time or a specific number of treatments, and either the claims administrator later reduces or terminates coverage for those treatments before the end of that period or the covered person requests an extension of the course of treatment beyond the approved period of time or number of treatments.

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

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

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

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

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

Dental

If a properly filed claim is denied in whole or in part, WDS notifies you and your provider with an explanation in writing. WDS may deny a claim on the basis of eligibility or for other reasons.

Claims Denied for Reasons Other Than Eligibility

If you or your authorized representative disagrees with the claim denial, you may try to resolve any misunderstanding by calling or writing WDS and requesting an appeal of the decision. If you're dissatisfied with the outcome of the review, you may request a second review by the WDS Appeals Committee. (See *Contact Information*.)

You have 180 days after receiving a claim denial notice to request an appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

WDS will review your written appeal and notify you or your representative of its decision within these time frames:

- within 72 hours for urgent appeals. These pertain to claims that have to be decided more quickly because using the normal time frames for decision-making could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed without the care or treatment that is the subject of the appeal;
- within 30 days for post-service appeals. These appeals involve the payment or reimbursement of costs for dental care that has already been provided; or
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim. These relate to claims where the plan has previously approved an ongoing course of treatment over a period of time or a specific number of treatments, and either the claims administrator later reduces or terminates coverage for those treatments before the end of that period or the covered person requests an extension of the course of treatment beyond the approved period of time or number of treatments.

For second-level appeal reviews, your request for a review by the WDS Appeals Committee must be made within 90 days of the postmarked date of the letter notifying you of the informal review decision. Your request should include the information noted above, plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The WDS Appeals Committee includes only persons who weren't involved in either the original claim decision or the informal review. The WDS Appeal Committee will review your claim and make a determination within 30 days of receiving your request, or within 20 days for experimental/investigational procedure appeals, and send you a written notification of the review decision. Upon request, you'll be granted access to and copies of all relevant information used in making the review decision. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, WDS will consult with a dental professional advisor.

The decision of the WDS Appeals Committee is final. If you disagree with the outcome of your appeal and you have exhausted the appeals process provided by your plan, there may be other avenues available for further action. If so, these will be provided to you in the final decision letter. If legal action is taken, the suit must be filed within six years after the event on which the claim is based or you forfeit your right to legal action.

AUTHORIZED REPRESENTATIVE

You may authorize another person to represent you and whom WDS can contact regarding specific appeals. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization, a request will be made to obtain a completed Authorized Representative form. The appeal process won't commence until this form is received. If the form or some other document confirming the right of the individual to act on your behalf (that is, power of attorney) isn't returned, the appeal will be closed.

Claims Denied Due to Eligibility Issues

If you have eligibility questions or believe you've had a claim denied because WDS indicates that you or a dependent isn't covered under the plan, call Benefits, Payroll and Retirement Operations. (See *Contact Information*.) A staff member may be able to resolve the eligibility issue, eliminating the need to file a formal appeal.

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

- your name and address, as well as each dependent's name and address (if applicable);
- hire letter or job announcement, or retirement determination of eligibility;
- your PeopleSoft employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a dependent); and
- the reason for the appeal.

ELIGIBILITY APPEALS

Mail eligibility appeals to:

Benefits, Payroll and Retirement Operations
The Chinook Building, CNK-ES-0240
401 Fifth Avenue
Seattle, WA 98104-2333

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

- within 3 business days for urgent appeals (call 206-684-1556 to file an urgent appeal);
- within 14 days for pre-service appeals (within 30 days if you are notified that an extension is necessary);
- within 20 days for post-service appeals (within 40 days if you are notified that an extension is necessary);
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

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

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

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

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

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

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

Vision

If a properly filed claim is denied in whole or in part, VSP notifies you and your provider with an explanation in writing. VSP may deny a claim on the basis of eligibility or for other reasons.

Claims Denied for Reasons Other Than Eligibility

If you or your representative disagrees with the claim denial, you may try to resolve any misunderstanding by calling VSP and providing more information. If you'd rather communicate in writing or if the issue isn't resolved with a call, you may file a written appeal with VSP. (See *Contact Information*.)

You have 180 days after receiving a claim denial notice to file a written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

VSP will review the written appeal and notify you or your representative of its decision within these time frames:

- within 72 hours for urgent appeals. These pertain to claims that have to be decided more quickly because using the normal time frames for decision-making could seriously jeopardize the life or health of the patient or the ability of the patient to regain maximum function or, in the judgment of a physician, would subject the patient to severe pain that could not be adequately managed without the care or treatment that is the subject of the appeal;
- within 30 days for pre-service appeals. These relate to claims for a benefit that must be approved before the patient receives vision care—for example, vision therapy;
- within 30 days for post-service appeals (first- and second-level appeals). These appeals involve the payment or reimbursement of costs for vision care that has already been provided; or
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim. These relate to claims where the plan has previously approved an ongoing course of treatment over a period of time or a specific number of treatments, and either the claims administrator later reduces or terminates coverage for those treatments before the end of that period or the covered person requests an extension of the course of treatment beyond the approved period of time or number of treatments.

Your appeal is reviewed by someone different from the original decision makers and without deference to the initial decision. The appeal reviewer applies plan provisions and his/her discretion in interpreting plan provisions, and then notifies you of the decision within the time frames listed above. If the claim appeal is denied, you're notified in writing of reasons for the denial.

If you disagree with the resolution of your claim, you have 60 days after receiving the denial to submit a second-level appeal with any further documentation to VSP.

VSP has sole discretionary authority to determine benefit payment under the plans; its decisions are final and binding.

If the appeal is denied, legal remedies may be pursued, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event the claim is based on or you forfeit your right to legal action.

Claims Denied Due to Eligibility Issues

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

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

- your name and address, as well as each dependent's name and address (if applicable);
- hire letter or job announcement, or retirement determination of eligibility;
- your PeopleSoft employee ID (as it appears on your pay stub) or Social Security number (even if the appeal is for a dependent); and
- the reason for the appeal.

ELIGIBILITY APPEALS

Mail eligibility appeals to:

Benefits, Payroll and Retirement Operations
The Chinook Building, CNK-ES-0240
401 Fifth Avenue
Seattle, WA 98104-2333

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

- within 3 business days for urgent appeals (call 206-684-1556 to file an urgent appeal);
- within 14 days for pre-service appeals (within 30 days if you are notified that an extension is necessary);
- within 20 days for post-service appeals (within 40 days if you are notified that an extension is necessary); and
- within the time frames for urgent, pre-service or post-service appeals for concurrent appeals, depending on the nature of the claim.

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

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

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

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

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

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

Flexible Spending Accounts

If a properly filed claim is denied, you (or your representative) may submit a written appeal to:

Fringe Benefits Management Company (FBMC)
P.O. Box 1878
Tallahassee, FL 32302-1878

Your written appeal must be filed within 180 days after you receive the initial notice of denial from FBMC. You must indicate the reason for your appeal and may include any relevant information or documents.

FBMC will give you a written decision within 60 days of receiving your appeal, indicating the specific plan provision behind the decision and advising you of your right to obtain free copies of related documentation.

If the appeal is denied, you may pursue legal remedies, but you or your representative must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event on which the claim is based.

Life Insurance Plan

The county administers eligibility for participation in the life insurance plan according to the terms of the insurance contract. Aetna Life Insurance has the sole discretionary authority to apply the terms of the plan for the purpose of determining eligibility for claims payment and resolving claims appeals under the plan.

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

Claims Denied for Any Reason

If you or your beneficiary disagrees with a claim denial, you, your beneficiary or representative (referred to as "you" in the rest of this section) may file a written appeal. You have 60 days after receiving a claim denial notice to file the written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

Aetna will review the written appeal and notify you of its decision within 60 days after receiving the appeal. If Aetna requires additional time, you will be notified in writing that an additional period of up to 60 days is necessary.

Aetna will give you a written decision and explain the specific plan provisions behind the denial (if applicable).

Aetna has sole discretionary authority to determine benefit payment under the life insurance plan, and its decision is final and binding. In reviewing your claim, Aetna applies the plan terms. Benefits are paid only if you meet the eligibility and participation requirements and Aetna determines that you're entitled to the benefits.

If the appeal is denied, you may pursue legal remedies, but you must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within two years after the event on which the claim is based. If you don't file a claim or appeal within the specified period, you forfeit the right to further appeal.

IF YOU HAVE QUESTIONS ABOUT ELIGIBILITY

If you have questions about your eligibility to participate in this plan, contact Benefits, Payroll and Retirement Operations at 206-684-1556 or kc.benefits@kingcounty.gov. You may also write to:

Benefits, Payroll and Retirement Operations
The Chinook Building, CNK-ES-0240
401 Fifth Avenue
Seattle, WA 98104-2333

When writing, be sure to include your name and address, your PeopleSoft employee ID (as it appears on your pay stub) and a phone number where you can be reached during weekday business hours.

Accidental Death and Dismemberment Insurance Plan

The county administers eligibility for participation in the accidental death and dismemberment (AD&D) insurance plan according to the terms of the insurance contract. CIGNA Group Insurance has the sole discretionary authority to apply the terms of the plan for the purpose of determining eligibility for claims payment and resolving claims appeals under the plan.

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

Claims Denied for Any Reason

If you or your beneficiary disagrees with a claim denial, you, your beneficiary or representative (referred to as "you" in the rest of this section) may try to resolve any misunderstanding by calling CIGNA and providing more information. If you'd rather communicate in writing or if the issue isn't resolved with a call, you may file a written appeal. You have 60 days after receiving a claim denial notice to file the written appeal. Be sure to include the reasons for the appeal and any information or documentation helpful to reviewing the claim.

CIGNA will review your written appeal and notify you of its decision within 60 days after receiving the appeal. If CIGNA requires additional time, you'll be notified in writing that an additional period of up to 60 days is necessary.

CIGNA will give you a written decision and explain the specific plan provisions behind the denial (if applicable).

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

If the appeal is denied, you may pursue legal remedies, but you must exhaust this claim appeal process first. If legal action is taken, the suit must be filed within three years after the time written proof of loss is required to be furnished. If you don't file a claim or appeal within the specified period, you forfeit the right to further appeal.

IF YOU HAVE QUESTIONS ABOUT ELIGIBILITY

If you have questions about your eligibility to participate in this plan, contact Benefits, Payroll and Retirement Operations at 206-684-1556 or kc.benefits@kingcounty.gov. You may also write to:

Benefits, Payroll and Retirement Operations
The Chinook Building, CNK-ES-0240
401 Fifth Avenue
Seattle, WA 98104-2333

When writing, be sure to include your name and address, your PeopleSoft employee ID (as it appears on your pay stub) and a phone number where you can be reached during weekday business hours.

Assignment of Benefits

Plan benefits are available only to you and the eligible dependents you cover. In general, they cannot be assigned or given away to another person and are not subject to attachment or garnishment. However, there are exceptions. Contact Benefits, Payroll and Retirement Operations for details. (See *Contact Information*.)

Determining Payment of Benefits

In paying for services, the plans may, at their option, pay you, the provider or another third-party administrator. The plans also will make payments on behalf of an enrolled child to his/her parent who may not be enrolled in the plan or to 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. When the plans make payments according to the information in this section, they're released from liability to anyone who disagrees with their decision to pay certain individuals or agencies.

Third-Party Claims

If you receive health benefits for any condition or injury for which a third party is liable, the plans may have the right to recover the money they paid for benefits. Third-party claims are handled differently by the different health plans. (For details, see the separate sections on third-party claims under the Deputy Sheriff Plan, Group Health, WDS and VSP in the *Health Care* section.)

Correcting Mistakes in Payments

Each plan has the right to recover amounts it paid that exceed the amount for which it is liable. These amounts may be recovered from one or more of the following (to be determined by the plan):

- 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 the dependent's behalf.

The plan's right of recovery includes benefits paid in error due to, but not limited to, any false or misleading statements made by you or your dependents.

Change or Termination of the Plans

The county fully intends to continue the plans indefinitely but reserves the absolute right to amend or terminate them, in whole or in part, for any reason at any time, according to the amendment and termination procedures described in the legal documents. If the county amends or terminates the plans, bona fide claims incurred before the amendment or termination will be paid.

Employment Rights Not Implied

The benefit information in this guide does not create a contract of employment between the county and any employee.

Contact Information

For questions about...	Contact...	By writing or calling...	Or visiting or e-mailing...
How to enroll for health coverage	Benefits, Payroll and Retirement Operations	The Chinook Building, CNK-ES-0240 401 Fifth Ave. Seattle, WA 98104-2333 206-684-1556 206-296-7700 (fax)	www.kingcounty.gov/employees/benefits kc.benefits@kingcounty.gov
How to find benefits information and forms	Benefits, Payroll and Retirement Operations	The Chinook Building, CNK-ES-0240 401 Fifth Ave. Seattle, WA 98104-2333 206-684-1556 206-296-7700 (fax)	www.kingcounty.gov/employees/benefits kc.benefits@kingcounty.gov
Deputy Sheriff Plan Gold Group No. 725069-10-011 Silver Group No. 725069-10-012	For medical: Aetna	1-800-654-3250	www.kingcare.com kingcare@aetna.com
	For claims reimbursement: Aetna	Aetna, Inc. P.O. Box 14079 Lexington, KY 40512-4079	www.kingcare.com kingcare@aetna.com
	For medical preauthorizations: Aetna	1-888-632-3862	N/A
	For prescription drugs: Express Scripts	Express Scripts, Inc. Member Reimbursements P.O. Box 66583 St. Louis, MO 63166 Express Scripts Home Delivery Service P.O. Box 52112 Phoenix, AZ 85072-2122 1-800-332-2213 1-800-899-2114 (TTY)	www.express-scripts.com
Group Health Gold Group No. 0953800 Silver Group No. 0975800	Group Health	Group Health P.O. Box 34585 Seattle, WA 98124-1585 1-888-901-4636	www.ghc.org info@ghc.org
		For mail-order prescriptions: 1-800-245-7979	For online prescription drug refills: www.MyGroupHealth.com

For questions about...	Contact...	By writing or calling...	Or visiting or e-mailing...
Dental plan Group No. 00152	Washington Dental Service (WDS)	Washington Dental Service P.O. Box 75983 Seattle, WA 98175-0983 1-866-229-4102	www.deltadentalwa.com cservice@deltadentalwa.com
Vision plan Group No. 12-029826	Vision Service Plan (VSP)	Vision Service Plan P.O. Box 997100 Sacramento, CA 95899-7100 1-800-877-7195 1-800-428-4833 (TTY)	www.vsp.com
Flexible spending accounts	Fringe Benefits Management Company (FBMC)	FBMC P.O. Box 1878 Tallahassee, FL 32302-1878 1-866-879-8689 1-866-440-7145 (fax)	www.myFBMC.com
Life insurance Group No. 723832	Aetna Life Insurance	Aetna Life Insurance Company P.O. Box 14547 Lexington, KY 40512-4547 For conversion/ portability: 1-800-826-7448 For claims and evidence of insurability: 1-800-523-5065 For beneficiaries: 1-800-523-5065 to request paper copy For customer service: 1-888-584-2983 1-800-803-5934 (fax)	N/A

For questions about...	Contact...	By writing or calling...	Or visiting or e-mailing...
Accidental death and dismemberment (AD&D) insurance Group No. OK821586	CIGNA Group Insurance	CIGNA Group Insurance CIGNA Customer Service Center P.O. Box 20310 Lehigh Valley, PA 18002-0310 For conversion: 1-800-557-7975, ext. 7424 For claims: 1-800-362-4462 For beneficiaries: 1-800-557-7975, ext. 7767 For travel assistance in the U.S./Canada: 1-888-226-4567 1-800-336-2485 (TTY) Collect outside U.S./Canada: 202-331-7635 Fax for travel assistance: 202-331-1528	For travel assistance: cigna@worldwideassistance.com
COBRA	Fringe Benefits Management Company (FBMC)	FBMC P.O. Box 1878 Tallahassee, FL 32302-1878 1-866-879-8689 1-866-440-7145 (fax)	www.myFBMC.com
King County Employees Deferred Compensation Plan	Benefits, Payroll and Retirement Operations	Benefits, Payroll and Retirement Operations The Chinook Building, CNK-ES-0240 401 Fifth Ave. Seattle, WA 98104-2333 T. Rowe Price P.O. Box 17215 Baltimore, MD 21297-1215 For county assistance: 206-263-9250 For T. Rowe Price assistance: 1-888-457-5770	If you're enrolled: http://rps.troweprice.com If you're not enrolled: http://rps.troweprice.com/scm/scmKingCounty/0,,,00.html moneca.allen@kingcounty.gov
State retirement information	Washington State Department of Retirement Systems	Washington State Department of Retirement Systems P.O. Box 48380 Olympia, WA 98504-8380 1-800-547-6657 1-866-377-8895 (TTY)	www.drs.wa.gov recep@drs.wa.gov

For questions about...	Contact...	By writing or calling...	Or visiting or e-mailing...
City of Seattle retirement information	Seattle City Employees' Retirement System	Seattle City Employees' Retirement System 720 Third Avenue, Suite 1000 Seattle, WA 98104-1829 206-386-1293 206-386-1506 (fax)	www.seattle.gov/retirement
Making Life Easier	Making Life Easier	1-888-874-7290	www.kingcounty.gov/employees/EAP
Individual insurance policies	Statewide Health Insurance Benefits Advisors (SHIBA)	SHIBA HelpLine Office of Insurance Commissioner P.O. Box 40256 Olympia, WA 98504-0256 1-800-562-6900 206-727-6221 (King County only)	www.insurance.wa.gov/shiba SHIBAhelpLine@oic.wa.gov
Medicare	Centers for Medicare & Medicaid Services, Region 10	Centers for Medicare & Medicaid Services, Region 10 2201 Sixth Avenue, MS-40 Seattle, WA 98121 206-615-2306 206-615-2027 (fax)	www.medicare.gov

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