The Power of Benefits

PUBLIC UTILITY DISTRICT #1 OF CHELAN COUNTY

Introduction to The Power of Benefits

Your Chelan County PUD Benefits Program is an important part of the total compensation (pay plus benefits) you receive from the District. These benefits help provide financial security for you and your family—now and in the future.

This handbook is your guide to the Benefits Program. Review the handbook carefully, share it with your family, and keep it in a handy location for easy reference.

This handbook describes current benefits. However, benefits are subject to change. You will be notified when changes occur. Changes and updates will be posted on the HR Web site.

Although this handbook includes certain key features and brief summaries of the Chelan County PUD Benefits Program, it does not provide detailed descriptions. If you have questions about specific plan details, contact Human Resources.

We have made every attempt to ensure the accuracy of this information. However, if there is any discrepancy between this handbook and the insurance contract, plan documents or other legal documents, the contracts, plan documents and other legal documents will govern.

This handbook does not create a contract of employment with the Chelan County PUD.

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Important Contacts

For More Information on These Benefits…..	
457 and 401(a) Plans	**Mission Square** PO Box 96220, Washington, DC 20090-6220 (800) 669-7400, Fax: (202) 682-6439, *www.icmarc.org*
Dental	**Delta Dental of Washington** PO Box 75983, Seattle, WA 98175-0983 (800) 554-1907, *www.DeltaDentalWA.com*
Disability Plan	**Mutual of Omaha** Mutual of Omaha Plaza Omaha, NE 68175-0001 (800) 877-5176, Fax: (402) 997-1865
Employee Assistance Plan **24-hour crisis services**	**Aetna Behavioral Health** To schedule an appointment: (888) 238-6232
Flexible Spending Accounts	**OneBridge Benefits** PO Box 80866, Seattle, WA 98108 (888) 338-4415
HRA VEBA	**HRA VEBA** (888) 659-8828, *www.hraveba.org*
Life and AD&D Plan	**Mutual of Omaha** Mutual of Omaha Plaza Omaha, NE 68175-0001 (800) 877-5176, Fax: (402) 997-1865
Long-term Care Plan	**UNUM Life Insurance Company** (800) 693-4988
Medical/Rx/Vision	**Premera Blue Cross** PO Box 3060, Spokane, WA 99220-3060 (800) 722-1471, *www.premera.com*
Personal Leave Plan	**Chelan County PUD Benefits Department** (509) 661-4448
Retirement Plan	**Department of Retirement Systems** (800) 547-6657, *www.drs.wa.gov*
Wellness Program	**Chelan County PUD Benefits Department** (509) 661-4448

I. Life Events Guide

Highlights

This section can help you make informed benefit decisions and changes when you experience certain life events. It is organized by event so you can find the information you need when you need it. Details include what you will have to do, what you will need and when coverage begins or ends.

The Chelan County PUD Benefits Program is regulated by federal law, and important restrictions apply. Once you have made your benefit elections for a given year, you generally cannot change those elections until the next open enrollment – unless you have a qualified change in status.

For example, there is no need to cover your spouse under two health plans simply because you expect your spouse may lose his/her health coverage during the year. If your spouse loses health coverage under his/her plan during the year, that would be a qualified change in status allowing you to make changes consistent with that event – like adding health coverage for your spouse under the Chelan County PUD health plan. Status changes include:

- Birth or adoption;
- Marriage;
- Divorce;
- Relocation;
- Dependent age 26 or over.
- Gain or loss of other medical/dental coverage;
- Death of a dependent.

See the sections on each benefit in this handbook for more specifics.

When you join Chelan County PUD

What to do

1. Complete an enrollment form by the deadline shown on your enrollment materials. If you miss this deadline, you will receive default coverage and will have to wait until the next open enrollment to make changes. Default coverage is:

Medical
Chelan County PUD CDHP for employee only

Dental
Employee-only dental coverage

Employee Life Insurance
Basic coverage only, no supplemental

AD&D Insurance
Basic coverage only, no supplemental

Long-Term Disability Insurance
Basic coverage only, no supplemental

Long-Term Insurance
Basic coverage only, no supplemental care

You may make changes if you experience a change in status or other event that would allow you to change your election before the next open enrollment.

2. Decide if you want to start participating in the 457/401(a) plans. You will need to complete the appropriate forms. Please contact Human Resources to obtain those forms.

3. Designate your beneficiary(ies) for life and AD&D insurance as well as the 457/401(a) and PERS retirement plan after you enroll.

What you will need

- Your dependents' birth dates and Social Security numbers;
- Names, Social Security numbers and addresses for beneficiary designations.
- Copy of marriage license.
- Copy of dependent child's birth certificate.

When coverage/participation begins

Participation in the Retirement Plan automatically begins for all eligible employees on the first day of work. For other benefits, coverage or participation begins on the first day of the month following date of hire.

If you move

What to do

- Update your address with Human Resources. Human Resources will forward your address change to Premera, Delta Dental Plan and the Department of Retirement Systems.
- Update your emergency contact information as necessary.

If you change your name

What to do

- Send a copy of your Social Security card to Human Resources. This will automatically change your name at Chelan County PUD and Department of Retirement Systems;
- Wait one pay period after you contact Human Resources, then contact Premera to order new ID cards;
- Revise your beneficiary designations, as appropriate.

If you get married

What to do

- Report your marriage to HR within 60 days or wait until the next open enrollment. You can add coverage for your new spouse and any new dependents. HR will let you know what changes you can make;
- Update your records – by calling HR – including you marital status, spouse's name and birth date, new dependent children's names and birth dates, and change of address, if applicable;
- Change your beneficiary designation(s), as appropriate. Contact HR to obtain necessary forms;
- Update your emergency contact information;
- Update your W-4 withholding form, if applicable. Contact payroll to obtain the necessary forms;
- Send a copy of your new Social Security card to HR if your name is changing.

What you will need

- Copy of marriage license or certificate;
- Spouse's birth date and Social Security card;
- Names, birth dates and Social Security cards of spouse's eligible children;
- New beneficiary designations, if appropriate.

If you become a parent

You may become a parent through:

- Birth;
- Adoption or children placed with you for adoption;
- Gaining legal custody;
- Marriage.

What to do

- Enroll your new child for health care coverage within 60 days of becoming a parent or wait until the next open enrollment.
- If you and your spouse both have medical coverage, review the Health Care Coverage section of this handbook to see whose benefits will pay first;
- Find out what resources are available through the Employee Assistance Plan. In addition to counseling, the Employee Assistance Plan offers referrals and information for parents – from finding child care to talking with your teen.

What you will need

- Copy of the child's birth certificate, adoption papers (from the court) or legal custody documents;
- Copy of your marriage certificate for stepchildren;
- Child's name, birth date and Social Security card;
- Spouse's name, birth date and Social Security card if you are adding coverage for your spouse.

If you take a medical leave

What to do

- After five continuous workdays or absence due to a medical reason, you must be under the care of a physician and you may apply for disability benefits;
- Print an "Application for Leave" packet from the HR Web site to apply for short-term disability;
- Your physician will need to provide documentation found in the leave packet;
- Contact the Employee Assistance Plan at 1-888-238-6232 if you or family members would like help with any issues related to your disability;
- Contact Benefits to determine if your leave qualifies under the Family Medical and Leave Act (FMLA);
- If your illness or injury is work related, contact Chelan County PUD Workers Compensation Administration.

If you take a medical leave longer than six months

What to do

- If you are approved by Mutual of Omaha for long-term disability, contact Benefits to review your options;
- Call the Employee Assistance Plan with any personal concern related to your leave.

Other leaves

What to do

- Contact HR to discuss:
  - Required forms;
  - Paid/unpaid leave;
  - Use of Paid Leave (PL);
  - Continuation of benefits and payment of premiums;
  - Military Leave;
- Discuss your leave request with your manager;
- Notify your manager of any changes in your return-to-work plans;
- Call the Employee Assistance Plan with any personal concerns related to your leave.

If you divorce or legally separate

What to do

- Report your divorce or legal separation to Benefits within 60 days. Notification within 60 days ensures COBRA rights to your ex-spouse and eligible dependents;
- Update your records–by calling HR–including your change of name or address, if applicable;
- Review your beneficiary designation(s) and make appropriate changes – there may be certain restrictions (contact Benefits if you have questions);
- Update your emergency contact information;
- Review your W-4 withholding form;
- Send a copy of your new Social Security card to HR if your name is changing;
- Contact the Employee Assistance Plan if you or family members would like assistance with any adjustments related to the divorce or separation.

What you will need

- A copy of the divorce decree or legal separation documents;
- Copy of the Medical Child Support Order (MCSO) or Qualified Domestic Relations Order (QDRO), if applicable.

If you die

What survivors should do

- Contact Benefits to file a claim for life insurance and, if applicable, AD&D benefits;
- COBRA information is automatically mailed to eligible dependent survivors;
- Your Retirement Plan and 457 beneficiary(ies) may contact Benefits to file a request for benefits, as applicable;
- Your family members may contact the Employee Assistance Plan for help in coping with their loss or to obtain legal or financial assistance.

What survivors will need

- One or more copies of the certified death certificate.

If your dependent dies

What needs to be done

- Contact Benefits to file a claim for life insurance;
- Contact Benefits within 30 days of the death to make any eligible changes to your benefits;
- You or your family members may contact the Employee Assistance Plan for help in coping with your loss or to obtain legal or financial assistance.

What you will need

- One or more copies of the certified death certificate.

If you leave Chelan County PUD

What to do

- Decide whether you want to continue health care coverage and participation in the Health Care Flexible Spending Accounting under COBRA (you must do so within 30 days of the date your coverage ends or you receive the COBRA notice from the plan administrator – whichever is later). If you enroll and send in your payment within the stated deadline, your COBRA coverage is retroactive to the first of the month following the end of your employment – there is no gap in coverage;
- Continue your life and/or AD&D coverage through the available conversion options if you wish. You have 30 days to decide. See the Life and AD&D section of this handbook for details. You will also receive information separately from the insurance company;
- Decide if you want to convert your long-term care coverage. You will need to contact UnumProvident if you are requesting to continue coverage;
- If you are vested in the PERS Retirement Plan, you are eligible to receive a benefit at retirement. Please contact DRS at (800) 547-6657 for more information;
- Contact HR to update your records with any changes, such as new address, etc.

If you are planning to retire

What to do

- Contact Benefits three months before your planned retirement date to determine your retiree medical benefits;
- Call the Washington State Employees Retirement System (800) 547-6657. You are responsible for making all arrangements with PERS regarding your retirement;
- For salaried employees, complete a Retirement/Resignation Notification Form and present to your supervisor. Print a copy from the HR Web site (look under "Forms") at least one month before your planned retirement date. Bargaining Unit employees may submit a resignation in writing;
- Call Social Security at least two months before your retirement begins for information on how to apply for Social Security and Medicare benefits (if applicable). Find out if your Social Security benefits will be affected if you work past age 65;
- Contact former employers if you have benefits coming to you from their plans.

What you will need

- Your birth certificate;
- Your marriage certificate.

If you are rehired

What to do

Complete an enrollment form by the deadline shown on your enrollment materials. If you miss this deadline, you will receive default coverage and will have to wait until the next open enrollment to make changes. Default coverage is:

Medical
Chelan County PUD, CDHP for employee only

Dental
Employee only

Employee Life Insurance
Basic coverage only, no supplemental

AD&D Insurance
Basic Coverage

Long-term Disability Insurance
Basic coverage only, no supplemental

Flexible Spending Accounts
No participation

You may, however, make changes if you experience a change in status or other event that would allow you to change your election before the next open enrollment.

What you will need

- Your dependents' names, addresses, birth dates and Social Security cards;
- Names and addresses for beneficiary designations.

Dependent life events

Some life events may directly affect your spouse or a dependent and are considered qualified status changes that entitle you to make changes to your benefit elections, provided you notify Benefits within 60 days of the event. Examples of qualified life events are:

- Your spouse loses or gains other health coverage due to a change in employment status;
- A dependent child loses other health coverage;
- A dependent child loses eligibility for Chelan County PUD health benefits due to age or change in marital status.

II. Premera Blue Cross Health Care Plan

Highlights

For many Chelan County PUD employees, health care coverage is the most important benefit they receive from the District. It offers quality care, choices and financial protection.

Your health care coverage is designed to help manage medical/vision and prescription drug cost for you and for the District.

At the Chelan County PUD, you have the choice of selecting from two medical/vision and prescription drug plan options as described below:

- Our two Plans are self-insured and contract with Premera Blue Cross to administer claims, provide customer service and use Premera's nationwide network (BlueCard);
- The plans provide comprehensive coverage for medical services, such as visits to your doctor, inpatient and outpatient surgical procedures, emergency care, vision care and prescription drugs;
- The plan pays a percentage of covered services after you have satisfied an annual deductible;
- You may choose to receive care from any doctor or hospital, inside or outside the Premera Blue Cross network and still receive coverage (at different levels) under the plan.

BENEFITS	CDHP	PPO PLAN 3
Deductibles	$1,250/Person $2,500/Family	$300/Person $900/Family
Coinsurance	80/20/in network (allowable charges) 60/40 out of network (allowable charges)	80/20/in network (allowable charges) 60/40 out of network (allowable charges)
Out of pocket (Including deductible)	$3,300/Person $6,600/Family	$1,300/Person $3,900/Family
Physician	80/20 after deductible	$20 Co-payment
Prescription Drugs (30 days supply)	80/20 after deductible	$10 co-payment generic $25 co-payment brand $40 co-payment brand non-formulary
Hospital (inpatient and outpatient	80/20/in network (after deductible) 60/40 out of network (allowable charges)	80/20/in network (allowable charges) 60/40 out of network (allowable charges)
Emergency	80/20 after deductible	$50 Co-payment
Vision Exam	80/20 after deductible	$20 Co-payment (one exam per year)
Vision Hardware	$300 allowance every 24 months	$300 allowance every 24 months
Chiropractic	80/20 after deductible	$20 Co-payment

Eligibility

You are eligible for benefits if you are:

- Full-time or limited assignment bargaining unit;
- Seasonal greater than six months bargaining unit;
- Full-time exempt or nonexempt salaried;
- Part-time exempt or non-exempt salaried;
- Full-time limited assignment salaried;
- Commissioner.

If you are eligible for health care benefits, the following family members are also eligible:

- Your spouse; as defined by federal law.
- Your dependent children, including adopted children, children placed with you for adoption and stepchildren. Children can be covered up to age 26.

You may be able to extend health care coverage past the normal age limits for an enrolled child incapable of self-support due to a mental or physical disability. Proof of disability must be provided 31 days before the child's 26th birthday, and then periodically. To arrange extended coverage for a disabled child, please contact Benefits.

Enrollment

If you belong to an eligible class, you are eligible to enroll in health care benefits effective the first day of the month following date of hire. Your eligible family members are also covered the first of the month following date of hire.

Making changes during the year

Please consider your benefit enrollment options carefully because—unless you have a qualifying change in status—the choices you make will be in effect through out the year. Examples of events (known as qualifying changes in status) that allow you to make changes to your health care elections as well as your Flexible Spending Accounts (FSA) are:

- Your marriage, divorce, legal separation or annulment;
- Birth, adoption or placement for adoption of a dependent child;
- Death of your spouse or dependent;
- Any employment status change that results in you, your spouse or dependent gaining or losing eligibility (such as beginning or ending employment, changing from full-time to part-time or visa versa, taking or returning from an unpaid leave, experiencing a strike or lockout, or changing worksites);

- Dependent ceases to satisfy eligibility requirements.

Any change you make must be because of and correspond with the qualifying change in status.

You must make any changes to your elections within 60 days of the qualifying event. Otherwise you will need to wait until the next open enrollment. Contact Benefits for details about changing your elections.

FMLA leave

If you take an FMLA (Family and Medical Leave Act) leave of absence, you may continue your coverage (by continuing to pay your portion of the premium), or you may cancel your coverage for the duration of your leave and be reinstated in the same elections when you return. The Family and Medical Leave Administrative Policy may be found of the HR Web site. If you have questions, contact Benefits.

Military Leave

If you take a leave of absence for voluntary or involuntary duty with certain uniformed services (for example, the U.S. armed forces, National Guard, or commissioned members of the Public Health Service), coverage will remain in effect for you and your covered dependents for the lesser of the period of your leave or 24 months as long as you continue to pay your portion of the required premiums (as described under “Purchasing continued health coverage under COBRA” later in this section).

For authorized duty leaves of 31 days or more, your right to continue program coverage will be the same as described under “Purchasing continued health coverage under COBRA” later in this section, and will run concurrently with the COBRA period also described later in this section. Continued coverage during an authorized duty leave will not end due to coverage under another health plan if the health plan is either CHAMPUS or other military coverage.

Court order

You may change your dependent child’s health care coverage election to comply with a court or state administrative order from a divorce, legal separation, annulment or change in legal custody.

When coverage begins

As an eligible employee, you generally will receive enrollment information and instructions within the first 30 days of employment. Coverage for you and any enrolled family member begins the first of the month following date of hire.

The self-insured Premera Blue Cross plan

The plan is administered for Chelan County PUD by Premera Blue Cross. Premera Blue Cross is a national provider of health care benefits (available under the BlueCard program). Its nationwide network of health care providers has 80 percent of hospitals and nearly 90 percent of physicians' contracted directly with the Bluecard program. Its network in the Wenatchee area offers the widest possible access.

How the plan works

Why use network providers

Providers who join the PPO network are carefully screened and regularly monitored by Premera Blue Cross to meet established standards for high-quality medical care. They agree to a discounted rate in exchange for being listed as a network provider. As a result, the cost of coverage from network providers is lower and the savings can be passed along to you in the form of higher coverage levels.

The advantages of receiving care from Premera PPO network providers are:

- Your benefits are higher for most services from network providers;
- You do not need to file claims for service from network providers—they will do it for you. After Premera Blue Cross pays its share, the provider will bill you for any remainder.

How to find network providers

Provider directories are available on the Premera Web site at www.premera.com or by calling (800) 722-1471.

The BlueCard program

Premera Blue Cross, like all Blue Cross and/or Blue Shield licensees, participates in a program called "BlueCard." Enrollees can take advantage of BlueCard when they are outside Washington and Alaska and receive covered services from hospitals, doctors, and other medical care providers who have contracted with the local Blue Cross and/or Blue Shield licensee, called the "Host Blue" in this section. The national BlueCard program is available throughout the United States, the Commonwealth of Puerto Rico, Jamaica and the British and U.S. Virgin Islands.

Your identification card tells contracting providers which independent Blue Cross and/or Blue Shield Licensee covers you. It is important to note that receiving services through BlueCard does not change covered benefits, benefit levels, or any stated residence requirements of this program. When you use your identification card, you will receive many of the conveniences you're accustomed to from Premera Blue Cross. In most cases, there are no claim forms to submit because contracting providers will handle claim submission for you.

Deductible

The deductible is the amount you must pay for most covered expenses each year before the Plan begins to pay benefits. The annual deductible varies between the plans offered. Please refer to Highlights in the beginning of this section for more information.

The deductible does not apply to certain benefits under the PPO plan; these include:

- Newborn care;
- Prescription drugs;
- Health education network;
- Professional services subject to a co-payment;
- Separate charges for office visits for obstetrical care;
- Outpatient services for physical, speech and occupational therapy, radium or X-ray therapy, chemotherapy;
- Diagnostic imaging (including X-ray) and laboratory procedures covered under the Professional Services Benefit or the outpatient services part of the Hospital Benefit;
- Physician-billed drugs;
- Immunizations;
- Allergy tests and allergy shots;
- Infusion therapy drugs and solutions;
- Vision services.

You will still need to satisfy the deductible for all other services and supplies not listed above.

Coinsurance

Once your deductible is satisfied, the Plan pays a share of covered expenses and you pay a share; your share is called your coinsurance.

The amount the Plan pays toward covered expenses depends on whether you see a network or non-network provider and the type of service you receive. After the deductible, the plan pays:

- Network: 80 percent of allowable charges for covered services and supplies from network providers (your coinsurance is 20 percent);
- Non-network: 60 percent of allowable charges from non-network providers (your coinsurance is 40 percent). In some cases the plan pay nothing is you see a non-network provider (i.e. preventative care). If you see a non-network provider, deductibles and out-of-pocket limits do not apply.

Co-payments

A co-payment is a flat dollar amount you pay when you receive a service or supply. Under the PPO plan, co-payments apply to:

- Office visits with network providers;
- Outpatient mental health treatment visits with network providers;
- Prescription drugs;
- Vision exams;
- Emergency room charges;
- Chiropractic visits with network providers.

After you pay the applicable co-payment, these services and supplies are covered at 100 percent of allowable charges.

Out-of-pocket limit

To protect you against the high cost of medical care, the PPO/CDHP plans set an annual limit on how much you have to pay in coinsurance for covered expenses incurred by you and your family. This is called your out-of-pocket limit. The annual out-of-pocket limit varies between the plans offered. Please refer to Highlights in the beginning of this section for more information.

Covered Services and Supplies

Alternative medicine

Services provided by a licensed naturopath, acupuncturist, massage therapist, dietitian or chiropractor shall be covered to the same extent, and subject to the same limitations, as services provided by any other covered provider. All services must be medically necessary and will be subject to all other terms and conditions of this program. For example, massage therapy benefits are subject to the terms and conditions that apply to coverage of physical therapy.

Ambulance services

Benefits for licensed ambulance services are provided at 80 percent of allowable charges.

This benefit is provided when your licensed ambulance transportation is medically necessary to the nearest accredited hospital or facility equipped to treat a condition eligible under this program. Ambulance service is only covered when any other mode of transport would endanger your health or safety. Air ambulance service is only covered when the use of ground ambulance would cause further injury or life threatening delays in treatment. Air ambulance service which is deemed not medically necessary will be covered up to the amount that would have been provided for ground ambulance.

Cardiac rehabilitation outpatient therapy

Benefits for services furnished by a preferred provider are provided at 80 percent of allowable charges. Benefits for services furnished by a nonpreferred provider are provided at a constant 60 percent of allowable charges.

Benefits for cardiac rehabilitative outpatient therapy are provided when furnished by a provider whose program has been approved by Premera.

This benefit is limited to medically necessary acute cardiac rehabilitative therapy only, when initiated within three months subsequent to one of the following cardiac events:

- Myocardial infarction (MI);
- Coronary revascularization (CABG);
- Coronary angioplasty (PTCA);
- Other, as recommended and approved by Premera.

In addition to "General limitations and exclusions," this benefit does not cover prevention or maintenance programs.

Chemical dependency treatment

Institutional, professional, and other related services will be covered to the same extent as any other condition for chemical dependency treatment as described below.

Benefits for inpatient and outpatient chemical dependency treatment and supporting services are provided. Covered services must be furnished by a state-approved treatment program.

Detoxification services do not apply toward the above chemical dependency treatment benefit limit.

For the purpose of chemical dependency treatment, benefits for “medically necessary” services will be determined in accordance with the current edition of Patient Placement Criteria for Treatment of Substance-Related Disorders, published by the American Society of Addiction Medicine.

In addition to “General limitations and exclusions,” this benefit does not cover:

- Treatment of nondependent alcohol or drug use or abuse;
- Voluntary support groups, such as Alanon or Alcoholics Anonymous;
- Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing, or to driving rights, except as deemed medically necessary by us.

Contraception services

Your program provides benefits for the contraception services, drugs and supplies below on the same basis as any other covered care.

- Prescription drugs and devices for contraception and oral contraceptives (including emergency contraception) and prescription barrier devices, such as diaphragms and cervical caps, dispensed by a licensed pharmacy are covered on the same basis as other covered prescription drugs. See the prescription drug benefit for important information on your program's drug benefit;
- Contraceptive surgeries, implants and injections and surgical sterilization and implantable contraceptives (including hormonal implants) are covered on the same basis as any other surgery. Injectable contraceptives and related professional services are covered on the same basis as other injectable drugs;
- Professional consultations office visits and consultations related to contraception are covered as any other professional office visit.

Benefits are not provided for nonprescription contraceptive drugs, supplies or devices, reversal of sterilization, or services, drugs or supplies for fertility enhancement.

Dental care

This program covers dental expenses in two situations only:

Dental injury benefits for services furnished by a licensed physician or dentist are provided at 100 percent of allowable charges.

This benefit is provided for repair of accidental injury to natural teeth, to a maximum of $500 per accident. Treatment must begin within 30 days of the accident, and benefits for the treatment of that injury will be provided for a period of 12 months following the date of the injury. In the case of injury to a natural tooth, the tooth must have been your natural living tooth that was free from decay and otherwise functionally sound in Premera's judgment at the time of the accidental injury. "Functionally sound" means that the affected teeth:

- Do not have extensive restoration, veneers, crowns or splints;
- Do not have periodontal disease or any other condition that, in our judgment, would cause the tooth to be in a weakened state prior to the injury.

Dental injuries caused by biting or chewing are not covered, even if due to a foreign object in food.

General anesthesia hospital or ambulatory surgical center and anesthesiologist services are covered the same as they are for any medical condition when general anesthesia is medically necessary for dental procedures as described below. The medical program will cover general anesthesia and related hospital or ambulatory surgical center services if medically necessary for dental procedures for one of two reasons:

- The enrollee is under age 7 or is disabled physically or developmentally and has a dental condition that cannot be safely and effectively treated in a dental office;
- The enrollee has a medical condition besides the dental condition needing treatment that the attending provider finds would create an undue medical risk if the treatment were not done in a hospital or ambulatory surgical center.

This general anesthesia benefit does not cover the dentist's services.

Durable medical equipment and medical supplies

Benefits for services furnished by a preferred provider are provided at 80 percent of allowable charges. Benefits for services furnished by a nonpreferred provider are provided at a constant 60 percent of allowable charges.

Benefits will be provided for the rental of durable medical equipment but not to exceed the purchase price, when medically necessary and prescribed by a preferred provider for therapeutic use in direct treatment of a covered illness or injury. Premera may also provide benefits for the initial purchase of equipment, in lieu of rental. However, no benefits will be provided in subsequent calendar years for charges not initially reimbursed because the maximum has been reached. Examples of durable medical equipment are a wheelchair, hospital-type bed, traction equipment, ventilators, and diabetic equipment such as injection aids, blood glucose monitor, insulin pumps and accessories to pumps, and insulin infusion devices.

In cases where there is an alternative type of equipment that is less costly and serves the same medical purpose, Premera will provide benefits only up to the lesser amount.

Repair or replacement of durable medical equipment medically necessary due to normal use or growth of a child is covered.

Benefits will be provided for medical supplies such as syringes, rib belts, crutches, infusion therapy supplies, diabetic supplies (including test strips for blood glucose monitors, and visual reading and urine test strips) not provided under the prescription drug benefit. This benefit will also cover eyeglass lenses and frames if they are medically necessary after cataract surgery because an intraocular lens cannot be implanted. All medical supplies must be medically necessary and prescribed by a preferred provider.

In addition to "general limitations and exclusions," the durable medical equipment and medical supplies benefit does not cover environmental control equipment (i.e., air conditioners, dehumidifiers, purifiers), heating pads, deluxe or special equipment such as motorized wheelchairs or beds, shower equipment, exercise equipment (i.e., cycles, weights), or whirlpool baths.

Health education network

Benefits for education services furnished by preferred or nonpreferred providers are provided at 100 percent of the class fee.

This benefit provides for outpatient educational programs such as self-management training and education for diabetes, including medical nutritional therapy when performed by a covered provider with expertise in diabetes, and respiratory rehabilitation, to a maximum of $250 per enrollee, per calendar year. The program must be approved by us.

Home health care

Benefits for services furnished by a preferred home health agency are provided at 80 percent of allowable charges. Benefits for services furnished by a nonpreferred home health agency are provided at a constant 60 percent of allowable charges.

The services of a home health agency will be covered in the enrollee's home up to a maximum of 130 visits per enrollee per calendar year for medically necessary treatment of an illness or injury, subject to the conditions and limitations specified throughout this benefit. A visit of any duration by an employee of a home health agency for the purpose of providing services under the plan of treatment shall constitute one visit.

The following must be satisfied to be eligible for coverage under this benefit:

- The enrollee must be homebound or the Medical Director must determine that the enrollee will benefit optimally by having medically necessary treatment provided through home care services.

Benefits are limited to the following in the enrollee's home and must be provided by employees of and billed by the home health agency:

- Physician services;
- Nursing services by a registered nurse or licensed practical nurse;
- Physical therapy by a licensed physical therapist;
- Occupational therapy by an occupational therapist certified by the American Occupational Therapy Association;
- Speech therapy by a speech therapist certified by the American Speech and Hearing Association;
- Medical social services by a person with a master's degree in social work;
- Home health aide who is under the supervision of a registered nurse, physical therapist, or certified speech therapist. Such services are limited to part-time care including ambulation and exercise, personal care or household services essential to achieve the medically desired results, assistance with medications, reporting changes in the enrollee's condition and needs, and completion of appropriate records;
- Respiratory therapy by an inhalation therapist certified by the National Board of Respiratory Therapists;
- Medical supplies dispensed by the home health agency that would have been provided on an inpatient basis;
- Nutritional guidance by a licensed or certified dietitian;
- Nutritional supplements such as diet substitutes administered intravenously or externally.

If this benefit is exhausted, the enrollee may apply for an extension with Premera. Limited extensions may be granted by us if it is determined the treatment is medically necessary.

Any expense for home care that qualifies both under this benefit and the hospice services benefit of this program will be covered only under the benefits Premera determines to be the most appropriate and which will avoid duplication of benefits.

In addition to "general limitations and exclusions," this benefit does not cover:

- Service to other family members;
- Service of volunteers, household members, family or friends;
- Food, clothing, housing or transportation;
- Supportive environmental equipment, including but not limited to, ramps, handrails, or air conditioners;
- Homemaker or housekeeping services, except for services of a home health aide specified earlier in this benefit;
- Financial or legal counseling services;
- Custodial care, except for services of a home health aide specified earlier in this benefit;
- Services or supplies not included in the written treatment plan, not specifically set forth as a covered service under this benefit, or limited or excluded under the "general limitations and exclusions" section of this program.

Hospice services

Benefits for services furnished by a preferred hospice are provided at 80 percent of allowable charges. Benefits for services furnished by a nonpreferred hospice are provided at a constant 60 percent of allowable charges.

The terminally ill enrollee will be eligible for services of a hospice up to a lifetime maximum of six months per enrollee for medically necessary treatment or palliative care (medical relief of pain and other symptoms), subject to the conditions and limitations specified throughout this benefit. Benefits may be provided for an additional six months of care in cases where the enrollee is facing imminent death or is entering remission.

Benefits are limited to the following in the enrollee's home and must be provided by employees of and billed by the hospice:

- Physician services;
- Nursing services by a registered nurse or licensed practical nurse;
- Physical therapy by a licensed physical therapist;
- Occupational therapy by an occupational therapist certified by the American Occupational Therapy Association;

- Speech therapy by a speech therapist certified by the American Speech and Hearing Association;
- Medical social services by a person with a master's degree in social work;
- Home health aide who is under the supervision of a registered nurse, physical therapist or certified speech therapist. Such services are limited to part-time care including ambulation and exercise, personal care or household services essential to achieve the medically desired results, assistance with medications, reporting changes in the enrollee's condition and needs, and completion of appropriate records;
- Respiratory therapy by an inhalation therapist certified by the National Board of Respiratory Therapists;
- Medical supplies dispensed by the hospice that would have been provided on an inpatient basis;
- Nutritional guidance by a licensed or certified dietitian;
- Nutritional supplements such as diet substitutes administered intravenously or externally.

When the enrollee is confined as an inpatient in a hospice that is not an accredited hospital or skilled nursing facility, the regular inpatient hospital benefits of this program will be covered for short-term care as an inpatient and shall be charged against the limitations of this benefit.

Respite care provides for continuous care of the enrollee to provide temporary relief to family members or friends from the duties of caring for the enrollee. Respite care is limited to 120 hours per three-month period, subject to the overall six-month hospice lifetime benefit.

Any expense for hospice care that qualifies both under this benefit and the home health care benefit of this program will be covered only under the benefits Premera determines to be the most appropriate and which will avoid duplication of benefits.

In addition to "general limitations and exclusions," this benefit does not cover:

- Services for spiritual counseling or bereavement counseling;
- Service to other family members;
- Service of volunteers, household members, family or friends;
- Food, clothing, housing or transportation;
- Supportive environmental equipment, including but not limited to, ramps, handrails, or air conditioners;
- Homemaker or housekeeping services, except for services of a home health aide specified earlier in this benefit;
- Financial or legal counseling services;
- Custodial care, except that benefits will be provided for palliative care to a terminally ill enrollee;

- Services or supplies not included in the written treatment plan, not specifically set forth as a covered service under this benefit, or limited or excluded under the "general limitations and exclusions" section of this program.

Hospital services

Benefits for services furnished by a preferred hospital are provided at 80 percent of allowable charges, except as stated below. Benefits for services furnished by a nonpreferred hospital are provided at a constant 60 percent of allowable charges, except as stated below. However, if such services are the result of a medical emergency or accidental injury, benefits will be provided at the preferred hospital benefit level.

This benefit is provided for medically necessary inpatient and outpatient hospital services in an accredited hospital, for any illness, injury or physical disability. For inpatient hospital obstetrical care and newborn care, refer to the “obstetrical care” and “newborn care” benefits.

Covered inpatient services include:

- Hospital charges for room, board and general nursing care. Services of a personal nature such as charges for radio, television, telephone, guest meals, etc. are not covered;
- General nursing care billed by a hospital is covered as an ancillary when billed separate from the room and board charges;
- Intensive care and coronary care unit charges;
- Ancillaries;
- Treatment for medically necessary inpatient detoxification services provided on the same basis as any other emergency medical condition so long as the enrollee is not yet enrolled in other chemical dependency treatment. For treatment of chemical dependency other than detoxification services, refer to the "chemical dependency treatment" benefit.

Except as specifically provided, the duration of hospitalization shall not exceed 365 days per calendar year for all eligible illness, accidental injury and disability combined.

Covered outpatient services include:

- Emergency room services are subject to a $50 co-payment per visit. The co-payment will be waived if the enrollee is directly admitted from the emergency room;
- Treatment of accidental injuries;
- Surgery;
- Diagnosis or treatment of illness;
- Ancillaries;
- Treatment for medically necessary outpatient detoxification services provided on the same basis as any other emergency medical condition so long as the enrollee is not yet enrolled in other chemical dependency treatment. For treatment of chemical dependency other than detoxification services, refer to the "chemical dependency treatment" benefit.

The following outpatient services will be covered at 100 percent of allowable charges when furnished by a preferred hospital and at 70 percent of allowable charges when furnished by a nonpreferred hospital:

- Physical (including massage), speech and occupational therapy, after an applicable co-payment per visit to a preferred or nonpreferred provider. These visits will be charged against the 20 visit per calendar year maximum set forth under the "Professional Services" benefit;
- Radium or X-ray therapy and chemotherapy;
- Diagnostic imaging (including X-ray) and laboratory procedures.

Infusion therapy

All benefits are based on allowable charges.

	Preferred Infusion Therapist	**Nonpreferred Infusion Therapist**
Infusion therapy services	80 percent	a constant 60 percent
Drugs and solutions	100 percent	a constant 70 percent
Supplies	Covered by durable medical equipment and medical supplies benefit	Covered by durable medical equipment and medical supplies benefit

This benefit covers professional services, drugs and solutions required for home infusion therapy when furnished and billed by an infusion therapy provider. Infusion therapist visits are counted toward the home health benefit's 130-visit maximum per calendar year.

In addition to "general limitations and exclusions," this benefit does not cover:

- Charges in excess of the average wholesale price shown in the "Pharmacist's Red Book" for drugs and solutions;
- Over-the-counter drugs, solutions and nutritional supplements;
- Services or supplies covered by the home health or hospice benefit;
- Infusion therapy supplies. See the durable medical equipment and medical supplies benefit for coverage.

Mastectomy and breast reconstruction services

Institutional, professional and other related services will be covered to the same extent as any other condition for mastectomy and breast reconstruction services as described below.

This benefit is provided for mastectomy necessary due to disease, illness or accidental injury. For any enrollee electing breast reconstruction in connection with a mastectomy, this benefit covers:

- Reconstruction of the breast on which mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Prostheses;
- Physical complications of all stages of mastectomy, including lymphedemas.

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

Mental health services

Benefits for services furnished by a preferred provider are provided as follows:

- Inpatient professional and institutional services (including ancillaries) - a constant 80 percent of allowable charges.;
- Outpatient professional and institutional services (including ancillaries) - a constant 100 percent of allowable charges after your co-payment, deductible and co-insurance per visit.

Benefits for services furnished by a nonpreferred provider are provided as follows:

- Inpatient professional and institutional services (including ancillaries) - a constant 60 percent of allowable charges.;
- Outpatient professional and institutional services (including ancillaries) - a constant 70 percent of allowable charges after your co-payment, deductible and co-insurance per visit.

Benefits for mental health services, including treatment of eating disorders (such as anorexia nervosa, bulimia or any similar condition), are provided up to the benefit maximums stated below. Covered mental health services include inpatient care, partial hospitalization and outpatient treatment to manage or lessen the effects of a psychiatric condition. Services must be consistent with generally recognized standards within a relevant health profession as determined by us.

For chemical dependent treatment benefit information, please see the chemical dependency treatment benefit.

Covered services must be furnished by one of the following types of providers:

- Accredited hospital;
- State hospital which is operated and maintained by the State of Washington for the care of the mentally ill ~ Licensed Community Mental Health Agency;
- Physician (M.D. or D.O.);
- Licensed clinical psychologist (Ph.D.);
- Any other provider listed under the definition of "Provider" who is licensed or certified by the state in which the care is provided, and who is providing care within the scope of his or her license.

The above providers must have in effect a plan for quality assurance and peer review and treatment must be supervised by a physician (M.D. or D.O.) or a licensed clinical psychologist.

Benefits are provided up to the following benefit levels:

- Benefits for outpatient therapeutic professional or institutional care, including ancillaries, are provided.
- "Outpatient therapeutic visit" (outpatient visit) means a clinical treatment session with a mental health provider of a duration consistent with relevant professional standards as defined in the Physicians Current Procedural Terminology, published by the American Medical Association.
- Benefits for inpatient professional or institutional care, including ancillaries, are provided.

As an alternative to inpatient care, your program covers "partial hospital days." Two partial hospital days will count as one inpatient day.

Mental Health Services And Your Rights: Premera Blue Cross and state law have established standards to assure the competence and professional conduct of mental health service providers, to guarantee your right to informed consent to treatment, to assure the privacy of your medical information, to enable you to know which services are covered under this plan and to know the limitations of your coverage. If you want a more detailed description of covered benefits for mental health services under this plan, or if you have a question or concern about any aspect of your mental health benefits, please contact Premera Blue Cross at one of the following telephone numbers:

Local and toll-free number: 1-800-722-1471

Local and toll-free TDD number for the hearing impaired: 1-800-842-5357

If you want to know more about your rights under the law, or if you think anything you received from us may not conform to the terms of your contract or your rights under the law, you may contact the Office of Insurance Commissioner at 1-800-562-6900. If your have a concern about the qualifications or professional conduct of your mental health service provider, please call the State Health Department at 360-236-4010.

Neurodevelopmental therapies

Benefits for services furnished by a preferred provider are provided at 100 percent of allowable charges. For office visits, you pay an applicable co-payment per visit. Benefits for services furnished by a nonpreferred provider are provided at a constant 60 percent of allowable charges. For office visits, you also pay an applicable co-payment per visit.

Benefits are provided up to a maximum of 30 days/60 visits per enrollee, per calendar year. This benefit provides for services furnished by providers licensed to deliver occupational therapy, speech therapy and physical therapy for the treatment of neurodevelopmental diseases for enrollees age 6 and under, upon the referral and periodic review of a preferred physician (M.D. or D.O.), or where the services are provided by such physician. A formal written treatment plan is required.

Services must be medically necessary to restore and improve function or to maintain a condition where significant deterioration in the enrollee's condition would result without the service.

Newborn care

Institutional, professional and other related services will be covered to the same extent as any other condition for newborn care as described below. The deductible is waived for newborn care.

Newborn children are covered automatically for the first three weeks from birth when the mother is eligible to receive obstetrical care benefits under this program. To continue benefits beyond the three-week period, please see the dependent eligibility and enrollment guidelines outlined under the "Who is eligible for coverage" and "Life Events Guide" sections.

If the mother is not eligible to receive obstetrical care benefits under this program, the newborn is not automatically covered for the first three weeks. For newborn enrollment information, please see the "Who is eligible for coverage" and "Life Events Guide" sections.

The regular benefits of this program will apply and may include the services listed below. Services must be consistent with accepted medical practice and ordered by the attending provider in consultation with the mother.

Hospital nursery care as determined necessary by the attending provider, in consultation with the mother, based on accepted medical practice. Also covered are any required re-admissions to a hospital and outpatient or emergency room services for medically necessary treatment of an illness or injury.

Note: 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, this restriction does not apply in any case in which the decision to discharge the mother or her newborn child prior to the expiration of the minimum length of stay is made by an attending provider in consultation with the mother.

Professional care such as:

- Inpatient newborn care;
- Follow-up care consistent with accepted medical practice which is ordered by the attending provider, in consultation with the mother. Follow-up care includes services of the attending provider, a home health agency and/or a registered nurse;
- Circumcision during the first three weeks, or for up to six months following birth for an enrolled dependent child.

Please Note: Attending provider as used in this benefit means a physician (M.D. or D.O.), a physician's assistant, a certified nurse midwife (C.N.M.), a licensed midwife or an advanced registered nurse practitioner (A.R.N.P.).

Obesity services

Medical and surgical treatment for obesity or morbid obesity treatment will be covered to the same extent as any other condition, if your medical condition meets Premera's written medical policy.

Obstetrical care

Institutional, professional, and other related services will be covered to the same extent as any other condition for obstetrical care as described below.

Obstetrical benefits are provided to a female subscriber or a male subscriber's enrolled spouse. Obstetrical benefits include, but are not limited to, prenatal care during the pregnancy, childbirth (i.e., vaginal delivery or cesarean section), voluntary termination of pregnancy and medically necessary follow-up care.

Professional services: Medical and surgical care, including prenatal and after care, shall be covered to the same extent as for any other medical condition for such period of time as determined by the attending provider in consultation with the mother. Such care must be based on accepted medical practice. If the attending provider bills a single fee for childbirth that includes prenatal and postpartum services, this program will cover that fee as it would any other surgery. Please see the "Surgical services" benefit for details on surgery coverage.

Hospital services: Shall be covered to the same extent as for any other medical condition for such period of time as determined by the attending provider in consultation with the mother. Such care must be based on accepted medical practice.

Follow-up care: At the time of discharge, determination of the type and location of follow-up care, including in-person care, must be made by the attending provider in consultation with the mother. These decisions must be based on accepted medical practice.

Special provisions:

- Complications of pregnancy for a subscriber, enrolled spouse or enrolled dependent child will be covered to the same extent as any other condition;
- Obstetrical benefits will not be provided for pregnancies which are the result of, or for the purposes of, surrogacy;
- Medically necessary diagnostic and screening procedures, pre- and post-procedure genetic counseling for prenatal diagnosis of congenital disorders of the fetus will be covered to the same extent as any other medical condition. However, benefits will not be provided for sex typing or paternal typing, except as may be required for prenatal diagnosis of congenital disorders;

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn to less than 48 hours following vaginal delivery, or less than 96 hours following a delivery by cesarean section. However the plan or issuer may pay for a shorter stay if the attending provider (e.g., your physician, nurse, midwife, or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96-hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your plan administrator.

Orthognathic surgery

Institutional, professional, and other related services will be covered to the same extent as any other condition for orthognathic surgery, subject to a maximum benefit of $5,000 per enrollee, per lifetime.

Orthodontic treatment is not covered under this benefit.

Orthopedic appliances

Benefits for services furnished by a preferred provider are provided at 80 percent of allowable charges. Benefits for services furnished by a nonpreferred provider are provided at a constant 60 percent of allowable charges.

This benefit provides for medically necessary orthopedic appliances such as therapeutic shoes for prevention of complications associated with diabetes; and braces and splints as may be reasonably required for normal daily activities for treatment of any illness or injury eligible under this program.

In addition to “General limitations and exclusions,” this benefit does not cover orthopedic appliances prescribed primarily for use during participation in sports, recreational and similar activities, corrective shoes, and arch supports (except as required for prevention of complications associated with diabetes).

Orthotics

Benefits for services furnished by a preferred provider are provided at 80 percent of allowable charges. Benefits for services furnished by a nonpreferred provider are provided at a constant 60 percent of allowable charges.

This benefit provides for one pair, per enrollee, per calendar year, of casted orthotics (including foot impression castings) medically necessary for prevention of complications associated with diabetes or for the treatment of any illness or injury eligible under this program. In addition to “General limitations and exclusions,” this benefit does not cover orthotics prescribed primarily for use during participation in sports, recreational and similar activities, corrective shoes and arch supports (except as required for prevention of complications associated with diabetes).

Prescription Drug Benefit

Subject to the provisions stated in this benefit, benefits are available for prescription drugs dispensed by a licensed pharmacy. In no case will the enrollee's out-of-pocket expense exceed the cost of the drug or supply.

Retail dispensing limits:

- Benefits are provided for up to a 30-day supply of covered medication unless the drug maker's packaging limits the supply in some other way.

Please note: Retail pharmacy co-payments do not apply toward any of this program's deductibles or out-of-pocket maximum.

Home delivery dispensing limits:

- For a double co-pay, benefits are provided up to a 90-day supply of covered medication unless the drug maker's packaging limits the supply in some other way.

Please note: Home delivery pharmacy co-payments do not apply toward any of this program's deductibles or out-of-pocket maximum.

What is covered

This benefit covers the following items when dispensed by a licensed pharmacy for use outside of a medical facility:

- FDA-approved drugs which by federal or state law require a prescription. These are known as "legend drugs." This benefit includes coverage for off-label use of FDA-approved drugs as provided under this program's definition of "Prescription drugs;
- Prescriptive oral agents for controlling blood sugar levels;
- Compounded medications where at least one ingredient is a covered prescription drug;
- Disposable diabetic testing supplies such as test strips, tapes, reagents, and lancets. Please note, the co-payment applies to each supply dispensed;
- Vitamins which by law require a prescription;
- Injectable prescription medications for self-administration, insulin, insulin needles and syringes;
- Glucagon and allergy emergency kits;
- Prescription smoking cessation drugs, to a maximum of $250 per enrollee per calendar year;
- Take-home prescription contraceptive drugs and devices.

For benefit information concerning therapeutic devices, appliances, medical equipment, medical supplies, diabetic equipment and accessories (except for those specifically stated as covered in this benefit), please see the Durable medical equipment and medical supplies benefit.

For benefit information concerning immunization agents and vaccines and professional services to administer the medication, see the Professional services benefit.

Retail pharmacy benefit

After the required co-payment, deductible and co-insurance benefits are provided at the following levels:

- Participating pharmacies: For each new prescription or refill, benefits are provided at 100 percent of the allowable charge. Premera will pay the participating pharmacy directly;
- Nonparticipating pharmacies: For each new prescription or refill, benefits are provided at 60 percent of the allowable charge. You pay the full price for the drug(s) and submit a claim for reimbursement. See "Submission of prescription drug claims" later in this benefit. This benefit applies to all prescriptions filled by a nonparticipating pharmacy, including those filled via mail or other home delivery.

If you need a list of participating pharmacies, please call Premera. You can also call the toll-free telephone number for the pharmacy locator line on the back of your ID card.

Home delivery pharmacy benefit

You can often save time and money by filling your prescriptions through the home delivery pharmacy benefit. For each new prescription or refill, benefits are provided at 100 percent of the allowable charge after the co-payments listed earlier in this benefit. Premera will pay the participating home delivery pharmacy directly. This benefit is limited to prescriptions filled by Premera's participating home delivery pharmacy.

For more information on the home delivery pharmacy benefit, or to obtain order forms, please contact Premera's customer service department.

Exclusions

This benefit does not cover the following:

- Drugs and medicines which may be lawfully obtained over the counter ("OTC") without a prescription. OTC drugs are excluded even if prescribed by a practitioner. Examples of non-covered items include, but are not limited to: nonprescription vitamins, food and dietary supplements, herbal or naturopathic medicines, nutritional and dietary supplements;
- Fertility drugs, regardless of their intended use;
- Drugs dispensed for treatment of obesity or to manage weight;
- Drugs to treat sexual dysfunction;
- Drugs which are prescribed or used for cosmetic purposes, including, but not limited to, hair loss, wrinkles and onychomycosis;
- Drugs for experimental or investigative use;
- Biological sera, blood, blood derivatives or components;

- Prescriptions or refills in excess of the quantity specified by the prescriber, or that are dispensed after one year from the date the prescription was written;
- Drugs dispensed for use or administration in a health care facility or providers office, or take home drugs dispensed and billed by a medical facility;
- Human growth hormone drugs;
- Replacement of lost or stolen medication;
- Infusion therapy drugs or solutions, drugs requiring parenteral administration or use, and injectable medications. (The exception is injectable drugs for self-administration, such as insulin and glucagon).

Submission of prescription drug claims

To make a claim for covered prescription drugs, please follow these steps:

- Participating pharmacies: You don't have to send Premera a claim; just show your ID card to the pharmacist, who will bill Premera directly. If you don't show your ID card, you will have to pay the full cost of the prescription and submit the claim yourself;
- Nonparticipating pharmacies: You will have to pay the full cost for new prescriptions and refills purchased at these pharmacies. Fill out a prescription drug claim form and send it to the address shown on the claim form.

If you need a supply of claim forms, contact Premera customer service department at (800) 722-1471.

Professional services

Benefits for services furnished by a preferred provider are provided at 80 percent of allowable charges, except where otherwise specified. Benefits for services furnished by a nonpreferred provider are provided at a constant 60% percent of allowable charges for services which are covered at 80 percent of the allowed charge when provided by a preferred provider and at a constant 70 percent of allowable charges for services which are covered at 100 percent of the allowed charge when provided by a preferred provider.

Benefits are available for the following professional services:

- Office and home visits for medical and surgical services for illness, injury or physical disability, after an applicable co-payment per visit. Benefits for visits furnished by preferred providers are provided at 100 percent of allowable charges after the co-payment;
- Outpatient hospital and skilled nursing facility visits;

- Second opinions by a provider of your choice, after an applicable co-payment per visit. If the second opinion disagrees with the first opinion, Premera will pay for a third opinion. The third opinion must be by a physician who is not affiliated with the first or second physician. Benefits for office and home visits furnished by preferred providers are provided at 100 percent of allowable charges after the co-payment;
- Surgery performed in an outpatient surgical center;
- Inpatient visits for medical and surgical services for illness, injury or physical disability;
- Emergency room visits;
- Outpatient hospital surgical services, including anesthesia and postoperative care. Benefits are only provided for services of an assistant surgeon when medically necessary;
- Parenteral chemotherapy, X-ray and radium therapy. Benefits for services furnished by preferred providers are provided at 100 percent of allowable charges;
- Diagnostic imaging (including X-ray) and laboratory services. Benefits for services furnished by preferred providers are provided at 100 percent of allowable charges;
- Up to a maximum of 60 visits per enrollee in each calendar year for outpatient physical (including massage), occupational, cardiac therapy and speech therapy services by a licensed therapist. To be covered, the therapy must be certified by a physician as medically necessary to restore and improve a function that was previously normal, but was lost following an accidental injury or illness. Benefits for services furnished by preferred providers are provided at 100 percent of allowable charges after the applicable co-payment;
- Magnetic resonance imaging (MRI) procedures, including all charge components. Benefits for services furnished by preferred providers are provided at 100 percent of allowable charges;
- Mammography screening or diagnostic mammography services when recommended by;
- A physician's assistant under the supervision of a preferred physician;
- A preferred advanced registered nurse practitioner ;
- A preferred physician. Benefits for services furnished by preferred providers are provided at 100 percent of allowable charges;
- Routine well physical examinations shall be covered at 100 percent of allowable charges after an applicable co-payment per visit to a maximum of $500 per calendar year.

For organ, bone marrow or stem cell transplant procedure benefit information, please see the transplants benefit.

For benefit information on well child care furnished during the first three weeks after birth, please see the newborn care benefit.

Prostheses

Benefits for services furnished by a preferred provider are provided at 80 percent of allowable charges. Benefits for services furnished by a nonpreferred provider are provided at a constant 60 percent of allowable charges.

This benefit provides for the purchase of a prosthesis intended for functional purposes when replacing a body part when prescribed by a preferred provider. This benefit will not be provided for cosmetic prostheses (except as provided under the "Mastectomy and breast reconstruction services" benefit) or electronic prostheses. Replacement will be provided only if the original prosthesis cannot be made functional.

Rehabilitation services

Benefits for services furnished by a preferred provider are provided at 80 percent of allowable charges. Benefits for services furnished by a nonpreferred provider are provided at a constant 60 percent of allowable charges.

Benefits are provided up to a maximum of 30 days/60 visits, per calendar year for inpatient and outpatient services combined. Treatment of an eligible injury or illness will be covered if such treatment is medically necessary to improve or restore lost bodily function that was previously normal. Care provided must be under the direction of a physiatrist (physician specializing in rehabilitative medicine) and have a formal written treatment plan with specific goals.

In the event the enrollee is an inpatient in an accredited hospital, room and board charges will be subject to the limitations as specified in this benefit on the day the type of care rendered becomes primarily rehabilitative.

Rehabilitation care must be provided by a multidisciplinary team whose members meet individual licensing, registration, or certification requirements of their respective professions. Team members include, but are not limited to:

- Rehabilitation nursing staff;
- Physical therapist;
- Respiratory therapist;
- Occupational therapist audiologist;
- Speech therapist;
- Orthotist/Prosthetist;
- Social service personnel;
- Nutritionist/Dietitian;
- Psychologist/mental health professional;
- Recreation therapist;
- Massage therapist.

When a psychologist or mental health professional is acting as part of the rehabilitation team and is included in the written treatment plan, such service will be provided under this benefit and not under the mental health services benefit.

During a hospital confinement for rehabilitation, all diagnostic laboratory, radiology and other services and supplies will be included as part of this benefit.

Skilled nursing facility

Benefits for services furnished by a preferred provider are provided at 80 percent of allowable charges. Benefits for services furnished by a nonpreferred provider are provided at a constant 60 percent of allowable charges.

This benefit is provided for medically necessary care received in a skilled nursing facility. Skilled nursing facility benefits will be provided to the same extent as care received as an inpatient in an accredited hospital (refer to the "hospital services" benefit) to a maximum of 120 days per enrollee per calendar year.

Temporomandibular Joint (TMJ) Disorders and Myofascial Pain Syndrome (MPS)

Benefits for services furnished by a preferred provider are provided at 80 percent of allowable charges. Benefits for services furnished by a nonpreferred provider are provided at a constant 60 percent of allowable charges. Preferred and nonpreferred provider professional benefits are subject to an applicable co-payment per office visit.

Benefits are provided up to a maximum of $1,000 per enrollee, per calendar year, to a lifetime maximum of $5,000. Orthodontic treatment is not covered under this benefit.

Medical services and supplies are those which are:

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint or myofascial pain syndrome, under all the factual circumstances of the case;
- Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food;
- Recognized as effective, according to the professional standards of good medical practice;
- Not experimental or primarily for cosmetic purposes.

Transplants

Institutional, professional, and other related services and supplies will be covered at the preferred provider level, to the same extent as any other condition, for transplants as described in the "covered transplants" provision later in this benefit. Transplant services are subject to the six month waiting period stated below.

Your program does not provide benefits for an organ, bone marrow, or stem cell transplant including any procedure associated with the transplant, for instance, testing, blood typing, chemotherapy, radiation or hospitalization, unless you have been covered under a medical contract for six consecutive months. However, this waiting period does not apply if the transplant is needed as a direct result of:

- An accidental injury that occurs on or after your effective date of coverage under this program;
- A congenital anomaly of a child who has been covered through us since birth;
- A congenital anomaly of a child who has been covered through us since placement for adoption with the subscriber.

In addition, if you need the transplant because of a pre-existing condition, this program can only provide benefits for covered transplant expenses incurred after you have met your pre-existing condition waiting period. See "Waiting period for pre-existing conditions" for details.

Solid organ transplants and bone marrow/stem cell reinfusion procedures must not be considered experimental or investigative for the treatment of your condition. (Refer to the definition of "experimental or investigative services.") We reserve the right to base coverage on all of the following:

- Solid organ transplants and bone marrow/stem cell reinfusion procedures must meet Premera's criteria for coverage. Premera reviews the medical indications for the transplant, documented effectiveness of the procedure to treat the condition, and failure of medical alternatives.

The types of solid organ transplants and bone marrow/stem cell reinfusion procedures that currently meet Premera's criteria for coverage are:

- Heart;
- Heart/double lung;
- Single lung;
- Double lung;
- Liver;
- Kidney;
- Pancreas;
- Pancreas with kidney;
- Bone marrow (autologous and allogeneic);
- Stem cell (autologous);
- You have satisfied your waiting period;

- Your medical condition must meet Premera's written standards;
- The transplant or reinfusion must be furnished in an approved transplant center. ("Approved transplant center" is a hospital or other provider that has developed expertise in performing solid organ transplants, or bone marrow or stem cell reinfusion, and is approved by us.) Premera has agreements with approved transplant centers in Washington and Alaska, and Premera has access to a special network of approved transplant centers around the country. Whenever medically possible, Premera will direct you to an approved transplant center that Premera has contracted with for transplant services.

Of course, if none of Premera's centers or the network centers can provide the type of transplant you need, this benefit will cover a transplant center that meets written approval standards set by us.

Benefits for transplant or reinfusion related expenses do not apply to the transplant benefit's coverage for travel and lodging.

Procurement expenses are limited to $75,000 per transplant. Covered services include: selection, removal (harvesting) and evaluation of the donor organ, bone marrow or stem cell; transportation of donor organ, bone marrow and stem cells, including the surgical and harvesting teams; donor acquisition costs such as testing and typing expenses; and storage costs for bone marrow and stem cells for a period of up to 12 months.

Transportation and lodging expenses: Reasonable and necessary expenses for travel, lodging, and meals for the transplant recipient (while not confined) and one companion, except as stated below, are covered but limited as follows:

- The transplant recipient must reside more than 50 miles from the approved transplant center;
- The travel must be to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure, or necessary post-discharge follow-up;
- When the recipient is not a dependent minor child, transportation, covered lodging and meal expenses for the recipient and one companion will be reimbursed up to $80 per day;
- When the recipient is a dependent minor child, transportation, covered lodging and meal expenses for the recipient and two companions will be reimbursed up to $125 per day;
- Covered transportation, lodging, and meal expenses incurred by the transplant recipient and companion(s) are limited to $7,500 per transplant;

In addition to "general limitations and exclusions," the transplants benefit does not cover;

- Services and supplies that are payable by any government, foundation, or charitable grant. This includes services performed on potential or actual living donors and recipients, and on cadavers;
- Donor costs for a solid organ transplant or bone marrow or stem cell reinfusion that is not covered under this benefit or for a recipient who is not an enrollee;
- Donor costs for which benefits are available under other group or individual coverage;
- Nonhuman or mechanical organs, unless Premera determines they are not "experimental/investiga-

tive services" according to the criteria stated under "definitions";

- Personal care items;
- Anti-rejection drugs, except those administered by the transplant center during the inpatient or outpatient stay in which the transplant was performed. Take-home drugs are only covered under your prescription drug benefit.

Treatment of Phenylketonuria (PKU)

Benefits are provided at 80 percent of allowable charges.

This benefit is provided for the formula necessary for the treatment of phenylketonuria, and will not be subject to this program's waiting period for pre-existing conditions as stated under "waiting periods."

Vision Services

Eye examinations

Preferred providers covered at 100 percent of allowable charges after an applicable co-payment, deductible and co-insurance per visit. Nonpreferred providers covered at 80 percent of allowable charges after a applicable co-payment per visit.

This benefit provides for one eye examination for the determination of a refractive error every calendar year.

Vision hardware (lenses, frames And contacts)

Each enrollee will be entitled to reimbursement toward the cost of vision hardware at 100 percent of allowable charges to a maximum of $300 every two (2) calendar years.

In addition to "general limitations and exclusions," the vision services benefit does not cover:

- Routine examination in connection with employment;
- Sunglasses or safety glasses, either plain or prescription;
- Services or supplies primarily for beautification;
- Special procedures such as orthoptics and visual training.

What is not covered

This section of your booklet explains circumstances in which all the benefits of this program are limited or in which no benefits are provided. Benefits can also be affected by Premera's Case Management provisions and your eligibility. In addition, some benefits have their own specific limitations.

General limitations and exclusions

Benefits will not be provided any enrollee under the terms of this Contract for any of the following, including any complications that arise from the correction or treatment of any condition that is excluded or limited in this contract and will not be credited to the deductible requirement.

Assisted fertility treatment

Your program does not cover frigidity; infertility; sterility; artificial insemination or in vitro fertilization.

Benefits from other sources

Your program does not cover benefits payable under the terms of any commercial premises or homeowner's medical premises coverage, or motor vehicle medical, motor vehicle personal injury protection, motor vehicle no-fault, or similar contract or insurance, when such contract or insurance is issued to or provides benefits for any enrollee under this Contract. Any benefits provided by us contrary to this exclusion are provided solely to assist the enrollee. By providing such benefits, the group is not waiving any right to reimbursement or to subrogation as provided in this contract.

Biofeedback and self-care

Your program does not cover biofeedback and other forms of self-care or self-help training and any related diagnostic testing.

Blood and blood products

Your program does not cover replaceable blood or blood products except for the administration and processing of blood. The drawing and processing of autologous blood for transfusion is also excluded.

Chemical dependency

Your program does not cover any treatment for chemical dependency, except as specifically provided.

Cosmetic services

Cosmetic surgery is covered only for: treatment to correct conditions that impair bodily function; repair of a defect which is the direct result of an accidental injury, providing such repair is started within 12 months of the date of the accident; treatment of a congenital anomaly for a dependent child; and as stated under the mastectomy and breast reconstruction services benefit.

Counseling

Counseling, education, or training services, except as stated under "health education network" and "chemical dependency treatment." This includes vocational assistance and outreach; and family, marital, social, sexual, lifestyle and fitness counseling.

Custodial care

Your program does not cover custodial care; services furnished by an institution that is a place of rest, place for the aged, nursing or convalescent home or similar institutions, except as specifically provided.

Dental care

Your program does not cover dental care or conditions, whether resulting from disease or dental treatment, removal or replacement of teeth or structures directly supporting the teeth, except as specifically provided; malocclusion, including operations for developmental abnormalities; treatment for surgical orthodontia; extractions or dental X-rays, except for treatment of a fractured jaw or dental injury as described in the "dental care benefit."

Experimental or investigative services

Your program does not cover experimental or investigative services, except as otherwise defined. Your program also does not cover medical, surgical or hospital services or supplies incident to the placement of nonhuman or manufactured organs, and other organ transplants, except as specifically provided.

Hair prostheses and hair loss treatment

Hair prostheses, such as wigs or hair weaves, transplants, and implants. Drugs, supplies, equipment, or procedures to replace hair, slow hair loss, or stimulate hair growth.

Hearing devices

Your program does not cover hearing devices.

Immunizations

Benefits for immunizations are provided at 100% of allowable charges. Immunization benefits are subject to the calendar year limit for preventive care services specified above. Services that are related to a specific illness, injury or definitive set of of symptoms are covered under the non-preventive medical benefits of this plan. This benefit doesn't cover:

- Services not named above as covered.
- Charges for preventive medical services that exceed what's covered under this benefit.
- Inpatient routine newborn exams while the child is in the hospital following birth. These services are covered under the Newborn Care benefit.
- Routine or other dental care.
- Routine vision and hearing exams.
- Services that are related to a specific illness, injury or definitive set of symptoms exhibited by the member.
- Physical exams for basic life or disability insurance.
- Work-related disability evaluations or medical disability evaluations.

Legal liability

Your program does not cover services or supplies for which the enrollee is not legally liable.

Mental health services

Your program does not cover treatment of psychiatric conditions or neuropsychiatric disorders except as specifically provided under the “mental health services” benefit. However, benefits for therapeutic and supporting services provided to enrolled family members to assist in a chemically dependent enrollee’s diagnosis and treatment are provided under the “chemical dependency treatment” benefit.

Military and war-related conditions, including illegal acts

This includes:

- Acts of war, declared or undeclared, including acts of armed invasion;
- Service in the armed forces of any country, including the air force, army, coast guard marines, national guard, navy, or civilian forces or units auxiliary thereto;
- An enrollee’s commission of an act of riot or insurrection;
- An enrollee’s commission of a felony or act of terrorism.

Non-covered drugs

Your program does not cover drugs and medicines except as specifically provided.

Orthognathic surgery, TMJ, and myofascial pain syndrome

Your program does not cover orthognathic surgery, treatment of temporomandibular joint dysfunction or treatment of myofascial pain syndrome, except as specifically provided.

Orthopedic appliances

Your program does not cover orthopedic appliances prescribed primarily for use during participation in sports, recreational and similar activities.

Rehabilitation therapy

Except as specifically provided, your program does not cover speech, developmental, educational, recreational, occupational and rehabilitative therapy; cognitive therapy or mental rehabilitation for a brain injured patient; hospitalization for which confinement is primarily for speech, developmental, educational, recreational, occupational, rehabilitative therapy, or cognitive therapy/mental rehabilitation, and physical therapy when rendered in conjunction with these therapies; or services or supplies for learning disabilities.

Reverse sterilization

Your program does not cover reversal of sterilization procedures.

Routine foot care

Your program does not cover routine foot care, arch supports, corrective shoes and elastic stockings, except as specifically provided.

Service and supplies which are not medically necessary

Your program does not cover services and supplies to the extent that they are not medically necessary for treatment of an injury, illness or physical disability; hospitalization for conditions for which patients are not usually hospitalized; any service or benefit not listed as covered in this contract.

Service when you are not covered on this program

Your program does not cover services you received prior to your effective date of coverage under this program.

Sex transformations or gender reassignment

Your program does not cover treatment or surgery for sex transformations or gender reassignment, including any direct or indirect complications and aftereffects thereof.

Sexual dysfunction

Your program does not cover treatment or surgery for sexual dysfunction, including impotence and frigidity, regardless of origin or cause; surgical or medical treatment of impotence, including drugs or medications or penile or other implants, and any direct or indirect complications and aftereffects thereof.

Thermography

Your program does not cover services or supplies for thermography.

Vision hardware

Your program does not cover eyeglass lenses and frames except as specifically provided. However, after cataract surgery, this program will cover eyeglass lenses and frames if they are medically necessary because an intraocular lens cannot be implanted.

Vision therapy

Your program does not cover vision therapy, eye exercises, pleoptics or orthoptics, or any other type of training to correct muscle imbalances of the eyes. Your program also does not cover any type of surgery to change the refractive nature of the cornea. Any direct or indirect complications of such treatment are not covered.

Work-related conditions

Your program does not cover services or supplies for which you are entitled to receive benefits under:

- Occupational coverage required of, or voluntarily obtained by, the employer;
- State or federal workers' compensation acts;

- Any legislative act providing compensation for work-related illness or injury.

This exclusion applies whether or not a proper or timely claim for benefits has been made under the above-listed programs.

However, this exclusion does not apply to sole proprietors, partners or executive officers who are full-time employees of the group if they are exempt from the above laws and if the group does not furnish them with workers' compensation coverage. They will be covered under this program for conditions arising solely from their occupations with the group. Coverage is subject to the other terms and limitations of this program.

How to file a medical claim

To be reimbursed for medical/vision/prescription drugs under the PPO plan, complete and submit a claim form to Premera at:

Premera Blue Cross
PO Box 91059
Seattle, WA 98111-9159

Claim forms can be obtained from Premera on their Web site www.premera.com or by calling customer service at (800) 722-1471.

Along with your claim form you will need to include an itemized bill containing this information:

- Individual charges;
- Patient's name;
- Service or supply received;
- Date received;
- Subscriber's name (District employee).

You must file a claim within 365 days from the date you received treatment. Benefits will not be paid if you file after the time limit. If your claim is denied, you will have the right to a review as described in "facts about your benefits" section.

Coordination of benefits— If you have additional health care coverage

You may also be covered under one or more other group or individual programs, such as one sponsored by your spouse's employer. This program includes a "coordination of benefits" feature to handle such situations. Premera will coordinate the benefits of this program with those of your other programs to make certain that, in each calendar year, the total payments from all programs are not more than the total allowable expenses. All of the benefits of this program are subject to coordination of benefits.

If you do have other coverage besides this program, Premera recommends that you send your claims to them and the other carriers at the same time. In that way, the proper coordinated benefits may be most quickly determined and paid.

Primary or secondary

An important part of coordinating benefits is determining the order in which the programs provide benefits. One program is responsible for providing benefits first. This is called the "primary" program. The primary program provides its full benefits as if there were no other programs involved. The other programs then become "secondary." This means they reduce their payment amounts so that the total benefits from all programs are not more than the allowable expenses. Coordination of benefits always considers amounts that would be payable under the other program, whether or not a claim has actually been filed.

Here is the order in which the programs should provide benefits:

First: A program that does not provide for coordination of benefits.

Next: A program that covers you as other than a dependent.

Next: A program which covers you as a dependent. For dependent children the following rules apply:

- When the parents are not separated or divorced: The program of the parent whose birthday falls earlier in the year will be primary, if that is in accord with the coordination of benefits provisions of both programs. Otherwise, the rule set forth in the program which does not have this provision shall determine the order of benefits.
- When the parents are separated or divorced: If a court decree makes one parent responsible for paying the child's health care costs, that parent's program will be primary. Otherwise, the program of the parent with custody will be primary, followed by the program of the spouse of the parent with custody, followed by the program of the parent who does not have custody.

When coverage ends

Chelan County PUD health care coverage for you and your enrolled family members ends the last day of the month in which your employment with the District ends or you cease to meet the eligibility requirements for health care coverage. Coverage will also end when the District terminates the health care coverage benefits.

Coverage for your enrolled dependents ends when:

- Your coverage ends for any reason;
- An individual no longer meets eligibility requirements, for example if your spouse is legally separated or divorced from you or if your child reaches the age limit.

When health care coverage ends for you or your enrolled family members, you may be eligible to buy continued coverage as described in the next section.

Purchasing continued health care coverage under COBRA

In most cases when Chelan County PUD health care coverage ends for you or your enrolled family members, a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 gives you the right to purchase the same coverage for a specific period.

Under COBRA, you must pay the full cost of continued coverage after taxes, including the amounts both an employee and employer normally contribute for active employees and covered family members. The law allows a small administration fee.

Health care coverage available to COBRA participants is the same as that is available to active employees and their families. If your COBRA coverage continues through an open enrollment, you will be able to change your elections the same as any other participant.

Keep in mind that if coverage changes for active employees, it changes for COBRA participants. COBRA coverage will no longer be available to individuals who become covered under another group health plan or Medicare after the date of their COBRA election.

The event that causes your health care coverage to end (the COBRA qualifying event) determines how long you or your family members can purchase continued coverage under COBRA:

- You may purchase up to 18 months for yourself and your covered dependents if you lose coverage because of a reduction in work hours below the minimum that makes you eligible for coverage, or because employment terminates (except for gross misconduct).
- If you are on a leave of absence under the Family and Medical Leave Act of 1993 (FMLA) and do not return to active employment at the end of FMLA leave, a qualifying event will occur-allowing you and our dependents to continue coverage for up to 18 months, on the later of the date:
  - The District receives notice that you will not be returning to work, or;
  - Your FMLA leave ends.
- Your spouse and/or dependent children may purchase coverage up to 36 months if they lose coverage because you:
  - Divorce or become legally separated;
  - Become entitled to Medicare, or;
  - Die.
- A child who ceases to be your eligible dependent may purchase coverage for up to 36 months.

If during an 18-month COBRA coverage period, you or your dependent receive a determination from Social Security Administration of being disabled within the first 60 days of your continuation coverage period, the COBRA coverage continuation period may be extended for an additional 11 months for the disabled person and other covered family members—a combined total of up to 29 months of COBRA coverage. You must provide a copy of the Social Security determination letter to Benefits within 60 days of the date of the letter and within the first 18 month coverage continuation period. You may be charged higher premiums, up to 150 percent of the premium cost, for the 11 month extension.

If another qualifying event occurs while your coverage is continued under COBRA, the following applies:

- Generally, the COBRA coverage period is measured from the date of the first qualifying event (or, if later, the date coverage is lost from the qualifying event).
- The number of months of COBRA coverage is determined by the event with the longer coverage period (only one period applies—the different coverage periods are not added together); in no event will the total continuation coverage period exceed 36 months.
- A special rule applies for employees who become covered by Medicare, then lose District health care coverage because of a termination of employment or reduction of hours. The employee may elect to continue coverage for up to 18 months. Eligible dependents may elect to continue coverage for 36 months from the date the employee became covered by Medicare or 18 months from the date of employment termination or reduction in hours, whichever is longer.

To be eligible for COBRA coverage, you or your dependents must notify Benefits if coverage ends due to divorce or legal separation or loss of eligibility by a dependent within 60 days of the event. If you do not notify Benefits within 60 days of the divorce or legal separation or loss of eligibility as a dependent, your dependents lose the right to COBRA coverage.

In other circumstances, the District's COBRA administrator will notify you that continued coverage is available and provide a more detailed explanation of your COBRA rights along with an application to enroll.

You have 60 days to elect continued coverage from the later of the date you are notified of eligibility or the date your group coverage ends. You then have 45 days from the date you sign your application and elect COBRA coverage to make your first payment.

COBRA continued health care coverage ends the date any of the following occurs:

- Required premiums are not paid on time;
- Your maximum COBRA coverage period expires;
- The District terminates all group health care coverage for all employees;
- You obtain coverage under another group health plan after the date of the COBRA election, unless the new group plan has a pre-existing condition clause that affects you and your dependents (in this case, COBRA coverage does not end until the exclusion of limitation no longer applies).

A special rule applies to the extra 11 months of COBRA coverage in the event you are disabled. This coverage will end on the first day of the month that begins more than 30 days after Social Security finds you no longer disabled. You must tell the District no more than 30 days after finding that you are no longer disabled.

You COBRA rights are subject to change. If the law changes, your rights will change accordingly.

The Trade Act of 2002 created a new tax credit for certain individuals who became eligible for

trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (eligible individuals). Under the new tax provisions, eligible individuals can take a tax credit for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact/2002act_index.asp.

Certain individuals who, under limited circumstances, become eligible to take advantage of trade adjustment assistance pursuant to the Trade Act may receive a second 60-day COBRA election period. If you are receiving trade adjustment assistance or if you are eligible for trade adjustment assistance, please contact HR for more information.

Third party liability

If you are injured in an accident and someone else is legally liable for your health care bills, your Chelan County PUD benefits will cover your expenses as described in this handbook but has the right to recover payments from the responsible person. If you receive payment from that person or a third party as a result of a judgment or settlement, the plan will have the right to be paid back from your payment within certain limits set by law. You or your representative must cooperate fully in collecting from the responsible person.

This applies even if the amount you receive did not compensate you in full for your losses. This right gives the plan a priority over any funds paid, including any claim for non-medical or non-dental charges, lawyer fees, or other costs. The plan may pursue any claim you have against a third party or insurer, whether or not you choose to pursue that claim. The plan's rights and priority are limited to the extent the plan has made or will make benefit payments for the injury or illness but do extend to any costs that result from the enforcement of its rights under the plan.

You and anyone who represents you must cooperate fully with the plan when it works to collect from a person who is responsible for injury or death. In addition, you and anyone who represents you must do nothing to prejudice the right of the plan to recover the benefits it has paid.

III. Delta Dental Plan

The Chelan County PUD dental plan in self insured and administered through Delta Dental Plan.

You may elect dental coverage for yourself and you may also enroll your spouse , your eligible child or eligible children or your family (spouse and children).

The enrolled family members you choose for medical/vision will be the same for the dental plan.

If you have a change in family or employment status, you may elect to change your enrollment by adding or deleting dependents consistent with the reason for the change.

Eligibility

You are eligible for benefits if you are:

- Full-time or limited assignment bargaining unit;
- Seasonal greater than six months bargaining unit;
- Full-time exempt or nonexempt salaried;
- Part-time exempt or non-exempt salaried;
- Full-time limited assignment salaried;
- Commissioner.

If you are eligible for dental benefits, the following members are also eligible:

- Your lawful spouse;
- Your dependent children, including adopted children, children placed with you for adoption and stepchildren. Children can be covered up to age 26.

You may be able to extend dental coverage past the normal age limits for an enrolled child incapable of self-support due to a mental or physical disability. Proof of disability must be provided 31 days before the child's 26th birthday, and then periodically. To arrange extended coverage for a disabled child, please contact Benefits.

Enrollment

If you belong to an eligible class, you are eligible to enroll in dental benefits effective the first day of the month following date of hire. Your eligible family members are also covered the first of the month following date of hire.

Making changes during the year

Please consider your benefit enrollment options carefully because—unless you have a qualifying change in status—the choices you make will be in effect through out the year. Please see the "making changes during the year" section under "Premera Blue Cross health care plan" for more information.

When coverage begins

As an eligible employee, you generally will receive enrollment information and instructions within the first 30 days of employment. Coverage for you and any enrolled family member begins the first of the month following date of hire.

If you retire from service, coverage will end.

What is covered

This section describes benefits payable for covered dental services. Our dental plan does not pay for treatment ordered before you became covered or for services received after coverage ends.

Class 2 and Class 3 include a $50 deductible per person/$150 family.

The program maximum is the maximum dollar amount Delta Dental will cover for a given benefit period. The program maximum for the Chelan PUD dental plan is $2,000.

Class 1 Diagnostic and preventive services

Diagnostic and preventative services are covered at 100% for allowable procedures.

- Diagnostic
  - Covered dental benefits
    - Routine exams
    - X-Rays
    - Emergency examination
    - Examination by a specialist in an American Dental Association recognized specialty
  - Limitations
    - Examination is covered twice in a benefit period
    - Complete series (four bitewing x-rays and up to 10 periapical x-rays) or panorex X-rays are covered in a five-year period
    - Supplementary bitewing X-rays are covered once in a benefit period

- Exclusions
    - Diagnostic services and X-rays related to TMJ
    - Consultations or elective second opinions
    - Study models
    - Caries susceptibility test
- Preventive
  - Covered dental benefits
    - Prophylaxis (cleaning)
    - Periodontal maintenance
    - Fissure sealants
    - Topical application of fluoride or preventative therapies
    - Space maintainers when used to maintain space for eruption of permanent teeth
  - Limitations
    - Prophylaxis is covered twice in a benefit period (higher for Periodontal Case type 3)
    - Topical application of fluoride or preventative therapies (but not both) is covered twice in a benefit period
    - Fissure sealants are available once every two years
  - Exclusions
    - Plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits)
    - Cleaning of a prosthetic appliance
    - Replacement of a space maintainer previously paid for by Delta Dental

Class II restorative and periodontics

Are covered at 80 percent after applicable deductibles for allowable procedures or 90% if seen by a Delta Dental preferred provider.

- Covered dental benefits
    - Restorative
        - Amalgam, composite or filled resign restorations (fillings)
        - Stainless steel crowns
    - Prosthodontics
        - Repair or relining of dentures/partials
    - Oral surgery
        - Removal of teeth and surgical extractions
        - Preparation of the mouth for the insertion of dentures
        - General anesthesia/intravenous sedation
    - Periodontics
        - Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth. Services covered include periodontal scaling/root planning, gingivectomy and limited adjustments to occlusion (eight teeth or less)
        - General anesthesia/intravenous sedation
    - Endodontics
        - Procedures for pulpal and root canal treatment
        - Services covered include pulp exposure treatment, pulpotomy and apicoectomy

Class III crowns, bridges and implants

Are covered at 70 percent after applicable deductible for allowable procedures:

- Restorative
    - Crowns, inlays and onlays
- Prosthodontics
    - Dentures, fixed bridges, removable partial dentures and the adjustment or repair of an existing prosthetic device
- Implants
    - All implant benefits must be preauthorized prior to commencement of treatment or the procedure may be denied
    - Coverage for placement repair and removal of implant
    - Endosseous, transosseous, endodontic and mandibular staple implants
    - Connecting bars

What is not covered

- Services for injuries or conditions that are compensable under worker's compensation or employers liability laws, and services that are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 139a, section 1902 of the Social Security Act;
- Dentistry for cosmetic reasons;
- Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures include restoration of tooth structures lost from attrition, abrasion or erosion and restorations for malalignment of teeth;
- Experimental services or supplies;
- Application of desensitizing agents;
- General anesthesia/intravenous sedation, except as specified for certain oral, periodontal or endodontic surgical procedures;
- Analgesics such as nitrous oxide, conscious sedation, euphoric drugs, injections or prescription drugs;
- In the event an eligible person fails to obtain a required examination from a Delta Dental-approved consultant dentist for certain treatments, no benefit shall be provided for such treatment;
- Hospitalization charges and any additional fees charged by the dentist for hospital treatment;
- Broken appointments;
- Patient management problems;
- Completing insurance forms;
- Habit breaking appliances or orthodontic services or supplies;
- Delta Dental shall have the discretionary authority to determine whether services are covered benefits in accordance with the general limitations and exclusions in the contract;
- This program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no fault, uninsured motorist, underinsured motorist, or other similar type of coverage.

How to file a dental claim

If you select a dentist who is a member of Delta Dental, you will not have to send in claim forms. If you select a dentist who is not a member of Delta Dental, you are responsible for having your dentist complete and sign a claim form. Delta Dental accepts any American Dental Association-approved claim form. Claim forms may be mailed to:

Delta Dental of Washington
PO Box 75983
Seattle, WA 98175-0983

Along with your claim form you will need to include an itemized bill containing this information:

- Group #00994
- Your identification number
- Individual charges
- Patient's name
- Service or supply received
- Date received
- Subscriber's name (District employee)

You must file a claim within 6 months from the date you received treatment. Benefits will not be paid if you file after the time limit. If your claim is denied, you will have the right to a review as described in Facts about your Benefits section.

When coverage ends

Chelan County PUD dental coverage for you and your enrolled family members ends the last day of the month in which your employment with the District ends or you cease to meet the eligibility requirements for dental coverage. Coverage will also end when the District terminates the dental coverage benefits.

Coverage for your enrolled dependents ends when:

- Your coverage ends for any reason;
- An individual no longer meets eligibility requirements, for example if your spouse is legally separated or divorced from you or if your child reaches the age limit or gets married.

When dental coverage ends for you or your enrolled family members, you may be eligible to buy continued coverage as described in the next section.

Purchasing continued dental coverage under COBRA

In most cases when Chelan County PUD health care coverage ends for you or your enrolled family members, a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 gives you the right to purchase the same coverage for a specific period. See Purchasing "Continued health care coverage under COBRA" under medical/vision. The rules covering COBRA continuation for medical/vision also apply to continuation of dental coverage. Your right to continue dental coverage is independent of your right to continue medical/vision coverage (e.g., you can elect to continue dental even if you do not continue medical/vision coverage).

Third party liability

If you are injured in an accident and someone else is legally liable for your dental bills, your Chelan County PUD benefits will cover your expenses as described in this handbook, but has the right to recover payments from the responsible person. If you receive payment from that person or a third party as a result of a judgment or settlement, Delta Dental will have the right to be paid back from your payment within certain limits set by law. You or your representative must cooperate fully in collecting from the responsible person.

This applies even if the amount you receive did not compensate you in full for your losses. This right gives Delta Dental a priority over any funds paid, including any claim for non-medical or non-dental charges, lawyer fees, or other costs. Delta Dental may pursue any claim you have against a third party or insurer, whether or not you choose to pursue that claim. Delta Dental's rights and priority are limited to the extent Delta Dental has made or will make benefit payments for the injury or illness, but do extend to any costs that result from the enforcement of its rights under the plan.

You and anyone who represents you must cooperate fully with Delta Dental when it works to collect from a person who is responsible for injury or death. In addition, you and anyone who represents you must do nothing to prejudice the right of Delta Dental to recover the benefits it has paid.

IV. Flexible Spending Accounts

Highlights

Most Chelan County PUD employees have out-of-pocket health care costs; many also have dependent care expenses. That is why the District offers two Flexible Spending Accounts (FSAs), allowing you to pay some of these amounts with before-tax dollars to reduce your taxable income.

Depending on your needs, you can participate in either or both accounts:

- The Health Care FSA – for eligible expenses not covered by any medical, dental or vision plan.
- The Dependent Care FSA – for day care expenses for your children or other eligible dependents while you work.

You direct money from your paycheck to these accounts based on the amount of health care and/or dependent care expenses you think you will have during the year. This money is deducted from your paycheck before taxes are withheld. This reduces your taxable income so you pay less tax. As you incur eligible expenses, you request reimbursement from your before-tax dollars in the appropriate account.

These accounts are based on current tax laws. If tax laws change, the FSAs and the benefits they provide may be affected.

Using a flexible spending account is not without risk on your part. If when you terminate employment (or otherwise cease being eligible to participate) or get to the end of the calendar year, your covered expenses are less than the balance in your flexible spending account, you will forfeit that excess amount.

Chelan County PUD reserves the right in its sole discretion to amend or terminate its benefit plans, including the Health Care and Dependent Care Flexible Spending Account programs, at any time, for any reason, in whole or in part. Chelan County PUD's ability to amend or terminate a plan such as the FSA programs applies to individuals who are currently participating in the plan and receiving plan benefits, as well as to individuals who have not yet begun participation in the plan.

Eligibility

You may enroll in the FSAs if you are:

- Full-time or limited assignment bargaining unit;
- Seasonal greater than six months bargaining unit;
- Full-time exempt or non-exempt salaried;
- Part-time exempt or non-exempt salaried;
- Part-time bargaining unit;
- Full-time limited assignment salaried;
- Commissioner.

Participation is optional. You may sign up for either or both of these accounts.

When participation begins

As an eligible employee, generally you will receive enrollment information and instructions within your first 31 days of employment. Participation begins the first of the month after date of hire.

Enrollment

Taking advantage of the accounts is easy. If you are a new employee, you may enroll when you become eligible for Chelan County PUD's Benefits Program. At the annual open enrollment, you decide the amount you want to contribute to the FSAs for the next plan year – from Jan. 1 to Dec. 31.

Each year at annual open enrollment, you can choose whether or not to participate and change the amount you are contributing.

Making changes during the Year

Once you enroll, you cannot increase or decrease your contributions until the next annual open enrollment unless you have a qualifying change in status that allows you to make an election change in the middle of the year.

The following status changes may allow you to change your dependent care and health care FSAs:

- Your marriage, divorce, legal separation or annulment;
- Birth, adoption or placement for adoption of a dependent child;
- Death of your spouse or dependent;
- Any employment status change that results in you, your spouse or dependent gaining or losing eligibility for health coverage (such as beginning or ending employment, changing from full time to part time or vice versa, taking or returning from an unpaid leave, experiencing a strike or lockout, or changing work sites); or
- Dependent ceases to satisfy eligibility requirements for health coverage.

Any increase or decrease in your contribution must be because of and correspond with the qualifying change in status for health coverage. These rules on change due to cost or coverage do not apply to the Health Care FSA, and you may not change your election to the Health Care Reimbursement Plan if you make a change due to cost or coverage for insurance. For the dependent care FSA, the event must affect eligible dependent care expenses.

You must make any changes to your elections within 30 days of the qualifying event. Otherwise, you will need to wait until the next open enrollment. Contact Benefits for details about changing your elections.

Special enrollment

If you decline coverage for yourself or your dependents in the health care flexible spending account plan because of other health insurance, you may in the future be able to enroll yourself or your dependents in these heath care benefits and the health care FSA.

In addition, if you gain a new dependent from marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents.

You must make changes to your elections within 30 days of the qualifying event, or wait until the next open enrollment. Contact Benefits for details about this special enrollment.

Changes in cost

If you change your dependent care provider midyear, you can change your dependent care FSA contributions to correspond with the new provider's charges. Similarly, if your dependent care provider (other than a provider who is your relative) raises or lowers its rates midyear, you can increase or decrease your contributions.

How the accounts work

Step 1: When you enroll, you elect how much you want to contribute to each account. You may participate in one, both or neither of the FSAs.

Step 2: Your contributions are deducted in equal amounts from 24 of your 26 paychecks throughout the year. These contributions are deducted before federal income, Social Security taxes are withheld.

Step 3: After you incur an eligible expense, you have the option to use your Benefit Card to pay for the service or submit a reimbursement request online at www.myonebridge.com or by using the HRAgo mobile app to receive a reimbursement check or direct deposit from the appropriate account. Reimbursements are not subject to federal income or Social Security taxes.

To be eligible for reimbursement, the expense must be incurred during the plan year regardless of when you actually pay the bill. Contact OneBridge Benefits at (888) 338-4415 to find out how orthodontic expenses are reimbursed – it depends on your treatment contract.

Be sure to plan the amount you will contribute to your FSAs very carefully. At year-end, after all expenses are paid, you forfeit any money remaining in your accounts. The plan year is Jan. 1 to Dec. 31. Expenses must be incurred from Jan. 1 to Mar. 15. Remember, money directed to the accounts cannot be transferred between accounts or rolled over into the next year.

Since you reduce your Social Security taxes by contributing to the accounts, your future Social Security benefits may be affected. Most experts say the tax advantages you get now offset any potential future benefit reductions; however, you may want to talk with your tax adviser.

Estimating your tax savings

Because your FSA contributions are made before taxes, you pay for eligible health care and dependent care expenses with before-tax dollars.

Example

Suppose you earn $30,000 a year and your out-of-pocket health care expenses are $1,000 a year. The example below shows what your net income would look like with and without the FSA.

	Without an FSA	With an FSA
Gross Income	$ 30,000	$ 30,000
Annual Health FSA contributions	- 0	- 1,000
W-2 Income	30,000	29,000
Standard Deduction	-5,000	-5,000
Personal Exemptions	- 3,200	- 3,200
Taxable Income	21,800	20,800
Income Tax (15%)	$ 2,905	$ 2,755
FICA Tax on W-2 Income (7.65%)	+ 2,295	+ 2,219
Total Federal Taxes	5,200	4,974
After Tax Income	24,800	24,026
After Tax Health Care Expenses	- 1,000	- 0
Spendable Income	$ 23,800	$ 24,026
Tax Savings with FSA		$226

* This example assumes single filing status and is based on 2007 tax brackets, exemptions and standard deductions as well as the federal income tax laws in effect on January 1, 2007. Your actual savings may vary depending on your personal financial situation.

Health care flexible spending account

You can use this account to pay for eligible health care expenses that are not reimbursed through any medical, dental or vision care plan for you or your family members. Eligible expenses are most expenses the IRS considers tax deductible, for example:

- Deductibles;
- Office visit co-pays;
- Prescription drug co-pays;
- Vision expenses;
- Dental expenses;
- Orthodontic expenses;
- Approved over the counter medications prescribed by licensed physician.

You may request reimbursement from the account for expenses for you and any dependent eligible for Chelan County PUD medical benefits. You will need to provide supporting documentation to be reimbursed for your expenses so make sure you keep copies.

Certain expenses do not qualify for reimbursement through the account for expenses for you and any dependent eligible for Chelan County PUD medical benefits.

Certain expenses do not qualify for reimbursement through the account even though the IRS may consider them to be tax deductible medical expenses – for example, health and long-term care insurance premiums (including Medicare Part B premiums), and any surgery or treatment primarily for cosmetic reasons. You also cannot use the health care FSA for any amounts you claim as health care deductions on your income tax return.

How much you can contribute

You can set aside $2,850 a year in your health care FSA.

Tax deduction vs. the account

For each expense you incur, you must choose between itemizing the expense on your federal income tax return or using your account. To be deductible on your federal income tax return, your health care expenses must exceed 7.5% of your adjusted gross income, and only the portion over 7.5% is deductible. Most people find the FSA is the best choice, since their health care expenses are not high enough to qualify for the tax deduction. You many want to consult a professional tax adviser to help you decide which approach is best for you.

Requesting reimbursement

You may submit a claim for health care FSA reimbursement as soon as your plan year starts. For quick reimbursements submit your claims online at www.myonebridge.com or on the HRAgo mobile app. Reimbursement forms are available from Benefits, the HR Web site, and from OneBridge Benefits.

Here are some hints for requesting reimbursement:

- For expenses covered by any medical, dental or vision plan, submit your claims to all insurance plans first. Along with your reimbursement request, submit a copy of the statement you receive (Explanation of Benefits) from all insurance plans to:

  OneBridge Benefits FSA
  PO Box 80866
  Seattle, WA 98108

- For office visit and prescription drug co-pays, use your Benefits Card to pay your provider. You will receive e-mail requesting supporting documentation when necessary.

For expenses not covered by your health care benefits, use your online account or HRAgo mobile app to submit a copy of the itemized statement which should include the date services were performed and the amount. You will be reimbursed up to the annual amount you have elected to contribute for the year, minus any previous reimbursements, and regardless of the amount paid into the health FSA when the claim is processed.

Using Your OneBridge Benefits Card

The OneBridge Benefits Card provides for a quick and easy way to access your Health FSA, this funded card provides an immediate payment method for out-of-pocket expenses.

Here are some tips when using the Benefits Card. For detailed information on the Benefits card refer to the OBB Benefits Card FAQ on the resource page of your www.myonebridge.com online account.

- You can use your card to pay for qualified expense covered under your Health FSA benefit plan.
- Save your supporting documentation. The benefits available on your OneBridge Benefits Card are tax-free, and the IRS request us to verify that every transaction is for a qualified expense. When the electronic transaction data we receive isn't enough, we'll ask you to submit copies of your documentation.
- The best kind of supporting documentation is Explanation of Benefits (EOB) from your insurance provider. However, an itemized statement or detailed receipt from your merchant or provider will work.
- Supporting documentation can be provided online at www.myonebridgebenefits.com, on the HRAgo mobile app, or by completing and mailing the Benefits Card Supporting Documentation Form to OneBridge.

Dependent care flexible spending account

If you pay someone to take care of your children or a disabled dependent relative while you work, you may be eligible to pay for these expenses before taxes by using the dependent care FSA.

Whose expenses are eligible

You may use this account to pay expenses for anyone who qualifies as your dependent under IRS regulations – not just your children. Those who qualify include:

- Children under age 13 you or your spouse can claim as dependents on your federal income tax return. In case of divorce or legal separation, only the parent with custody for a longer period than the other parent may use the account to pay for care of an eligible child (This applies even if the parent with custody does not claim the tax exemption for the child);
- Your spouse, parents or other individuals who live in your home, who you claim as dependents for income tax purposes and who are mentally or physically unable to care for themselves. If the dependent care services are provided outside your home, the spouse, parent or other dependent must normally spend at least eight hours a day in your home to qualify.

Eligible expenses are similar to those that qualify for the Child and Dependent Care Tax Credit on your federal income tax return – the purpose must be to allow you to work. If you are married, both you and your spouse must work or be actively looking for work, unless your spouse is a student or incapable of self-care (see "How much you can contribute").

Dependent costs not eligible for reimbursement include overnight camp, school-related costs for children in kindergarten or older, most food or clothing, transportation expenses between your home and the location you receive dependent care, care not related to work such as babysitting while you go out for entertainment and housekeeping expenses not related to dependent care.

Eligible dependent care providers

Care in your home and outside your home is eligible, subject to the following restrictions:

- If day care is provided at a day care center that cares for more than six individuals, expenses are reimbursable only if the center complies with all state and local licensing requirements;
- Services in someone's home are reimbursable. If the home is required by state law to be licensed (usually based on the number of individuals who receive care in that home), the provider must have a license for your expenses to be reimbursed;
- Services outside your home for anyone other than your children under age 13 are reimbursable only if that dependent spends at least eight hours each day in your home;
- Eligible providers include any of your relatives except:
  - Anyone you claim as a dependent on your income tax return; or
  - Any child of yours who will be under age 19 at the end of your tax year (generally, December 31). This applies even if you do not claim that child as a dependent.

How much you can contribute

You can contribute $5,000 a year to your dependent care FSA. This maximum may be reduced in the following situations:

- If you are married and file separate federal income tax returns, you and your spouse are limited to $2,500 each.
- You cannot be reimbursed for more than your or your spouse's earned income for the year. For example, if your spouse is employed part time and earns $3,500, then $3,500 if your limit for the year.
- If your spouse is an unemployed full-time student or incapable of self-care due to disability, your spouse's earned income is assumed to be $250 a month (if you have one dependent) or $500 a month (for two or more dependents).
- The $5,000 IRS maximum is a family limit. If your spouse's employer sponsors a dependent care account like this, you can use either account or split the limit between accounts.

From time to time, special limits set by the federal government may restrict contributions for certain highly paid individuals. You will be notified if these restrictions apply to you.

FSA or tax credit

In most cases, you must choose between using the dependent care FSA or claiming the Child and Dependent Care Tax Credit when you file your federal income tax return. With the tax credit, you save when you file your return; with the FSA you save throughout the year. The one that will save you the most is based on your annual income, tax filing status (head of household, married or married filing separately), eligible dependents and day care expenses.

FSA contributions reduce, dollar for dollar, the maximum on which the tax credit is based.

You may want to consult a professional tax advisor to help you decide which approach is best for you. Changes in tax law may affect the amount you save, so be sure to review your situation each year before you enroll.

When you file your income tax return

If you participate in the dependent care FSA, you must complete an IRS Form 2441 (Child and Dependent Care Expenses) and attach it to your federal income tax return Form 1040. If you use a 1040A, attach a Schedule 2. On the form, you show expenses reimbursed through the account.

Requesting reimbursement

Reimbursement requests are available from the HR Web site or from Benefits. Here are some hints for requesting reimbursement:

- Use your Benefits Card or pay your provider first out of your pocket;
- Get an itemized receipt (a copy of your cancelled check is not acceptable) showing:
  - Provider's name, address and tax ID number
  - Description and date of services
  - Amount you paid
- Submit the receipt and a reimbursement requests online at www.myonebridge.com, on the HRAgo mobile app, or by mail to:

OneBridge Benefits FSA
PO Box 80866
Seattle, WA 98108

You will be reimbursed the amount of your request up to the balance in your dependent care account when the claim is processed. If there is not enough money in your account to cover the entire claim, you will receive a partial payment. After additional funds have been withheld, submit another request to be reimbursed for the remaining amount.

Using Your OneBridge Benefits Card

The OneBridge Benefits Card provides for a quick and easy way to access your Dependent Care FSA, this funded card provides an immediate payment method for out-of-pocket expenses.

Here are some tips when using the Benefits Card. For detailed information on the Benefits card refer to the OBB Benefits Card FAQ on the resource page of your www.myonebridge.com online account.

- You can use your card to pay for qualified expense covered under your Dependent Care FSA benefit plan.
- Save your supporting documentation. The benefits available on your OneBridge Benefits Card are tax-free, and the IRS requests us to verify that every transaction is for a qualified expense. When the electronic transaction data we receive isn't enough, we'll ask you to submit copies of your documentation.
- Acceptable documentation is an itemized statement showing provider name, address and tax ID number, description and date of services, and the amount you paid.
- Supporting documentation can be provided online at www.myonebridgebenefits.com, on the HRAgo mobile app, or by completing and mailing the Benefits Card Supporting Documentation Form to OneBridge.

When participation ends

If you terminate or change employment status so that you are no longer eligible for any FSA, your contributions will stop with your last paycheck or when eligibility ends.

After you are no longer eligible:

- You may continue to incur eligible dependent care claims through the year and submit these claims up to the balance of your dependent care FSA;
- You may be reimbursed from your health care FSA for expenses incurred through the end of the month in which your employment terminates or your eligibility ends, unless you elect COBRA;
- You may elect to continue in the health care FSA for the remainder of the year in which your employment ends through COBRA if your current FSA balance exceeds your year-to-date reimbursements. You can continue to submit claims for health care expenses incurred up to your last COBRA payment in the same plan year;
- Your COBRA FSA contributions are made on an after-tax basis. See the "Health care coverage" section for information about your COBRA rights and the time coverage can be continued.

If your employment terminates or eligibility stops, you will have 90 days after the end of that year to request reimbursement from your FSA for expenses incurred through year-end.

V. Personal Leave (PL) Plan

The Chelan County PUD personal leave plan provide income in place of your regular pay to provide you with the opportunity to take time off from work for rest, recreation, and personal needs, including illness, bereavement and to care for eligible dependents.

Eligibility

You are eligible for PL benefits if you are:

- Full-time or limited assignment bargaining unit;
- Seasonal greater than six months bargaining unit;
- Full-time exempt or nonexempt salaried;
- Part-time exempt or non-exempt salaried;
- Part-time bargaining unit;
- Full-time limited assignment salaried.

Enrollment

If you belong to an eligible class, you are automatically enrolled.

Personal leave accrual table

Except in a leave without pay status (and Workers Compensation for bargaining unit employees), PL will accrue according to the following table (excluding part time employees):

Years of Service	Accrual per Year	Accrual per Pay Period
1-5	21 Days[1]	6.46154
6-10	27 Days	8.30769
11	28 Days	8.61538
12	29 Days	8.92308
13	30 Days	9.23077
14	31 Days	9.53846
15	32 Days	9.84615
16	33 Days	10.15385
17-25	34 Days	10.46154
After 25 years	35 Days	10.76923

(Footnotes) [1] Days for purposes of this section means eight (8) hours.

Salaried

Regular part-time employees will accrue personal leave based on actual hours paid. Strategic-level positions (Red Competency Band) have a PL accrual rate of 27 days for the first 10 years of service and then move to 28 days, etc.

Accrued PL shall not exceed 1350 hours or the number of hours accrued by each employee as of December 31, 2004. Any hours above this limit will be cashed out at the end of the year.

Accrued PL shall not exceed 800 hours for employees hired on or after April 1, 2012.

Personal leave usage-salaried exempt employees

If you are in a salaried exempt position, it means your job is classified under the Fair Labor Standards Act as executive, computer-related, administrative or professional. You are paid a salary and do not receive overtime pay or compensatory time. In recognition of the extra demands, no pay deductions will be made for partial-day absences of four hours or less.

Personal leave usage-salaried non-exempt employees

If you are a salaried non-exempt employee your primary functions involve support functions. You are eligible for overtime. You will be required to take personal leave in one half hour increments.

Bargaining unit

Although this section includes certain key features and brief summaries of the Chelan County PUD Bargaining Unit Personal Leave Plan, it does not provide a detailed description. Please refer to the Collective Bargaining Agreement, Article 5, Section 1 for a complete description.

Personal leave usage-bargaining unit

The following are conditions for the usage of PL:

- Having accrued a minimum of eight (8) hours;
- Approval of your supervisor;
- Notification is at least twice as early as the length of the requested leave;
- Approval for the use of unplanned PL should be sought as early as possible;
- Accrued PL shall not exceed 1,200 hours or the number of hours accrued by each employee as of April 1, 1996. Any hours above this limit will be cashed out at the end of the year; and
- 40 hours of PL must be used each year during the second through fifth years and at least 80 hours must be used thereafter.
- Accrued PL shall not exceed 800 hours for employees hired on or after April 1, 2012.

When you leave employment

All accrued, but unused Personal Leave shall be cashed out upon termination or retirement. Effective April 1, 2005 90% of accrued PL shall be transferred to VEBA and the remainder cashed out.

VI. Disability Plan

Highlights

Your Chelan County PUD disability benefits—short-term and long-term disability –provide income in place of your regular pay if you are sick or injured and unable to work due to a qualifying disability (see definition below). This benefit is for non-occupational injuries. Here is how the two plans work together:

- Short-term disability begins after you have been unable to work for 40 consecutive hours and have a qualifying disability. During the first 40 hours you must use personal leave (PL) or, if you have no PL available, you may take the time as unpaid leave. You must contact Human Resources to apply for short-term disability benefits.

If approved, STD pays 70 percent of your eligible earnings. STD coverage is provided for up to 180 consecutive days.

- Long-term disability follows short-term disability benefits, and if approved, begins after you are totally disabled for 180 consecutive days. It pays 60 percent or 66 2/3 percent of your eligible earnings depending on whether you have enrolled for optional coverage.

Short-term disability (STD)

Eligibility

You are eligible for benefits if you are:

- Full-time or limited assignment bargaining unit;
- Full-time exempt and non-exempt salaried;
- Part-time exempt or non-exempt salaried;

When Coverage Begins

Coverage begins 30 days after date of hire.

You must be actively at work on the day you become eligible for this plan. If you are absent on that day, you will not be eligible until you have returned to work one full day.

STD benefits will not be paid until all the proper documentation is received and Mutual of Omaha has approved the requested leave. All forms should be sent to Benefits.

Enrollment

If you belong to an eligible class, you are automatically enrolled in STD.

Eligible earnings

STD benefits are based on current regular base pay, excluding overtime.

STD/FMLA coordination

If the employee qualifies for leave in accordance with Family Medical Leave Act (FMLA), this period of leave will run concurrently with approved Short-term Disability leave.

How STD benefits work

STD benefit payments equal 70 percent of your current eligible earnings. These payments are reduced by any benefits you receive from state sponsored plans or other disability payments. You may supplement the 30 percent from your accrued PL bank and receive 100 percent of your eligible earnings. STD is provided for 180 consecutive calendar days.

STD benefits are reserved for approved for approved medical leaves of absence. To be covered, the disabling illness or injury must not be work related. Payments begin after you are disabled due to injury or illness for 40 consecutive hours. Short-term disability payments continue through the first 180 consecutive calendar days of your disability or until you recover, whichever comes first.

How to file an STD claim

STD has a 40 consecutive hours waiting period before benefits begin. After 40 consecutive hours of absence due to your illness or injury, you must be under the care of a physician and you must apply for disability benefits.

To apply for benefits, access the application for leave packet which can be found on our Intranet site or contact human resources. You are also required to coordinate your disability absence with your supervisor. Please follow the directions found on the application to apply to Mutual of Omaha for disability certification. As a follow up to your application:

- You will receive a notification in the mail/email regarding your leaves provisions under Family Medical Leave Act;
- Once your disability is approved and you have met the 40-consecutive-hour- waiting requirement, you will receive disability benefit payments from Chelan County PUD;
- If you are unable to return to work as originally scheduled, you must contact Mutual of Omaha and provide clinical evidence from your treating physician prior to your certified return to work date to continue receiving benefits; and
- You will not receive disability pay until Mutual of Omaha has received information from your physician and has certified your disability.

Duration and benefits

STD benefits are payable for approved leaves after the 40 consecutive hours of absence and for as long as 180 consecutive calendar days. However, limited assignment and seasonal employees may not use their STD to extend employment beyond the length of anticipated assignment. The amount of your benefit is either 70 percent but you can supplement STD with 30 percent from your PL bank to receive up to 100 percent of your regular base pay.

Since STD benefits do not begin until you are disabled for at least 40 consecutive hours, if you do

not have a PL balance, it is possible you would not be paid for the first 40 hours of your disability.

How benefits are paid

STD benefit payments are made on your regular paydays. You will be paid in the same manner as your regular pay. STD benefits are subject to all payroll deductions you have authorized as well as applicable taxes.

Payment for personal leave and holidays

You continue to accrue PL during your entire STD period. If you become sick or injured during a scheduled personal leave, you cannot convert your PL pay to STD benefits unless you have been involved in an accident. However, the 40-hour waiting period still applies.

There is no holiday pay while you are receiving STD benefits. All days during your STD disability period are counted as STD days and you will be paid STD benefits.

Cost of coverage

Chelan County PUD pays the full cost of STD and pays STD benefits out of the general assets. There is no cost to you.

Definition of disability

The STD Plan provides benefits if you are totally disabled due to an illness or injury that is not work-related and you are under the regular care of a physician. To be total disabled means that:

- Due to an illness or injury, you are unable to perform your job for the District;
- You are not working, except as permitted while in a partial return to work status; and
- You are not receiving disability benefits or any form of periodic payment in lieu of wages from any other employer.

You must provide medical evidence of total disability to Mutual of Omaha.

The District has the right to request a second medical opinion at the District's expense.

Reinstating your STD benefits

- If you return to work and become disabled again in less than 30 calendar days, your unused balance of STD days will be available. You will not be required to fulfill another 40 hour waiting period;
- If you return to work for 30 calendar days or longer and become disabled again with a different disability, full coverage will be reinstated once you satisfy the 40 hour waiting period. Employees will not be eligible to receive benefits for the same disability within 180 days of the employees release to work except as defined above.

Right of appeal

Please refer to Policy 112 for specific appeal language.

Long-term Disability

When coverage begins

Coverage begins on the date you are hired.

If you are away from work due to illness or injury on the day your coverage is scheduled to begin, it will be delayed until you return to active work.

If you enroll in the 66 2/3 percent level after your initial eligibility period, or cancel and then renew this coverage level, coverage begins the date the insurance company agrees in writing to cover you at the additional level. You will be required to show evidence of insurability.

Enrollment

If you belong to an eligible class, you are automatically enrolled in LTD at the 60 percent level. You will have the option to elect coverage at the 66 2/3 percent level. If you do not choose the 66 2/3 percent option at initial enrollment and decide to increase coverage at a future open enrollment, you will need to submit evidence of insurability and be approved before the higher coverage becomes effective.

Eligible earnings

LTD benefits are based on your pre-disability earnings in effect on your last day of active work.

Pre-disability earnings means your monthly rate of earnings from the District, including contributions you make through a salary reduction agreement with the District, including the Chelan County PUD Section 457 deferred compensation arrangement.

Pre-disability earnings do not include:

- Overtime pay;
- Bonuses or incentive pay;
- The Districts contribution on your behalf to the 401 (a) matching plan;
- The Districts contribution to the PERS Retirement System;
- Any other compensation

If you are paid hourly, your monthly rate of earnings is based on your hourly pay rate multiplied by the number of hours you are regularly scheduled to work per month, but not more than 173 hours.

How LTD benefits work

To obtain LTD benefits, you must be totally disabled while under this coverage. Benefits begin the first day after you have remained totally disabled for 180 days.

For LTD, you are considered disabled if, solely because of injury or disease, you are unable to perform all material duties of your regular occupation. After you have received LTD benefits for 24 months you are considered disabled if, solely because of injury or disease, you are unable to perform

all material duties of any occupation for which you are qualified (based on education, training or experience).

Pre-existing condition limitation

You will not receive LTD benefits for any disability period that results from an injury or illness for which you received treatment 90 days before your LTD coverage became effective. (This applies to a disability occurring within 12 months of the effective date of coverage.)

LTD waiting period

Your LTD waiting period is 180 calendar days of continuous disability. A disability period will be considered continuous even if you return to your regular job for up to 180 days during the benefit waiting period. The benefit waiting period will be extended by the number of days you temporarily returned to work.

Monthly benefit

Your monthly benefit under the 60 percent and 66 2/3 percent options are described below:

The lesser of: 60 percent or 66 2/3 percent of you eligible earnings or $5,000 minus any other benefits you receive for that month.

LTD benefits are reduced by any benefits you receive from state-sponsored plans, family benefits from social security or other group insurance plans, the Jones Act, workers' compensation, occupational disease, government retirement plans or any other statutory program.

Regardless of how much you receive from social security, or any other source, the plan pays a minimum of $100 a month.

Proof of disability

Although information from your physician will be considered, the insurance company determines whether your disability qualifies and you are totally disabled for LTD payment purposes. This determination is based on objective medical evidence.

To verify disability, the insurance company will require proof of disability and may assign doctors to perform periodic medical exams. No benefit will be paid if you fail to attend that exam or fail to provide information required to confirm your claim.

How long benefits may continue

LTD benefits stop on the earlier of the following dates:

- The date you recover from your disability;
- Whichever of the following dates applies:

Age when disability began	Maximum benefit period
61 or younger	To age 65, or 3 years 6 months, if longer
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year

Mental illness, alcoholism and drug abuse limits

The insurance company will pay monthly LTD benefits for no more than 24 months during your lifetime for disability caused or contributed by mental illness, alcoholism or drug abuse.

Benefit Adjustment during Return to Work

During the first 12 months, your work earnings will be deductible income as determined below:

- Determine the amount of your LTD benefit as if there was no deductible income and add your work earnings to that amount;
- Determine 100 percent of your indexed pre-disability earnings;
- The difference is your deductible income.

After your first 12 months, one half of your work earnings will be deductible income.

Exclusions

LTD benefits will not be paid if your disability is a result of:

- Injuries intentionally self-inflicted while sane or insane; or
- Any act or hazard of a declared or undeclared war.

When coverage ends

If you are not already receiving LTD benefits, your LTD coverage ends when you:

- Are no longer a District employee;
- No longer meet the eligibility requirements;
- Stop paying your premium;
- Reach the date the policy terminates.

VII. UNUM Long-Term Care (LTC) Plan

Long-term care insurance is a valuable benefit that can help relieve the financial burden of caring for you or a family member who becomes sick or disabled. Long-term care is the type of care received when someone needs assistance with Activities of Daily Living (ADLs) due to an accident, illness or advancing age or needs supervision due to a cognitive impairment (like Alzheimer's disease). This plan covers both care provided in a long-term care facility (such as a nursing home) and care provided in home by professionals.

Chelan County PUD provided base plan

- Long-term Care facility monthly benefit amount: $2,000;
- Assisted living facility benefit percentage: 60 percent of the LTC facility monthly benefit;
- Professional home care benefit percent: Based on 50 percent of the LTC facility monthly amount;
- Long-term care facility benefit duration: two years;
- Plan lifetime maximum of $48,000.

Voluntary long-term care plan buy up options

- Increase facility benefit amount in $1,000 increments up to $6,000 monthly benefit;
- Increase facility benefit duration to 3 years or 6 years;
- Add total home care benefit option;
- Add compound inflation protection – benefit amounts increase by 5 percent each year.

LTC is also available for your spouse, children, parents, spouse's parents, brothers and sisters at the District's rates. Spouses are billed through payroll deductions. All other family members are direct billed.

Eligibility

You are eligible for benefits if you are:

- Full-time or limited assignment bargaining unit;
- Full-time exempt or nonexempt salaried;
- Part-time exempt or non-exempt salaried;
- Part-time bargaining unit;
- Full-time limited assignment salaried;
- Commissioner.

Enrollment

If you belong to an eligible class, you are eligible to enroll in LTC benefits effective the first day of the month following date of hire. Your eligible family members can also apply and their coverage effective date will be the month following when they are approved if approved before the 15th of the month and the month after that if approved after the 15th.

Making changes during the year

You can make changes in your long-term care coverage at anytime by completing a new LTC enrollment form. Any increase in coverage will be subject to approval by Unum's underwriting with the evidence of insurability medical questionnaire. No evidence of insurability is needed if you are decreasing your benefit.

When coverage begins

As an eligible employee, you generally will receive enrollment information and instructions within the first 30 days of employment. Coverage for you begins the first of the month following date of hire for the base plan LTC coverage.

Evidence of insurability

If you enroll with 30 days of the date you are first eligible, you are covered for the base plan and any buy-up LTC insurance without providing evidence of insurability. Family members must always provide evidence of insurability.

If you choose to buy additional coverage, you may do so. Coverage will be in effect after UNUM has received your application for additional coverage and has approved you.

How to file a claim

Contact UNUM directly at (800) 693-4988.

When coverage ends

Coverage ends on the date any of these events occurs:

- You are no longer an eligible employee;
- You no longer make any required contributions;
- You terminate employment for any reason, including retirement;
- The plan is terminated.

Once LTC ends you have options for ongoing coverage—you may port your coverage by changing to direct billing and paying the premium yourself.

Portability

After coverage ends, you and your enrolled family members will be able to take your coverage with you without providing evidence of insurability.

To port coverage, you must complete the Election of Portability form that is submitted to Unum and pay premiums within 31 days after this coverage ends. Obtain a portability form from Benefits and contact UNUM to begin the process.

VIII. Mutual of Omaha Life and AD&D Plan

The Chelan County PUD benefits program coverage includes life insurance and accidental death and dismemberment (AD&D) insurance to protect you and your family in case of death or certain serious injuries.

This section describes:

- Basic life insurance for you;
- Additional voluntary life insurance for you;
- Additional voluntary life insurance for your spouse;
- Additional voluntary life insurance for your child(ren);
- Basic AD&D insurance for you.

Life insurance

Chelan County PUD provides basic life insurance for you equal to one times your eligible earnings. You may also elect additional voluntary life insurance for yourself, your spouse and your children.

Eligibility

You are eligible for benefits if you are:

- Full-time or limited assignment bargaining unit;
- Seasonal greater than 6 months bargaining unit;
- Full-time exempt or non-exempt salaried;
- Part-time exempt or non-exempt salaried;
- Part-time bargaining unit;
- Full-time limited assignment salaried;
- Commissioner.

You may enroll your eligible spouse and children 14 days and older and up to age 23 in voluntary life insurance.

Any individual insured as an employee cannot also be insured as a dependent. If it is determined at the time of a claim that an employee was enrolled as a dependent, no benefit will be paid as a dependent.

Enrollment

If you belong to an eligible class, you are automatically enrolled in basic life benefits effective the first day of the month following date of hire. You may request to elect, drop, increase, decrease or change enrollment in additional voluntary insurance for you or your eligible family members at any time.

When coverage begins

As an eligible employee, you generally will receive enrollment information and instructions within the first 30 days of employment. Basic Life coverage for yourself begins the first day of the month following date of hire. Additional voluntary life coverage for you and any enrolled family member begins on the first day of the month that coincides with or follows the latest of the day:

- You begin active work;
- You submit a written request to enroll for insurance, if applicable; or
- Mutual of Omaha approves Evidence of Insurability, if required.

If you are away from work due to an illness or injury on the day coverage would begin, life insurance will be delayed until the day you return to work. Your families' life insurance coverage will begin when yours begins.

If a family member is confined at home, in a hospital or elsewhere due to illness or injury on the day coverage would begin, life insurance coverage will be delayed until they are no longer confined.

If you retire from service, coverage will end.

Eligible earnings

Benefits are based on your pay in effect on your last full day of active work. If you have any questions about how your benefits are calculated, contact Benefits.

Basic life insurance

Your basic life insurance equals one times your eligible earnings rounded up to the next $1,000, if not already a multiple of $1,000. The plan maximum is $350,000; the plan minimum is $22,000.

Voluntary life insurance

Additional voluntary life insurance for you and your family is optional. The cost depends on your age and the dollar amount of coverage. Voluntary life is independent of basic life and is a separate policy. The policies are similar but are different in some areas.

- Employee–You may purchase additional voluntary life insurance at one, two, three or four times your eligible earnings. Your additional voluntary coverage may not exceed $600,000.
- Spouse–You must be enrolled in voluntary life in order to purchase and retain voluntary dependent life insurance for your spouse. You may purchase coverage for your spouse at the following levels: $10,000, ½ your salary, or one times your salary. However, the amount purchased cannot exceed 50 percent of the additional voluntary life insurance you elect for yourself.

- Children–You must be enrolled in voluntary life in order to purchase and retain voluntary dependent life insurance for your child. The coverage is $10,000 per child.

Voluntary life evidence of insurability

If you enroll within 31 days of the date you are first eligible, you can be covered up to four times your salary not to exceed $250,000 without providing evidence of insurability. If you enroll your spouse within 31 days of the date you are first eligible or have acquired a spouse, your spouse may be covered for $10,000 without providing evidence of insurability. Enrollment for you and your spouse at any other time requires evidence of insurability. Children do not require evidence of insurability.

Changing your voluntary life insurance coverage

You may request to elect, drop, increase, decrease or change enrollment in additional voluntary insurance for you or your eligible family members at any time. Adding or increasing voluntary coverage, for yourself or your spouse, outside of the initial eligibility period always requires evidence of insurability. Child(ren) can be enrolled at any time without evidence of insurability, as long as you are already enrolled in voluntary life. When evidence of insurability is required, the expanded coverage and payroll deductions will begin the month following approval by the carrier.

Life insurance taxability

In certain circumstances, the federal government requires the value of group basic life insurance above $50,000 to be included in an employee's taxable income. Although you do not receive a larger paycheck, this additional income—usually a small amount shows on your pay stub and is included in the gross earnings on your W-2 at the end of the year.

Contributions for voluntary life insurance are made after taxes and are not included in taxable income on your W-2.

Accelerated benefit

If you (or a family member) become terminally ill and a physician certifies your illness is expected to result in death within 24 months, you may elect to have Mutual of Omaha pay part of your life insurance benefit while you are alive.

- For basic life, you may request up to 75 percent of your life insurance amount to a maximum of $262,500, whichever is less.
- For additional voluntary life, you may request up to 50 percent of your life insurance amount to a maximum of $100,000, whichever is less.

At your death, benefits payable to your beneficiaries will be reduced by the accelerated benefit you received.

If you become totally disabled

Your life insurance (basic and any additional voluntary life you have previously elected) will continue, at no cost to you, if you become totally and permanently disabled. (Totally disabled means that you have a condition that prevents you from doing any work for which you are or could be qualified through education, training or experience).

The amount of your continued coverage equals the amount you had as an active employee at the time of your disability less any reductions due to age. The life coverage will continue until you die, are no longer disabled or reach the limiting age of 65 years.

You may apply to convert to an individual life policy if you no longer qualify for coverage under this provision.

Your beneficiary

If you die, benefits will be paid to your beneficiaries. You may designate one or more beneficiaries. For two or more beneficiaries, your benefit will be paid in equal share unless otherwise designated by you. Note: If you are legally married or legally separated and you designate someone other than your spouse as beneficiary, your spouse may be required to give legal consent.

If you do not name a beneficiary, benefits will be paid to the first survivor on the list—your:

- Spouse;
- Children;
- Parents;
- Your estate

To designate or change your beneficiary, contact Benefits at benefits@chelanpud.org or by calling extension 4448.

You are automatically the beneficiary for your family members covered by voluntary life insurance.

Circumstances that affect your coverage

If you reach an age shown below, the amount of insurance will be the amount determined from the schedule of insurance multiplied by the appropriate percentage below:

Age: 70 or over

Percentage: 67%

How to file a claim

Contact Benefits at benefits@chelanpud.org or by calling extension 4448.

When coverage ends

Coverage ends on the date any of these events occurs:

- You are no longer an eligible employee;
- You no longer make any required contributions;
- You terminate employment for any reason, including retirement;
- You are placed in a temporary layoff status;
- The plan is terminated; or

- For your family, when a dependent no longer meets eligibility requirements, for example if your spouse is legally separated or divorced from you or if your child reaches the age limit of 23 or gets married.

Once life insurance ends you have options for ongoing coverage—conversion as described in the following section.

Conversion

After coverage ends, you and your enrolled family members may be able to convert to an individual whole life insurance policy without providing evidence of insurability.

To convert, you must apply to the insurance company and pay premiums within 31 days after this coverage ends. Contact Mutual of Omaha at 800-826-8054 to begin the process.

Accidental death and dismemberment (AD&D) coverage

Chelan County PUD provides AD&D insurance for you equal to one times your eligible earnings to a maximum of $350,000.

This coverage will pay benefits for death or for a covered loss resulting from an accident. If you die, accidental death benefits will be paid to your beneficiaries.

AD&D benefits are in addition to your life insurance benefits.

Eligibility

You are eligible for benefits if you are:

- Full-time or limited assignment bargaining unit;
- Seasonal greater than 6 months bargaining unit;
- Full-time exempt or non-exempt salaried;
- Part-time exempt or non-exempt salaried;
- Part-time bargaining unit;
- Full-time limited assignment salaried; or
- Commissioner.

When coverage begins

If you belong to an eligible class, you are automatically enrolled in AD&D effective the first day of the month following date of hire. Coverage for you begins the on the first day of the month after you begin work.

If you are away from work due to an illness or injury on the day coverage would begin, AD&D insurance will be delayed until the day you return to work.

Eligible earnings

Benefits are based on your pay in effect on your last full day of active work. If you have any questions about how your benefits are calculated, contact Benefits at benefits@chelanpud.org or by calling extension 4448.

Benefit schedule

AD&D coverage will pay benefits within 365 days if you die or are injured in an accident, as described below. No more than 100% will be paid for all losses resulting from one accident.

For this loss from an accident	Benefits will be this percent of your coverage amount
Life, Quadriplegia	100%
One hand, one foot or sight in one eye, hearing (both ears), speech,	50%
Two or more of the losses listed above	100%
Loss of Thumb and Index Finger of same Hand or Uniplegia	25%
Paraplegia or Hemiplegia	50%
Triplegia	75%

Additional AD&D benefits

Additional benefits are available for AD&D losses for the following circumstances:

- Airbag Benefit – Additional benefits for accidental deaths occurring while driving or riding in front seat directly behind an Airbag
- Seat Belt Benefit – Additional benefits for accidental deaths occurring while wearing a seat belt
- Child Care Benefit – Additional benefits for the spouse of an employee who has died in an accidental death and has child care needs
- Higher Education Benefit – Additional benefits for the children of an employee who has died in an accidental death
- Spouse Education Benefit – Additional benefits for the education of a spouse of an employee who has died in an accidental death

Contact Benefits at benefits@chelanpud.org for information on these additional benefits.

Circumstances that affect your coverage

If you reach an age shown below, the amount of insurance will be the amount determined from the schedule of insurance multiplied by the appropriate percentage below:

Age: 70 or over

Percentage: 67%

Your beneficiary

If you die, benefits will be paid to your beneficiaries. You may designate one or more beneficiaries. For two or more beneficiaries, your benefit will be paid in equal share unless otherwise designated by you. If you are legally married or legally separated and you designate someone other than your spouse as beneficiary, your spouse must give legal consent.

If you do not name a beneficiary, benefits will be paid to the first survivor on the list—your:

- Spouse;
- Children;
- Parents;
- Your estate.

To designate or change your beneficiary, contact Benefits at benefits@chelanpud.org or call extension 4448.

How to file a claim

Contact Benefits at benefits@chelanpud.org or call extension 4448.

When coverage ends

Coverage ends on the date any of these events occurs:

- You are no longer an eligible employee;
- You terminate employment for any reason, including retirement;
- The plan is terminated.

IX. Deferred Compensation 457 Plan and 401(a) Matching Plan

Whether just starting your career or approaching retirement, it is always a good time to save for your future. The Chelan County PUD 457 plan and 401(a) matching plan offers an easy and convenient way to put money aside for your retirement. Through this plan, you have flexible contributions, a wide choice of investment options and—unlike a traditional bank account—a way to reduce your current income taxes.

Contributions to the 457/401(a) matching plans

The 457/401(a) matching Plans include three types of contributions:

- Before-tax contributions equal to plan maximums for the current year (additional allowances for employees age 50 and older);
- District matching contributions;
- Rollover contributions.

Here are some key features of the plan:

- Before-tax contributions are taken from your eligible earnings before federal income taxes are withheld. This allows you to defer paying taxes on these contributions while investing in your future;
- District contributions [401(a) Plan] will match your before-tax contributions at $0.50 for each $1.00 you contribute to the plan, up to 5 percent of eligible earnings;
- District contributions are fully vested immediately.

Highlights

- You have a variety of investment options to choose from. You may select the fund or a mix of funds for investing your contributions and may transfer among the investment options without restriction;
- 457 Plan loans are allowed, subject to plan rules;
- As an active employee you may withdraw all or a portion of your 401(a) account balances if you are age 59-1/2 or older without penalties;
- You must separate from service to access the 457 funds;

- Full payment of your accounts can be made when you retire, die become totally disabled or leave the company for any other reason. You may also leave your money in the plan until you wish to take a distribution;
- Federal income taxes are deferred on your before-tax contributions, District contributions and investment earnings as long as they remain in the plan.

Eligibility

You are eligible to participate in the 457/401(a) matching plans if you are:

- Full-time or limited assignment bargaining unit (401(a);
- Full-time exempt or nonexempt salaried;
- Part-time exempt or non-exempt salaried;
- Part-time bargaining unit;
- Full-time limited assignment salaried;
- Commissioner.

Enrollment

You may enroll in the 457 immediately upon hire. You may contact Mission Square at (800) 669-7400 to enroll or enroll online at: www.icmarc.org.

Contributions

The table below shows the types of contributions currently allowed under the 457/401(a) matching plans:

Type of Contribution	Who Makes the Contribution	Federal Income Taxes*
Before-tax	You contribute a portion of eligible earnings	Taxable upon withdrawal
District match	District matches before tax contributions (up to certain limits)	Taxable upon withdrawal
Rollover	You direct an eligible distribution from another plan or IRA to be directly transferred to this plan	Taxable upon withdrawal

Investment earnings on all contributions are taxable when withdrawn.

Your before –tax contributions

Your before-tax contributions to the 457 plan can be up to the IRS before-tax limit as shown below:

$20,500 in 2022

If you are age 50 or older you are allowed to contribute an additional contribution as shown below:

$6,500 in 2022

Advantages of before-tax contributions

When you save on a before-tax basis, you contribute money to the plan before federal income taxes are withheld from your pay. This lowers your taxable income and your current federal income taxes-a good way to invest for the future and defer taxes at the same time. Your contributions **are** considered wages for Social Security taxes.

District matching contributions

When you contribute to your account, the District makes a matching contribution (Bargaining Unit employees must wait 1 year to receive the match). For each $1.00 you contribute the District will contribute $0.50 up to 5 percent of salary. The amount of the match is based on an annualized base pay (or hourly rate) exclusive of overtime or any additional pay.

Rollover contributions (Roll-ins)

Only approved balances from an eligible governmental 457(b), 401(k), 403(b) or 401(a) plan or an Individual Retirement Account (IRA) may be rolled over to the 457 Plan. Other plans, when withdrawn, may be subject to the 10 percent early withdrawal federal tax penalty.

Investment funds

A wide array of core investment options is available through the District's Plans. Each option is explained in further detail in the Plans' fund data sheets. Investment option information is also available through HR or online at www.icmarc.org. Please consider the investment objectives, risks, carefully before investing.

Vesting

Vesting refers to the percentage of your account you are entitled to receive from the Plans upon the occurrence of a distributable event. Your contributions to the 457 Plan and any earnings they generate are always 100% vested (including any rollovers from previous employers). For the 401(a) Plan, employees are 100% vested upon entry into the Plan.

Distributions

Qualifying distribution events are as follows:

- Retirement;
- Permanent disability;
- Financial hardship (as defined by the Internal Revenue Code and your Plan's provisions);
- Severance of employment (as defined by the Internal Revenue Code);
- Attainment of age 70 ½ (if allowed by your Plan);
- Death (your beneficiary receives your benefits);
- In-service transfer to purchase service credit (for the 457 Plan only).

Ordinary income tax will apply to each distribution. Distributions from the 401(a) plan received prior to age 59½ may also be assessed a 10 percent early withdrawal federal tax penalty.

Distribution options

- Leave the value of your account in the Plan until a future date;
- Receive:
  - Periodic payments
  - Fixed annuity payments
  - A lump sum
  - Partial lump sum
- Roll over your account balance to an eligible governmental 457(b), 401(k), 403(b) or 401(a) plan or to an IRA.

Loans

Your 457 Plan allows you to borrow the lesser of $50,000 or 50 percent of your total account balance. The minimum loan amount is $1,000, and you have up to 5 years to repay your loan—up to 15 years if the money is used to purchase your primary residence.

Hardship withdrawals

Hardship withdrawals are strictly regulated by the IRS. They may be approved for the amount needed to meet an immediate and heavy financial need (including federal, state or local taxes or penalties reasonably expected to result from your hardship withdrawal), but no more than the value of the account.

Income taxes

Because your contributions to the 457 Plan are taken out of your paycheck before taxes are calculated, you pay less in current income tax. You do not report any current earnings or losses on your 457 Plan account on your current income tax return either. Your 457 Plan account is tax deferred until you withdraw money, usually at retirement.

Employer contributions to the 401(a) Plan and any earnings are tax-deferred until you withdraw money, usually at retirement.

Distributions from the 457 & 401(a) Plans are taxable as ordinary income during the years in which they are distributed or made available to you or to your beneficiary(ies) at your then current tax rate. Distributions from the 401(a) Plan received prior to age 59½ may also be subject to a 10% early withdrawal federal tax penalty.

When you leave employment

Decide if you want to access your 457/401(a) investments. If so, please contact Mission Square at (800) 669-7400. You may roll over your account balances to another eligible governmental 457(b), 401(k), 403(b) or 401(a) plan if your new employer's plan accepts such rollovers. You may also roll over your account balances to an IRA. You are not required to remove or transfer these investments.

X. Public Employees Retirement System (PERS) Retirement Plan

Highlights

The Chelan County PUD retirement plan provided through the State of Washington Department of Retirement Systems (DRS) helps provide a foundation for your retirement. The plan pays a monthly income at retirement. You are required to make a contribution to the plan. Contribution levels are set by the DRS and are deducted from your pay.

Please note: this publication provides a high-level description of the plans available, and should not be used as a basis for any choices you make.

The State of Washington Department of Retirement Systems offers three retirement plans as outlined below:

- PERS Plan 1 is for employees who established membership before Oct. 1, 1977;
- PERS Plan 2 is for employees who established membership on or after Oct. 1, 1977;
- PERS Plan 3 was passed by the 2000 Legislature and went into effect March 1, 2002 for state employees, Sept. 1, 2002 for local government employees.

Eligibility

You are eligible for benefits if you are:

- Full-time or limited assignment bargaining unit;
- Seasonal greater than six months bargaining unit;
- Full-time exempt or nonexempt salaried;
- Part-time exempt or non-exempt salaried;
- Part-time bargaining unit;
- Full-time limited assignment salaried;
- Commissioner (membership is optional).

Enrollment

If you belong to an eligible class, you are eligible to participate in the retirement plan automatically on your first day of work. You will be enrolled in the appropriate plan based on your previous membership (if any) in PERS:

- If you are a PERS Plan 1 member, you will remain a PERS 1 member;
- If you have no previous PERS membership, you'll be temporarily enrolled in PERS Plan 2, and will have 90 days to choose to stay in PERS Plan 2 or go to PERS Plan 3;
  - Your plan choice is irrevocable;
    - If you choose Plan 3, you must also select a rate option;
    - If no plan choice is made you will be defaulted to Plan 3 with 5 percent deduction;
    - Rate option choice is irrevocable unless you change employers;
- If you are a PERS Plan 2 member who did not choose Plan 2 (enrolled prior to September 1, 2002) you may choose to transfer to Plan 3 during any January open enrollment;
  - The decision to transfer to Plan 3 is irrevocable;
  - If you choose to stay in Plan 2, no action is necessary;
- PERS Plan 3 participants have 90 days to choose a rate option and investment program;
  - No deductions are taken until your choice has been made;
  - A 5 percent deduction will be taken automatically if no choice is received within 90 days;
  - Rate option choice is irrevocable unless you change employers.

Restoration of previously withdrawn funds

If you were previously a Plan 1 or 2 member and had withdrawn your funds, you may be eligible to re-establish your service credit through restoration upon re-employment. Contact DRS for more information.

PERS retirement eligibility

PERS Plan 1

- Any age with 30 or more years of service credit;
- At least age 55 with 25 or more years of service credit;
- At least age 60 with five or more years of service credit.

PERS Plan 2

- Age 65 or older and have at least five service credit years;
- At least age 55 and have at least 20 service credit years. If you retire before age 65, your benefit will be reduced.
- At least age 58 and have 30 service credit years. If you retire before age 62, your benefit will be reduced.

PERS Plan 3

At age 65:

- At least 10 service credit years;
- Five service credit years, including 12 service credit months that were earned after age 44;
- Five service credit years that were earned under Plan 2 and transferred to PERS Plan 3 before June 1, 2003.
- A reduced benefit is available as early as age 55.

How your normal retirement benefit is calculated

PERS Plan 1 and 2 defined benefit:

PERS is intended to provide you with a reliable source of income after you retire. Your "defined benefit" is guaranteed for your lifetime and is based on:

- Your service credit years;
- Your highest average income (average final compensation).

A formula is applied using the information above as follows:

Plan 1 and 2: 2 percent of your average final compensation (AFC) is paid for every service credit year you have at retirement. Both member and matching employer contributions fund this benefit.

Plan 3: 1 percent of your AFC is paid for every service credit year you have at retirement. This benefit is funded by matching employer contributions only.

PERS Plan 3 defined contribution

PERS Plan 3 member contributions or "defined contributions" are invested and managed by a private investment company (Mission Square). The amount of benefit you receive is in direct relationship to investment performance.

Plan 3 members are allowed six contribution rate packages to choose from:

1. Option A: 5 percent fixed rate all ages
2. Option B: 5 percent up to age 35
   6 percent ages 35 through 44
   7.5 percent age 45 and older
3. Option C: 6 percent up to age 35
   7.5 percent ages 35-44
   8.5 percent ages 45 and older
4. Option D: 7 percent fixed rate all ages
5. Option E: 10 percent fixed rate all ages
6. Option F: 15 percent fixed rate all ages

Your contribution rate choice is irrevocable unless you change employers.

Early retirement benefit (PERS Plan 2/3)

Your early retirement benefit is calculated the same way as a normal retirement benefit, based on service credit years and average final compensation and 1 or 2 percent. If you are vested and terminate before age 65 and have at least five years of service in a PERS eligible position, you will have these choices:

- You can wait and receive your full retirement benefit when you reach age 65;
- You can have your payments begin as early as age 55, although your monthly amount will be adjusted to reflect receiving your benefit for a longer period of time;
- You may cash out your contributions and waive participation.

Early retirement factors PERS Plan 2/3

Your Age at Retirement	At least 20 (or 10 for PERS Plan 3), less than 30 service credit years	30 or more service credit years
55 Years	37 percent of benefit	80 percent of benefit
56	40 percent of benefit	83 percent of benefit
57	43 percent of benefit	86 percent of benefit
58	49 percent of benefit	89 percent of benefit
59	55 percent of benefit	92 percent of benefit
60	61 percent of benefit	95 percent of benefit
61	67 percent of benefit	98 percent of benefit
62	73 percent of benefit	100 percent of benefit
63	82 percent of benefit	100 percent of benefit
64	91 percent of benefit	100 percent of benefit
65	100 percent of benefit	100 percent of benefit

Retirement from inactive service-early retirement reduction factors PERS Plan 1

Age	Reduction Factor
60	.61
61	.67
62	.73
63	.82
64	.91

Leaving the District

If you terminate before meeting the minimum service credit requirement for vesting, you will not be eligible to receive a defined benefit under any of the PERS plans. However, if you begin employment for another Washington State public company, your service credit years will transfer to the new employer.

Withdrawal of member contributions

Once terminated, you will have the option of withdrawing your member contributions and the interest they accrued. If you withdraw under Plan 1 or 2, you terminate all rights to a future benefit, if any. Withdrawal of Plan 3 contributions does not cancel your rights to your defined benefit. The service credit you accrued during your employment will be retained.

Starting your retirement benefit

Please contact DRS directly at (800) 547-6657 for all your distribution options.

XI. Employee Assistance Plan

Highlights

From time to time, anyone may need help with personal issues, which also can affect your job performance. The Chelan County PUD recognizes this, and offers an Employee Assistance Program (EAP) designed to help you and your family with almost any work-related or personal difficulty.

- To ensure confidentiality, the District contracts with an outside EAP firm, Aetna, to administer the EAP program. The District receives no individual information from Aetna;
- You can call the Aetna EAP 24 hours a day, seven days a week at the toll free line: 1-888-AETNA-EAP / 1-888-238-6232;
- Each family member receives up to six sessions per issue, per year.

Eligibility

You are eligible for benefits if you are:

- Full-time or limited assignment bargaining unit;
- Seasonal greater than six months bargaining unit;
- Full-time exempt or nonexempt salaried;
- Part-time salaried;
- Full-time temporary exempt or nonexempt salaried;
- Commissioners;
- Seasonal less than six months bargaining unit;
- Temporary less than six months bargaining unit;
- Temporary part time nonexempt;
- Full-time limited assignment salaried;
- On-call; or
- Students.

When coverage begins

Coverage begins the first day of employment with the District.

Enrollment

If you belong to an eligible class, you are automatically enrolled in EAP.

About Aetna EAP

Aetna, who administers the EAP, manages and coordinates a network of affiliated providers.

Local providers are individual private practitioners, agencies or groups of mental health professionals who contract with Aetna.

All professionals providing counseling through the Aetna EAP must have specific credentials and are experienced in dealing with mental health care, substance abuse assessment and human relations. These professionals include social workers, mental health professionals, psychologists, and marriage and family therapists.

Each individual or organization is carefully screened and reviewed before becoming an affiliated provider. Participating providers receive ongoing supervision and training as well.

Types of assistance the plan offers

The EAP can assist you with a complex range of issues that may affect you or your family—alcoholism and drug abuse, emotional, financial and marital/interpersonal concerns. When you need help, simply call the Aetna EAP at 1-888-AETNA-EAP / 1-888-238-6232. There is no charge to you, and your call will be kept strictly confidential.

This phone line is staffed by specially trained EAP representatives. When you make the initial call, you will be asked for certain basic information such as your name, address, phone number, employer and the reason for the call.

Counseling

1 to 6 Face-to-Face Assessment and Counseling Sessions are available per issue at an office convenient to home or work. The Aetna EAP has developed an extensive network of counselors in each community where services are provided as well across the country so services can be easily accessed. Aetna contracted counselors are either certified or licensed and have experience in a broad range of personal, family and work related concerns. Among other things, the EAP can help with:

- Work/family life issues;
- Emotional issues;
- Parenting issues;
- Relationship concerns;
- Depression;
- Stress;
- Alcohol/drug dependencies;
- Family counseling;
- Grief counseling; and
- Spousal/child/parent abuse.

Legal services

Employees who use the EAP to access legal services will be given the opportunity to consult with an attorney via the telephone or a referral will be made to an attorney for an in-person consultation. The referral lawyers have agreed to provide the initial half-hour consultation at no cost to you. If you decide to retain the lawyer for further services, the lawyer charges you at a special 25 percent reduced rate from their regular fees, because you were referred through the Aetna EAP.

Financial services

Employees who contact their EAP with financial concerns can be connected to a financial consultant who is able to discuss these concerns and provide suggestions regarding a course of action. This telephonic consultation is provided free of charge to the employee or their dependent family members. The financial consultant will review the client's past financial history, assess the current situation and problem solve with the client to develop a resolution strategy. When appropriate, the EAP can provide a local community referral for a specific concern. A 25 percent discount off Tax Preparation fees is also available.

Additional Worklife Services

Additional telephonic counseling and referral services are also available through the Aetna EAP. Some of these include Identity Theft Services, Child and Elder Care, Personal/Convenience, Discount Programs, etc.

24-Hour crisis counseling

Employees, dependents and their household members who need an immediate response for crisis counseling or after-hours assistance are instructed to use the toll-free hotline number 1-888-AETNA-EAP / 1-888-238-6232 twenty four hours a day, seven days a week to confidentially discuss your concerns.

Confidentiality

Confidentiality is essential. All discussions with the EAP professional are confidential. Information regarding contact with the EAP cannot be released without written consent, except in the following situations: by court order, imminent threat of harm to self or others, or in situations of abuse (such as child or elder abuse).

When employees are referred to additional resources for help and elect to use those resources, the resulting co-payments and fees, if any, would be their responsibility.

When coverage ends

Your EAP coverage ends when you:

- Are no longer a District employee;
- No longer meet the eligibility requirements; or
- The date the policy terminates.

XII. Wellness Plan

Highlights

Chelan County PUD offers a wellness plan to all of its employees. The Chelan PUD Wellness plan is intended to assist employees in making voluntary behavior changes which will reduce their health and injury risk, improve their health consumer skills and enhance their individual productivity, quality of life and well-being.

Eligibility

You are eligible for the wellness program if you are employed by the Chelan County PUD:

When coverage begins

Coverage begins the first day of employment with the District.

Wellness Plan Guiding Principles

- Individuals need to assume responsibility for their health and be the primary agent in prevention;
- Health interventions that address personal health practices are of vital importance;
- Time-honored medical practices such as an annual physical are significant;
- Prevention and early detection significantly reduce health care costs;
- Chronic conditions such as heart disease, stroke, obesity and diabetes are largely preventable;
- Every opportunity should be taken to learn how to practice prevention.

Types of Wellness Programs the Plan Offers

To help employees build and maintain optimal health, Chelan County PUD offers many wellness program components at no or very little cost to the employee.

Annual Health Fair

Annually in the fall, the District in conjunction with Confluence Health offers a health fair at no charge to all employees. The health fair is transported on-site to Rock Island Dam, Rocky Reach Dam and to Headquarters. The following services are included in the health fair at no cost;

Biometric Screening

Our biometric screening includes component results:

- Cholesterol screening;
- Glucose;
- BUN;
- Creatinine;
- Calcium;
- Sodium;
- Potassium;
- Chloride;
- CO2;
- Albumin;
- Bilirubin;
- Triglycerides:
- PSA (males only)

Flu Shots

Voluntary flu shots are offered to all employees at no cost.

Blood Pressure

Blood pressure checks are available during the health fair. You may also get your blood pressure check during working hours by visiting the headquarters safety department.

DexaScan

A DexaScan machine is available during the health fair to check bone density.

Monthly Healthy Newsletter/Family Safety & Health magazine

On a monthly basis, employees receive two newsletters full of helpful tips on healthy and safe living at no cost.

Premera 24-Hour NurseLine

Premera offers at no charge to employees and their covered dependents a 24-hour nurse line to ask questions and get help with non-emergency issues. The direct number is 1-800-841-8343.

Local Gym Memberships through Payroll Deduction

Some local gyms in the area offer corporate membership discounts through payroll deductions for Chelan County PUD employees. For a gym to be eligible, they must first have an employee sponsor and at least 10 employees on the contract for payroll deduction.

Gym	Employee Sponsor
Gold's Gym	Rosanna Sokolowski
YMCA	Carla Truscott
WRAC	Richard Dinius
CrosSport	Debra Vaughn
Wenatchee Valley College	Beverly Freeman

If you have specific questions about a particular fitness organization, please contact the appropriate employee sponsor.

Onsite Health and Wellness Classes

In connection with the Wenatchee Valley College Continuing Education Department, the District offers classes at no cost to employees and spouses.

Other Offerings

- Premera web site offers a free Health Risk Assessment;
- Water coolers throughout the District;
- Group sports spectator activities (i.e. Wenatchee Wild and AppleSox games) and
- Healthy eating choices at Gerald's cafeteria.

When coverage ends

Your wellness program coverage ends when you:

- Are no longer a District employee;
- No longer meet the eligibility requirements; or
- The date the program terminates.

XIII. HRA VEBA Plan

Highlights

If you are benefit-eligible, you have access to a tax-advantaged account — called an HRA VEBA. You can use the account to pay for eligible healthcare expenses just like other accounts, such as a Flexible Spending Account (FSA). But, the HRA VEBA is unique because:

- Only CCPUD contributes: IRS rules do not allow employee contributions.
    - If you enroll in a Chelan PUD medical plan (either the Preferred Provider Organization or the Consumer Directed Health Plan), Chelan PUD automatically makes a monthly $100 contribution to your HRA VEBA. Bargaining unit employees receive an additional $100 monthly contribution to the HRA VEBA effective 4/1/22 for a total of $200 per month ongoing.
    - If you enroll in the Chelan PUD CDHP, Chelan PUD contributes an additional $1,250 in January, which you may use to offset the deductible or pay for other out-of-pocket medical expenses.
    - At resignation or retirement, 90% of the value of your PL is sent to HRA VEBA.

- Your HRA VEBA is tax-free: This includes federal income tax and FICA taxes (Social Security and Medicare). By paying less in taxes, you get to keep more for yourself. As long as you use the funds for qualifying healthcare expenses, you never pay a dime in taxes!

- You can use it now or later:
    - You can use the money to pay for IRS-permitted medical expenses* that you, your legal spouse or covered dependents incur.
    - Any unused money in your account carries forward year after year, so you can use the money now or save it for later — even in retirement.

- You can invest it: You can invest the money in your HRA VEBA in a variety of available investment funds.

- You take it with you:
    - When you retire or no longer work for Chelan PUD, 90% of the value of your PL account goes to HRA VEBA and goes with you.
    - Any balance passes to your beneficiaries when you die.

** Eligible expenses are defined in IRS code section 213(d).*

Eligibility

You are eligible to participate in the HRA VEBA if you are:

- Full-time or limited assignment bargaining unit;
- Seasonal greater than six months bargaining unit;
- Full-time or limited assignment exempt or nonexempt salaried;
- Part-time salaried;
- Commissioner.

Enrollment

As an eligible employee, CCPUD will automatically start your HRA VEBA enrollment, and then provide you with instructions to complete the enrollment online (usually within the first 30 days of employment). After you enroll and Chelan PUD has made its first contribution to your HRA VEBA, you will receive a welcome packet from the HRA VEBA administrator. It will contain:

- Your account number;
- Claims-eligibility status;
- Investment allocation;
- Instructions on how to access your account online.

When your participation begins

You are eligible to participate on the first of the month following your date of hire. Your first deposit will occur the week following the first payroll in the month you become eligible and complete the enrollment process.

Investment of contributions

Contribution(s) will be invested in the HRA VEBA Stable Value fund until you make a change. You can view available investment fund options and change your investment allocation online at www.hraveba.org or from the mobile app, HRAgo®.

Eligible expenses

With the HRA VEBA, you can use tax-free funds to help cover for 213(d) medical expenses incurred by you, your legal spouse, or eligible dependents, either now or during retirement. Eligible expenses include:

- Annual deductibles;
- Co-payments;
- Co-insurance;
- Prescription drugs;
- Dental;
- Vision;
- Laser eye surgery;
- Retiree medical premiums (medical, dental, and vision);
- Tax-qualified long-term care (subject to IRS limits).

Internal Revenue Code 213(d) outlines qualified medical expenses and premiums. For a quick reference, see Qualified Expenses & Premiums in the Resource section on hraveba.org.

When your participation ends

When you retire or leave CCPUD, you will no longer receive CCPUD contributions, but your account remains active and you can continue to use the funds in the account until there is no balance. If you die, your beneficiaries can use the account balance to pay for their eligible medical expenses.

How to use your account

Using your HRA is easy! You can access your account online anytime at hraveba.org or on the mobile app, HRAgo®, to:

- Submit a claim and provide supporting documentation;
- Elect direct deposit of reimbursements;
- Choose to receive communication electronically instead of paper;
- Set up automatic reimbursement of monthly retiree medical premiums;
- Access paper forms.

If you have questions

If you have any questions about your HRA VEBA, call the Customer Care Center at 1-888-659-8828 or send an email to customercare@hraveba.org. You will also find information online at www.hraveba.org.

XIV. Facts About Your Benefits

Highlights

This handbook is an easy-to-understand summary of the main features of your benefit plans. As a summary, it does not cover every circumstance that might apply to you. You may review the plan documents and insurance contracts for a more detailed look at your benefits. Please contact the respective plan administrator for further information.

The plan administrator has complete and exclusive discretionary authority to construe the terms of the plan, determine eligibility for benefits and make all fiduciary decisions required to operate the plan. The plan administrator's decisions are binding on all persons.

If case of a conflict, the plan documents and contracts govern all matters. If you have questions, please contact Benefits at extension 4448.

Future of the plans

Chelan County PUD reserves the right in its sole discretion to alter, amend, delete, cancel, terminate or otherwise change the plans or any plan provisions at any time and for any reason, subject to state law and its duty, if any, to negotiate in good faith with its union representatives. The District will provide you with a written notice of changes to its medical plan at least 30 days before the changes take effect, unless exigent circumstances exist.

If the plans are terminated, coverage for you and your eligible family members will end; benefits for any legitimate claims incurred before plan termination will be paid.

Protection of benefits

In general, your benefits cannot be assigned, sold, transferred, encumbered or used to secure debts. Benefits also cannot be subject to attachment, garnishment or any other legal process. However, state Domestic Relations Orders (DROs) transferring 457 and pension benefits in connection with a legal separation or divorce, and Medical Child Support Orders (MCSOs) issued by a court or state agency of competent jurisdiction and requiring health care coverage for eligible children, are enforced. DROs and MCSOs are described later in this section.

Domestic Relations Orders (DROs)

The Retirement Equity Act of 1984 requires that employee pension benefit plans, such as the DRS Retirement Plan and 457 plan, recognize DROs with respect to the assignment of plan benefits incident to legal separation or divorce. In general, a DRO is a court order, judgment or decree that:

- Is made pursuant to a state domestic relations law (including community property laws);
- Relates to the provision of child support, alimony payments or marital property rights; and

- Creates or recognizes an alternated payee's right to receive all or a portion of a participant's benefit under a pension plan.

If specified by the court order, a distribution may be made from either the 457 plan or DRS Retirement Plan (or both) to the alternate payee before the participant qualifies to receive retirement benefits.

Court orders requiring a division of benefits under the DRS Retirement Plan and/or 457 plan must be sent to the plan administrator for a determination of whether the court order is a DRO. No distributions will be made until the plan administrator determines the order is a DRO.

If you are a party in a divorce settlement that affects your interest in the 457 plan or the DRS Retirement Plan, you may contact the plan administrator to receive copies of each plan's procedures regarding DRO determinations and model DROs.

Medical Child Support Orders (MCSOs)

Health plans such as those sponsored by the District are required to honor court orders which require a parent to provide health care coverage for a child, even if the parent has not voluntarily enrolled the child in the plans. The plans honor only MCSOs. In general, a MCSO is a court order, judgment or decree which:

- Is made pursuant to a law relating to medical child support with respect to a group health plan;
- Provides for health benefit coverage for a child of an employee who is participating in one of the District's health plans; and
- Includes the following administrative information: the names and addresses of both the employee and the child, a reasonable description of the type of coverage to be provided to the child (or manner in which the type of coverage is determined), the period covered by the order, and information identifying the plans to which the order applies.

Generally, a MCSO cannot require a plan to provide any type or form of benefit, or any option, which would not otherwise be available under that plan.

Court orders that require health care coverage for a child must be sent to the plan administrator. No coverage will be provided pursuant to a court order until the plan administrator receives the order.

If you are a party in a divorce settlement that requires continued health care coverage for a child, you may contact the plan administrator to receive a copy of the procedures regarding MCSO determinations. The procedures are available to participants and beneficiaries free of charge.

If your health or welfare benefit claim is denied

Most employee benefit plans have specific procedures and timeframes, by law, to evaluate and process claims for benefits, as well as appeals of denied claims. The timeframes and rules for making decisions on claims and appeals vary, depending on the type of claim and the benefit plan involved. The following sections provide information about the specific timelines and information requirements that apply to your claims and appeals filings and the claim administrator's claims and appeals determinations. **Note that if you fail to appeal a denied claim by the deadline for making such an appeal, you will have permanently waived your right to appeal the denial of your claim.**

Claim administrators

The insurance companies with respect to the life, AD&D, long-term disability and long-term care benefits will have the authority, in their sole discretion, to interpret the terms of the applicable portions of the welfare plan, decide questions of eligibility for coverage or benefits and make any related findings of fact. All decisions will be final and binding on participants and beneficiaries. Chelan County PUD has the authority, in its sole discretion, to interpret the medical/prescription, dental, short-term disability and flexible spending account portions of the welfare plan, decide questions of eligibility for coverage or benefits and make any related findings of fact. All decisions of Chelan County PUD with respect to these benefits will be final and binding on participants and beneficiaries.

If medical examination is required

During the claims and appeals process, the entity responsible for claims reviews may require a medical examination of the insured, at the plan's expense. If a medical examination is required, you will be notified of the date and time of the examination and the physician's name and location. It is important that you keep any appointments made since rescheduling examinations may delay the claim process.

Initial claims review procedures

If you believe that you are entitled to a benefit under one of the plans or to a greater benefit than the amount you received, then you, your beneficiary (if applicable) or your authorized representative may file a claim with the appropriate claim administrator. For instructions and timeframes regarding filing claims under specific plans, refer to the specific plan sections of this handbook.

The length of time the claim administrator has to evaluate and process your claim generally begins on the date the claim is received by the plan. The claim administrator will consider the claim and notify you of the decision on the claim, in writing or electronically, within the appropriate timeframe described in the following sections, unless the claim administrator determines that special circumstances require an extension of time to process the claim.

If an extension is necessary under any of the plans, the claim administrator will notify you of any such extension, the reasons for it and the date by which the claim administrator expects to render the decision, within the original decision timeframe.

If the claim administrator denies the claim, you will receive notice that sets forth:

- The specific reasons for the denial;

- References to the specific provisions of the plan document on which the denial is based;
- A description of any additional material or information necessary for your to perfect the claim and an explanation of why such material or information is necessary;
- A description of the plan's claim appeal procedure (and the time limits applicable to such procedure);
- In case of a claim for health care or disability benefits, the following additional information will be provided:
  - If an internal rule, guideline, protocol, or other similar criterion was relied on in making the adverse determination, the notice will provide either the specific rule, guideline, or protocol, or a statement that such a rule, guideline or protocol was relied upon and that a copy of such rule, guideline or protocol will be provided free of charge upon request;
  - If the adverse determination is based on a medical necessity or experimental treatment or similar exclusion or limit, the notice will contain either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request.

Claims appeal procedures

You can use these procedures if, in response to your claim, you, your beneficiary (if applicable) or your authorized representative received:

- No reply after the initial decision period, as listed above;
- Notice of an extension to the initial decision period, as listed above, then no reply before the end of the extension; or
- A denial from the claim administrator.

If the claim is denied, in whole or in part, or if you believe benefits under the plan have not been properly provided, you may appeal the denial. You will be provided detailed information about your right to appeal, along with the appeals process and timeframes, if your claim is denied. If you don't appeal within the designated timeframes, you may lose your right to later file suit. To appeal a claim denial, you must file a second request for appeal within a certain period of time after receiving the claim denial, as described in the previous sections. Plan provisions require that you pursue the claim and appeal rights described here before seeking any other legal recourse regarding claims for benefits.

During the appeal, you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim for benefits. For purposes of this claims procedure, a document, record or other information will be considered "relevant" to a claim if such document, record or other information:

- Was relied upon by the claim administrator in making its initial decision on the claim;
- Was submitted, considered or generated in the course of deciding the claim, without regard to whether the document, record or other information was relied upon by the claim

administrator in reaching its decision on the claim; or

- Demonstrates compliance with the administrative processes and safeguards require under Department of Labor regulations in making the benefit determination.

You may submit any written comments, documents, records or other information relating to your claim. In making its determination, the decision-maker will take into account all the comments, documents, records and other information that you submitted relating to the claim, without regard to whether they were submitted or considered by the claim administrator in making an initial decision on the claim.

The decision-maker will conduct a review and make a final decision within a certain period of time after receiving your written request for review, as described in the previous sections. For certain plans, if the decision-maker needs more than this initial period of time to make a decision due to special circumstances, it will notify you in writing within the initial decision timeframe and explain why more time is required and the date the plan expects to make a decision.

For the medical plans, dental plan, disability plans and Health Care FSA, a new decision-maker will review your denied claim. The appeal will not be conducted by the individual who denied the initial claim or that person's subordinate. The new decision-maker will not give deference to the original decision on your claim. That is, the reviewer will give the claim a "fresh look," and make an independent decision about the claim within the timeframes.

If your claim was denied based on a medical judgment, the reviewer will consult with a health care professional who has appropriate training and experience in the field of medicine involved in your claim. The health care professional that is consulted will not be the same person who was consulted on the initial decision of a subordinate of such individual. A medical judgment includes whether a treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate. The plan will also identify any medical or other experts whose advice was obtained in considering the original decision on your claim, whether or not the plan relied on their advice.

Timeframes for appeal filing and determination – all health care benefits

If the claim is a post-service claim, you will receive a decision within a reasonable period of time but not later than 30 days after receipt of your second appeal request.

If the claim is a pre-service claim, you will receive a decision within a reasonable period of time but not later than 15 days after receipt of your second appeal request.

If the claim is an urgent care claim, you will receive notice as soon as possible, considering the medical situation, but no later than 36 hours after receipt of your second appeal request.

Your privacy rights under HIPAA

The Plan is required by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and its implementing privacy rules to maintain the privacy of your "protected health information." These privacy requirements apply to all group health benefits, including the Premera Blue Cross Health Plan, the health care FSA and the long-term care plan, referred to as "HIPAA Benefits."

"Protected health information" is information that identifies you and relates to your physical or mental health. The Plan provided you with a Notice of Privacy Practices "Notice") summarizing the Plan's responsibilities and your rights concerning your protected health information.

Generally, the Plan may disclose your protected health information to the District (the "Plan Sponsor") to enable the Plan Sponsor to carry out the Plan's administrative functions relating to HIPAA Benefits. Protected health information may not be disclosed to the Plan Sponsor for other employment-related purposes without your prior authorization. Limited exceptions allowing other disclosures are detailed in the Notice.

You have the right to inspect and obtain a copy of your protected health information. You may access your protected health information by submitting a written request. You may also request that your protected health information be amended. In certain circumstances your request for access to or amendment of your records may be denied, as outlined in the Notice.

For more information, review the Notice of Privacy Practices you received from the Plan you participate in. Also, the Plans' responsibilities with respect to HIPAA Benefits and your rights are more fully described in federal regulations which can be found at www.hhs.gov/ocr/hipaa. Finally, if you have questions about privacy or wish to object to or complain about any use or disclosure of your protected health information as explained above, the contact information is provided in the Notice.

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