EMPLOYEE BOOKLET

WASHINGTON FIRE COMMISSIONERS ASSOCIATION
HEALTH CARE BENEFITS PLAN

High Deductible Health Plan Option

PLAN EFFECTIVE:
January 1, 2006

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PLAN CONTACTS

ELIGIBILITY
See your district administrator for eligibility information

BENEFITS OR CLAIM PAYMENTS
Trusteed Plans Service Corporation ..... (253) 564-5611 or (800) 426-9786

IN-PATIENT HOSPITAL ADMISSIONS
Qualis Health ..... (800) 783-8606

PRESCRIPTION DRUGS
Retail Purchases: Express Scripts ..... (800) 206-4005
Mail Order: Express Scripts ..... (800) 206-4005

MEDICAL SUMMARY OF BENEFITS

BENEFIT PERIOD	Calendar Year
BENEFIT LIMITATION	Services from non-Preferred Providers are limited to a Usual, Customary and Reasonable (UCR) allowance.
OUT-OF-POCKET MAXIMUM	100% payment when out-of-pocket expenses for allowable Deductible and Coinsurance reach $2,500 in a Calendar Year for Employee-only Coverage; $5,000 in a Calendar Year for Employee & Family Coverage.
LIFETIME MAXIMUM BENEFIT	$2,000,000

	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
The Deductible is waived for the following services:		
PREVENTIVE CARE		
Routine Physical Exam—*Limited to one (1) adult exam per Calendar Year*	Covered at 100%	Covered at 60%
Well-Child Care	Covered at 100%	Covered at 60%
Immunizations	Covered at 100%	Covered at 60%
Routine gynecological exam	Covered at 100%	Covered at 60%
All of the above are limited to a combined maximum of $300 per Calendar Year		
Mammogram—*Screening & diagnostic*	Covered at 100%	Covered at 60%
Smoking Cessation Program—*Limited to $500 per lifetime*	Covered at 75%	Covered at 75%
DEDUCTIBLE ***The Calendar Year Deductible applies to all of the following Medical Plan services shown on this Page and the next Page:***	$1,250 for Employee-only Coverage per Calendar Year, $2,500 for Employee & Family Coverage per Calendar Year	
PHYSICIAN SERVICES		
Inpatient	Covered at 80%	Covered at 60%
Outpatient		
Office Visit	Covered at 80%	Covered at 60%
X-ray and Lab	Covered at 80%	Covered at 60%
HOSPITAL SERVICES		
Inpatient		
Room & Board	Covered at 80%	Covered at 60%
Intensive and Coronary Care Units	Covered at 80%	Covered at 60%
X-ray and Lab	Covered at 80%	Covered at 60%
Hospital Miscellaneous Expenses	Covered at 80%	Covered at 60%
Emergency Room		
Services and Supplies	Covered at 80%	Covered at 60%
X-ray and Lab	Covered at 80%	Covered at 60%
Outpatient Department	Covered at 80%	Covered at 60%
Inpatient Rehabilitative & Cardiac Rehabilitative Care–*Limited to $30,000 per Calendar Year*	Covered at 80%	Covered at 60%
MATERNITY & NEWBORN BENEFIT *Employee and Spouse Only*	Covered the same as any other condition.	Covered the same as any other condition.
MASTECTOMY & BREAST RECONSTRUCTION	Covered the same as any other condition.	Covered the same as any other condition.

OTHER BENEFITS	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
Ambulance	Covered at 80%	Covered at 80%
Blood—*Processing and administration of blood and blood components*	Covered at 80%	Covered at 80%
Chemical Dependency Treatment *Limited to $5,000 per 2 Calendar Years & $10,000 lifetime maximum*	Covered at 80%	Covered at 60%
Chiropractic Care—*Limited to 30 visits per Calendar Year; X-ray limit of $100 per Calendar Year*	Covered at 80%	Covered at 80%
Diabetes Care Training	Covered at 80%	Covered at 60%
Durable Medical Equipment	Covered at 80%	Covered at 60%
Family Planning	Covered at 80%	Covered at 60%
Hearing Aid Benefit Exam—*Limited to 1 per 24 months* Hardware—*Limited to $700 per 24 months*	 Covered at 80% Covered at 80%	 Covered at 80% Covered at 80%
Home Health *Limited to 130 visits per Calendar Year*	Covered at 80%	Covered at 80%
Hospice *Limited to 6 months per Calendar Year*	Covered at 80%	Covered at 80%
Home Infusion Therapy—*Limited to $25,000 per Calendar Year*	Covered at 80%	Covered at 80%
Mental Health Treatment Outpatient—*To 20 visits per Calendar Year* Inpatient—*To 8 days per Calendar Year*	 Covered at 80% Covered at 80%	 Covered at 60% Covered at 60%
Necessary Medical Supplies	Covered at 80%	Covered at 80%
Neurodevelopmental Therapy—*Through age 6* *Limited to $1,000 per Calendar Year*	Covered at 80%	Covered at 60%
Outpatient Physical, Speech & Occupational Therapy & Cardiac Rehabilitative Care — *Limited to $2,000 per Calendar Year*	Covered at 80%	Covered at 60%
Outpatient Prescription Drugs *Retail - Limited to 34-day supply* *Mail-Order- Limited to 90-day supply* *Up to a 2-month supply may be dispensed at one time for certain maintenance medications. Not all medicines taken on an ongoing basis are part of this benefit—only those on the Maintenance Medication List. Please refer to the Maintenance Medication List, which can be obtained from the Claims Administrator (TPSC), for other restrictions that may apply.*	**Express Scripts Pharmacies** Paid at 80% Paid at 80%	**Other Pharmacies** Paid at 50% Not Available
Skilled Nursing Facility *Limited to 90 days per Calendar Year*	Covered at 80%	Covered at 80%
Temporomandibular Joint Dysfunction *Limited to $1,000 per Calendar Year & $5,000 lifetime maximum*	Covered at 80%	Covered at 60%
Transplant Benefit – *Requires pre-authorization, is subject to the limitations described and is limited to $300,000 per lifetime*	Covered the same as any other condition.	Covered the same as any other condition.
Medically Necessary Eligible Non-Listed Services	Covered at 80%	Covered at 60%

VISION SUMMARY OF BENEFITS

EXAM—*Limited to one (1) per Calendar Year*	Covered at 100%
MATERIALS—*Limited to $200 per 2 Calendar Years* Eyeglass Lenses and Frames *and/or* Contact Lenses	Covered at 80%

NOTE: Vision Benefits are not subject to the Medical Plan Calendar Year Deductible.

INTRODUCTION

The Washington Fire Commissioners Association, hereinafter referred to as the "Association" or “WFCA”, as the Plan Sponsor, hereby establishes the benefits, rights and privileges which shall pertain to participating Employees, hereinafter referred to as "Participants" or "Covered Persons", and the eligible Dependents of such Participants.

Masculine pronouns used in this document shall include masculine or feminine gender unless the context indicates otherwise. Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

PURPOSE

The purpose of this document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of eligible Medical, Prescription Drug, and Vision expenses. This document will also serve as the Employee booklet.

EFFECTIVE DATE

The effective date of the Plan is January 1, 2006.

NAMED FIDUCIARY, PLAN SPONSOR AND PLAN ADMINISTRATOR

The Named Fiduciary, Plan Sponsor and Plan Administrator is the Washington Fire Commissioners Association who shall have the authority to control and manage the operation and administration of the Plan. The Washington Fire Commissioners Association has delegated responsibilities for the day-to-day operation and administration of the Plan to Trusteed Plans Service Corporation, as Claims Administrator. The Association shall have the authority to amend the Plan, to determine its policies, to appoint and remove other administrators, fix their compensation (if any), and exercise general administrative authority over them.

The Plan Administrator can, at its discretion, interpret all Plan provisions.

The Named Fiduciary, Plan Sponsor and Plan Administrator is the Association, whose street address and telephone number are: 605 - 11th Ave S.E., Suite 205, Olympia, WA 98501, (360) 943-3880. Address mail to: P. O. Box 134, Olympia, WA 98507.

FINANCING

The amount of contributions to the Plan are to be made on the following basis:

1. The Plan Sponsor shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by participating fire protection districts.
2. Notwithstanding any other provision of the Plan, the Plan Sponsor’s obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Plan Sponsor’s obligation with respect to such payments.
3. In the event that the Plan Sponsor terminates the Plan, then as of the effective date of termination, the participating fire protection districts shall have no further obligation to make additional contributions to the Plan.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment, and in such case shall apply the amount of such payment to or for the benefit of such Participant, his spouse, adult child, guardian of a minor child, or other relative of a Dependent of such covered Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan will not be deemed to constitute a contract of employment.

ELIGIBILITY

WHO MAY RECEIVE BENEFITS

The following is a description of the qualifications needed to be eligible.

In order for a Dependent to be covered under the Plan, the Employee must also be enrolled in the Plan (except in the case of COBRA continuation coverage).

Individuals who are working in violation of U.S. immigration laws or those individuals who have made false representations of any kind in order to obtain employment are excluded from eligibility for participation in the Plan. Any loss of coverage resulting from this situation will not be a qualifying event for Continuation Coverage Rights under COBRA.

Employees - Employees of participating fire protection districts working a minimum number of hours per week as designated by the fire protection district and who have met the eligibility waiting period described in "When Coverage Begins".

Ineligible classes of Employees are active LEOFF I personnel (i.e. personnel who were covered by the LEOFF Act prior to October 1, 1977) and their Dependents and retired LEOFF I personnel and their Dependents.

Fire Commissioners - commissioners of districts participating in the WFCA-sponsored health plan.

WFCA Staff – as determined by the IRSRA Committee.

Spouse - Spouse means the lawful spouse of an Employee, unless legally separated or divorced. Common law marriages are not recognized under this Plan. A spouse shall be a “Dependent” for purposes of this Plan.

Children - Children include: Natural, legally adopted or children under legal guardianship - unmarried to their 23rd birthday, if they are dependent on the Employee for support. See the subsection titled “Pre-Adoption Health Coverage” in the “Federal Laws and Regulations” section for information on adopted children.

Step-children - unmarried, to their 23rd birthday, if they are dependent on the Employee and the Employee's Spouse for more than 50% of their support **or** the Employee and the Employee's Spouse are required to provide health benefits pursuant to a court order.

Foster children are not eligible for coverage under this Plan.

Physically or mentally disabled children - unmarried children described above with no age limitation if: 1) they are dependent on the Employee as defined by the IRS, 2) they are unable to be self-supporting because of a permanent physical or mental disability, 3) they are not covered by another group plan, 4) medical verification is submitted as requested, and 5) they were disabled prior to attaining age 23.

A child meeting the definition set forth above shall be a “Dependent” under this Plan.

NOTES:

- If both the husband and wife are employed by a Participating Fire District, and both are eligible for Dependent Coverage, both may elect Dependent Coverage for the eligible Dependents and benefits will be processed according to the Coordination of Benefits Provision. Likewise, an Employee may be covered as both an Employee and as a Dependent.
- See additional Eligibility information in the “Qualified Medical Child Support Order” provisions in the section titled FEDERAL LAWS AND REGULATIONS.

EFFECTIVE DATE OF COVERAGE

HOW TO ENROLL

Each participating fire protection district has enrollment forms which should be properly completed within thirty-one (31) days of eligibility.

New Dependents of Employees must be enrolled in this Plan within thirty-one (31) days of marriage or other eligibility described in the section titled "Eligibility" (in the case of birth or adoption or placement for adoption, within sixty [60] days of birth or adoption).

If coverage for a Dependent is not elected when initially eligible, that Dependent may only be enrolled as allowed under the Special Enrollment Provisions.

CHANGES IN ENROLLMENT

The Claims Administrator should be notified within thirty-one (31) days if any change occurs which affects eligibility to participate in this Plan.

Commissioners who have been covered by this Plan but who later terminate their coverage under this Plan are not eligible to re-enroll in this Plan.

WHEN COVERAGE BEGINS

Participant Coverage under the Plan shall become effective with respect to a Covered Person on the date of eligibility provided that written application for such coverage is made as provided in this Plan.

New Employees and their eligible Dependents will be covered on the Employee's date of hire.

Fire Commissioners and their eligible Dependents will be covered on the first of the month following the date of application.

Newborn children, newly adopted children, new spouses or step-children will be covered on the date of birth, adoption, or placement for adoption, marriage or upon meeting the eligibility requirements described in the section titled "Eligibility" if enrollment forms have been properly completed.

All coverage will commence at 12:01 a.m. on the date such coverage is in effect.

SPECIAL ENROLLMENT PROVISIONS

HIPAA requires a group health plan to offer a Special Enrollment opportunity upon the exhaustion of COBRA continuation coverage, the loss of eligibility for coverage that is not COBRA continuation coverage, or the termination of Employer contributions toward coverage that is not COBRA continuation coverage. This Special Enrollment right is available to eligible Employees, dependents of eligible Employees, and dependents of COBRA qualified beneficiaries. Also, HIPAA requires a group health plan to offer a Special Enrollment opportunity to certain newly acquired spouses and dependents of Participants, and to Employees who have previously declined coverage but who have since acquired a new spouse or dependent.

Opportunity #1—Individuals Who Lose Coverage: For this Special Enrollment right to apply:

1. The Employee or dependent of an Employee must be eligible, but not enrolled, for coverage under the terms of this Plan, and when coverage under this Plan was previously offered, the Employee or dependent had coverage under any group health plan (or through health insurance). (An individual who initially declined enrollment even though he did not have other coverage, but then acquires other coverage and is again offered the opportunity to enroll in this Plan would also be eligible for Special Enrollment.)
2. The Employee or dependent must lose coverage under a group health plan or health insurance (including coverage under a state health benefits risk pool, a public health plan, or Medicaid).
3. The Employee or dependent must have lost health insurance or other group health plan coverage because:
    - The coverage was provided under COBRA, and the COBRA coverage was exhausted. Exhaustion includes the following:
        - ⇨ The entire 18-, 29-, or 36-month COBRA period must be completed;
        - ⇨ The Employer or other responsible entity *(other than the COBRA individual)* failed to remit premiums on a timely basis;
        - ⇨ The individual no longer resides in the service area for an HMO (or similar program) and there is no other COBRA coverage available; or
        - ⇨ The individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.
    - The coverage was non-COBRA coverage and (a) the coverage terminated due to loss of eligibility for coverage, or (b) Employer contributions for the coverage were terminated. "Loss of eligibility" ***includes*** (but is not limited to):
        - ⇨ Legal separation, divorce, cessation of dependent status, death of an Employee, termination of employment, reduction in the number of hours of employment;
        - ⇨ Coverage offered through an HMO in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area;
        - ⇨ Coverage offered through an HMO in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, and no other benefit package is available to the individual;
        - ⇨ A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and
        - ⇨ A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

Loss of eligibility ***does not*** include (a) a loss resulting from the failure of the individual to pay premiums on a timely basis; (b) a termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan); (c) a reduction of contributions or level of benefits; or (d) an increase in cost of coverage.

4. The Employee or dependent must request Special Enrollment in this Plan within thirty-one (31) days after a loss of coverage or the Employer's cessation of contributions for such coverage. If the loss of eligibility is due to a situation in which an Employee incurs a claim that would meet or exceed a lifetime maximum on all benefits, the Employee must request Special Enrollment within thirty-one (31) days after a claim is denied because of the operation of the lifetime limit. If all other eligibility requirements are met, coverage will be effective on the first day following the loss of other coverage so that there is no lapse in coverage.

Opportunity #2—Acquisition of a New Dependent

1. In the case of a new dependent as a result of marriage, an Employee may enroll himself and his dependents, provided that the Employee requests Special Enrollment within thirty-one (31) days after the date of marriage and all other eligibility requirements are met. Coverage will be effective on the date of marriage.
2. In the case of a new dependent as a result of birth, adoption, or placement for adoption, an Employee may enroll himself and his dependents, provided that the Employee requests Special Enrollment within sixty (60) days of birth, adoption, or placement for adoption. Coverage will be effective on the date of birth, adoption, or placement for adoption.
3. In the case of a dependent over the age of 18 whose coverage was previously terminated due to loss of dependent status, but who later fulfills the eligibility requirements under the section entitled "Who May Receive Benefits", you may enroll this dependent only, provided that you request Special Enrollment within thirty-one (31) days after the dependent regains dependent status as defined by this Plan. Coverage will be effective on the first day of the month following the change in the dependent's status.

NOTE: The Enrollment Date for anyone who enrolls under a Special Enrollment Provision is the first date of coverage. Thus, the time between the dates a special enrollee first becomes eligible for enrollment under this Plan and the first day of coverage is not treated as an eligibility waiting period.

OPEN ENROLLMENT PROVISION

You may also enroll or make coverage selection changes during the annual open enrollment period (provided all other eligibility requirements are met). The annual open enrollment is during the months of November and December for coverage to be effective the following January 1st.

ACTIVE EMPLOYEES/SPOUSES AGE 65 OR OVER

Active Employees and/or Dependent spouses age 65 or over of Active Employees will receive the same benefits as Employees and Dependent Spouses under age 65, unless the individual elects Medicare as the primary payor of health care benefits. If Medicare coverage is selected as primary payor, no benefits will be provided under this Plan.

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

Participant Coverage shall automatically terminate immediately upon the earliest of the following dates, except as provided in any COBRA Continuation of Coverage Provision or Family Medical Leave Act (FMLA):

1. On the last day of the month immediately following the date of termination of the Participant's employment or layoff;
2. On the last day of the month immediately following the date the Participant ceases to meet the eligibility provisions of the Plan;
3. On the last day for which contributions were paid, if required contributions for coverage are not remitted;
4. On the date the Plan is terminated;
5. On the date the Participant dies; or
6. On the date the Participant enters the armed forces of any country as a full-time member if active duty is to exceed thirty (30) days, except as allowed under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

If employment is obtained by misrepresentation or fraud (including misrepresentation of immigration status in obtaining or maintaining employment), coverage is immediately lost under the Plan. Any such loss of coverage because of false representations in obtaining employment would be retroactive to the Employee's original Effective Date. The loss of coverage resulting from this situation will not be a qualifying event for Continuation Coverage Rights under COBRA.

DEPENDENT TERMINATION

The Dependent Coverage of a Participant shall automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation of Coverage Provision:

1. On the last day of the month immediately following the date the Dependent ceases to be an eligible Dependent under the Plan;

2. On the last day of the month immediately following the date of termination of the Participant's coverage under the Plan;

3. On the last day of the month immediately following the date the Participant ceases to meet the eligibility provisions of the Plan;

4. On the last day for which contributions were paid, if required contributions for Dependent Coverage are not remitted;

5. On the date the Plan is terminated;

6. On the last day of the month in which the Participant dies; or

7. On the date the Dependent enters the armed forces of any country as a full-time member if active duty is to exceed thirty (30) days.

FEDERAL LAWS AND REGULATIONS

HIPAA PRIVACY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose Protected Health Information (PHI). The following HIPAA definition of PHI applies to this Plan Document:

> Protected Health Information. Protected health information means information that is created or received by the Plan and relates to the past, present, or future physical or mental health or condition of a Participant or Dependent; the provision of health care to a Participant or Dependent; or the past, present, or future payment for the provision of health care to a Participant or Dependent; and that identifies the Participant or Dependent or for which there is a reasonable basis to believe the information can be used to identify the Participant or Dependent. Protected health information includes information of persons living or deceased.

The Plan Sponsor shall have access to PHI from the Plan only as permitted under this Plan Document or as otherwise required or permitted by HIPAA. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner inconsistent with 45 C.F.R. § 164.504(f).

CONTINUATION COVERAGE RIGHTS UNDER COBRA

The following information about your right to continue your health care coverage in the Plan is important. Please read it very carefully.

Introduction

The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. COBRA (and the description of COBRA coverage contained in this notice) applies only to the group health plan benefits offered under the WFCA Plan (the medical) and not to any other benefits offered under the WFCA Plan, or other group health plan benefits not offered under the WFCA Plan.

The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the WFCA Plan. It can also become available to your spouse and dependent children, if they are covered under the WFCA Plan, when they would otherwise lose their group health coverage under the WFCA Plan.

COBRA Administrator

The name, address and telephone number of the COBRA Administrator responsible for the administration of COBRA for the WFCA Plan, and to whom you can direct questions about COBRA, is shown in the subsection entitled "WFCA Plan Contact Information" at the end of this notice.

What is COBRA Coverage?

COBRA coverage is a continuation of WFCA Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed below in the section entitled "Who Is Entitled to Elect COBRA?

After a qualifying event occurs and any required notice of that event is properly provided to the COBRA Administrator, COBRA coverage must be offered to each person losing WFCA Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the WFCA Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

Who is entitled to elect COBRA?

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the WFCA Plan who is or may become a qualified beneficiary.

If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the WFCA Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the WFCA Plan because any of the following qualifying events happens:

- Your spouse dies;

- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, Part D, or any combination); or
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

If you are the dependent child of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the WFCA Plan because any of the following qualifying events happens:

- Your parent-employee dies;
- Your parent-employee's hours of employment are reduced;
- Your parent-employee's employment ends for any reason other than his or her gross misconduct;
- Your parent-employee becomes entitled to Medicare benefits (Part A, Part B, Part D, or any combination);
- Your parents become divorced or legally separated. Also, if the employee reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation; or
- You stop being eligible for coverage under the WFCA Plan as a "dependent child."

Electing COBRA after leave under the Family and Medical Leave Act (FMLA)—Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the WFCA Plan during the leave. Contact the COBRA Administrator for more information about these special rules.

When is COBRA Coverage Available?

The WFCA Plan will offer COBRA coverage to qualified beneficiaries only after the COBRA Administrator has been timely notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction in hours of employment, death of the employee, or the employee's becoming entitled to Medicare benefits (Part A, Part B, Part D, or any combination), the Employer must notify the COBRA Administrator of the qualifying event within 30 days following the date coverage would otherwise end under the WFCA Plan. (However, you or your family should also notify the COBRA Administrator promptly in writing of these changes (as well as any entitlement to Medicare) to avoid confusion over the status of your health care in the event there is a delay or oversight on the Employers part in providing that notification to the COBRA Administrator.)

You Must Notify the Plan Administrator of Certain Qualifying Events By This Deadline

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the Employer in writing within 60 days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the WFCA Plan as a result of the qualifying event. (However, you or your family should also notify the COBRA Administrator promptly in writing of these changes (as well as any entitlement to Medicare) to avoid confusion over the status of your health care in the event there is a delay or oversight on the Employer's part in providing that notification to the COBRA Administrator.)

In providing this notice, you must use the Plan's form entitled "Notice of Qualifying Event Form" (you may obtain a copy of this form from your Employer or the COBRA Administrator at no charge), **and you must follow the Notice Procedures specified in the section below entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to the Employer and/or the COBRA Administrator during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

Electing COBRA Coverage

To elect COBRA, you must complete the Election Form that is part of the WFCA Plan's COBRA election notice and mail, fax or hand-deliver it to the COBRA Administrator. (Once the COBRA Administrator receives notice that a qualifying event has occurred, an election notice will be provided to qualified beneficiaries. You may also obtain a copy of the Election Form from the COBRA Administrator.)

If mailed, your election must be postmarked (and if faxed or hand delivered, your election must be received by the individual at the address specified on the Election Form) no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event (or, if later, 60 days after the date that WFCA Plan coverage is lost). IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Each qualified beneficiary will have an independent right to elect COBRA. **Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the WFCA Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

Special Considerations in Deciding Whether to Elect COBRA

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the WFCA Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Length of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods.

COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

Death, divorce, legal separation, or child's loss of dependent status—When WFCA Plan coverage is lost due to the death of the employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, Part D, or any combination), the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage under the WFCA Plan's medical component can last for up to a total of 36 months from the date coverage would otherwise end under the WFCA Plan.

If the covered employee becomes entitled to Medicare within 18 months before his or her termination of employment or reduction of hours—When WFCA Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the WFCA Plan's medical component for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage under the WFCA Plan's Medical component for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Termination of employment or reduction of hours—Otherwise, when WFCA Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage under the WFCA Plan's medical component generally can last for only up to a total of 18 months from the date coverage would otherwise end under the WFCA Plan.

Extension of Maximum Coverage Period

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. These extension opportunities do not apply to a period of COBRA coverage resulting from a covered employee's death, divorce, or legal separation or a dependent child's loss of eligibility.)

Disability extension of COBRA coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the covered employee's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

You must notify the COBRA Administrator of a qualified beneficiary's disability by this deadline—**The disability extension is available only if you notify the COBRA Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:**

- The date of the Social Security Administration's disability determination;
- The date of the covered employee's termination of employment or reduction of hours; and
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the WFCA Plan as a result of the covered employee's termination of employment or reduction of hours.

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

No disability extension will be available unless you follow the Plan's notice procedures and meet the notice deadline—**In providing this notice, you must use the WFCA Plan's form entitled "Notice of Disability Form"** (you may obtain a copy of this form from the COBRA Administrator at no charge), **and you must follow the procedures specified in the section below entitled "Notice Procedures." If these procedures are not followed or if the notice is not provided to the COBRA Administrator in writing during the 60-day notice period and within 18 months after the loss of coverage due to the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

Second qualifying event extension of COBRA coverage

An extension of WFCA Plan coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the WFCA Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the WFCA Plan if the first qualifying event had not occurred. (This extension is not available under the WFCA Plan when a covered employee becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

You must notify the COBRA Administrator of a second qualifying event by this deadline—**This extension due to a second qualifying event is available only if you notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of:**

- the date of the second qualifying event; and
- the date on which the qualified beneficiary would lose coverage under the terms of the WFCA Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the WFCA Plan).

No extension will be available unless you follow the WFCA Plan's notice procedures and meet the notice deadline—**In providing this notice, you must use the WFCA Plan's form entitled "Notice of Second Qualifying Event Form"** (you may obtain a copy of this form from the COBRA Administrator at no charge), **and you must follow the procedures specified in the section below entitled "Notice Procedures." If these procedures are not followed, or if the notice is not provided to the COBRA Administrator in writing during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

COBRA coverage will automatically terminate before the end of the maximum period if:

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, Part D, or any combination) after electing COBRA;
- the employer ceases to provide any group health plan for its employees; or
- during a disability extension period, at the end of the month that begins more than thirty (30) days from the date the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate). For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period."

COBRA coverage may also be terminated for any reason the WFCA Plan would terminate coverage of a participant or beneficiary not receiving COBRA coverage (such as fraud).

You must notify the COBRA Administrator if a qualified beneficiary becomes entitled to Medicare or obtains other group health plan coverage—You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, Part D, or any combination) or becomes covered under other group health plan coverage. You must use the WFCA Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability Form" (you may obtain a copy of this form from the COBRA Administrator at no charge), and you must follow the notice procedures specified below in the section entitled "Notice Procedures." In addition, if you were already entitled to Medicare before electing COBRA, notify the COBRA Administrator of the date of your Medicare entitlement at the address shown in the section below entitled "Notice Procedures."

You must notify the COBRA Administrator if a qualified beneficiary ceases to be disabled—If a disabled beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination. You must use the WFCA Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability Form" (you may obtain a copy of this form from the COBRA Administrator at no charge), and you must follow the notice procedures specified below in the section entitled "Notice Procedures."

Cost of COBRA Coverage

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of COBRA coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Payment for COBRA Coverage

How premium payments must be made—All COBRA premiums must be paid by check. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the individual at the payment address specified in the election notice provided to you at the time of your qualifying event. However, if the WFCA Plan notifies you of a new address for payment, you must mail or hand deliver all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

When premium payments are considered to be made—If mailed, your payment is considered to have been made on the date that it is postmarked. If hand delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand delivering a check if your check is returned due to insufficient funds or otherwise.

First payment for COBRA coverage—If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand delivered.) See the section above entitled "Electing COBRA Coverage."

Your first payment must cover the cost of COBRA coverage from the time your coverage under the WFCA Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, Donna's employment terminates on September 30, and she loses coverage on September 30. Donna elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator using the contact information provided below to confirm the correct amount of your first payment.

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it.

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the Plan.

Monthly payments for COBRA coverage—After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the WFCA Plan will continue for that month without any break. The COBRA Administrator will send monthly notices of payments due for these coverage periods (that is, **the COBRA Administrator will send a bill to you for your COBRA coverage. NOTE: It remains your responsibility to pay your COBRA premiums on time if, for some reason, you do not receive a bill for that month's COBRA coverage).**

Grace periods for monthly COBRA premium payments—Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the WFCA Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, you will lose all rights to COBRA coverage under the WFCA Plan.

More Information About Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered employee during COBRA coverage period

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the WFCA Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the WFCA Plan, the child must satisfy the otherwise applicable WFCA Plan eligibility requirements (for example, regarding age).

Alternate recipients under QMCSOs

A child of the covered employee who is receiving benefits under the WFCA Plan pursuant to a qualified medical child support order (QMCSO) received by the WFCA Plan during the covered employee's period of employment with the Employer is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Employer and/or COBRA Administrator informed of any changes in the addresses of family members.

You should also keep a copy, for your records, of any notices you send to the Employer and/or COBRA Administrator, along with proof that it was mailed.

WFCA Plan—Notice Procedures

Warning: If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable).

Notices Must Be Written and Submitted on WFCA Plan Forms: Any notice that you provide must be in writing and must be submitted on the WFCA Plan's required form (the WFCA Plan's required forms are described above in this booklet, and you may obtain copies from the Employer or the COBRA Administrator without charge. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed) notices are not acceptable.

How, When, and Where to Send Notices: You must mail, fax or hand deliver your Notice of Qualifying Event Form to:

To Your Employer's Human Resource Department

You must mail, fax or hand deliver your Notice of Disability Form, Notice of Second Qualifying Event Form, or Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability Form to:

WFCA Plan COBRA Administrator
Trusteed Plans Service Corporation (TPSC)
6901 6th Avenue, Tacoma, WA 98406
Phone Number: (253) 882-0206 Fax Number: (253) 564-5881

However, if a different address for notices to the WFCA Plan appears in the most recent WFCA Plan Booklet(s), you must mail, fax or hand deliver your notice to that address (if you do not have a copy of the most recent WFCA Plan Booklet(s), you may request one from the Employer or the COBRA Administrator.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If faxed or hand delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the paragraphs above entitled "You must notify the COBRA Administrator of a qualified beneficiary's disability by this deadline," and "You must notify the COBRA Administrator of a second qualifying event by this deadline.")

Information Required for All Notices: Any notice you provide must include: (1) the name of the Plan (Washington Fire Commissioners Association Health Care Benefits Plan (WFCA Plan)); (2) the name and address of the employee who is (or was) covered under the WFCA Plan); (3) the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event; (4) the qualifying event and the date it happened; and (5) the certification, signature, name, address, and telephone number of the person providing the notice.

Additional Information Required for Notice of Qualifying Event: If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the WFCA Plan that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the WFCA Plan that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional Information Required for Notice of Disability: Any notice of disability that you provide must include: (1) the name and address of the disabled qualified beneficiary; (2) the date that the qualified beneficiary became disabled; (3) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (4) the date that the Social Security Administration made its determination; (5) a copy of the Social Security Administration's determination; and (6) a statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled.

Additional Information Required for Notice of Second Qualifying Event: Any notice of a second qualifying event that you provide must include: (1) the names and addresses of all qualified beneficiaries who are still receiving COBRA coverage; (2) the second qualifying event and the date that it happened; and (3) if the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

Additional Information Required for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability: Any Notice of Other Coverage that you provide should include the name and address of the qualified beneficiary who obtained other coverage, the date that the other coverage became effective (and, if there were any preexisting condition exclusions applicable to the qualified beneficiary, the date that these were exhausted or satisfied), and evidence of the effective date of the other coverage (such as a copy of the insurance card or application for coverage). Any Notice of Medicare Entitlement should include the name and address of the qualified beneficiary who became entitled to Medicare, the date that Medicare Entitlement occurred, and a copy of the Medicare card showing the date of Medicare entitlement. Any Notice of Cessation of Disability must include the name and address of the qualified beneficiary, the date of the Social Security Administration's determination that he or she is no longer disabled, and a copy of the Social Security Administration's determination.

Who May Provide Notices: The covered employee (i.e., the employee or former employee who is or was covered under the WFCA Plan), a qualified beneficiary who lost coverage due to the qualifying event described in the notice, or a representative acting on behalf of either may provide notices. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

It is the intent of this Plan to comply with all provisions of the Uniform Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Employees going into or returning from military service may elect to continue Plan coverage as mandated by USERRA. These rights apply only to eligible Employees and eligible Dependents covered under the Plan before leaving for military service.

The maximum period of coverage of a person under such an election shall be the lesser of:

a. The 24-month period beginning on the date that Uniformed Service leave commences; or
b. The period beginning on the date that Uniformed Service leave commences and ending on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

A person who elects to continue Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

A Pre-Existing Condition Limitation may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, Plan Exclusions and

waiting periods may be imposed for any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, military service.

There are time limits for reporting back to work upon release from the military as well as notice requirements. For further details, please contact the Employer.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

Under the FMLA, eligible Employees are entitled to an unpaid leave of absence for up to twelve (12) weeks (spouse of Employees who are also Employees of the same fire protection district are eligible for a maximum combined total of twelve (12) weeks leave under this act) within a twelve (12) month period, provided the leave is for:

1. the birth of a son or daughter or to provide care for the Newborn;
2. the placement with the Employee of a son or daughter for adoption or foster care;
3. a "serious health condition" of the Employee's spouse, son, daughter or parent; or
4. a "serious health condition" of the Employee that makes the Employee unable to perform the function of his job.

A "serious health condition" exists whenever an Illness, Injury, impairment or mental condition involves Inpatient care or continuing care by a healthcare provider, as defined in Section 825.114 of the Family and Medical Leave Act of 1993.

An Employee is considered eligible, if:

1. the Employee has worked for the district for at least twelve (12) consecutive months, and
2. has been employed for at least 1,250 hours of service during the twelve (12) month period immediately preceding the commencement of the leave, and
3. is employed at a work-site with fifty (50) or more Employees within a seventy-five (75) mile radius at other work-sites of the Employer.

The twelve (12) month period is based on a twelve (12) month period measured forward from the date any Employee's first FMLA leave begins.

Generally, leave must be taken all at once. However, under certain circumstances, the leave may be taken intermittently or on a reduced leave schedule. If the leave is taken because of a birth or placement of a child for adoption or foster care, an Employee may take leave intermittently or on a reduced schedule only if the Employer agrees.

Prior to taking family leave, Employees must give the Employer at least thirty (30) days advance notice of the intended leave dates or as much notice as is practical, whichever is less. In addition, the Employee may be required to provide certification for the Medical Necessity of the leave.

The FMLA requires the Employer to continue group coverage during the FMLA leave. If the coverage is contributory, the Employee's share of the premiums will be due at the same time they would be made if by payroll deduction. Coverage will terminate if the Employee does not make the required premium contributions for coverage (if any) within thirty (30) days of the premium due date as described above.

Employees returning from leave as described under FMLA, and who choose not to continue their coverage, will have their coverage reinstated to the same level of benefits as if the leave had not taken place, or if the premium payments had not been missed. The Employee will not be required to satisfy a new waiting period or new Pre-Existing Condition Waiting Period.

This is a summary of the FMLA rules. For more information, contact your Employer.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

The Claims Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a “Qualified Medical Child Support Order” (“QMCSO”) if such an individual is not already covered by the Plan as an eligible Dependent, once the Claims Administrator has determined that such order meets the standards for qualification set forth below.

DOL guidance provides that a Plan must enroll an Employee involuntarily if the Employee’s enrollment is necessary for a child to have coverage that is required under a QMCSO. It follows that an Employee would also be unable to drop his or her coverage while a QMCSO is in effect if the Employee’s enrollment is necessary for a child to have coverage.

“Alternate Recipient” shall mean any child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant’s eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an eligible Dependent.

“Medical Child Support Order” shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant’s child or directs the Participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or

2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an Employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";

2. a. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Claims Administrator will assume that all are designated;
   b. Informs the Claims Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and

3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated Dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Beneficiaries without regard to this Section 4.05, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Claims Administrator shall, as soon as administratively possible:

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Claims Administrator shall:

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
   a. Whether the child is covered under the Plan; and
   b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Claims Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

PRE-ADOPTION HEALTH COVERAGE

A child under the age of eighteen (18) is eligible for coverage from the time the child is placed for adoption in the home of a Plan Participant, and shall be treated in the same manner as a natural child of a Participant, even if the adoption has not become final.

MEDICAL PLAN

COINSURANCE

Coinsurance is the percentage share payable by you on claims for which the Plan provides benefits at less than 100% of the allowed amount.

DEDUCTIBLE

The Employee-Only Coverage Deductible (single Deductible) is the dollar amount of Covered Expenses (shown in the Medical Summary of Benefits), which must be Incurred during the Calendar Year before any other Covered Expenses can be considered for payment (unless otherwise noted).

The Employee & Family Coverage Deductible (Family Deductible) is the dollar amount of Covered Expenses (shown in the Medical Summary of Benefits), which must be Incurred during the Calendar Year before any other Covered Expenses can be considered for payment (unless otherwise noted). Either one person must satisfy the entire Family Deductible; or, the entire Family must Incur combined expenses totaling the entire Family Deductible amount before the Plan pays on behalf of any member of the Family.

ALLOCATION AND APPORTIONMENT OF BENEFITS

The Claims Administrator reserves the right to allocate any applicable Deductible amount to any eligible charges and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

OUT-OF-POCKET MAXIMUM

Out-of-Pocket Maximum for Employee-Only Coverage: The Deductible and Coinsurance amounts that are required to be paid for Covered Expenses are subject to the annual Employee-Only Coverage Out-of-Pocket Maximum (single Out-of-Pocket Maximum) as shown in the Medical Summary of Benefits. Coinsurance, Deductible, and Outpatient prescription drugs apply to the Out-of-Pocket Maximum. Non-covered services and expenses incurred over the maximum allowable amounts covered by the Plan will not apply to the Out-of-Pocket Maximum.

Out-of-Pocket Maximum for Employee & Family Coverage: The Deductible and Coinsurance amounts that are required to be paid for Covered Expenses are subject to the annual Employee & Family Coverage Out-of-Pocket Maximum (Family Out-of-Pocket Maximum) as shown in the Medical Summary of Benefits. Either one person must satisfy the entire Family Out-of-Pocket Maximum; or the entire Family must satisfy the Family Out-of-Pocket Maximum in combined expenses. Coinsurance, Deductible, and Outpatient prescription drugs apply to the Out-of-Pocket Maximum. Non-covered services and expenses incurred over the maximum allowable amounts covered by the Plan will not apply to the Out-of-Pocket Maximum.'

LIFETIME MAXIMUM BENEFIT & AUTOMATIC RESTORATION/REINSTATEMENT OF MAXIMUM BENEFIT

The total medical expense benefits (including Prescription Drug benefits) payable for a Covered Person under all Washington Fire Commissioners Association Health Care Benefit Plan options shall not exceed the Lifetime Maximum Benefit of $2,000,000 even though they may not have been continuously covered.

If less than the full Lifetime Maximum Benefit applicable to the Covered Person is available as of January 1st of each year (as a result of benefits paid or payable with respect to charges previously Incurred), the used portion of the Lifetime Maximum Benefit shall automatically be restored to the extent of: (1) The amount needed to restore the full Lifetime Maximum Benefit applicable to the Covered Person, or (2) Twenty thousand dollars ($20,000.00), whichever is less. Benefits listed with a separate lifetime maximum (Transplants, Chemical Dependency Treatment, Smoking Cessation, and Temporomandibular Join Dysfunction) do not restore under this provision.

LOCATING A PREFERRED PROVIDER

To locate a Preferred Provider, refer to your Plan ID card. You may contact the Preferred Provider Network directly, or contact the Claims Administrator.

LOCATING A MEMBER PHARMACY

To locate a member pharmacy, refer to your Plan ID card. You may contact the pharmacy benefit manager directly, or contact the Claims Administrator.

PREFERRED PROVIDER SERVICE AREA

1. If the Participant, or his covered Family member, do not reside within the Preferred Provider Service Area and services are received from a non-Preferred Provider, benefits will be provided as if the services of a Preferred Provider has been used.

2. If the Participant, or his covered Family member, reside within the Preferred Provider Service Area and services are obtained from a non-Preferred Provider, benefits will be provided at the non-Preferred Provider level unless:

   a) The claimant has traveled outside of the Preferred Provider Service Area and Emergency medical services are required; OR
   b) There is no Preferred Provider facility within the Preferred Provider Service Area which is able to render a Medically Necessary treatment. If this is the case, documentation must be provided and is subject to approval of the Claims Administrator; OR
   c) The claimant is transported by Ambulance or other Emergency medical personnel to the nearest medical facility equipped to render Medically Necessary care due to medical Emergency. If this is the case, documentation must be provided and the claimant must be transferred to a Preferred Provider facility as soon as medically possible.

3. Services of non-Preferred Providers will be processed as if a Preferred Provider had been used, if the Participant or his covered Family member:

   a) uses the services of a Preferred x-ray facility who subsequently uses a non-Preferred radiologist for reading the x-ray;
   b) uses the services of both a Preferred facility and a Preferred surgeon and receives services from a non-Preferred anesthesiologist;
   c) uses the services of both a Preferred facility and a Preferred surgeon and receives services from a non-Preferred assistant surgeon;
   d) in the case of a medical Emergency, uses a Preferred facility and receives care from a non-Preferred urgent care clinic that is affiliated with that facility; or
   e) in the case of a medical Emergency, uses a Preferred facility and receives care from a non-Preferred surgeon, anesthesiologist or other ancillary provider.
   f) uses the services of a Preferred Provider which subsequently uses a non-Preferred Provider laboratory to process test material.

BENEFITS PROVIDED BY YOUR MEDICAL PROGRAM

In order to be eligible for benefits under this provision, expenses actually Incurred by a Covered Person must meet all of the following requirements:

1. They are ordered by a Physician and administered by a Physician And/Or Licensed Health Care Provider;

2. They are Medically Necessary for the diagnosis and treatment of an Illness or Injury unless otherwise specifically included as a Covered Expense; and

3. They are not excluded under any provision or section of this Plan.

Covered Expenses include the following and are payable—based on the Deductibles and Coinsurance levels, and maximum amounts—as outlined in the Medical Summary of Benefits:

BENEFITS NOT SUBJECT TO THE ANNUAL DEDUCTIBLE:

I. Preventive Care

   A. Well-Child Care covers routine physical exams, related laboratory services and immunizations for children through age 6. All charges are subject to the annual preventive care benefit allowance as shown in the Medical Summary of Benefits.

   B. Adults & Children age 7 and older: Routine physical exam, including charges for x-ray, lab and immunizations associated with the routine exam, subject to the annual preventive care benefit allowance as shown in the Medical Summary of Benefits.

   C. Routine gynecological exams, including charges for x-ray and lab associated with the gynecological exam, subject to the annual preventive care benefit allowance as shown in the Medical Summary of Benefits.

II. Additional Preventive Care Benefits

A. Screening and diagnostic mammogram services.

B. The services of a Physician, Psychologist, or smoking cessation provider will be provided for a smoking cessation program, to the lifetime maximum as shown in the Medical Summary of Benefits. To receive benefits for smoking cessation, you must complete the full course of treatment. No benefits will be provided for Inpatient services; vitamins, minerals and other supplements; acupuncture; books or tapes. No benefits will be provided for hypnotherapy unless performed by a licensed provider. No other benefits for smoking cessation will be provided under this Plan. However, over-the-counter drugs prescribed by a Physician, Psychologist, or smoking cessation provider to ease nicotine withdrawal will be covered, subject to the lifetime maximum, if part of a smoking cessation program and you complete the full course of treatment. Prescription drugs are covered under the prescription drug benefit of this Plan.

BENEFITS AFTER SATISFACTION OF THE ANNUAL DEDUCTIBLE AS SPECIFIED IN THE MEDICAL SUMMARY OF BENEFITS

III. Physicians Services

Includes but is not limited to: Inpatient and Outpatient visits, surgical care, allergy shots, chemotherapy, x-ray, radium or diagnostic x-ray and laboratory services.

IV. Hospital Charges

Charges made by a Hospital, for:

A. Daily Room and Board and general nursing services, or confinement in an Intensive Care Unit or Coronary Care Unit. Room and Board (other than Coronary Care Unit and Intensive Care Unit) is limited to the Hospital's average Semi-Private room rate. If a facility has only private rooms, the Plan will determine benefits based on the average charges of other facilities in the area (according to UCR).

B. Medically Necessary services and supplies other than Room and Board furnished by the Hospital, including but not limited to: Inpatient miscellaneous service and supplies, Outpatient Hospital treatments, Emergency room services, hemodialysis, and x-ray and linear therapy.

V. Maternity & Newborn Care Benefit

A. Routine obstetrical/maternity benefits, including termination of Pregnancy and Cesarean surgeries, will be provided for Employees and covered spouses only. Included in this benefit are charges for a birthing center. Maternity benefits are not subject to any Pre-Existing Condition Waiting Period contained in this Plan.

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

Dependent children are not eligible for benefits under this provision, except for charges Incurred due to complications arising from Pregnancy.

Benefits are also not provided for pregnancies that are the result of, or for the purposes of, surrogate maternity.

B. Medical facility charges Incurred by a well Newborn during the initial period of confinement (48 hours or 96 hours, as outlined above) will be covered as charges of the baby. This benefit includes, within the first 96 hours following birth, the medical facility nursery expenses for a healthy Newborn, routine pediatric care for a healthy Newborn child while confined in a Hospital or medical facility immediately following birth, and Phenylketonuria (PKU) testing.

If the baby is ill, suffers an Injury, premature birth, congenital abnormality or requires care other than initial routine care, benefits will be provided on the same basis as for any other eligible expense, provided the child is properly enrolled and coverage is in effect.

VI. Mastectomy and Breast Reconstruction Services

Benefits are provided for mastectomy Medically Necessary due to Illness or accidental Injury. For any Covered Person electing breast reconstruction in connection with a mastectomy, this benefit covers:

A. Reconstruction of the breast on which mastectomy has been performed.

B. Surgery and reconstruction of the other breast to produce a symmetrical appearance.

C. Prostheses.

D. Physical complications of all stages of a mastectomy, including lymphedemas.

Services are to be provided in a manner determined in consultation with the attending Physician and the patient.

VII. Chemical Dependency Treatment

Chemical Dependency Treatment includes Room and Board, general nursing care and other services and supplies furnished by an Alcoholism Treatment Center or Drug Addiction Treatment Facility for Medically Necessary Inpatient or Outpatient treatment, up to the stated benefit limits as shown in the Medical Summary of Benefits.
No benefits will be provided for recovery houses, residential crisis treatment centers or residential treatment facilities which provide an alcohol-free or drug-free residential setting or for Emergency service patrol.

VIII. Hearing Aid Benefit

Charges Incurred for treatment relating to hearing loss, including exams, hearing aid(s), ear mold(s), and necessary repairs, up to the stated benefit limits as shown in the Medical Summary of Benefits. To be eligible for this benefit, the patient must be examined within three (3) months prior to obtaining the hearing aid and submit written Physician certification of hearing loss to the Claims Administrator.

Additionally, replacement of hearing aids that are lost, broken or stolen are not covered unless three years have elapsed since the initial purchase of the hearing aid.

IX. Home Health Care

Charges made by a Home Health Care Agency for care in accordance with the written Home Health Care Plan filed by the attending Physician with the Claims Administrator. Coverage is limited as shown in the Medical Summary of Benefits, with visits limited to four (4) hours of care. The attending Physician must certify that the proper treatment of the Illness or Injury would require confinement as a resident Inpatient in a Hospital in the absence of the services and supplies provided as part of the Home Health Care Plan. Such expenses, up to the stated benefit limits as shown in the Medical Summary of Benefits, include:

A. Part-time or intermittent nursing care by a Registered Nurse or by a Licensed Practical Nurse, a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse.

B. Home health aides;

C. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under this Plan if the Covered Person had remained in the Hospital.

Specifically excluded from coverage under this benefit are the following:

A. Services and supplies not included in the Home Health Care Plan.
B. Services of a person who ordinarily resides in the home of the Covered Person, or is a Close Relative of the Covered Person.
C. Services of any social worker.
D. Transportation services.
E. Non-medical or Custodial Care.

X. Hospice

Charges made by a Hospice will be considered for a Covered Person who is in the latter stages of a terminal Illness and who is homebound, and would otherwise require hospitalization.

The following services, up to the stated benefit limits as shown in the Medical Summary of Benefits, will be considered Covered Expenses:

A. Nursing care by a Registered Nurse or by a Licensed Practical Nurse, a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse

B. Medical supplies, including drugs and biologicals and the use of medical appliances.

C. Physician's services.

D. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.

E. Respite Care will be provided up to a maximum of 5 days per 3-month period of Hospice care.

Specifically excluded from coverage under this benefit is Custodial Care.

XI. Mental Health Treatment

Benefits are provided for Psychiatric Care as outlined in the Medical Summary of Benefits for neuropsychiatric disorders, and include only those disorders listed in the International Classification of Diseases as: a) psychoses, b) neuroses, c) personality disorders, and d) other non-psychotic mental disorders. Coverage for treatment for the neuroses known as eating disorders is limited to anorexia nervosa and bulimia.

XII. Skilled Nursing Facility

Charges made by a Skilled Nursing Facility for the following services and supplies furnished by the facility, up to the Semi-Private rate. Only charges Incurred in connection with recuperation from the Illness or Injury for which the Covered Person is confined will be eligible for benefits. Such confinement must commence within fourteen (14) days of being discharged from a Hospital; said Hospital confinement must have been for a period of not less than three (3) consecutive days; and both the Hospital and convalescent confinements must have been for the care and treatment of the same Illness or Injury. These expenses include:

A. Room and Board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily Room and Board charge allowed will not exceed the facility's average Semi-Private charges or an average Semi-Private rate made by a representative cross section of similar institutions in the area.

B. Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physicians' fees.

C. Drugs, biologicals, solutions, dressings and casts, furnished for use during the convalescent period.

Specifically excluded from coverage under this benefit is Custodial Care. A hospitalization or confinement to a Skilled Nursing Facility will **not** be considered to be Medically Necessary if the patient's Illness or Injury could safely and appropriately be diagnosed or treated while not confined.

XIII. Transplant Benefit

All transplants must be pre-authorized; that is, the Plan conditions receipt of transplant benefits on approval of the benefit in advance of obtaining medical care. Contact the Claims Administrator prior to undergoing any transplant procedure. Services and supplies in connection with transplant procedures are covered up to the stated benefit maximum as shown in the Medical Summary of Benefits, subject to the following conditions:

A. Only human tissue-to-tissue transplants will be considered as eligible for coverage under the Plan. The following transplant procedures will be considered as covered: cornea, heart, heart/lung combined, kidney, kidney/pancreas combined, liver, lungs (single/bilateral/lobar). All other transplant procedures, including Experimental and/or Investigational, non-human organ or artificial organ implant procedures, are specifically excluded. No benefits will be provided for selective islet cell transplants of the pancreas, transplant of a lung or other organ (except kidney) from a living donor unless such donor has been declared brain dead by the attending provider.

B. Allogenic (related or unrelated) bone marrow transplants will be provided, limited to the following malignancies or conditions: acute leukemias (lymphocytic or non-lymphocytic), chronic myelogenous leukemia, aplastic anemia, lymphoma (Hodgkin and Non-Hodgkin), neuroblastoma state III and IV in children over one year of age, or multiple myeloma.

   Autologous (self-donor) bone marrow transplants or stem cell support will be provided, limited to the following malignancies or conditions: Lymphoma (Hodgkin or Non-Hodgkin), neuroblastoma, acute leukemias (lymphocytic or non-lymphocytic) or multiple myeloma. Bone marrow transplants and stem cell support for other conditions will not be covered.

   Services and supplies related to removal and treatment of the bone marrow and the hospitalization from the day of bone marrow infusion until the patient is discharged will be applied toward the stated benefit maximum as shown in the Medical Summary of Benefits.

C. Prior to undergoing any transplant procedure, a second opinion must also be obtained and submitted to the Claims Administrator as part of the pre-authorization process. This mandatory second opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

D. If the donor is covered under this Plan, Covered Expenses Incurred by the donor will be eligible for benefits, subject to the donor's transplant lifetime maximum.

E. If the recipient is covered under this Plan, Covered Expenses Incurred by the recipient will be eligible for benefits. Expenses Incurred by the donor, who is not otherwise covered under this Plan, will be considered Covered Expenses, to the extent that such expenses are not payable by the donor's own benefit plan, up to $25,000. Any donor benefit will be charged against the recipient's stated benefit maximum as shown in the Medical Summary of Benefits.

F. If both the donor and the recipient are covered under this Plan, Covered Expenses Incurred by each person will be treated separately for each person, subject to their own transplant lifetime maximums.

G. The reasonable and customary cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ, will be considered Covered Expenses.

H. Transportation and lodging, for the Covered Person and Family will be covered when the Covered Person is required to travel 30 miles or more from home in conjunction with a covered transplant procedure, up to $2,500 per transplant.

I. Transplants will not be covered unless the Covered Person has been covered by this Plan and/or the prior Association-sponsored plan for twelve (12) consecutive months, whether or not the condition is a Pre-Existing Condition or an Emergency.

XIV. Other Benefits

A. Charges for professional Ambulance service to the nearest facility equipped to treat the specific Illness or Injury. Ambulance service is covered only when another means of transportation would be dangerous to the Covered Person's health.

B. Chiropractic care, if the service provided is within the lawful scope of the chiropractor's license.

C. Treatment or services rendered by a licensed physical, speech, occupational or cardiac rehabilitation therapist on an Outpatient basis or in the home, subject to the limits as shown in the Medical Summary of Benefits. Massage therapy performed by a licensed physical therapist will be considered Covered Expenses if treatment is part of and secondary to an ongoing physical therapy treatment plan. Included are the fees of a legally qualified speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to an Illness or Injury, other than a functional nervous disorder, or due to surgery performed on account of an Illness or Injury. If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy.

If you had an Inpatient rehabilitative admission for the condition and did not exhaust your Inpatient benefit limit as shown in the Medical Summary of Benefits, you may apply to the Claims Administrator, in writing, for additional Outpatient benefits beyond the stated limit. Limited extensions may be granted up to the balance of the unused Inpatient benefit if the services are determined to be Medically Necessary.

D. Charges, up to the stated benefit limits as shown in the Medical Summary of Benefits, for a) cardiac rehabilitative care and b) rehabilitative physical therapy to assist in the use of and recovery of use of limbs. Services must be performed by a licensed physical or occupational therapist within the scope of their license, in an acute care Inpatient setting, when Medically Necessary as prescribed by a Physician. Inpatient provider services that are primarily for the purpose of rehabilitation will be provided the same as any other Inpatient treatment. Such services must occur within 36 months of the date of Injury or onset of Illness.

E. Charges for Inpatient and Outpatient x-rays, microscopic tests, and laboratory tests.

F. Charges for the following services:

1. Radiation therapy or treatment.
2. The processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if replaced.
3. Oxygen and other gases and their administration.
4. Diabetes care training; including self-management training and education, including nutritional education, if recommended by a Physician and/or Other Licensed Healthcare Provider with expertise in diabetes.
5. The cost and administration of an anesthetic.

6. Necessary medical supplies, such as dressings, sutures, casts, splints, trusses, crutches, braces (except dental braces), and Orthotics (except corrective shoes).

7. Neurodevelopmental therapy for children through age 6 up to the stated benefit limit as shown in the Medical Summary of Benefits. This includes services and supplies for learning disabilities in cases where significant deterioration would result without such services or supplies.

8. Charges for home infusion therapy up to the stated benefit limit as shown in the Medical Summary of Benefits.

9. Charges for Phenylketonuria (PKU) formula. This benefit is not subject to any Pre-Existing Condition Waiting Periods.

G. Durable Medical Equipment:

1. The lesser of: a) the rental (up to the purchase price, including sales tax) of wheelchairs, hospital beds, respirators or other Durable Medical Equipment required for temporary therapeutic use, OR b) the purchase (including sales tax) of this equipment if economically justified.

   NOTE: Items that may be useful to persons in the absence of Illness or Injury, such as air conditioners, purifiers, humidifiers, special furniture, bicycles, whirlpools, hot tubs, spas, dehumidifiers, exercise equipment, health club memberships, etc., are not included, whether or not they have been prescribed or recommended by a Physician.

2. Artificial limbs, eyes or larynx, Orthopedic Appliances, or other Prosthetic Appliances.

For repairs or replacements of Durable Medical Equipment, you must have:

a. The attending Physician's prescription; and
b. A written explanation from the Physician as to why repair or replacement is necessary; and
c. An itemized repair or replacement cost statement.

For repairs, the Plan will pay up to the maximum which would be allowed for replacement of the equipment.

NOTE: No benefit is provided for cosmetic prostheses (except as provided for under the Mastectomy and Breast Reconstruction benefits of this Plan).

H. Services for voluntary sterilization for Participants and Dependent spouses are covered as indicated in the Medical Summary of Benefits under “Family Planning”. Reversal of these procedures is not covered.

I. Charges made by an Ambulatory Surgical Center or Minor Emergency Medical Clinic.

J. Services for the treatment of Temporomandibular Joint dysfunction by a Physician or licensed Dentist. These benefits are limited as shown in the Medical Summary of Benefits. Services received from a licensed Dentist are limited to Usual, Customary and Reasonable charges and are payable at the Preferred Provider benefit level.

The following services are not included in the Temporomandibular Joint Dysfunction benefit: (a) restorative techniques to provide for proper occlusion, and (b) orthodontic treatment.

K. Charges for surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or any other similar state statutes requiring such surcharges will be considered Covered Expenses by this Plan. Local, state and federal taxes associated with supplies or services covered under this Plan will also be considered Covered Expenses by this Plan.

I. <u>Outpatient Prescription Drugs</u>

Benefits for Outpatient prescription drugs are provided in three (3) ways:

1. Employees and their eligible Dependents may purchase prescription drugs at Express Scripts member pharmacies by showing their ID card. Covered Persons will be required to pay the applicable Deductible and Coinsurance (as stated in the Medical Summary of Benefits) at the time of purchase for covered prescriptions, subject to the Limitations and Exclusions set forth below. Purchases are limited to a 34-day supply. Up to a 2-month supply may be dispensed at one time for certain maintenance medications. Not all medicines taken on an ongoing basis are part of this benefit—only those on the Maintenance Medication List. Please refer to the Maintenance Medication List, which can be obtained from the Claims Administrator (TPSC), for other restrictions that may apply.

2. Employees and their eligible Dependents that purchase prescription drugs from non-member pharmacies or that fail to use their ID Card must pay the cost of the prescription in full and file a claim for reimbursement directly with Express Scripts (less the applicable Deductible and Coinsurance stated in the Medical Summary of Benefits).

3. Employees and their eligible Dependents may purchase prescription drugs through the Express Scripts, the mail order pharmacy vendor, subject to the applicable Deductible and Coinsurance (as stated in the Medical Summary of Benefits) for covered prescriptions. Eligible prescriptions will be mailed directly to the Participant's home. Mail order prescriptions are limited to a 90-day supply.

Outpatient Prescription Drug Limitations

This Plan requires that unless your Physician states that a Brand Name Drug is Medically Necessary, a Generic Drug will be dispensed. If your Physician authorizes a Generic Drug prescription and you elect to receive a Brand Name Drug, you will be required to pay the difference in cost between the Generic Drug and Brand Name Drug.

For secondary coverage on Prescription Drugs, claims should be submitted to the Claims Administrator (TPSC).

The Outpatient prescription drug benefit includes, but is not limited to::

A. Drugs requiring a prescription, subject to the Medical Plan Limitations and Exclusions of the Plan.
B. Insulin and insulin syringes.
C. Prenatal vitamins.
D. Oral and injectable contraceptives.

The following are excluded:

A. Experimental and/or Investigational drugs, including compounded medications for non-FDA approved use.
B. Drugs intended for use in a Physician's office or another setting other than home use.
C. Therapeutic devices or appliances, support garments and other non-medical substances, Rogaine, anorexients (weight loss medications), non-prenatal prescription vitamins, fertility medications, medications for sexual dysfunction, drugs with cosmetic indications, Retin-A for individuals over age 26, steroids for body building, over the counter medications, and replacement of lost or stolen prescriptions.

MEDICAL PLAN LIMITATIONS AND EXCLUSIONS

The following Exclusions and Limitations apply to expenses Incurred for all Covered Persons:

1. Charges Incurred prior to the effective date of coverage under the Plan, or after coverage is terminated;

2. Charges Incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country. An act of terrorism will not be considered an act of war, declared or undeclared;

3. An Illness, Injury or condition arising out of or in the course of employment or charges for which the Covered Person is entitled to benefits under any Worker's Compensation or Occupational Disease Law, or any such similar law (this Exclusion includes any occupational Injury or disease arising out of self-employment);

4. Charges Incurred for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage;

5. Charges resulting from treatment of Injuries or Illnesses received while committing or attempting to commit a felony;

6. Charges for vitamins; nutritional supplements; or devices which are not Medically Necessary (as determined by the Plan), unless specifically provided in any benefit section of this Plan;

7. Charges Incurred for services or supplies: a) which constitute personal comfort or beautification items, b) for television or telephone use, c) in connection with Custodial Care, education or training expenses actually Incurred by other persons, or d) occupational therapy except as otherwise noted in this Plan;

8. Charges Incurred in connection with the care or treatment of, or surgery performed for, a Cosmetic Procedure, unless Medically Necessary:

   a) Due to an Injury.
   b) When rendered to correct a congenital anomaly, i.e., a birth defect, for a covered Dependent.
   c) For reconstructive surgery as necessary for the prompt treatment of a diseased condition.
   d) By reconstructive breast surgery that is in connection with a mastectomy as provided under the Mastectomy and Breast Reconstruction Services benefit of this Plan.

9. Charges Incurred in connection with services and supplies which are not Medically Necessary for treatment of Injury or Illness or are in excess of Usual, Customary and Reasonable (UCR) charges as determined by the Plan or the Preferred Provider allowance, or are not recommended and approved by a Physician, unless specifically shown as a Covered Expense elsewhere in the Plan;

10. Charges for services, supplies or treatments not recognized by the American Medical Association as generally accepted and Medically Necessary for the diagnosis and/or treatment of an Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value, unless specified as a Covered Expense elsewhere in the Plan;

11. Charges for services rendered by a Physician and/or Licensed Health Care Provider if such Physician or provider is a Close Relative of the Covered Person, or resides in the same household of the Covered Person;

12. Charges Incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies;

13. Charges for confinement that occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or that occurs in an institution which is primarily a place for the treatment of chronic or long-term Injuries or Illnesses;

14. Charges for Physician-provided fees for any treatment which is not rendered by or in the physical presence of the Physician;

15. Except as specifically provided, charges Incurred in connection with the purchase or fitting of eyeglasses, contact lenses or such similar aid devices. This exclusion includes visual analysis, therapy or training, orthoptics;

16. Charges Incurred for dental treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or Alveolar processes. However, benefits will be payable for treatment required because of accidental bodily Injury to natural teeth (unless otherwise required by applicable law). Benefits for that Injury will be covered for six (6) months following the date of the Injury. This exception shall not in any event be deemed to include charges for treatment for the repair or replacement of a denture;

17. Charges for treatment of impotency (except for Medically Necessary treatment when there is an underlying medical condition), infertility, and procedures to restore fertility or to induce Pregnancy, including but not limited to: corrective or reconstructive surgery; hormone injections; in-vitro fertilization; artificial insemination; gamma intra-fallopian transfer (G.I.F.T.) and penile implants;

18. Charges for professional services on an Outpatient basis in connection with mental Illness, Alcoholism, drug addiction, functional nervous disorders, mental and nervous disorders of any type or cause, that can be credited toward earning a degree or furtherance of the education or training of a Covered Person regardless of the diagnosis;

19. Charges for Psychiatric Care or psychological counseling for marital, occupational, recreational, milieu or group therapy or counseling; or for education or training services, including but not limited to: vocational assistance, outreach, non-medical self-help such as “Outward Bound” or “Wilderness Survival”; social or cultural therapy; gym or swim therapy; work hardening; exercise; maintenance-level programs; and family, social, sexual, lifestyle, nutritional, and fitness counseling, unless specifically provided in any benefit section of this Plan;

20. Charges resulting from or in connection with the reversal of a sterilization procedure;

21. Charges for Experimental and/or Investigational procedures, drugs, or research studies, or for any services or supplies not considered legal in the United States;

22. Surgery (including reversals), treatment, programs or supplies intended to result in weight reduction (regardless of diagnosis);

23. Travel expenses, a) whether or not recommended by a Physician, b) Incurred by a Physician attending a Covered Person, or c) for a person accompanying a Covered Person, except as specifically provided under the Transplant Benefit;

24. Charges for missed or cancelled appointments; for telephone consultations; mailing and/or shipping and handling expenses; expenses for preparing medical reports, itemized bills or claim forms but not expenses Incurred by the Plan for utilization review, audits or investigation of a claim for benefits if approved by the Plan;

25. Charges for acupuncture, naturopathy, holistic medical procedures, or rolfing;

26. Hair transplant procedures, wigs, artificial hair pieces or drugs which are prescribed to promote hair growth;

27. Charges for diagnosis or any services, care or treatment including drugs, medications, surgery, medical, or Psychiatric Care or treatment, for sexual dysfunction, trans-sexualism, gender dysphoria or sexual reassignment;

28. Services related to any surgical procedure to correct near-sightedness or far-sightedness, including any related hardware;

29. Charges for Hospital care for dental procedures unless related to accidental bodily Injury to natural teeth;

30. Charges for Injuries related to semiprofessional or professional athletics, including practice;

31. Charges for hospitalization for minor conditions such as common colds, removal of small tumors, etc. unless such hospitalization is deemed Medically Necessary by the Plan;

32. Charges Incurred as a result of a self-inflicted Injury or charges for any Injury to a Covered Person sustained while under the influence of illegal drugs, unless such Injuries are the result of a medical condition;

33. Habilitative, education, or training services or supplies for dyslexia and for disorders or delays in the development of a child's language, cognitive, motor or social skills. However, this exclusion does not apply to evaluations or treatment of developmental disabilities in children under age seven (7) as stated under the Neurodevelopmental Therapy Benefit;

34. Any care connected with a Dependent child’s Pregnancy, except care furnished for the treatment of a complication of Pregnancy;

35. Private duty nursing;

36. Care rendered by any medical facility that is owned or operated by a government agency, except when the Plan refers you to the facility, the facility’s covered services are to treat a medical Emergency or an Injury that is treated within 72 hours of the Injury, or when the Plan is required by law to provide available benefits for covered services rendered by the facility;

37. Services and supplies to the extent that benefits are payable under the terms of any contract or insurance offering, including, but not limited to, motor vehicle medical, motor vehicle no-fault, or other personal Injury protection (PIP) coverage and commercial premises or homeowner's medical premises coverage, or similar type of coverage or insurance. Any benefits provided by this Plan contrary to this Exclusion are provided solely to assist the Covered Person. By providing such benefits, this Plan is not waiving any right to reimbursement, recovery, or to subrogation as provided in this Plan;

38. Services and supplies that are payable by any public program, government, foundation, or charitable grant, except as otherwise required by law;

39. Pre-Existing Conditions. Coverage will be provided for Covered Expenses for Pre-Existing Conditions after the Pre-Existing Condition Waiting Period ends;

40. Air travel, transportation by private automobiles or taxi service or other ground transportation, whether or not recommended by a Physician, except as provided herein under the Ambulance benefit;

41. Sanitarium or rest cures;

42. Charges for services Incurred as a result of a court order;

43. **Any services or supplies that are not specifically listed as a benefit of this Plan or an exception to these Medical Plan Limitations and Exclusions**.

PRE-EXISTING CONDITIONS

Claims resulting from Pre-Existing Conditions are excluded from coverage under the Plan except as specified below.

The Pre-Existing Condition limitation for a Covered Person will no longer apply after a period of three (3) consecutive months following the Covered Person's Enrollment Date. All eligible charges Incurred after this three-month Pre-Existing Condition Waiting Period will be considered eligible.

"Pre-Existing Condition" is a physical or mental condition, regardless of the cause of the condition for which medical advice, diagnosis, care or treatment was recommended or received within three (3) months prior to the person's Enrollment Date under this Plan. Genetic Information is not a Pre-Existing Condition in the absence of a diagnosis of the condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines.

EXCEPTION(s) TO THE PRE-EXISTING CONDITION WAITING PERIOD

1. Length of coverage under the prior Association-sponsored health plan will be automatically credited towards this Plan's Pre-Existing Condition Waiting Period.

2. The Pre-Existing Condition Waiting Period does not apply to Pregnancy or to Newborns enrolled within sixty (60) days of birth or children adopted or placed for adoption before attaining age 18 who are enrolled within sixty (60) days of placement or adoption.

3. The length of the Pre-Existing Condition Waiting Period may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan, provided there has not been a significant "break in coverage" between prior Creditable Coverage and the individual's Enrollment Date in this Plan. That is, so long as the person did not have a significant break in coverage (i.e., 63 or more consecutive days during which an individual does not have any Creditable Coverage), then one day from this Plan's Pre-Existing Condition Waiting Period will be subtracted for each day of Creditable Coverage from the other health plan. The eligibility waiting period does not count as a "break in coverage." All other Plan terms and limits still apply.

   Thus, in order to determine the length of an eligible person's Pre-Existing Condition Waiting Period for purposes of this Plan, an eligible person will need to request a certificate of Creditable Coverage from his or her prior plan. The Claims Administrator will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan if he or she is experiencing difficulty in obtaining a certificate. If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Condition Waiting Period imposed on that individual, that individual will be so notified.

   The Plan will provide a certificate of Creditable Coverage to Participants and Dependents covered under the Plan as required by HIPAA at the following times:

   - With respect to qualified beneficiaries who are entitled to elect COBRA continuation coverage, at the time they lose coverage under a plan in the absence of COBRA continuation coverage or alternative coverage.
   - With respect to individuals who are not qualified beneficiaries under COBRA, at the time they cease to be covered under the Plan.
   - With respect to qualified beneficiaries who elect COBRA continuation coverage, at the time the individual's coverage ends under COBRA.
   - Upon a Participant's (or his or her Dependent's) request, if such request is made within 24 months after the individual loses coverage under the Plan.

TRANSPLANT WAITING PERIOD

Transplants will not be covered unless the Covered Person has been covered by one of the Washington Fire Commissioners Association Health Care Benefit Plan options and/or the prior Association-sponsored plan for twelve (12) consecutive months, whether or not the condition is a Pre-Existing Condition or an Emergency.

PRE-NOTIFICATION OF HOSPITAL ADMISSION PROVISION

The pre-notification program helps the Claims Administrator to identify chronic Illnesses and catastrophic Injuries or disability for potential large case management. The Plan has contracted with Qualis Health to be its pre-notification clearinghouse.

PRE-NOTIFICATION OF INPATIENT HOSPITALIZATION

When your Physician recommends Hospitalization, you or your Physician must call Qualis Health as soon as possible but no later than 48 hours before the scheduled admission. Qualis Health only needs to be notified of Inpatient Hospitalizations. It is important to note that this telephone call is for the purpose of notice only; no approval or denial of the treatment will be made.

The telephone numbers for Qualis Health are in Seattle, (206) 364-9700 and outside Seattle (800) 783-8606.

EMERGENCY HOSPITALIZATION

If Emergency Hospitalization is necessary, you, a Family member, your Physician or the Hospital must contact Qualis Health within 48 hours following admission.

If you call Qualis Health on the weekend or at night, you should leave a message on the voice mail answering machine. Your message should include:

- Your name
- Patient's name, if other than you
- Identify yourself as a Washington Fire Commissioners Association plan Covered Person
- Telephone number where you or a Family member can be reached
- Name of Hospital where patient is being admitted
- Reason for Hospital admission
- Date of admission

MEDICAL CASE MANAGEMENT

This Plan may provide case management services to address chronic Illnesses and catastrophic Injuries or disabilities. The case manager cooperates with you and the entire health care team to promote quality of care and the best use of your health care dollars.

The case manager assesses information from you, your Family, and your Physician to develop a formal treatment plan to meet your specific Medically Necessary and appropriate needs. This treatment plan outlines specific goals and suggests alternative treatments to achieve them, if appropriate. (Determination of benefits for such alternative treatments shall be made by mutual agreement of the Plan Sponsor and the reinsurance carrier.) All treatments are closely monitored by the case manager to ensure that the service is appropriate and cost-effective. This allows you to get the most from your health care dollars without compromising the quality or integrity of your care.

VISION PLAN

The following are vision benefits under this program, which are subject to the Vision Plan Limitations and Exclusions shown below. Services may be received from the vision provider of your choice; there is no vision provider network. Covered services are limited to Usual, Customary and Reasonable charges.

COVERED VISION SERVICES

- Eye examination. "Eye examination" consists of the inspection of internal and external appearance of the eye, eye movement, visual acuity, visual field, color vision, glaucoma and a refraction test, to assess whether glasses or contact lenses are necessary.
- Single vision, bifocal and trifocal lenses.
- Contact lenses.
- Frames.

VISION PLAN LIMITATIONS

1) Exam is limited to one (1) per Calendar Year. Fittings for contact lenses are covered under the materials benefit allowance as shown in the Vision Summary of Benefits.

2) Lenses and frames are limited to the materials benefit allowance shown in the Vision Summary of Benefits.

3) Prescription sunglasses are provided only when visual correction is necessary.

4) Surgically implanted contact lenses, aphakic or lenticular lenses will be paid under the materials benefit allowance, with the balance to the Durable Medical Equipment benefit if such treatment is Medically Necessary.

5) Coverage is limited to services provided by optometrists, ophthalmologists and opticians, to the extent that such services are within the scope of their license.

VISION PLAN EXCLUSIONS

1) Charges for special procedures, such as orthoptics or vision training, or for special supplies, such as non-prescription sunglasses and subnormal vision aids.

2) Drugs or medications of any kind.

3) Charges for services or supplies which are received while the individual is not covered.

4) Charges for vision care services or supplies for which benefits are provided under any Workers' Compensation law or any other law of similar purpose, whether benefits are payable as to all or only part of the charges.

5) Charges for any eye exam required by an employer as a condition of employment or which an employer is required to provide under a labor agreement, or which is required by any law or government.

6) Services related to any surgical procedure to correct near-sightedness or far-sightedness.

CLAIMS PROCEDURES

The procedures outlined below must be followed by Covered Persons ("claimants") to obtain payment of health benefits under this Plan.

HEALTH CLAIMS

All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the claimant is entitled to them. The responsibility to process claims in accordance with the Plan may be delegated to the Claims Administrator; provided, however, that the Claims Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the claimant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there are three types of claims: Pre-service (Urgent and Non-urgent) which apply to transplants only, and Post-service.

PRE-SERVICE CLAIMS

A "Pre-service Claim" is a claim for transplant benefits under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "Pre-service Urgent Care Claim" is any claim for transplant benefits with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the claimant or the claimant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

A Pre-service Claim is considered to be filed when the request for approval of treatment or services is made and received by the Claims Administrator and includes the following information:

1. The proposed date of service;
2. The name, address, telephone number and tax identification number of the proposed provider of the services or supplies;
3. The proposed place where the services are to be rendered;
4. The diagnosis and procedure codes;
5. The anticipated amount of charges;
6. The name of the Plan or group number;
7. The name and Social Security Number of the covered Employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 48 hours from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

POST-SERVICE CLAIMS

A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

A Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan or group number;
7. The name and Social Security Number of the covered Employee; and

8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Claims Administrator within 45 days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

WHEN HEALTH CLAIMS MUST BE FILED

Health claims must be filed with the Claims Administrator within 12 months of the date charges for the service were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Charges are considered Incurred when treatment or care is given or supplies are provided. **Claims filed later than that date shall be denied.** However, on termination of the Plan, final claims must be received within ninety (90) days of termination.

TIMING OF CLAIM DECISIONS

The Plan shall notify the claimant, in accordance with the provisions set forth below, of any benefit determination (and, in the case of Pre-service Claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Urgent Care Claims:

- If the claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
- If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim. The claimant will be asked to supply the information within 48 hours. The claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of (a) the Plan's receipt of the specified information, or (b) the end of the period afforded the claimant to provide the information.

Pre-service Non-urgent Care Claims:

- If the claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- If the claimant has not provided all of the information needed to process the claim, then the claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The claimant will be asked to supply the needed information within 45 days. The claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period. In that case, the claimant will be notified of the determination by a date agreed to by the Plan and the claimant.

Post-service Claims:

- If the claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- If the claimant has not provided all of the information needed to process the claim then the claimant will be notified as to what specific information is needed as soon as possible, but no later than 30 days after receipt of the claim. The claimant will be asked to supply the needed information within 45 days. The claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period. In that case, the claimant will be notified of the determination by a date agreed to by the Plan and the claimant.

Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service Urgent Care Claims.

Extensions – Pre-service Non-urgent Care Claims. The 15-day processing period may be extended by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-service Claims. The 30-day processing period may be extended by the Plan for up to 15 days, provided that the Plan both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION

The Plan shall provide a claimant with a notice, either in writing or electronically (or, in the case of Pre-service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. A reference to the specific portion(s) of the Plan upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures;
5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's claim for benefits;
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the claimant, free of charge, upon request);
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental and/or Investigational), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided to the claimant, free of charge, upon request; and
9. In a claim involving Urgent Care, a description of the Plan's expedited review process.

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Full and Fair Review of All Claims: In cases where a claim for benefits is denied, in whole or in part, and the claimant believes the claim has been denied wrongly, the claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 60 days to appeal a second adverse benefit determination;
2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an individual employed by the Claims Administrator or an individual employed by the Plan Administrator, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Claims Administrator (for the first appeal) or the Plan Administrator (for the second appeal) shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;
7. That a claimant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits in possession of the Plan Administrator or the Claims Administrator, information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances; and
8. In an Urgent Care Claim, for an expedited review process pursuant to which
   - A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and
   - All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

FIRST APPEAL LEVEL

Requirements for First Appeal: The claimant must file the first appeal in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) with the Claims Administrator (who will perform the benefit determination on First Appeal) within 180 days following receipt of the notice of an adverse benefit determination. For Pre-service Urgent Care Claims, if the claimant chooses to orally appeal, the claimant may telephone the Claims Administrator as follows: Claims Manager, 1-800-426-9786, Ext. 211. To file an appeal in writing, the claimant's appeal must be mailed to the address as follows or faxed to the following number: Trusteed Plans Service Corporation, 6901 – 6th Avenue, Tacoma, WA 98406, FAX number: 253-564-5881 ATTN: Claims Manager.

It shall be the responsibility of the claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/claimant;
2. The Employee/claimant's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the claimant will lose the right to raise factual arguments and theories which support this claim if the claimant fails to include them in the appeal**;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the claimant has which indicates that the claimant is entitled to benefits under the Plan.

If the claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on First Appeal: The Plan shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the appeal.
- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the appeal.
- Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on First Appeal: The Plan shall provide a claimant with notification, with respect to Pre-service Urgent Care Claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Plan on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided free of charge upon request;
7. A description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is necessary;
8. A description of the Plan's review procedures and the time limits applicable to the procedures;
9. For Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claims; and
10. The following statement: "All claim review procedures provided for in the Plan must be exhausted before any legal action is brought."

Furnishing Documents in the Event of an Adverse Determination: In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as appropriate.

SECOND APPEAL LEVEL

Adverse Decision on First Appeal; Requirements for Second Appeal: Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the claimant has 60 days to file with the Plan Administrator a second appeal of the adverse decision. The claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the claimant's second appeal must be in writing (although oral appeals are permitted for Pre-service Urgent Care Claims) as described in the section entitled "Requirements for First Appeal" and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal: The Plan shall notify the claimant of the Plan's benefit determination on review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 36 hours after receipt of the second appeal.
- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.
- Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.
- Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal: The same information must be included in the Plan's response to a second appeal as a first appeal, except for (i) a description of any additional information necessary for the claimant to perfect the claim and an explanation of why such information is needed; (ii) a description of the Plan's review procedures and the time limits applicable to the procedures; and (iii) for Pre-service Urgent Care Claims, a description of the expedited review process applicable to such claim. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination: In the case of an adverse benefit determination on the second appeal, the Plan shall provide such access to, and copies of, documents, records, and other information described in items 3 through 7 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

Decision on Second Appeal to be Final: If, for any reason, the claimant does not receive a written response to the appeal within the appropriate time period set forth above, the claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate Named Fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within three (3) years after the Plan's claim review procedures have been exhausted.**

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a particular benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the claimant must complete a form which can be obtained from the Plan Administrator or the Claims Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the claimant's medical condition to act as the claimant's authorized representative without completion of this form, if deemed appropriate by the Plan Administrator or the Claims Administrator.

GENERAL PROVISIONS

ALTERNATE BENEFITS

Alternate benefits means payment for those services or supplies which are not otherwise Covered Expenses of the Plan, but that the Claims Administrator believes to be Medically Necessary and cost-effective. If payment for alternate benefits is approved by the Claims Administrator, the Covered Person will be notified of such approval and the duration of such approval.

The fact that alternate benefits are paid by the Plan shall not obligate the Plan to pay such benefits for other Covered Persons, nor shall it obligate the Plan to pay continued or additional alternate benefits for the same Covered Person. Payments for alternate benefits are Covered Expenses for all purposes under the Plan.

EXAMINATION

If necessary to assist in making a benefit determination, the Plan may request that the patient be examined by a Physician selected and paid by the Plan. If the patient chooses not to comply with this request, benefits will be denied.

RIGHTS OF RECOVERY

Whenever payments have been made by the Plan with respect to Covered Expenses in excess of the maximum amount of payment necessary to satisfy the intent of this Plan, the Plan Administrator shall have the right, exercisable alone and in its sole discretion, to recover such excess payments.

TIME LIMITATION

If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity, is less than that permitted by the law of the state in which the Plan is existent, such limitation is hereby extended to agree with the minimum period permitted by such law.

FREE CHOICE OF PROVIDER

The Covered Person shall have free choice of any legally qualified Physician and/or Licensed Health Care Provider and the provider-patient relationship shall be maintained.

WORKER'S COMPENSATION NOT AFFECTED

This Plan does not affect any requirement for and is not in lieu of coverage provided by Worker's Compensation Insurance.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby deemed amended to conform to the minimum requirements thereto.

STATEMENTS

In the absence of fraud, all statements made by a Covered Person will be deemed representations and not warranties. No such representations will void the Plan benefits or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Person.

MISCELLANEOUS

Section titles are for conveniences of reference only, and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plan or Plans, the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan and to the extent of such payments, this Plan will be fully discharged from liability.

The benefits that are payable will be charged against any applicable maximum payment or benefit of this Plan rather than the amount payable in the absence of this provision.

COORDINATION WITH MEDICARE

Notwithstanding all other provisions of this Plan, all Covered Persons who are eligible for Medicare benefits, will be entitled to benefits under this Plan in addition to Medicare.

This Plan will be primary (i.e., pays benefits before Medicare) in the following circumstances:

- For an Employee (NOT retiree) who is on Medicare because of age;
- For a spouse (NOT the spouse of a retiree) who is on Medicare because of age;
- For an Employee (NOT retiree) who is on Medicare because of an SSA Disability -AND- who is considered to be in "current employment status" as defined by Medicare;
- For a spouse (NOT the spouse of a retiree) who is on Medicare because of an SSA Disability;
- For the first thirty* (30) months of Medicare Coverage for ANY Employee, retiree, Employee's spouse, retiree's spouse who is on Medicare because of End-Stage Renal Disease (ESRD) - AND ONLY if the individual was not FIRST on Medicare for a reason that would make Medicare Primary.

* Up to 33 months depending on when dialysis commences

This Plan will be secondary (i.e., pays benefits after Medicare) in the following circumstances:

- For a retiree or retiree's spouse who is on Medicare because of age;
- For a retiree or retiree's spouse who is on Medicare because of SSA Disability;
- Only after thirty* (30) months of Medicare Coverage for ANY Employee, retiree, Employee's spouse, retiree's spouse who is on Medicare because of End-Stage Renal Disease (ESRD).

* Up to 33 months depending on when dialysis commences

When this Plan is secondary to Medicare, the Plan will coordinate benefits (i.e. reduce this Plan's benefits in most circumstances) by the amount Medicare would have paid, even if the person is not enrolled under Medicare (Part A, Part B and/or Part D).

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Benefits Subject to This Provision This provision shall apply to all benefits provided under any section of this Plan.

When This Provision Applies A Covered Person may incur medical or other charges related to Injuries or Illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges Incurred in connection with the Injuries or Illness. If so, the Covered Person may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supercedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

The Covered Person must:

1. Execute and deliver a Subrogation and Reimbursement Agreement;
2. Authorize the Plan to sue, compromise and settle in the Covered Person 's name to the extent of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Covered Person's rights to Recovery when this provision applies;
3. Immediately Reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise);
4. Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Illnesses or Injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Illness. If the Plan pays any medical or other benefits for the Injuries or Illness before these papers are signed and things are done, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

Amount Subject to Subrogation or Reimbursement ***Any amounts recovered will be subject to Subrogation or Reimbursement***. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

"Another Party" shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Illness.

"Another Party" shall include the party or parties who caused the Injuries or Illness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Illness.

"Recovery" shall mean any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

"Subrogation" shall mean the Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

"Reimbursement" shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Illness and for the expenses incurred by the Plan in collecting this benefit amount.

When a Covered Person Retains an Attorney If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. Additionally, the Covered Person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Covered Person's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Covered Person or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

When the Covered Person is a Minor or is Deceased These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

When a Covered Person Does Not Comply When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

AVAILABILITY OF BENEFITS

Benefits quoted to providers are not a guarantee of claim payment. Claim payment will be dependent upon eligibility at the time of service and all terms and conditions of the Plan.

For a written pre-treatment estimate, a provider of service must submit to the Claim Administrator their proposed course of treatment, including diagnosis, procedure codes, place of service and proposed cost of treatment. In some cases, medical records or additional information may be necessary to complete the estimate of benefits.

COORDINATION OF BENEFITS

The coordination of benefits provision is intended to prevent the payment of benefits which exceed Allowable Expenses. It applies when the Participant or any eligible Dependent who is covered by the Plan is also covered by any other plan or plans. When more than one coverage exists, one Plan normally pays its benefits in full and the other plans pay reduced benefits. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed one hundred percent (100%) of Allowable Expenses. Only the amount paid by the Plan will be charged against the Plan maximums.

The coordination of benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

COORDINATION OF BENEFITS DEFINITIONS

"Plan" as used in this Section will mean any plan providing benefits or services for or by reason of medical, dental or vision treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group, whether on an insured or uninsured basis, including but not limited to:

    a. Hospital indemnity benefits; and
    b. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims;

2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;

3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;

4. A licensed Health Maintenance Organization (H.M.O.);

5. Any coverage for students which is sponsored by, or provided through, a school or other educational institution; or

6. Any coverage under a governmental program and any coverage required or provided by any statute.

"Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

"Allowable Expenses" means any necessary item of expense, the charge for which is Usual, Reasonable and Customary, at least a portion of which is covered under at least one of the Plans covering the person for whom claim is made. When a Plan provides benefits in the form of services rather than cash payments, then the reasonable cash value of each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

"Claim Determination Period" means a Calendar Year or that portion of a Calendar Year during which the Covered Person for whom claim is made has been covered under this Plan.

COORDINATION ORDER OF BENEFIT DETERMINATION

Certain rules are used to determine which of the Plans will pay benefits first. This is done by using the **first** of the following rules which applies:

1. A Plan with no coordination provision will determine its benefits before a Plan with a coordination provision.

2. A Plan that covers a person other than as a Dependent will determine its benefits before a Plan that covers such person as a Dependent.

3. When a claim is made for a Dependent child who is covered by more than one Plan, the benefits as a Dependent of the parent whose birthday falls earlier in the Calendar Year are determined before those of the Plan of the parent whose birthday falls later in that year; except

    a. If both parents have the same birthday, the benefits of the Plan which covers the parent longer are determined before those of the Plan which covers the other parent for a shorter period;

b. If the other Plan does not have the rules stated in (3), but instead has the rule based on gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rules in the other Plan will determine the order of benefits.

4. When the parents of a Dependent child are divorced or separated, these are the rules for determining which Plan pays first:

   a. The Plan of the parent with custody;
   b. The Plan of the spouse of the parent with custody;
   c. The Plan of the parent without custody; and
   d. The Plan of the spouse of the parent without custody.

5. When the parents of a Dependent child are divorced or separated and there is a decree establishing financial responsibility for medical expenses of the Dependent child, benefits as a Dependent of the parent with financial responsibility are determined before benefits as a Dependent of the parent without financial responsibility.

6. A Plan that covers a person as a laid off Employee, a retired Employee or a Dependent of such Employee will determine its benefit after the Plan that does not cover such person as a laid off Employee, a retired Employee or a Dependent of such Employee. If one of the Plans does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.

7. When the above rules do not establish an order, benefits are determined first under the Plan that covers the person for the longest period of time.

EXCHANGE OF INFORMATION

This Plan and other plans may exchange information needed in order to coordinate benefits. No consent or notice is required. Covered Persons must furnish needed information.

PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator (the Washington Fire Commissioners Association). The Plan Administrator has retained the services of the Claims Administrator to provide certain claims processing and other technical services.

Plan Administrator An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

Duties of the Plan Administrator The duties of the Plan Administrator include the following:

- To administer the Plan in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the Plan;
- To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a Covered Person's rights;
- To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
- To keep and maintain documents and all other records pertaining to the Plan;
- To appoint and supervise a third party administrator to pay claims;
- To perform all necessary reporting as required by applicable law;
- To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan This document contains all the terms of the Plan and may be amended from time to time by the Association. Any changes shall be by an approved motion of the WFCA Insurance Rate Stabilization Reserve Account (IRSRA) Committee and shall become effective as of the date specified. A copy of any amendment shall be furnished to the Claims Administrator and to any other outside provider of plan administration services. Any such amendment so made shall be binding on each Participant and on any other Covered Persons referred to in this document.

The Association shall notify all participating fire districts of any amendment modifying the substantive terms of the Plan as soon as is administratively feasible.

The Association reserves the right at any time to terminate the Plan by a written instrument to that effect. All previous contributions made by participating fire protection districts shall continue to be issued for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination, or shall be distributed to the Association or any successor association, authorized by RCW 52.08.030(5) for like purposes for use in any program with similar purposes, until all contributions are exhausted.

DEFINITIONS

The following words and phrases shall have the following meanings when used in this document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this document for that information.**

ALCOHOLISM

"Alcoholism" means a morbid state caused by excessive and compulsive consumption of alcohol that interferes with the patient's health and social or economic functioning.

ALCOHOLISM TREATMENT CENTER OR DRUG ADDICTION TREATMENT FACILITY

"Alcoholism Treatment Center" or "Drug Addiction Treatment Facility" is a treatment facility that is approved by the Washington State Department of Social and Health Services (or another state) for treatment of Alcoholism or drug addiction

This does not include recovery houses, residential crisis treatment centers or residential treatment facilities that provide an alcohol-free or drug-free residential setting.

ALVEOLAR

“Alveolar” means pertaining to the ridge, crest or process of bone which projects from the upper and lower jaw and supports the roots of the teeth.

AMBULANCE

"Ambulance" means a specifically designed and equipped automobile or other vehicle such as an airplane, boat or helicopter which meets all local, state and federal regulations for transporting the sick and injured.

AMBULATORY SURGICAL CENTER

"Ambulatory Surgical Center" means an institution or facility, either free standing or as part of a Hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a Physician for the practice of medicine or Dentistry, or for the primary purpose of performing terminations of Pregnancy, shall not be considered to be an Ambulatory Surgical Center.

ASSOCIATION

“Association” means the Washington Fire Commissioners Association.

BENEFIT PERIOD

"Benefit Period" refers to a time period of one (1) year, as shown on the Medical Summary of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the one (1) year period so established;
2. The day the Lifetime Maximum Benefit applicable to the Covered Person is reached; or
3. The day the Covered Person ceases to be covered for benefits of this Plan.

BENEFIT YEAR

"Benefit Year" means a Calendar Year.

BRAND NAME DRUG

“Brand Name Drug” means a drug manufactured by a pharmaceutical company which has chosen to patent the drug's formula and register its Brand Name.

CALENDAR YEAR

"Calendar Year" means a period of time commencing on January 1 and ending on December 31 of the same given year.

CLAIMS ADMINISTRATOR

"Claims Administrator" means Trusteed Plans Service Corporation, the firm retained by the Plan Administrator, who is responsible for performing certain ministerial functions for the Plan, including but not limited to enrollment, premium collecting and claims processing and reporting.

CLOSE RELATIVE

"Close Relative" means the spouse, parent, brother, sister, child, aunt, uncle or grandparent of the Covered Person or the Covered Person's spouse.

COBRA

"COBRA" means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

CORONARY CARE UNIT

"Coronary Care Unit" means a section, ward, or wing within the Hospital which is separated from other facilities and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill coronary patients;
2. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and
3. Provides constant observation and treatment by Registered Nurses or other highly trained Hospital personnel.

COSMETIC PROCEDURE

"Cosmetic Procedure" means a procedure performed solely for the improvement of a Covered Person's appearance rather than for the restoration of bodily function.

COVERED EXPENSES

"Covered Expenses" means the Usual, Customary and Reasonable charges or the Preferred Provider allowance for Necessary or Medically Necessary treatments, services, or supplies that are listed as a covered benefit of the Plan.

COVERED PERSON

"Covered Person" means any Participant or Dependent of a Participant meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

CREDITABLE COVERAGE

“Creditable Coverage” shall mean prior medical coverage that an individual had from any of the following sources: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the Uniformed Services and their Dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition (e.g., a State Children’s Health Insurance Plan [SCHIP]), a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act.

CUSTODIAL CARE

"Custodial Care" means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

DENTIST

"Dentist" means a person duly licensed to practice Dentistry by the governmental authority having jurisdiction over the licensing and practice of Dentistry in the locality where the service is rendered.

DEPENDENT

“Dependent” means a Participant’s spouse or child, as defined under “Who May Receive Benefits” so long as the spouse or child is properly enrolled in this Plan.

DEPENDENT COVERAGE

"Dependent Coverage" means eligibility under the terms of the Plan for benefits payable as a consequence of Covered Expenses Incurred for an Illness or Injury of a properly enrolled Dependent.

DURABLE MEDICAL EQUIPMENT

"Durable Medical Equipment" means equipment that is:

1. Able to withstand repeated use;
2. Primarily and customarily used to serve a medical purpose; and
3. Not generally useful to a person in the absence of Illness or Injury.

EMERGENCY

"Emergency" means an Illness or Injury of sudden, acute onset resulting in a life-threatening situation requiring immediate Physician and Hospital attention. Examples of a medical Emergency are heart attacks or suspected heart attacks, coma, loss of respiration, stroke, acute appendicitis, etc.

EMPLOYEE

See definition of Covered Person.

EMPLOYER

“Employer” means participating fire protection districts.

ENROLLMENT DATE

"Enrollment Date" is the earlier of: a) the first day of coverage, or b) if there is an eligibility waiting period for benefits, the first day of the eligibility waiting period. However, the Enrollment Date for an individual who enrolls under a Special Enrollment Provision under this Plan will be the first date of coverage.

EXCLUSIONS

“Exclusions” means services and charges not covered under this Plan.

EXPERIMENTAL AND/OR INVESTIGATIONAL

The Plan Administrator or its designee has the discretion and authority to determine if a medical, surgical, diagnostic, psychiatric, substance abuse or other health care service, technology, supply, treatment, procedure, drug therapy or device is or should be classified as Experimental and/or Investigational. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for preauthorization under the Plan’s utilization management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:**

1. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.
2. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, or scientific literature on the subject, or a preponderance of such literature published in the United States and written by experts in the field; that shows that recognized medical or scientific experts classify the service or supply as Experimental and/or Investigational or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.

    - authoritative peer reviewed medical or scientific writings that will be considered include the following publications or sources of publications:
    - “United States Pharmacopoeia Dispensing Information”;
    - “American Hospital Formulary Service”;
    - “American Medical Association (AMA), Drug Evaluations” and “The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, or similar publications of the AMA;
    - specialty organizations recognized by the AMA;

- the National Institutes of Health (NIH);
- the Center for Disease Control (CDC);
- the Agency for Health Care Policy and Research (AHCPR)
- opinions of other agency review organization, e.g. ECRI Health Technology Assessment Information Service or HAYES New Technology Summaries;
- the American Dental Association (ADA), with respect to dental services or supplies;
- the latest edition of "The Medicare Coverage Issues Manual."

3. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered Experimental and/or Investigational if it is approved by the FDA as an "investigational new drug for treatment use"; or classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term in defined in FDA regulations; or approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.
4. The prescribed service or supply is available to the Covered Individual only through participation in Phase I or Phase II clinical trials; or Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

FAMILY

"Family" means a Participant and his eligible Dependents.

GENERIC DRUG

"Generic Drug" is a drug that is generally equivalent to a higher-priced Brand Name Drug that meets all FDA bioavailability standards.

GENETIC INFORMATION

"Genetic Information" means information about genes, gene products, and inherited characteristics that may derive from an individual or a Family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, Family histories and direct analysis of genes or chromosomes.

HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), which was enacted as part of a broad Congressional attempt at incremental health care reform. HIPAA required the Department of Health and Human Services to create standards for the electronic exchange, privacy and security of health information. The "HIPAA Privacy Rule" grants health care consumers a greater level of control over the use and disclosure of personally identifiable health information. In general, health care providers, health plans, and clearinghouses are prohibited from using or disclosing health information except as authorized by the patient or specifically permitted by the regulation.

HOME HEALTH CARE AGENCY

"Home Health Care Agency" means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.
2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at least one Registered Nurse to govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Nurse.
3. It maintains a complete medical record on each individual.
4. It has a full-time administrator.

HOME HEALTH CARE PLAN

"Home Health Care Plan" means a program for continued care and treatment of the Covered Person established and approved in writing by the Covered Person's attending Physician. The attending Physician must certify that the proper treatment of the

Illness or Injury would require confinement as a resident Inpatient in a Hospital in the absence of the services and supplies provided as part of the Home Health Care Plan.

HOSPICE

"Hospice" means a health care program providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse, and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

HOSPITAL

"Hospital" means an institution that meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense;
2. It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located which pertain to Hospitals;
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury;
4. Such treatment is provided for compensation by or under the supervision of Physicians with continuous twenty-four (24) hour nursing services by Registered Nurses;
5. It qualifies as a Hospital, a psychiatric Hospital, or a tuberculosis Hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
6. It is a provider of services under Medicare; and
7. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

HOSPITAL MISCELLANEOUS EXPENSES

"Hospital Miscellaneous Expenses" means the actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

ILLNESS

"Illness" means a bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder of a Covered Person. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Illness.

INCURRED

"Incurred" means the time or date a service or supply is actually provided to a Covered Person. With respect to a course of treatment or procedure that includes several stages or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

INJURY

"Injury" means trauma or damage to the Covered Person's body from an external force. Any loss which is caused by or contributed to by a hernia of any kind will be considered a loss under the definition of Illness, and not as a loss resulting from accidental injury.

INPATIENT

"Inpatient" refers to the classification of a Covered Person when a person is admitted to an institution such as a Hospital, Hospice, or Skilled Nursing Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such treatment.

INTENSIVE CARE UNIT

"Intensive Care Unit" means a section, ward, or wing within the Hospital which is separated from other facilities and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;
2. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and
3. Provides constant observation and treatment by Registered Nurses or other highly trained Hospital personnel.

LICENSED PRACTICAL NURSE

"Licensed Practical Nurse" (L.P.N.) means an individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

LIMITATIONS

“Limitations” are restrictions, such as age, period of time covered, and waiting periods, which may limit coverage or benefits under this Plan.

MEDICALLY NECESSARY or MEDICAL NECESSITY

“Medically Necessary” or “Medical Necessity” means a medical service or supply that:

1. is provided by or under the direction of a Physician or other duly licensed health care practitioner who is authorized to provide or prescribe it **and**
2. is determined by the Plan Administrator or its designee to meet **all** of the following requirements:
   - It is consistent with the symptoms or diagnosis and treatment of the illness or injury; **and**
   - It is not provided primarily for the convenience of the patient, Physician, Hospital, Health Care Provider, or health care facility; **and**
   - It is an “appropriate” service or supply given the patient’s circumstances and condition; **and**
   - It is a “cost-efficient” supply or level of service that can be safely provided to the patient; **and**
   - It is safe and effective for the Illness or Injury for which it is used.

   A medical service or supply will be considered to be “appropriate” if:

   1. It is a diagnostic procedure that is called for by the health status of the patient, and is (a) as likely to result in information that could affect the course of treatment and (b) no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient’s overall health condition.
   2. It is care or treatment that is (a) as likely to produce a significant positive outcome and (b) no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient’s overall health condition.

   A medical service or supply will be considered to be “cost-efficient” if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses Incurred in connection with the service or supply.

The fact that the Physician may provide, order, recommend or approve a service or supply **does not mean** that the service or supply will be considered to be Medically Necessary for the medical coverage provided by the Plan.

A hospitalization or confinement to a Skilled Nursing Facility or other specialized health care facility will **not** be considered to be Medically Necessary if the patient’s Illness or Injury could safely and appropriately be diagnosed or treated while not confined.

MEDICARE

"Medicare" means the programs established by Title I of Public Law 89-98 (79 Statutes 291) as amended entitled "Health Insurance for the Aged Act", and which includes Parts A, B and/or D and Title XVIII of the Social Security Act (as amended by Public Law 89-97, 79), as amended from time to time.

MINOR EMERGENCY MEDICAL CLINIC

"Minor Emergency Medical Clinic" means a free-standing facility which is engaged primarily in providing minor Emergency and episodic medical care to a Covered Person. A board-certified Physician, a Registered Nurse, and a registered x-ray technician

must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be a Minor Emergency Medical Clinic, by whatever actual name it may be called; however, a clinic located on or in conjunction with or in any way made a part of a regular Hospital shall be excluded from the terms of this definition.

NAMED FIDUCIARY

"Named Fiduciary" means the Association.

NEWBORN

"Newborn" refers to an infant from the date of his birth until the initial Hospital discharge or until the infant is ninety-six (96) hours old, whichever occurs first.

ORTHOPEDIC APPLIANCE

"Orthopedic Appliance" means a rigid or semi-rigid support used to restrict or eliminate motion in a diseased, injured, weak or deformed body member.

ORTHOTICS

“Orthotics” means mechanical appliances for orthopedic use.

OUTPATIENT

"Outpatient" refers to the classification of a Covered Person when that Covered Person received medical care, treatment, services or supplies at a clinic, a Physician's office, or at an institution where the patient is not a registered bed patient, such as a Hospital, an Outpatient Psychiatric Facility or an Outpatient Alcoholism Treatment Facility.

PARTICIPANT

"Participant" means the following who meet the qualifications as outlined in the Eligibility section of this Plan: a person employed in the regular business of and compensated for services by a participating fire protection district, WFCA staff and Fire Commissioners.

PARTICIPANT COVERAGE

"Participant Coverage" means coverage hereunder providing benefits payable as a consequence of an Injury or Illness of a Participant.

PHYSICIAN AND/OR LICENSED HEALTH CARE PROVIDER

"Physician and/or Licensed Health Care Provider” means legally licensed medical or dental providers, including but not limited to: Advanced Registered Nurse Practitioner A.R.N.P., Alcohol Treatment and Drug Addiction Facility, Certified Nurse Midwife C.N.M. if an A.R.N.P./C.N.M., Audiologists, Birthing Centers, Chiropractor D.C., Community Mental Health Center including those persons with the designation M.S.W., Dentist D.D.S. or D.M.D., Dietician D., C.D., or R.D., Durable Medical Equipment, Home Health Agency, Home Infusion Therapist, Hospice, Hospital, Laboratory, Licensed Practical Nurse L.P.N., Occupational Therapist O.T., Optometrist O.D., Physical Therapist P.T., Physician and Surgeon M.D. or D.O., Podiatrists D.P.M., Psychologist, Radiologic Technologists, Registered Nurse R.N., Respiratory Care Practitioners, Skilled Nursing Facility, Speech Therapist S.T., Surgical Assistant R.N. and Ambulatory Surgical Centers, to the extent that same, within the scope of their license, are **permitted to perform services provided in this Plan.**

A Physician and/or Licensed Health Care Provider shall not include the Covered Person, any Close Relative of the Covered Person, or one who resides in the same household as the Covered Person.

PLAN

"Plan" means this Washington Fire Commissioners Association Health Care Benefits Plan.

PLAN SPONSOR

"Plan Sponsor" means the Washington Fire Commissioners Association.

PRE-EXISTING CONDITIONS

“Pre-Existing Condition” is a physical or mental condition (other than Pregnancy), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within three (3) months prior to the person’s Enrollment Date under this Plan. Genetic Information is not a Pre-Existing Condition in the absence of a diagnosis of the condition. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines.

PREFERRED PROVIDER

"Preferred Provider" shall mean a provider who has signed a preferred participant agreement with a Preferred Provider organization that has been contracted by the Plan or any other reciprocal provider network. These participating providers have agreed to offer their services at special rates to enrollees of this Plan.

PREGNANCY

"Pregnancy" means that physical state which results in childbirth, abortion, or miscarriage.

PROSTHETIC APPLIANCE

"Prosthetic Appliance" means a device or appliance that is designed to replace a natural body part lost or damaged due to Illness or Injury, the purpose of which is to restore full or partial bodily function or appearance.

PSYCHIATRIC CARE

"Psychiatric Care", also known as psychoanalytic care, means treatment for a mental Illness or disorder or a functional nervous disorder by a duly licensed psychiatrist, Psychologist, licensed social worker or licensed professional counselor acting within the scope and Limitations of their respective license, provided that such treatment is Medically Necessary, and within recognized and accepted professional psychiatric and psychological standards and practices.

PSYCHIATRIC FACILITY

"Psychiatric Facility" means an administratively distinct governmental, public, private or independent unit or part of such unit that provides mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

PSYCHOLOGIST

"Psychologist" means an individual holding the degree of Ph.D. and acting within the scope of his license.

QUALIFIED BENEFICIARY

"Qualified Beneficiary" means a covered Employee or dependent who was covered under the Plan prior to the COBRA qualifying event and who is eligible to continue coverage under the Plan in accordance with applicable provisions of COBRA due to a COBRA qualifying event. A Qualified Beneficiary includes a child born to the covered Employee or placed with the covered Employee for adoption if the covered Employee is covered under the Plan through COBRA Continuation of Coverage.

REGISTERED NURSE

"Registered Nurse" means an individual who has received specialized nursing training and is authorized to use the designation of "R.N.", and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

RESPITE CARE

“Respite Care” means care provided by Home Health Care Agency in accordance with the written Home Health Care Plan for the purpose of giving temporary relief from care giving duties to a Covered Person’s unpaid caregiver.

ROOM AND BOARD

"Room and Board" refers to all charges by whatever name called which are made by a Hospital, Hospice, or Skilled Nursing Facility as a condition of occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care by whatever name called.

SEMI-PRIVATE

"Semi-Private" refers to a class of accommodations in a Hospital or convalescent nursing facility in which at least two patients' beds are available per room.

SKILLED NURSING FACILITY

"Skilled Nursing Facility" means an institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an Inpatient basis, for persons convalescing from Injury or Illness, professional nursing services rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities;
2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse;
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse;
4. It maintains a complete medical record on each patient;
5. It has an effective utilization review plan;
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, education or Custodial Care, or care of mental disorders; and
7. It is approved and licensed by Medicare.

This term also applies to expenses Incurred in an institution referring to itself as a convalescent nursing facility, extended care facility, convalescent nursing home, or any such other similar nomenclature.

TEMPOROMANDIBULAR JOINT

“Temporomandibular Joint” is the joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

USUAL, CUSTOMARY AND REASONABLE (UCR)

“Usual, Customary and Reasonable” is the lesser of the provider’s usual charge for the same services or supplies in the absence of insurance coverage and the charge customarily billed to private patients for the same or similar services or supplies by providers in the same geographic location (the same zip code region).

WELL-CHILD CARE

"Well-Child Care" means medical treatment, services or supplies rendered to a child through age 6 or a Newborn solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.

PLAN INFORMATION

1. Name of Plan:
   Washington Fire Commissioners Association Health Care Benefits Plan

2. Type of Plan:
   Joint local government entities Self-Funded Medical, Prescription Drugs and Vision Plan

3. Type of administration:
   Contract administration with the Claims Administrator. The funding for the benefits is derived from the funds of the Plan Sponsor (and contributions made by participating fire protection districts and covered Employees, if any). The Plan is self-funded.

4. Name, business address and telephone number of the Plan Sponsor:
   Washington Fire Commissioners Association
   P. O. Box 134
   Olympia, WA 98507
   (360) 943-3880

5. Name, business address and telephone number of the Plan Administrator and Named Fiduciary:
   Washington Fire Commissioners Association
   P. O. Box 134
   Olympia, WA 98507
   (360) 943-3880

6. Name and address for service of legal process:
   Same as shown in #5.

7. Name, business address and telephone number of the Claims Administrator:
   Trusteed Plans Service Corporation
   P.O. Box 1894
   Tacoma, Washington 98401-1894
   (253) 564-5850

8. Participating Employers: Participating Fire Protection Districts.

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