Washington State Auto Dealers Insurance Trust Basic Plan

a Benefit Program of the Washington State Auto Dealers Insurance Trust Benefit Plan

EFFECTIVE MAY 1, 2008

Welcome to the Basic Plan!

The Trustees of the Washington State Auto Dealers Insurance Trust are pleased to welcome you to the Washington State Auto Dealers Insurance Trust Basic Plan (the "Basic Plan" or "Plan"). The Basic Plan is available only to the eligible employees of auto dealers that are members of the Washington State Auto Dealers Association and to the eligible dependents of those employees.

The Trustees sponsor a comprehensive employee Benefit Plan, the Washington State Auto Dealers Insurance Trust Benefit Plan (the "Benefit Plan") for eligible employees of Dealers and their eligible dependents. The Benefit Plan encompasses several types of benefits, including insured medical benefits, self-insured medical benefits, self-insured vision benefits, insured dental benefits, insured life insurance benefits, and insured short-term and long-term disability benefits. Your Dealer determines which of the benefits of the Benefit Plan will be offered to you. This booklet describes only the benefits, terms, conditions and exclusions of the Basic Plan and is effective May 1, 2008.

You can obtain the Plan document and the Summary Plan Description of the Trust's comprehensive employee Benefit Plan from the Trust office.

If you have questions concerning the Plan, we encourage you to call the Trust office:

Washington State Auto Dealers Insurance Trust
Seattle/Bellevue: (425) 451-9866

Only the Board of Trustees is authorized to interpret the provisions of the Plan, and will do so only in writing. You should not rely on any representation – whether verbal or in writing – that anyone else may make concerning Plan provisions.

NOTICE

"This policy is issued by a self-funded multiple employer welfare arrangement. A self-funded multiple employer welfare arrangement may not be subject to all of the insurance laws and regulations of your state. State insurance insolvency guarantee funds are not available for a self-funded multiple employer welfare arrangement."

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Unlike the HRA Plan, you do not receive an annual allocation under this plan. All "healthcare dollars" must be earned through participation in the Plan's incentive programs. You can earn healthcare dollars by completing the online Health & Well-Being Assessment within 60 days of your effective date. Once you complete the Assessment, the Trust will credit $50 to your Plan account. You may also earn healthcare dollars by completing the Free & Clear® Tobacco Cessation Program.

Preventive Care

Recommended Preventive Care services are covered at 100%. See the "Preventive Care" section of this document for details.

Traditional Health Coverage

This coverage begins after the Deductible amount has been completely satisfied.

Deductible:	
EE (employee only)	$1,000
EE+CH (employee plus child/children)	$1,250
EE+SP (employee plus spouse)	$1,500
EE+ Family (employee plus spouse and child/children)	$2,000

Once this amount has been paid, the Plan will then pay:

70% for providers offering network discounts
50% for providers not offering network discounts

Pharmacy charges do not apply toward your Deductible amount.

Coinsurance Maximum

This is the maximum amount you will pay in coinsurance in any Plan year.

Providers offering discounts:		Providers not offering discounts:
EE	$5,000	
EE+CH	$6,250	*unlimited*
EE+SP	$7,500	
EE+Family	$10,000	

Pharmacy charges do not apply toward your annual out-of-pocket maximum.

Annual Out-of-Pocket Maximum

This is the total of your Deductible and coinsurance maximum.

Providers offering discounts:		Providers not offering discounts:
EE	$6,000	
EE+CH	$7,500	*unlimited*
EE+SP	$9,000	
EE+Family	$12,000	

Pharmacy charges do not apply toward your annual out-of-pocket maximum.

The amounts will be lower or higher if rollover Healthcare dollars are available or if you incur charges above Reasonable & Customary amounts.

Lifetime Maximum

$2,000,000

Preventive Care Benefit

100% coverage for eligible preventive benefits

The Basic Plan covers preventive services based on guidelines from the United States Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices, and the American Academy of Pediatrics. The Preventive Care Benefit includes screening tests, immunizations and counseling services designed to detect and treat medical conditions to prevent avoidable premature injury, illness and death. All discounted rates and reasonable and customary (R&C) charges will be paid by the Plan at 100%, with no out-of-pocket responsibility for preventive services (except for charges in excess of R&C). None of these charges will apply toward the Out-of-Pocket Maximum. Services that fall outside the Preventive Care Benefit and other services performed during a preventive office visit will be considered for coverage under your traditional health coverage.

Well Baby and Well Child Care

Baby/Child Preventive Care Office Visits

- Six (6) visits the first year after birth
- Three (3) visits the second year after birth (age 1)
- One (1) annual visit from ages 2 through 18

Baby/Child Screening Tests (annually, unless otherwise indicated)

- Lead level test (once, between 9-12 months of age)
- Vision screening
- Hearing screening
- Routine pelvic exam, Pap test and contraceptive management (screen all females who are age 18, or have been sexually active, whichever comes first)

Baby/Child Immunizations

Note: Actual dosing regimen to be determined by physician.

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- H. Influenza type B
- Polio
- Measles, Mumps, Rubella (MMR)
- Varicella (chickenpox)
- Influenza – flu shot (over 6 months of age)
- Pneumococcal conjugate (pneumonia)
- Meningococcal – Recommended for children ages 11-12 as well as any unvaccinated adolescents at high school entry (15 years old)
- Human Papillomavirus (HPV) – Recommended for girls ages 11-12 (can be started as early as 9 years of age), and women 13-26

This summary is for a full year in the Plan. If you join the Plan mid-year or have a qualified change of status, your actual benefit levels may vary. Additional limitations and exclusions may apply.

Adult Preventive Care

Adult Preventive Office Visits

- One annual office visit (after age 18)

Adult Screening Tests (annually, unless otherwise indicated)

- Coronary artery disease – periodic cholesterol and lipid screening for men beginning at age 35, and women beginning at age 45
- Clinical breast exam and mammogram – annual, beginning at age 40
- Routine pelvic exam, Pap smear and contraceptive management
- Colorectal cancer screening – annual fecal occult blood testing or flexible sigmoidoscopy every 3-5 years, or colonoscopy every 10 years, starting at age 50
- Prostate cancer screening – digital rectal examination and prostate-specific antigen at discretion of physician and patient, starting at age 50
- Diabetes (type II) screening – periodic blood glucose testing for high-risk individuals (e.g., with hypertension, hyperlipidemia)
- Osteoporosis screening – periodic bone-density screening for women over age 65 and women over 60 with increased risk for osteoporotic fractures

Adult Immunizations

- Influenza
- Pneumococcal conjugate (pneumonia)
- Tetanus/Diphtheria (DtaP)
- Measles, Mumps, Rubella (MMR) – for individuals under age 50 without previous immunization
- Hepatitis A – recommended for high-risk groups, such as international travelers, workers in food service or health-care industries
- Hepatitis B – recommended if some other risk factor is present
- Varicella (chickenpox) – recommended for all adults without evidence of immunity
- Meningococcal – considered for college students who live in dormitories and have a slightly increased risk of contracting meningococcal disease
- Zostavax (shingles)
- Human Papillomavirus (HPV) – Recommended for women 13-26
- Herpes Zosster

This summary is for a full year in the Plan. If you join the Plan mid-year or have a qualified change of status, your actual benefit levels may vary. Additional limitations and exclusions may apply.

Overview of the Basic Plan

The Basic Plan is an innovative approach to health benefits for eligible members of the Washington State Auto Dealers Insurance Trust. With the Basic Plan, you have health coverage available for you for which you and the Trust share the cost. This coverage has three components designed to work together to provide you flexibility and control in choosing the health care services you and your family members receive and in choosing how the cost of these services is paid. The Plan is designed to help you and your family take control of your health care dollars and decisions where it matters: the bottom line.

The Three Components of the Plan

Health Incentive Account (HIA)

Your Health Incentive Account (HIA) is credited with dollars ("healthcare dollars") that you can use to offset out-of-pocket expenses. You can earn healthcare dollars by participating in the Health and Well-Being Assessment. Once you have earned these healthcare dollars, the Trust credits them to your HIA.

Your HIA is a notational, or bookkeeping, account. If you cease to be covered by the Plan for any reason, the balance in your HIA terminates.

Traditional Health Coverage

After you pay your required Deductible amount, you and your family are covered by Traditional Health Coverage. Your Deductible is a specified amount that you must pay out-of-pocket on covered health services.

Any day and dollar limits associated with specific benefits under the Plan will only apply under the Traditional Health Coverage component, and not while you are in your Deductible.

Online Health Site

To help you make the most of your Plan coverage – and make the best use of your health care dollars – you'll have access to an Online Health Site. The Online Health Site features a combination of financial tools and health tools to help you make informed decisions about your health care.

http://www.myFirstChoice.fchn.com

Before using your Plan benefits, you need to know – and understand – how the different components of the Plan work and how they work together to provide your health coverage. That's the purpose of this Plan Description. You should read it thoroughly and refer to it frequently. If you have any questions about how the Plan works, contact First Choice Health Administrators at (800) 517-4078 or the Washington State Auto Dealers Insurance Trust at (800) 544-9420.

NOTE: Words and phrases within this document that are denoted with initial capitalization have the meaning ascribed to them within the document itself, or within the Definitions section.

Eligibility

Employee Eligibility

You are eligible to participate in this Plan as an employee if all the following conditions are satisfied:

- You are an active, full-time employee of your Dealer;
- You are not an excluded individual; and
- You satisfy all other requirements for eligibility that your Dealer establishes, subject to approval by the Trustees.

"Employee" means a common-law employee. "Active" means you are currently scheduled to work for the Dealer. "Full-time" means you are regularly scheduled to work at least 25 hours per week, or such greater number of hours per week (or analogous measure of employment) as your Dealer may require for full-time employee status. Employees must maintain full-time status during the entire dealer-specified waiting period in order to establish eligibility.

"Excluded individual" means:

- An individual who performs services for the Dealer and is paid by a temporary or other employment agency (for example, Manpower or Kelly), regardless whether a court or government agency determines that the individual is an employee of the Dealer; or
- An individual whom the Dealer classifies as an independent contractor, regardless whether a court or government agency determines that the individual is an employee of the Dealer.

Subject to the Trustees' approval, a Dealer may establish other requirements for eligibility to limit which employees are eligible to participate. For example, if the Trustees approve, a Dealer may: Require you to be employed by the Dealer for a minimum period of time;

- Limit eligibility to certain classes of employees;
- Limit eligibility to employees working at a certain location of the Dealer; or
- Require you to pay all or a portion of the premium for your coverage under the Plan.

Each Dealer determines which of its employees are and are not eligible to participate in the Plan (subject only to the Trustees' right to determine that individual is not an eligible employee of the Dealer).

You may obtain a statement of any other requirements established by your Dealer with the Trustees' approval from your Dealer or the Trust Office.

If you are a former full-time employee and you return to work for the Dealer within 31 days of the date your employment ended you are eligible to participate in the Plan with no interruption of coverage (subject to timely payment of premium).

You become covered by this Plan only after you are enrolled. See the sections called "Enrollment When You First Become Eligible," "Open Enrollment" and "Special Enrollment" below.

Retiree Eligibility

You are eligible to participate in the Plan (but only in the Basic Plan option) as a retiree if all the following conditions are satisfied:

- You retire from active employment with your Dealer; and
- You are between the ages of 55 to 64 at the time of your retirement; and
- Immediately before your retirement you have been continuously covered for a period of at least five years by a medical Plan of the Trust through your Dealer or through another participating employer in the Trust; and
- The dealership from which you retired maintains the health Plan for active employees through the WSAD Insurance Trust

You must pay the full premium required by the Trustees for your coverage under the Plan. Premium payment is due on the first of each month for coverage for that month. A 30-day grace period is allowed. If payment is not received in the Trust office within the grace period, coverage will be cancelled effective the last day for which timely premium was paid.

If you are age 65 or older and enrolled in Medicare Parts A and B of Medicare, the Plan will be a Medicare Supplement. If you are not enrolled in Medicare Parts A and B, the Trust will not provide the supplement.

Dependent Eligibility

If you are participating in the Plan (whether as an active employee or as a retiree), you can cover the following individuals under the Plan as your eligible dependents:

- Your lawful spouse, unless legally separated.
- Your unmarried eligible child.
- "Eligible child" means an unmarried child who satisfies one of the following descriptions:
    - Your natural child, step-child or adopted child who is under 19 years of age and has the same principal place of abode as you for more than half the calendar year.
    - Your natural child, step-child or adopted child who is under age 25 and a full-time student attending an accredited educational institution, has the same principal place of abode as you for more than half the calendar year and relies on you to provide over one-half of his or her support. "Educational institution" means an educational organization that normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on. A school vacation is considered a part of school attendance on a full-time basis only if the child was a full-time student in the immediately previous regular session and is registered as a full-time student for the next regular session.
    - Your natural child, step-child or adopted child of any age who is disabled, has the same principal place of abode as you for more than half the calendar year and relies on you to provide over one-half of his or her support.
    - A child for whom you or your spouse is the permanent legal guardian, who has the same principal place of abode as you for the entire year, relies on you to provide over one-half of his or her support and is a member of your household.

An individual who is participating in the Plan as an active employee or as a retiree is not eligible for coverage as your dependent.

A foster child is not eligible for coverage as your dependent.

For purposes of this section, "Dependent Eligibility," your "adopted child" means a child you have legally adopted or a child placed for adoption with you for the purpose of legal adoption in accordance with state law. "Placed for adoption" means you assume and retain a legal obligation for total or partial support of a child in anticipation of adoption of the child.

For purposes of this section, "Dependent Eligibility," your child is a "disabled child" if all the following conditions are satisfied:

- Your child became disabled before attaining age 19, and remains disabled. "Disabled" means that your child is incapable of self-support or self-sustaining employment by reason of developmental or physical disability.
- You remain covered under the Plan.
- The premiums, if any, for your child's coverage continue to be paid.
- Within 31 days after your child attains age 19 you complete and file with the Trust Office a copy of the most recent determination/re-determination of disability issued by the Social Security Administration.
- The Trust Office approves your request in your Request for Certification of Disabled Dependent form.
- The child does not elect COBRA continuation coverage on account of a loss of coverage due to the child attaining age 19. (That is, the child may be covered as a "disabled child" or elect COBRA coverage, but not both. If COBRA coverage is elected for the child, this provision for Continued Eligibility for a Disabled Child is not available after the COBRA coverage expires or terminates.)

You must provide the Trust Office with proof that your child is "disabled." The Trust Office will not request proof that your child is disabled more often than once a year after the first two years.

Child of Divorced Parents. If you are divorced from your child's other parent, your child is considered to rely on you to provide over one-half of his or her support as long as you and your former spouse together provide over half of the child's support during the calendar year and the child is in your custody or your former spouse's custody during the calendar year.

If you are an active employee, your Dealer may require you to pay all or a portion of the premium for your dependent's coverage under the Plan, subject to the Trustees' approval. If you are a retiree, you must pay the premium required by the Trustees for your dependent's coverage under the Plan.

If your spouse or child also works for the Dealer, he or she may be covered as an employee or a dependent but not both. If both parents are employees of the Dealer only one parent can cover the children as dependents.

Enrollment

Enrollment When You First Become Eligible

Active Employee

To enroll yourself and your dependents in the Plan when you first become eligible to participate as an active employee, you must complete and file with the Trust Office an Benefits Election Worksheet for yourself and any eligible dependents within 31 days after becoming eligible to participate under the "Employee Eligibility" rules above. If you timely file your completed Benefits Election Worksheet with the Trust Office, coverage for you and your eligible dependents will be effective the first day of the month that coincides with or next follows the date you become eligible to participate under the Employee Eligibility rules (your "effective date").

Retiree

To enroll yourself and your dependents in the Plan when you first become eligible to participate as a retiree, you must complete and file with the Trust Office an Benefits Election Worksheet for yourself and any eligible dependents within 31 days after you cease full-time employment with your Dealer.

If you timely file your completed Benefits Election Worksheet with the Trust Office and pay the necessary premiums, coverage for you and your eligible dependents will be effective the first day following the last day of your coverage as an active employee under a medical plan of the Trust (your "effective date").

Open Enrollment

If you or your eligible dependent is not enrolled under the "Enrollment When You First Become Eligible" provision above, you may not enroll yourself, him or her until the Plan's next Open Enrollment period, unless you, he or she qualifies under "Special Enrollment," below.

Enrollment in the Open Enrollment period is available only to active employees, their eligible dependents, and to the eligible dependents of retirees who are already participating in the Plan as retirees. Enrollment in the Open Enrollment period is not available to retirees who are not already enrolled or to their dependents.

During an Open Enrollment period you may enroll yourself or your eligible dependents in the Trust or add or drop coverages (if your Dealer permits you to select from more than one coverage).

To enroll yourself, your spouse or your eligible child under this Open Enrollment provision, all of the following requirements must be satisfied:

- If you want to enroll yourself, you are an eligible employee (see "Eligibility - Employee Eligibility" above);
- If you want to enroll your spouse or your child, he or she is eligible for coverage as a dependent (see "Eligibility - Dependent Eligibility"); and
- You complete and file with the Trust Office a Benefits Election Worksheet before the Open Enrollment period ends.

The Open Enrollment period occurs before the beginning of each Plan Year. The Trust Office determines when the Open Enrollment period begins and ends.

Special Enrollment

Special Enrollment describes the ways you can enroll yourself or your dependents before the Plan's annual Open Enrollment period if you or they are not enrolled under the "Enrollment When You First Become Eligible" provision.

Involuntary Loss of Other Coverage

This provision describes how you (if you are an eligible active employee of a Dealer) may enroll yourself, your spouse or eligible child for coverage under this Plan when you, he or she loses coverage under another health care program. If you are a retiree who is not already enrolled in the Plan, you may not enroll yourself or any dependent under this Involuntary Loss of Other Coverage provision. "Health care program" means an employer-sponsored group health plan or health insurance coverage (for example, a policy of individual health insurance).

NOTE: State-funded Medicaid/welfare programs are not considered "other coverage" for purposes of special enrollment. Loss of Medicaid coverage therefore does not trigger special rights.

To enroll yourself, your spouse or your eligible child under this "Involuntary Loss of Other Coverage" provision, all of the following requirements must be satisfied:

- You declined to elect coverage for yourself, your spouse or your child either when you first became eligible or at Open Enrollment because you, your spouse or your child were covered under another health care program;
- The coverage under the other health care program for you, your spouse or your eligible child terminated as a result of:
    - Loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or a reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to those events); or
    - You, your spouse or your eligible child incurs a claim that would meet or exceed a lifetime limit on all benefits;
    - The other healthcare program no longer offers any benefits to the class of similarly-situated individuals that includes you, your spouse or your eligible child;
    - You, your spouse or your eligible child was covered under COBRA at the time coverage under this Plan was previously offered and COBRA coverage has been exhausted (see below).

This condition is also satisfied if the employer contributions toward the other healthcare program cease (even if the individual remains eligible for the other healthcare program).

- If you want to enroll yourself, you are an eligible active employee of a Dealer (see "Eligibility - Employee Eligibility - Active Employee" above);
- If you want to enroll your spouse or your child, he or she is eligible for coverage as your dependent (see "Eligibility - Dependent Eligibility"); and
- You complete and file with the Trust Office an Benefits Election Worksheet within 30 days after coverage under the other health program ended.

You can enroll your spouse or child only if you already are a participant in the Plan (or you are enrolling yourself as an eligible active employee under this "Involuntary Loss of Other Coverage"

provision). If you are not already a participant in this Plan, you can enroll yourself as an eligible active employee of a Dealer only if either (a) you were covered under the other health care program and lost that coverage or (b) your spouse or child was covered under the other health care program and your are enrolling yourself and that spouse or child. Coverage under this Plan becomes effective on the first of the month following the loss of the other health plan coverage, subject to timely receipt of Benefit Election Worksheets (as described above) by the Trust Office and timely payment of any applicable premium.

For purposes of this “Involuntary Loss of Coverage” provision, exhaustion of COBRA coverage means that an individual's COBRA coverage ceases for any reason other than either failure of the individual to pay premiums on a timely basis or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan). Also, an individual is considered to have exhausted COBRA continuation coverage if the coverage ceases:

- due to the failure of the employer or other responsible entity to remit premiums on a timely basis; or
- when the individual no longer resides, lives, or works in a service area of an HMO or similar program (whether or not within the choice of the individual) and there is no similar COBRA coverage available to the individual.
- when the individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual

Marriage

This provision applies only if you are an eligible active employee of a Dealer or if you are an eligible retiree who is already enrolled in the Plan as a retiree.

You may enroll yourself (if you are an eligible active employee of a Dealer), or a new spouse or newly eligible child whom you acquire through marriage if you satisfy all the following conditions:

- You marry;
- If you want to enroll your new spouse or your newly-acquired child, he or she is eligible for coverage as a dependent (see "Eligibility - Dependent Eligibility");
- If you want to enroll yourself, you are an eligible active employee of a Dealer (see "Eligibility - Employee Eligibility - Active Employee" above) and you previously declined an opportunity to enroll yourself in the Plan; and
- You complete and file with the Trust Office an Benefits Election Worksheet within 30 days after the marriage.

You can enroll your spouse or child only if you already are a participant in the Plan (or are enrolling yourself as an eligible active employee of a Dealer under this “Marriage” provision). If you are a retiree who is not already enrolled in the Plan, you may not enroll yourself or any dependent under this “Marriage” provision. Coverage under this Plan becomes effective on the first of the month following the marriage, subject to timely receipt of Benefit Election Worksheets (as described above) by the Trust Office, and timely payment of any applicable premium. Under this provision, you may enroll only yourself (as an active employee of a Dealer, but not as a retiree) even though you don't enroll your new spouse or a newly acquired child.

Enrollments Based on Birth of Your Child, Adoption of Your Child or Placement of a Child for Adoption with You

This provision applies only if you are an eligible active employee of a Dealer or if you are an eligible retiree who is already enrolled in the Plan as a retiree.

If you are already a participant in the Plan, and if the premium paid on your behalf already covers all your eligible children, then you need to file an updated Benefits Election Worksheet with the Trust Office in order to enroll your newborn child, newly adopted child or child who is placed for adoption with you. "Placed for adoption" means you assume and retain a legal obligation for total or partial support of a child who has been placed with you in anticipation of your adoption of the child. The Trust Office may request additional information, including identifying information such as the child's Social Security number, if necessary to establish that the child is an eligible child.

If you are not a participant in the Plan, or if you are a participant, but the premium paid on your behalf does not cover your newborn child, adopted child or child placed for adoption, you may enroll yourself (as an eligible active employee of a Dealer, but not as a retiree), your spouse or your child under this provision only if all the following requirements are satisfied:

- Your child is born, you adopt your child or the child is placed with you for adoption;
- If you want to enroll your spouse or the child, he or she is eligible for coverage as a dependent (see "Eligibility - Dependent Eligibility");
- If you want to enroll yourself, you are an eligible active employee of a Dealer (see "Eligibility - Employee Eligibility - Active Employee" above) and you previously declined an opportunity to enroll yourself in the Plan; and
- You complete and file with the Trust Office an Benefits Election Worksheet within 60 days after the child's birth, adoption or placement for adoption.

You can enroll your spouse or your newborn child, adopted child or child placed for adoption only if you already are a participant in the Plan (or are enrolling yourself as an active employee of a Dealer under this provision). If you are a retiree who is not already enrolled in the Plan, you may not enroll yourself or any dependent under this provision. Coverage becomes effective on the date of the child's birth, adoption or placement for adoption subject to timely receipt of Benefit Election Worksheets (as described above) by the Trust Office, and payment of any applicable premium. Under this provision, you may enroll only yourself (as an eligible active employee of a Dealer, but not as a retiree), or only your spouse and yourself (if you are an eligible active employee of a Dealer) even though you don't enroll your newborn child, adopted child or child placed for adoption.

Coverage for newly enrolled children, employees, and dependent spouses becomes effective on the date of the child's birth, adoption or placement for adoption.

Enrollment of a Child for Whom You or Your Spouse is the Legal Guardian

You may enroll a child for whom you or your spouse becomes the legal guardian if all the conditions are satisfied:

- You are a participant in the Plan (not merely an eligible active employee or eligible retiree);
- The child is an eligible child (see "Eligibility - Dependent Eligibility"); and
- You file a copy of the guardianship papers and a completed Benefits Election Worksheet with the Trust Office within 30 days after the date you or your spouse became the child's legal guardian. Under this provision, you may enroll only the child for whom you or your spouse has become the legal guardian.

Coverage becomes effective on the first of the month following the date legal guardianship began, subject to timely receipt of Benefit Election Worksheets (as described above) by the Trust Office, and payment of any applicable premium.

Child Covered under Qualified Medical Child Support Order

If your child is not covered by this Plan, he or she may be enrolled in the Plan pursuant to a judgment, decree or order issued by a court or State agency of competent jurisdiction that the Trustees have determined is a qualified medical child support order within the meaning of ERISA section 609 ("QMCSO"). To enroll a child pursuant to a QMCSO entered by a court, you or your child's custodial parent must file the QMCSO and a completed Benefits Election Worksheet with the Trust Office. If the QMCSO is a National Medical Support Order, it will be sent to your Dealer first, to be forwarded to the Trust Office. A completed Benefits Election Worksheet must accompany the forwarded Order. If the Trust Office receives the QMCSO and completed Benefits Election Worksheet within 30 days after the date of the QMCSO, coverage will become effective on the date of the QMCSO, or such later date as the QMCSO specifies. In all other cases, coverage will become effective on the first of the month following the date the Trust Office receives the QMCSO and completed Benefits Election Worksheet. If the premium paid on your behalf does not already include coverage for your child enrolled though a QMCSO, the premium will increase to cover your child starting on the effective date of your child's coverage.

Re-Enrollment Following Leave

If you take a leave of absence and terminate coverage under the Trust, you may re-enroll under the Trust if all the following conditions are satisfied:

- The leave was authorized under the Family and Medical Leave Act of 1993 or the Washington State Family Leave Act; and
- You return to active employment with the Dealer from which you took the leave at the conclusion of a period not to exceed that defined by FMLA and Washington State Family Leave Act.

When Plan Changes Become Effective

No rights are vested under the Plan. The Trustees may change the Plan at any time. With one exception, all changes to the Plan apply to you and your eligible dependents as of the date the Trustees make the change effective. The exception is that if you or your dependent is an inpatient in a medical facility on the date a change in the Plan's terms, conditions, benefits, exclusions or limitations occurs, the change will not take effect until your or your dependent's discharge from that facility or from any other facility to which you were transferred, provided coverage under the Plan is still in effect.

When Coverage Ends

Coverage for you and your dependents terminates:

- On the last day of the month in which you fail to satisfy the requirements for an eligible active employee or eligible retiree (See "Eligibility - Employee Eligibility" or "Eligibility -

Retiree Eligibility") or you die. Note: you cease to be an active employee if, among other things, you are on a leave of absence from your Dealer (including leave under the Family and Medical Leave Act or similar State law, disability leave, and workers compensation leave). You may, however, be able to continue your coverage for a limited period. (See "Continuation of Coverage - Leave of Absence").

- For covered dependents only, on the last day of the month in which he or she fails to satisfy the requirement for an eligible dependent (See "Eligibility - Dependent Eligibility").
- On the last day of the month in which your Dealer (or the Dealer from which you retired) ceases to be a member of the Washington State Auto Dealers Association.
- If your Dealer fails to make the required premium payment to the Trustees on behalf of you or your dependent when due or within any grace period established by the Trustees, on the last day of the month for which the required premium was timely paid.
- If you are a retiree and you fail to make required premium payments to the Trustees on behalf of yourself or your dependent when due or within any grace period established by the Trustees, on the last day of the month for which the required premium was timely paid;
- On the last day of the month in which the subscription agreement between your Dealer (or the Dealer from whom you retired) and the Trustees terminates or is canceled (whether by the Dealer or by the Trustees).
- If the Trustees terminate the Plan, on the date of termination.

Coverage for your spouse also terminates on the last day of the month in which you and your spouse divorce, become legally separated or your marriage to your spouse is annulled. (See "Continuation of Coverage - Notices and Election").

Coverage for a child also terminates on the last day of the month in which he or she ceases to be an eligible child. (See "Eligibility - Dependent Eligibility.")

Termination for Cause

The Trustees, in their discretion, may terminate coverage (prospectively or retroactively) for you or your dependent, and may refuse any subsequent enrollment for you or your dependent, in the event:

- You fraudulently enroll yourself for coverage under the Plan;
- You fraudulently enroll an individual not your eligible dependent for coverage under the Plan;
- You fail to notify the Trust Office when your enrolled spouse or child is no longer eligible to be enrolled as a dependent under this Plan; or
- You cause or permit a fraudulent claim for benefits under the Plan to be made on behalf of you or your dependent.

You must notify the Trust Office when your enrolled spouse or child is no longer eligible to be enrolled as a dependent under this Plan. [See also “Notice of Qualifying Event to the Trust Office.”]

Upon termination of the Plan, the rights of you and your dependents to benefits are limited to claims incurred up to the date of termination.

Continuation of Coverage

Continuation of Group Health Plan Coverage Under COBRA

If you (or your spouse, or dependent child) lose Plan coverage due to termination of your employment, a reduction in your hours of employment or other “qualifying events,” you, he or she may be entitled to elect to continue coverage under the federal law known as “COBRA.” This coverage, known as "COBRA coverage” or “continuation coverage,” is explained in Appendix C — “Continuation of Group Health Plan Coverage — COBRA.”

Continuation of Group Health Plan Coverage Under USERRA

Under the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA), if you or your dependent will lose coverage under the Plan because you leave employment with your Dealer to perform service in the Uniformed Services, you may elect to continue Plan coverage for yourself and your eligible dependents for up to 24 consecutive months. Your rights and obligations relating to group health plan coverage under USERRA are explained in Appendix B — “Continuation of Group Health Plan Coverage — USERRA.”

Other Continuation of Coverage Benefits

Your medical, dental or vision benefits may contain continuation of coverage benefits other than COBRA. Consult the Summary Plan Document of the medical, dental or vision benefit under which you are enrolled. (See the Documents Appendix contained in the back of this SPD.)

Self-Payment in the Event of a Labor Dispute

If your compensation is suspended directly or indirectly as a result of strike, lockout or other labor dispute, you may pay required charges for yourself and your eligible dependents directly to the Trust for up to six months. This period of coverage will be concurrent with any period of continued coverage provided under COBRA.

Leave of Absence

Non-FMLA Leaves

You can continue coverage for yourself and your dependents for up to 90 days when your Dealer grants you a leave of absence (other than an FMLA leave) and the premiums on behalf of you and your dependents continue to be paid.

If you elect COBRA continuation coverage in connection with your non-FMLA leave of absence, the 90-day leave of absence period counts toward the maximum COBRA continuation period. [See also "Re-enrollment Following Family Leave."]

Leave Under the Family and Medical Leave Act (FMLA)

If you take an authorized family or medical leave of absence under the Family and Medical Leave Act of 1993 (FMLA), as amended, your coverage will be continued on the same basis as if you were actively at work during the period of FMLA leave. This means that if you were covered by the Plan on the day before you went on FMLA leave, your coverage will continue, with your Dealer continuing to pay its portion of the premium on behalf of you and your covered dependents and you paying your portion of the premium for yourself and your covered dependents.

If you do not pay your portion of the required premium (whether for your coverage or for dependent coverage) during your FMLA leave, coverage that the premium would have purchased will not be continued during the FMLA leave. That coverage will resume on the day you return to work, subject to any changes that may have occurred in the Plan during the time you were not covered, as long as you:

- return to work with the Dealer from which you took the leave immediately at the end of your FMLA leave, and
- pay your share of any required premiums on time.

During FMLA leave, you and your dependents are subject to all terms, conditions and limitations of the Plan.

You or your Dealer may be required to submit proof to the Trust Office that your leave is in accordance with FMLA. Continuation of coverage under FMLA leave is not concurrent with COBRA continuation coverage, if applicable, or extension of benefits due to permanent or temporary disability. Contact your Dealer for additional information regarding FMLA.

How the Basic Plan Works

The Plan's innovative approaches to health benefits put you in charge of the money you spend for health care services and help you get the most out of your Trust-sponsored health coverage. With the Plan, you have flexibility and control in choosing the health care services you and your family members receive – and in determining how the cost of these services is paid.

For information about how the Plan works, see:

- Health Incentive Account (HIA)
- Free & Clear Program
- Deductible
- Provider Network
- Traditional Health Coverage
- Case Management
- Coinsurance
- Out-of-Pocket Maximum
- Lifetime Benefit Maximum
- Inpatient Admission
- Pre-certification Requirements
- Online Health Site

Health Incentive Account (HIA)

Through this Plan the Trust provides you with an opportunity to earn additional healthcare dollars for credit to your HIA. You can earn healthcare dollars by participating in the Health and Well-Being Assessment. The Trust credits these additional healthcare dollars to your HIA -- the HIA is a notional bookkeeping account. You can use your HIA to offset your Deductible amount and/or to help cover your portion of the coinsurance in the Traditional Health Coverage component of the Plan.

The HIA is only available for IRC Section 213(d) Qualified Medical Expenses, and even these are subject to the terms of the Plan. You can never receive cash from your HIA except for reimbursement of expenses covered under the program.

NOTE: If your participation in the Plan ends for any reason, you forfeit any balance in your HIA.

Free & Clear® Program

The Free & Clear® Tobacco Cessation Program helps participants through the "quit process" to manage withdrawal symptoms, identify triggers and learn new behaviors and skills to remain tobacco free. Applicable services are paid for by the Plan. Participation in the Free & Clear® Program ends on the date that you cease to be eligible in accordance with the terms of the Plan.

Deductible

You will have to pay a specified out-of-pocket amount before the Traditional Health Coverage begins. This is called your annual Deductible. The annual Deductible can be offset by healthcare dollars.

Your annual Deductible is:

$1,000 - Employee only coverage
$1,250 - Employee plus child(ren) coverage
$1,500 - Employee plus spouse coverage
$2,000 - Family coverage

If you have participated in the Health and Well-Being Assessment (either in the current Plan year or a previous Plan year), you may have healthcare dollars credited to your HIA that you may use to offset your annual Deductible, therefore reducing the amount that you must pay out of your pocket before the Traditional Health Coverage begins. The Deductible resets at the beginning of each Plan year (May 1).

Provider Network

First Choice Health Network (FCHN) is the preferred provider network (PPO) for this Plan. To receive the network level of benefit coverage you must obtain care from FCHN providers and facilities within Washington, Alaska and Idaho.

Healthcare Direct is the preferred provider network for participants who live or work in Oregon and dependents with active student status in Oregon. Healthcare Direct is also available to participants for urgent or emergency care when traveling in Oregon.

Health InfoNet of Montana is the preferred provider network for participants who live in Montana and eligible dependents with active student status in Montana. HIN of Montana is also available to all participants for urgent or emergency care when traveling in Montana.

The Beech Street Network is the provider network for participants who live or work outside of the FCHN, Health InfoNet or Healthcare Direct service areas, as well as dependents with active student status outside of the FCHN and Healthcare Direct service areas, and is available to all participants for urgent or emergency care when traveling.

For more information, contact the appropriate provider network:

Network	**Service Area**	**Phone**	**Website**
First Choice Health Network	WA, AK & ID	800-430-3818	www.1stchoiceadmin.com
Healthcare Direct	OR	877-287-2922	www.hcdirect.net
Health InfoNet	MT	888-256-6556	www.healthinfonetmt.com
Beech Street Network	All other states/areas	800-877-1444, ext. 2	www.beechstreet.com

If you receive care from a non-network provider, your benefits will be paid at a lower non-network level. Urgent and emergency care received outside the United States will be paid at the preferred network level.

Providers Who Offer Network Discounts

If you visit a provider who offers network discounts, you will receive the highest level of benefits offered under this Plan. These providers have agreed to charge a “discounted fee” for their services. You will never pay for charges in excess of the discounted price, and in most cases, the provider will file a claim for you after your visit.

Providers Who Do Not Offer Network Discounts

If you visit a provider who does not offer network discounts, you may have to pay their full price at the time of service, then file a claim for reimbursement. Under your Traditional Health Coverage, you will be responsible for coinsurance, as well as the difference between the charge for the service and the Reasonable and Customary charges.

"Allowed Amount" means the maximum amount paid by the Plan for a medically necessary covered service. Generally, this is a contract amount agreed to by First Choice Health Network (FCHN) participating providers. The allowed amount paid by the Plan for services from non-network providers, and for out-of-area providers, is based on usual, customary and reasonable (UCR) rates or negotiated rates, if UCR information is not available.

Traditional Health Coverage

Once you have paid your annual Deductible amount, the Plan offers additional health coverage to protect you and your family. Allocations available in the HIA may be used to help offset the annual Deductible.

Case Management

A catastrophic medical condition may require long-term, perhaps lifetime, care involving extensive services in a facility or at home. Case Management is a program in which a nurse monitors such cases and explores and discusses coordinated and/or alternative types of appropriate Medically Necessary care. The case manager consults with the patient, family and attending physician.

A plan of care is developed which may include some or all of the following:

- Personal support to the patient
- Contacting the family to offer assistance and support
- Monitoring Hospital or skilled nursing facility stays
- Addressing alternative care options
- Assisting in obtaining any necessary equipment and services

Case Management may identify a custom treatment plan, if it would be beneficial to both the patient and the Plan. The Plan Administrator, the patient or designated representative, and the attending physician must all agree to any custom treatment plan.

Once agreement is reached, the specific Medically Necessary services stated in the treatment plan will be reimbursed, subject to all Plan terms and conditions.

Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis. The final decision on the course of treatment rests with patients and their providers.

Coinsurance

When using the Traditional Health Coverage, you pay a certain percentage of the cost of covered services through coinsurance. Generally, the Traditional Health Coverage pays 50% to 70% of the cost of most covered services, and your coinsurance amount is 30% to 50% up to a limit called the coinsurance maximum. The coinsurance maximum is the most you pay in coinsurance expenses for covered services in a Plan year when using providers offering network discounts. If you are using providers who do not offer network discounts there is no limit on coinsurance.

The annual coinsurance maximums for providers who offer network discounts are:

$5,000 - Employee only coverage
$6,250 - Employee plus child(ren) coverage
$7,500 - Employee plus spouse coverage
$10,000 - Family coverage

Out-of-Pocket Maximum

The Plan's out-of-pocket maximum is the most that you will pay toward covered health expenses in a Plan year for providers who offer network discounts. If you are using providers who do not offer network discounts, there is no out-of-pocket maximum. If you are using providers who offer network discounts, once you reach the out-of-pocket maximum under the Plan, the Plan pays 100% of covered services.

The Plan's out-of-pocket maximums for providers who offer network discounts are:

$6,000 - Employee only coverage
$7,500 - Employee plus child(ren) coverage
$9,000 - Employee plus spouse coverage
$12,000 - Family coverage

Your out-of-pocket maximum is the sum of your Deductible and your annual coinsurance maximum. The amounts above will be lower if Healthcare dollars are credited to your HIA (see Healthy Rewards Program section).

IMPORTANT! Amounts you pay toward the cost of certain medical services will not count toward your annual out-of-pocket maximum. These include any cost you pay:

- for any service that is not a covered service under the Traditional Health Coverage
- toward expenses that are paid to providers who do not offer First Choice discounts
- toward expenses that are in excess of annual maximums

Lifetime Benefit Maximum

All benefits paid under this Plan (whether as an active employee or retiree) apply toward the Lifetime Maximum Benefit. You and each covered dependent have a lifetime benefit maximum of $2,000,000. This is the total amount of benefits you can receive under the Plan in a lifetime. Once

you or your covered dependent reach this limit, you are responsible for the full cost of any additional services you or your dependents may receive.

Inpatient Admission

To help assure that your treatment is Medically Necessary under the terms of your health Plan, the Plan has partnered with First Choice Health Administrators to provide admission and concurrent review of inpatient admissions for Hospital (medical and surgical), rehabilitation, skilled nursing facility, psychiatric Hospital and detoxification facility. Transplant services require pre-certification before scheduling the procedure. For these services you or your physician must notify First Choice at 800-808-0450 prior to admission.

In case of an emergency, notify First Choice within 48 hours of your admission by calling the number listed on the back of your ID card – (800) 808-0450.

This notification process assists us in helping you manage your health care. If you have a serious or chronic condition, Case Management will be available to help you or your dependent in coordinating resources.

In the event of an emergency admission to a non-network hospital, treatment will be covered at the network benefit level for 24 hours, or for such additional time as is reasonable required to transfer to a network provider's care.

NOTE: Under federal law, benefits for any Hospital stay in connection with childbirth for the mother or the newborn cannot be restricted to less than:

48 hours – following a normal vaginal delivery
96 hours – following a Cesarean section

Although you are encouraged to call, neither you nor your physician needs to pre-notify First Choice for any length of stay less than these periods for childbirth. However, the physician, after consulting with the mother, may discharge the mother or newborn before the 48- or 96-hour timeframe noted above.

Pre-Certification Requirements

All inpatient admissions and certain outpatient services and procedures require FCHA pre-certification. If you receive covered care from a network provider without obtaining the required pre-certification approval, you will be assessed a penalty of $200 (or up to the billed amount, whichever is less).

Pre-certification is required for:

- Breast reduction
- Breast implant removal
- Dental trauma services (follow-up services)
- Durable medical equipment, medical supplies and prosthetics (if purchase exceeds $1000, or rental costs exceed $250 per month)
- Eyelid surgery (blepharoplasty, et al)
- Home health care services
- Home infusion therapy
- Hospice care
- Inpatient Hospital admissions
- Inpatient mental health

- Inpatient Rehabilitation
- Inter-facility transport via ambulance
- Orthognathic (jaw) surgery
- Organ and bone marrow transplants
- PET scans
- Reconstructive and/or cosmetic surgery
- Skilled nursing facility admissions
- Stereotactic radiosurgery (e.g., gamma knife)
- Surgical interventions and oral appliances for obstructive sleep apnea
- Unproven, investigational or experimental services (unless specifically and completely excluded)
- Varicose vein procedures

Online Health Site

The Plan offers online health and financial tools to help you manage your health and make the best use of your health care dollars.

Health Tools

The Plan offers several resources designed to help you stay healthy, deal with an illness or injury and prepare for a medical procedure or treatment, including:

- Online Provider Directory
- Health & Well-Being Assessment
- 24-Hour Nurseline

Whether you're going for a routine check-up, managing a medical condition or getting ready for surgery, the First Choice online health site delivers the information and support you need around these topics and more.

Online Provider Directory

The online provider directory will help you locate – and find information about – doctors and other health care services in your area. Whether you need a specialist, a pharmacy, a Hospital, a chiropractor or a nutritionist, you'll find it in one place. In addition, this directory will help you:

- find out which providers offer First Choice discounts
- get directions and a handy map

To access the directory, log in to **www.myFirstChoice.fchn.com** and click on "Find A PPO Provider." You will be able to access the secure site and search for providers and other pertinent information. You can also obtain a hard copy of the directory by calling First Choice Customer Service at 1-500-517-4078.

Health & Well-Being Assessment

Evaluate your overall health, help identify risks and find out how to help optimize your health. Use the Health & Well-Being Assessment to prepare for a routine physical – evaluate your health online, print out your family health history to share with your doctor, and find out what questions you should ask and what tests your doctor should perform. The assessment can be found at www.myFirstChoice.fchn.com; you will need to register and log in.

24-Hour Nurseline

Nurseline is staffed 24 hours a day, seven days a week by registered nurses. Nurses provide you and your family members with health care education and decision support for routine health conditions. The Nurseline number is (800) 756-7751.

Financial Tools

The Plan offers online financial tools to help you keep track of your health care dollars. You can review what you've spent on health care, view your HIA balance or look up the status of a particular claim any time of the day.

Covered Services

Services for which your Traditional Health Coverage will pay benefits include the following Hospital and medical services and supplies for treatment of an injury or disease. Only those services, supplies and treatments that are for the treatment of an injury or disease, Medically Necessary and rendered by a licensed provider are covered, according to Plan provisions.

This section provides a detailed description of services covered under Traditional Health Coverage. Services for which your Traditional Health Coverage will pay benefits include the following:

- Professional Services
- Maternity Care
- Mental Health and Chemical Dependency
- Hospital and Facility Services
- Professional Services

This section provides a detailed description of the eligible professional services.

NOTE: All inpatient admissions and certain outpatient services require FCHA pre-certification. If you receive covered care from a network provider without obtaining required pre-certification approval, you will be assessed a penalty of $200 or the full billed amount of the service, whichever is less.

Acupuncture

Acupuncture services will be covered when rendered by a provider acting within the scope of their licensure.

Benefits for Acupuncture are limited to $500 per person per Plan year.

Allergy Care – Injections and Tests

Allergy care is covered when administered by a physician, allergist, or specialist. Serum is covered only when received and administered within the provider's office. If received from a pharmacy, the serum **may** be covered under the pharmaceutical benefit. The following services are covered:

- Allergy Injections - Immunotherapy
- Allergy Tests

Allergy Injections- Immunotherapy

Also called allergy desensitization or allergy shots; immunotherapy is given to increase a person's tolerance to the substances that provoke allergy symptoms (allergens). Allergy shots reduce the sensitivity to certain substances but do not cure allergies.

Allergy Tests

An allergy skin test, also called a scratch test, is used to identify the substances that are causing allergy symptoms. It is the application of the allergen extract to the skin, scratching or pricking the skin to allow exposure, and then evaluating the skin's reaction.

Scratch Test - In this test, one or more small scratches or superficial cuts are made in the skin, and a minute amount of the substance to be tested is inserted in the scratches and allowed to remain there for a short time. If no reaction has occurred after 30 minutes, the substance is removed and the test is considered negative. If there is redness or swelling at the scratch sites, the test is considered positive.

RAST (radioallergosorbent test) is a blood test used to identify the substances that are causing allergy symptoms and to estimate a relative sensitivity.

Ambulance

Professional **ground transportation ambulance** services are covered in the following circumstances:

- When used to transport the patient from the place of accidental injury or serious medical incident to the nearest facility where treatment can be given.
- To transport a patient from one Hospital to another nearby Hospital when the first Hospital does not have the required services and/or facilities to treat the patient.
- To transport a patient from Hospital to home, skilled nursing facility or nursing home when the patient cannot be safely or adequately transported in another way without endangering the individual's health, whether or not such other transportation is actually available.
- To transport a patient from home to Hospital for Medically Necessary inpatient or outpatient treatment when an ambulance is required to safely and adequately transport the patient.
- To transport a patient upon medical stabilization from a non-discounted facility to a discounted facility when they were admitted due to a medical emergency to a non-discounted facility.

Notification is required except in a life-threatening circumstance.

Inter-facility ambulance transport (transport from one medical facility to another) requires pre-certification. Contact First Choice at 800-808-0450 prior to obtaining this service.

Anesthesia

The administration of anesthesia, other than local infiltration anesthesia, in connection with a covered surgical procedure, is covered, provided the anesthesia is administered and charged for by a physician other than the operating surgeon or his assistant.

Biofeedback

Biofeedback therapy is an electronic method which allows the patient to monitor the functioning of the body's autonomic systems (e.g., body temperature, heart rate) and is a covered benefit if Medically Necessary to treat a covered illness, injury or condition.

Blood Transfusions

Coverage is provided for blood transfusions to maintain or replace blood volume, to provide deficient blood elements and improve coagulation, to maintain or improve transport of oxygen, and in exchange for blood that has been removed in the treatment of Rh incompatibility in the newborn, liver failure in which toxins accumulate in the blood, or in some other types of toxemia.

Coverage is included for the following:

- Autologous
- Direct Donation
- Regular Administration
- Blood Products
- Cardiac Rehabilitation Therapy

Breast Reduction, Breast Implant Removal

Coverage is provided for breast reduction or breast implant removal when such a procedure is deemed Medically Necessary.

This benefit requires pre-certification. Contact First Choice at 800-808-0450 prior to obtaining these services.

Cardiac Rehabilitation Therapy

Coverage for cardiac rehabilitation therapy is provided in two phases. Phase I begins during/after the acute event (e.g., bypass surgery, myocardial infarction, angioplasty). It includes nursing services, physical therapy and teaching the patient how to deal with his/her condition. Phase II is a Hospital-based outpatient program after inpatient Hospital discharge. It is physician-directed with active treatment and EKG monitoring at a frequency of three (3) times per week for approximately 12 weeks.

Chiropractic

Chiropractic services are defined as those services for the detection and correction by manual or mechanical means of nerve interference resulting from or related to misalignment or partial dislocation of or in the vertebral column. Coverage includes initial consultation and treatment.

Benefits for chiropractic treatment are limited to a maximum of 15 visits per person per Plan year.

Dental Services and Oral Surgery

Charges for care rendered by a physician or dentist, which are required as a result of an accidental injury to the jaws, sound natural teeth, mouth or face, are covered, provided care commences within 90 days of the accident. Injury as a result of chewing or biting will not be considered an accidental injury.

Charges for surgical benefits for cutting procedures for the treatment of disease, injuries, fractures and dislocations of the jaw, when the service is performed by a physician or dentist, are also considered covered services.

The Plan will cover a Medically Necessary procedure in a Hospital or ambulatory surgical center and general anesthesia services related to dental conditions for all children under age 7.

NOTE: Normal extraction and care of teeth and structures directly supporting the teeth are not covered.

This benefit requires pre-certification. Contact First Choice at 800-808-0450 prior to obtaining these services.

Diagnostic Labs and X-rays

Coverage is provided when services are performed to diagnose specific symptoms or rule out medical conditions. Services include:

- Diagnostic X-ray, consisting of radiology, ultrasound, nuclear medicine and magnetic resonance imaging.
- Diagnostic laboratory and pathology tests.
- Diagnostic medical procedures consisting of EKG, EEG, and other electronic diagnostic medical procedures.
- Pre-admission, pre-surgical tests which are made prior to a covered person's inpatient or outpatient surgery.

For pre-admission and/or post-release testing to be covered, your doctor must specify required tests and approve the facility for testing. In most cases, the tests can be performed in the outpatient department of a Hospital, at an independent medical testing laboratory or in your doctor's office.

Pre-admission tests will be covered even if Hospitalization is delayed, postponed or cancelled.

Durable Medical Equipment

Coverage is provided for rental or, at the discretion of the Plan, purchase of Durable Medical Equipment that is prescribed by a professional provider and required for therapeutic use.

If purchased, charges for repair or Medically Necessary replacement of Durable Medical Equipment will be considered a covered expense.

Includes, but not limited to: crutches, commodes, Hospital beds, nebulizers, monitoring equipment and wheelchairs. Oral appliances prescribed for the treatment of sleep apnea are covered.

Durable medical equipment purchases of more than $1000 (or $250 per month rental) require pre-certification. Contact First Choice at 800-808-0450 prior to making these purchases or rentals.

Durable Medical Equipment is limited to $5,000 per person per Plan year.

Pre-certification is required before obtaining oral appliances related to the treatment of sleep apnea. Contact First Choice at 800-808-0450 prior to obtaining these services.

Eyelid Surgery (Blepharoplasty)

Coverage is provided for eyelid surgery (blepharoplasty) when such a procedure is deemed Medically Necessary.

This benefit requires pre-certification. Contact First Choice at 800-808-0450 prior to obtaining these services.

Family Planning

Coverage for family planning is provided for:

- D & C/Abortion – therapeutic or voluntary
- Diaphragm – Device and/or fitting
- IUD – Device and/or insertion and removal
- Tubal ligation
- Vasectomy
- Sterilization

Contraceptives administered in a doctor's office are covered, such as Depo-Provera®.

NOTE: Reversal of sterilization is not a covered service.

NOTE: Voluntary abortions are not covered for dependent children covered under the Plan.

Foreign Claims

Claims for services provided while you are out of the country are reimbursed at 80% of charges for emergent care and 50% of charges for non-emergent care. All monetary conversions and rate of exchange are calculated based on the date of service.

Hearing Exam

Routine hearing exams to detect/prevent auditory deterioration are limited to one visit per person per Plan year.

Home Health Care

Home Health Care expenses are covered if the services are provided by a licensed Home Health Care Agency, and:

- The charge is made by a Home Health Care Agency
- The care is given according to a Home Health Care treatment plan
- The care is given to a person in his or her home

Home Health expenses are charges for:

- Part-time or intermittent care by an R.N. or by an L.P.N. if an R.N. is not available
- Part-time or intermittent home health aide services for patient care
- Physical, occupational and speech therapy

The following expenses are covered to the extent they would have been covered under this Plan if the person had been confined in a Hospital or convalescent facility:

- Medical supplies
- Drugs and medicines provided by a physician
- Lab services provided by a home health care agency
- Phototherapy

The following expenses are not considered payable under Home Health Care:

- Services or supplies that are not part of the home health care treatment plan
- Services of a person who usually lives with the patient or who is a member of the patient's family
- Services of a social worker
- Transportation

This benefit requires pre-certification. Contact First Choice at 800-808-0450 prior to obtaining these services.

Benefits for home health care are limited to 130 days per person per Plan year.

Hospice Care

Hospice is a health care program providing a coordinated set of services rendered at home, in an outpatient setting or in an institutional setting for those suffering from a condition that has a terminal prognosis.

To be covered, the Hospice program must be licensed and the attending physician must certify that the terminally ill covered person has a life expectancy of six months or less. Charges incurred during periods of remission are not eligible under the provision of the Plan.

Hospice care for you and your eligible dependents is covered for up to six months. Benefits may be extended for additional coverage through Case Management and approval from the Trust. Services and supplies typically provided and billed by a Hospice are:

- Inpatient care
- Nutrition counseling and special meals
- Part-time nursing
- Homemaker services
- Bereavement counseling for immediate family members during the six-month period following the date of death, limited to a combined maximum of $500 per episode (immediate family members include husband, wife, and children)
- Respite care – limited to 5 days per episode
- Physical and chemical therapy

This benefit requires pre-certification. Contact First Choice at 800-808-0450 prior to obtaining this service

Hospital and Facility Services

This section provides a detailed description of services covered under Traditional Health Coverage. To make it easier for you to find, the list of eligible services are listed in alphabetical order within the following categories:

- Emergency Room Care
- Emergency Services
- Inpatient Medical Facility
- Inpatient Rehabilitation
- Outpatient Facility
- Skilled Nursing Facility
- Urgent Care Center

Emergency Room Care

Facility and professional provider services and supplies for the initial treatment of traumatic bodily injuries resulting from an accident are covered. There is a $100 emergency room co-payment, payable to the provider at the time services are requested.

Emergency medical care meeting the following definition is also covered: Facility and professional provider services and supplies for the initial treatment of a sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- Permanently placing the covered person's health in jeopardy,
- Causing other serious medical consequences,
- Causing serious impairment to bodily functions, or causing serious and permanent dysfunction of any bodily organ or part.

If the emergency room visit results in a Hospital admission, you should notify First Choice at 1-800-808-0450 within 48 hours of the admission**.** The $100 co-payment is waived if the emergency room visit results in a Hospital admission.

Emergency room care as described above will be reimbursed at 70% for providers who offer First Choice discounts and 70% of charges for providers who do not offer First Choice discounts.

Emergency Services

The Plan covers medical, surgical, Hospital, and related health care services and testing including ambulance service, required for serious accidents, sudden illness, or any medical emergency. "Medical emergency" means those health care services manifesting acute symptoms of sufficient severity such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in:

- Permanently placing the covered person's health in jeopardy,
- Causing other serious medical consequences,
- Causing serious impairment to bodily functions, or causing serious and permanent dysfunction of any bodily organ or part.

Inpatient Medical Facility

This benefit requires pre-certification. Contact First Choice at 800-808-0450 prior to obtaining these services.

The Plan pays benefits toward the cost of the following types of inpatient Hospital care services:

- Inpatient Room & Board
- Inpatient Ancillary Services

Inpatient Room and Board

Coverage provided for room and board is limited to the semi-private room rate.

Inpatient Ancillary Charges

Coverage is provided for necessary services and supplies including, but not limited to admission fees; use of operating, delivery, and treatment rooms; prescribed drugs; whole blood, administration of blood, blood processing, and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced); anesthesia, anesthesia supplies and the administration of anesthesia by an employee of the facility; medical and surgical dressings, supplies, casts and splints; diagnostic services; and therapy services; but not for the services of a physician, or drugs or supplies not consumed or used in the facility.

Inpatient Rehabilitation

Coverage is provided for Inpatient Rehabilitation. Most people who are admitted for Inpatient Rehabilitation are recovering from injuries or illnesses that severely impair their physical functioning or understanding. These include strokes, spinal cord injuries, traumatic brain injuries, chronic pulmonary problems, neurological disorders and other debilitating conditions.

Administered by treatment teams, individual patient programs can include these services:

- Behavioral medicine
- Case Management
- Dialysis
- Nutrition services
- Neuropsychology
- Occupational therapy (OT)

- On-site orthotic and prosthetic services
- Physical therapy (PT)
- Psychology
- Recreation therapy
- Rehabilitation engineering and technology
- Rehabilitation nursing
- Social work
- Speech and language therapy
- Vocational and community re-entry services

Mental health/Chemical Dependency rehabilitation is not covered under this benefit but rather under the Mental Health/Chemical Dependency benefit.

This benefit is limited to 60 days per Plan year.

This benefit requires pre-certification. Contact First Choice at 800-808-0450 prior to obtaining these services.

Outpatient Facility

Outpatient facility charges are covered only when required for a covered service or procedure. Coverage is provided for necessary services and supplies including, but not limited to: use of operating, delivery, and treatment rooms; prescribed drugs; whole blood, administration of blood, blood processing, and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced); anesthesia, anesthesia supplies and the administration of anesthesia by an employee of the facility; medical and surgical dressings, supplies, casts and splints; diagnostic services; and therapy services; but not for the services of a physician, or drugs or supplies not consumed or used in the facility.

Skilled Nursing Facility

Coverage is provided for skilled nursing facilities, a residential care setting offering a protective, therapeutic environment for individuals who require rehabilitative care or can no longer live independently because of a chronic physical or mental condition requiring round-the-clock skilled nursing care. Skilled nursing facilities must be licensed by the state and are subject to certain state and federal regulations. Skilled nursing facility care is limited to 60 days per person per calendar year.

Benefits include semi-private room and board and ancillary services. These services must be therapeutic or restorative and require in-facility delivery by licensed professional medical personnel, under the direction of a physician, to obtain the desired medical outcome. Skilled Nursing Facility stays primarily for maintenance of Custodial Care are not covered. Prior Hospitalization is not required.

This benefit requires pre-certification. Contact First Choice at 808-804-0450 before obtaining these services.

Urgent Care Center

Coverage is provided at an emergency medical service center, which is separate from any other Hospital or medical facility.

Immunizations for Travel

Immunizations for travel are covered, such as:

- Yellow fever
- Typhoid

Infertility Treatment

Coverage is provided for the initial evaluation treatment and correction of the underlying condition only.

Procedures that may produce a pregnancy, but do not correct the underlying cause of the infertility are not covered.

Examples of Treatments not covered are:

- Artificial Insemination
- Drug Therapy
- In-vitro fertilization
- Gamete (GIFT) and zygote (ZIFT) intrafallopian transfer procedures
- Drugs related to the inducement of pregnancy

Infusion Therapy

Coverage is provided for infusion therapy in both home and outpatient settings.

Home infusion therapy requires pre-certification. Contact First Choice at 800-808-0450 prior to obtaining this service.

Massage Therapy

Coverage is provided for therapeutic massage services rendered by a Licensed Massage Practitioner (LMP).

Massage therapy benefits are limited to $500 per Plan year.

Maternity Care

Benefits are payable for pregnancy-related expenses of female employees and covered spouses on the same basis as a covered illness. The expenses must be incurred while the person is covered under the Plan.

If you become pregnant, you are invited to enroll in the Precious Cargo™ maternity program provided by First Choice, by calling (800) 756-7751. Depending on your needs, a nurse will work with you throughout your pregnancy to provide support and help you carry out your doctor's instructions.

Prenatal care, including diagnostic and screening procedures and genetic counseling for prenatal diagnosis of congenital disorders of the fetus, is included.

Also covered are services rendered in a birthing facility, provided that the physician in charge is acting within the scope of his license and the birthing facility meets all legal requirements; and midwife delivery services, provided that the state in which such services are performed has legally recognized midwife delivery, and provided the midwife is licensed at the time delivery is performed; and home birthing.

Nursery charges, other Hospital services and supplies and physician's charges for Hospital visits for healthy newborn children will be covered under the mother's benefit.

Newborn children are covered for the first three weeks from birth when the mother is eligible to receive obstetrical care benefits under this Plan. If the member wishes to continue coverage for the newborn beyond that date, application must be made within the Plan's defined period, and the appropriate contributions must be made.

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, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Benefits for unenrolled newborn children will not be extended beyond the first three weeks after birth unless the newborn is properly enrolled as a dependent child within the time frames established by the Plan.

Please note: Included are services provided by a physician (M.D. or D.O.), a physician's assistant (P.A.), a certified nurse midwife (C.N.M.), a licensed midwife (L. M.) or an advanced registered nurse practitioner (A.R.N.P.).

Medical Supplies

Medical supplies that are prescribed by a licensed provider for a covered medical condition or diagnosis are covered, ***except*** for over the counter supplies. Over-the-counter supplies are ***excluded*** from the Plan.

Examples of medical supplies are diabetic equipment and supplies (blood glucose monitors, insulin pumps and accessories to pumps, insulin infusion devices, lancets, glucometers, syringes if not covered under the pharmacy benefit), injectables and ostomy supplies (including medical equipment and supplies directly related to ostomy care when surgery creates an opening for drainage from the kidney, the small intestines or the colon), and phenylketonuria (PKU) formula.

Mental Health/Chemical Dependency

Services covered under your mental health and Chemical Dependency coverage include:

- Inpatient Mental Health and Chemical Dependency treatment and supporting services. Benefits for Medically Necessary detoxification services are provided under the Emergency Room Services and Hospital Inpatient Care provisions and do not accrue toward the Chemical Dependency treatment maximum stated below.
- Outpatient Mental Health and Chemical Dependency Treatment

Chemical Dependency treatment is limited to $14,000 per member per 24 consecutive months.

Inpatient and Residential Treatment Center Mental Health and Chemical Dependency Confinement

An acute inpatient Hospitalization is described as treatment that includes 24-hour nursing care and daily, active treatment under the direction of a psychiatrist, or, for children and adolescents, a board certified/eligible child and adolescent psychiatrist.

Residential Treatment Center is medically-supervised, psychiatric residential treatment – a level of care that includes individualized and intensive treatment on a 24-hour basis in a residential setting.

Charges of a facility and/or professional provider related to or because of psychiatric illness are covered as follows:

- Inpatient facility charges;
- Individual Psychotherapy;
- Group Psychotherapy;
- Psychological Testing;
- Family Counseling (counseling with family members to assist in the covered person's diagnosis and treatment);
- Electro-Convulsive Therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same professional provider.

Mental health inpatient confinement is limited to 10 days per person per Plan year. Chemical Dependency treatment is limited to $14,000 per person per 24 consecutive months.

Outpatient Mental Health and Chemical Dependency Treatment

Outpatient mental health treatment and Chemical Dependency treatment is described as the diagnosis or treatment of a mental disease, disorder, or condition listed in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association, as revised, whether or not the cause of the disease, disorder, or condition is physical, chemical, or mental in nature or origin. Care must be provided by a physician or licensed mental health/Chemical Dependency provider. Covered services include but are not limited to:

- Assessment
- Diagnosis
- Individual, group, family or conjoint psychotherapy,
- Medication management
- Psychological testing and assessment,
- Electroconvulsive treatment (ECT)
- Crisis intervention
- Rehabilitation (drug and alcohol related)

ECT and methadone maintenance treatments are covered under this benefit, but do not apply to the outpatient mental health/Chemical Dependency limits.

Outpatient services are limited to 10 visits per Plan year for individual and group therapy combined. Chemical Dependency treatment is limited to $14,000 per person per 24 consecutive months.

Alternative Levels of Care

Alternative levels of care for Mental Health are covered as follows and are limited to 15 visits per person per Plan year. Chemical Dependency treatment is limited to $14,000 per person per 24 consecutive months.

Acute Partial Hospitalization This is treatment that includes daily nursing care and active treatment in a structured treatment program lasting 5-7 days per week and delivering at least 20 hours of active treatment per week, with patients going home each evening and/or weekend.

Intensive Outpatient Treatment (IOP) IOP is a structured program that includes combinations of individual and group process therapy, meeting at least three times per week, and delivering at least 4 hours of treatment per week.

Naturopath Services

Office visits to a licensed naturopath are covered. Surgical procedures and injections performed by a naturopath are not covered. In addition, medicine, herbs, supplements and vitamins dispensed by a naturopath are not covered.

Naturopath Services are limited to $500 per person per Plan year.

Nutritional Counseling

Coverage is provided for health services rendered by a registered dietician, or other licensed provider, for individuals with medical conditions that require a special diet. Some examples of such medical conditions include diabetes mellitus, coronary heart disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, and phenylketonuria.

Organ and Bone Marrow Transplant Services

You must contact First Choice in order for care to be pre-certified prior to services occurring. To pre-certify, call 1-800-808-0450.

The Organ and Bone Marrow Transplant Services Benefit is subject to a separate, benefit-specific 12-month waiting period. Your 12-month transplant waiting period must be over. This benefit does not cover a transplant that is performed in the first 12-month period of coverage under the Plan.

Coverage is provided for the expenses for human-to-human organ or tissue transplants including:

- Kidney
- Heart/lung
- Liver
- Living donor liver transplant
- Islet
- Bone marrow/Stem cell
- Pancreas
- Heart
- Lung
- Kidney/pancreas
- Multi-visceral (liver, stomach, jejunum, ileum, pancreas and/or colon)
- Intestinal

Cornea transplants are covered under the surgery/surgical services benefits and are not considered under the Organ and Bone Marrow Transplant benefit, nor are they subject to Organ and Bone Marrow Transplant maximums.

Organ and Bone Marrow Transplant services are limited to $500,000 per person per lifetime. Limits begin to accrue once the Hospitalization is initiated.

Covered expenses incurred by the donor of an organ or tissue for transplant to a recipient who is a covered person under this Plan are covered the same as any other sickness when the donor is a covered person under this Plan.

Covered expenses incurred by the donor of an organ or tissue for transplant, when the donor is not a covered person under this Plan, are covered to the extent of any benefits remaining after payment of the covered person's expenses as a recipient, when the donor's expenses are not covered under any group or individual insurance policy or Benefit Plan and are charged to the recipient.

Covered expenses include:

- Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;
- Services and supplies furnished by a facility provider;
- Treatment and surgery by a professional provider; and
- Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

Surgical, storage and transportation costs directly related to the procurement of an organ or tissue used in a transplant described above will be covered for each such procedure completed. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue. If a covered transplant procedure is not done as scheduled due to the intended recipient's medical condition or death, benefits will be paid for charges incurred for organ or tissue procurement as described above.

Coverage is provided, for transplant recipients and family members, for the cost of travel and lodging only if the transplant recipient resides more than 50 miles from the designated transplant facility. There is a combined episodic maximum of $10,000 per covered person. This maximum applies to all associated transportation, lodging and meal expenses incurred by the transplant recipient and companion(s).

The Plan covers the following expenses:

- Transportation for the patient and a companion traveling on the same day(s) to and/or from the site of the transplant for the evaluation, transplant procedure, or necessary post-discharge follow-up.
- Reasonable and necessary expenses for lodging and meals for the patient (while not Hospitalized) and companion. Benefits are paid at a rate of up to $50 per day for one person. If the patient is a dependent child, the transportation expenses of two companions will be covered, and lodging and meal expenses will be reimbursed up to $100 each day.
- Travel and lodging expenses – but only if the transplant recipient resides more than 50 miles from the designated transplant facility.

Orthognathic (Jaw) Surgery

Coverage is provided for orthognathic (jaw) surgery when such a procedure is deemed Medically Necessary.

This benefit requires pre-certification. Contact First Choice at 800-808-0450 prior to obtaining these services.

Orthotic Devices

Coverage is provided for orthotic devices (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including custom shoes and custom molded inserts, if prescribed by a physician.

Orthopedic shoes and shoe inserts are limited to a combined maximum of $250 per person per Plan year.

Positron Emission Tomography (PET) Scan

Coverage is provided for positron emission tomography (PET) scan when such a procedure is deemed Medically Necessary.

This benefit requires pre-certification. Contact First Choice at 800-808-0450 prior to obtaining these benefits.

Podiatry

Coverage is provided for certain surgical podiatry services, including incision and drainage of infected tissue of the foot, removal of lesions of the foot, removal or debridement of infected toenails, and treatment of fractures and dislocations of bones of the foot. Podiatry services not covered are those procedures considered to be a part of a routine foot care, or of a cosmetic nature.

Prescription Drug Benefits

Prescription drug coverage is provided for Medically Necessary outpatient prescription drugs and supplies for pregnancy or the treatment of an accidental injury or sickness. You or your dependent must be covered at the time the prescription or refill is filled. For more information, see:

- Pharmacy Benefits
- Eligible Prescription Drugs
- Drugs Not Covered

Pharmacy Benefits

The Plan contracts with a number of retail pharmacies and a mail order pharmacy that offers First Choice discounts on prescription drugs. For a list of participating pharmacies, contact First Choice Customer Service at 1-800-517-4078.

Prescription drugs are fully covered after you pay the applicable coinsurance amount. Mail-order pharmacy services are provided by Walgreens.

Pharmacy charges do not apply to your coinsurance maximum or your out-of-pocket maximum.

Prescription Drugs *BASIC PLAN*	Providers Offering First Choice Discounts	Providers **Not** Offering Network Discounts
Retail & Mail Order	70%	50%

Specialty Pharmacy Program	The co-insurance level for drugs received under the MedImpact Specialty Pharmacy Plan is 25% (the Plan pays 75%). Drugs that fall under the Specialty Pharmacy Program may include, but are not limited to, drugs for Cystic Fibrosis, Multiple Sclerosis, Viral Hepatitis and others as determined by the Plan. Please call 1-800-517-4078 for more information and/or how to enroll in this Program. The Plan year out-of-pocket maximum is $2,000. This maximum applies to only the Specialty Pharmacy Program.

Eligible Prescription Drugs

Federal Legend Drugs that are not specified below will be considered eligible for reimbursement.

Drugs Not Covered

The following prescription drugs are not covered:

- Non-Federal Legend Drugs
- Non-systemic contraceptives, implants
- Mifeprex
- Drugs to treat impotency
- Anti-obesity preparations
- Fertility agents
- Growth hormones
- Growth hormone receptor antagonist (i.e. Somavert)
- Accutane
- Homeopathics
- Vitamins (except those listed above)
- Dental fluoride products
- Drugs whose sole purpose is to promote or stimulate hair growth or for cosmetic purposes only.
- Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual.
- Medication for which the cost is recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed Hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent Hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
- Charges for the administration or injection of any drug.

For questions regarding coverage for specific drugs, contact First Choice Customer Service at 1-800-517-4078.

Preventive Care

The Plan covers preventive services based on guidelines from the United States Preventive Services Task Force, the American Cancer Society, the Advisory Committee on Immunization Practices, and the American Academy of Pediatrics. The Preventive Care Benefit includes screening tests, immunizations and counseling services designed to detect and treat medical conditions to prevent avoidable premature injury, illness and death. All discounted rates and reasonable and customary (R&C) charges will be paid by the Plan at 100%, with no out-of-pocket responsibility for preventive services (except for charges in excess of R&C). None of these charges will apply toward the out-of-pocket maximum. Services that fall outside the Preventive Care Benefit and other services performed during a preventive office visit will be considered for coverage under your HIA and/or the traditional health coverage.

Well Baby and Well Child Care

Baby/Child Preventive Care Office Visits

- Six (6) visits the first year after birth
- Three (3) visits the second year after birth (age 1)
- One (1) annual visit from ages 2 through 18

Baby/Child Screening Tests (annually, unless otherwise indicated)

- Lead level test (once, between 9-12 months of age)
- Vision screening
- Hearing screening
- Routine pelvic exam, Pap test and contraceptive management (screen all females who are age 18, or have been sexually active, whichever comes first)

Baby/Child Immunizations

Note: Actual dosing regimen to be determined by physician.

- Hepatitis A
- Hepatitis B
- Diphtheria, Tetanus, Pertussis (DtaP)
- H. Influenza type B
- Polio
- Measles, Mumps, Rubella (MMR)
- Varicella (chickenpox)
- Influenza – flu shot (over 6 months of age)
- Pneumococcal conjugate (pneumonia)
- Meningococcal – recommended for children ages 11-12, as well as any unvaccinated adolescents at high school entry (15 years old)
- Human Papillomavirus (HPV) – recommended for girls ages 11-12 (can be started as early as 9 years of age), and women ages 13-26

Adult Preventive Office Visits

- One annual office visit (after age 18)

Adult Screening Tests (annually, unless otherwise indicated)

- Coronary artery disease – periodic cholesterol and lipid screening for men beginning at age 35, and women beginning at age 45
- Clinical breast exam and mammogram – annual, beginning at age 40
- Routine pelvic exam, Pap smear and contraceptive management
- Colorectal cancer screening – annual fecal occult blood testing or flexible sigmoidoscopy every 3-5 years, or colonoscopy every 10 years, starting at age 50
- Prostate cancer screening – digital rectal examination and prostate-specific antigen at discretion of physician and patient, starting at age 50
- Diabetes (type II) screening – periodic blood glucose testing for high-risk individuals (e.g., with hypertension, hyperlipidemia)
- Osteoporosis screening – periodic bone-density screening for women over age 65 and women over 60 with increased risk for osteoporotic fractures

Adult Immunizations

- Influenza
- Pneumococcal conjugate (pneumonia)
- Tetanus/Diphtheria (DtaP)
- Measles, Mumps, Rubella (MMR) – for individuals under age 50 without previous immunization
- Hepatitis A – recommended for high-risk groups, such as international travelers, workers in food service or health-care industries
- Hepatitis B – recommended if some other risk factor is present
- Varicella (chickenpox) – recommended for all adults without evidence of immunity
- Meningococcal – considered for college students who live in dormitories and have a slightly increased risk of contracting meningococcal disease
- Human Papillomavirus (HPV) – recommended for women ages 13-26
- Herpes Zosster

Professional Services

Professional services are those services billed by a provider's office rather than by a facility, such as office visits and inpatient Hospital visits. Covered professional services are:

- Office Visits - Visits made by patients to health service providers' offices for diagnosis, treatment, and follow-up.
- Inpatient Hospital Visit - A visit by a provider for persons admitted to health facilities that provide room and board, for the purpose of observation, care, diagnosis or treatment.
- Home Visit – Visit made by a provider to a patient's home for diagnosis, treatment and follow-up.

Prosthetics

Coverage is provided for the purchase and fitting of external prosthetic appliances which are used as a replacement or substitute for a missing body part, and are necessary for the alleviation or correction of illness, injury, or congenital defect.

Replacement or repair, as appropriate, of external prosthetic appliances is covered if necessitated by such circumstances as normal anatomical growth, physical changes that render the device ineffective, or excessive wear.

Coverage is limited to the initial purchase and subsequent repair cost necessitated by physical growth and normal use. Duplicate items are not covered. Coverage is not available for items primarily for use during or to enable sports and/or recreational activities.

Coverage for internal prosthetic appliances includes the purchase, maintenance, or repair of permanent or temporary internal aids and supports for defective body parts; specifically, intraocular lenses, artificial heart valves, cardiac pacemakers, artificial joints, and other surgical materials such as screw nails, sutures and wire mesh.

Second Surgical Opinion

Coverage is provided for an opinion provided by a second physician, when one physician recommends surgery to an individual.

Stereotactic Radiosurgery (Gamma Knife)

Coverage is provided for stereotactic radiosurgery when such a procedure is deemed Medically Necessary.

This benefit requires pre-certification. Contact First Choice at 800-808-0450 prior to obtaining these services.

Surgery

Coverage is provided for surgery rendered in both inpatient and outpatient settings for the treatment of disease or injury. Separate payment will not be made for pre-operative care or post-operative care normally provided by the surgeon as part of the surgical procedure.

Breast reconstruction coverage

Other covered services also include breast reconstruction – for you and your covered dependents – if you or your family members received benefits for a mastectomy, and/or elected breast reconstruction in connection with the mastectomy. As long as the breast reconstruction is performed in a manner determined by the patient in consultation with the attending physician, benefits include:

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

Surgical Services

Coverage is provided for the following surgical services:

- Assistant Surgeon
- Bilateral Surgical Procedures
- Co-surgeon
- Multiple Surgical Procedures

Assistant Surgeon

Benefits may be provided for services of a physician who actively assists the operating surgeon when it is determined that the condition of the patient or the type of surgical service requires such assistance.

When considered necessary by the surgeon, the service of an assistant surgeon is a covered service. The benefit payable for the assistant surgeon's services is 20% of the benefit payable for the primary surgeon.

Bilateral Surgical Procedures

Bilateral surgical procedures are defined as more than one procedure associated with a single surgical event. For bilateral procedures, 50% of the eligible benefit for the primary surgical procedure will be considered.

Co-Surgeon

A co-surgeon is usually a surgeon who is in the operating room performing a different surgery than the other surgeon who is present at the same time. Also, a co-surgeon is allowed in complicated surgeries (such as heart surgery) due to the length of time of the operation. The co-surgeons have the same responsibility. Co-surgeon services are covered at 50% of the eligible benefit of the surgeon's fee.

Multiple Surgical Procedures

For multiple surgeries (related operations or procedures performed through the same incision or in the same operative field, performed at the same operative session), the Plan considers, as an eligible expense, 100% of the eligible surgical allowance for the highest paying procedure plus 50%

of the eligible surgical allowance for the second highest paying procedure and 50% of the eligible surgical allowance for each additional procedure. For example, if the benefit normally pays 80%, the primary surgical procedure would be paid at 80%, the remaining surgical procedures would be paid at 50% of the 80% benefit.

Temporomandibular Joint Dysfunction (TMJ)

Medical services and supplies for treatment of temporomandibular joint (TMJ) disorders are covered on the same basis as any other medical condition up to a calendar year maximum of $1,000 per person.

There is no benefit for appliances used in the treatment of TMJ.

The lifetime benefit maximum is $5,000 per person.

Therapy Services

Coverage is provided for therapy services when used for the treatment of a sickness or injury to promote the recovery of the covered person. To be covered, the therapy services must be rendered in accordance with a physician's written treatment plan.

Services covered under the Plan include:

- **Chemotherapy:** The treatment of malignant disease by chemical or biological antineoplastic agents. The cost of the antineoplastic agent is included.
- **Dialysis Treatment**: The treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, to include hemodialysis or peritoneal dialysis.
- **Occupational Therapy**: The treatment of a physically disabled person by means of constructive activities designed and adapted to promote the functional restoration of the person's abilities lost or impaired by disease or accidental injury, to satisfactorily accomplish the ordinary tasks of daily living. Physical, speech and occupational therapies have a combined limit of $2,000 per person per Plan year.
- **Physical Therapy**: The treatment by physical means, hydrotherapy, heat, or similar modalities; physical agents; biomechanical and neurophysical principles; and devices to relieve pain, restore maximum function lost or impaired by disease or accidental injury, and prevent disability following disease, injury or loss of body part. Physical, speech and occupational therapies have a combined limit of $2,000 per person per Plan year.
- **Radiation Therapy**: The treatment of disease by X-ray, gamma ray, accelerated particles, mesons, neutrons, radium or radioactive isotopes.
- **Respiratory Therapy**: The introduction of dry or moist gases into the lungs for treatment purposes.
- **Speech Therapy**: Speech therapy is covered to restore speech loss or correct impairment due to a congenital defect, illness or injury such as stroke, head injury or vocal cord injury. Physical, speech and occupational therapies have a combined limit of $2,000 per person per Plan year.
- Treatment for learning disabilities and developmental delays is covered for children under the age of 7. Services for the treatment of learning disabilities and developmental delays apply toward the $2,000 limit for physical, speech and occupational therapies.

Varicose Vein Procedures

Coverage is provided for Medically Necessary procedures to remove or reduce pain or physical damage caused by varicose veins.

This benefit requires pre-certification. Contact First Choice at 800-808-0450 prior to obtaining these services.

Wigs

Benefits are provided when baldness is a result of chemotherapy, alopecia, radiation therapy or surgery. Wigs are limited to $200 per person per Plan year.

Services, Supplies, and Medical Expenses Not Covered

Certain services and supplies – and certain medical expenses – are not eligible for benefits under your Traditional Health Coverage.

No benefits are payable under your Traditional Health Coverage for any charges for services, treatments, care, procedures, supplies or accommodations directly or indirectly related to the following:

- That are for your convenience, or that of your family, including services of a personal nature such as meals, for guests, long distance telephone charges, radio or television charges, barber or beautician charges.

- The difference in cost between a private room and a semi-private room.

- Organ Transplants, including any direct or indirect complications and aftereffects thereof, except as specifically stated under the Organ and Bone Marrow Transplant Benefit.

- Counseling, education or training services, except as stated underChemical Dependency Treatment, Diabietic Care, Free and Clear Tobacco Cessation, and Nutritional Counseliung. This includes vocational assistance and outreach, and family, marital, social, sexual, lifestyle, and fitness counseling.

- Human growth hormone therapy.

- Therapy designed to provide a changed or controlled environment.

- Any care connected with a dependent child's pregnancy, except care furnished for the treatment of a complication of pregancy.

- Conditions caused by or arising from:

    - Acts of war (declared or undeclared), terrorism or armed invasion or aggression.
    - 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.
    - Voluntary participation in a riot or insurrection.
    - You or your dependents commission of a felony or act of terrorism.

- Treatment of caffeine dependence.

- Suicide or attempted suicide, including any direct or indirect complications and after-effects thereof. This exclusion does not apply when the suicide or attempted suicide resulted from a medical condition (including both physical and mental health conditions).

- Any self-inflicted injury received while under the influence of alcohol or drugs or a combination thereof (including while operating a motor vehicle). An arresting officer's determination that an individual was under the influence is sufficient. Operating a motor vehicle with a blood alcohol content or breath alcohol content above the applicable legal limit is sufficient. This exclusion does not apply when the injury resulted from a medical condition (including both physical and mental health conditions). This exclusion does not apply to expenses for Chemical Dependency treatment as specified in this Plan.

- Services and supplies to the extent that benefits are payable under the terms of any contract or insurance offering: Motor vehicle medical no-fault, or personal injury protection (PIP) coverage; or commercial premises or homeowner's medical premises coverage; or similar type of coverage or insurance.

- Hospital care for dental procedures, unless adequate treatment cannot be provided without the use of Hospital facilities, and you have a medical condition, in addition to the dental condition requiring treatment, that makes Hospital care Medically Necessary.

- Appliances used in the treatment of temporomandibular joint disorder (TMJ).

- Services and supplies provided by an acupuncturist, naturopathic physician, dietitian/nutrionist, or massage practioner, except as specifically stated under the Acupuncture, Massage Therapy, Naturopathic Services and/or Nutritional Counseling Benefits.

- Chiropractic care, except as specified under the Chiropractic Benefit.

- Treatment of psychiatric conditions and eating disorders such as anorexia nervosa, bulimia, or any similar conditions, except as specified under the Mental Health Care benefit.

- To the extent that you or your dependent is reimbursed or in any way indemnified for those expenses by or through Medicare or any other public program.

- For vocational work hardening or training programs regardless of diagnosis or symptoms that may be present or for non-Medically Necessary education, except as specifically provided in this Plan.

- For telephone consultations, charges for failure to keep a scheduled visit, or charges for completion of a claim form.

- Surrogate mother charges.

- Charges for equipment containing features of an aesthetic nature or features of a medical nature which are not required by the patient's condition.

- For the administration of the Flu Mist.

- Preservation of tissues or cells, except where Medically Necessary to facilitate services or procedures as outlined in the Organ and Bone Marrow Transplant benefit

- Enteral feeds.

- Examination or treatment ordered by a court in connection with legal proceedings will not be reimbursed.

- For air ambulance.

- Services and supplies that are not Medically Necessary in our judgment, even if they are court-ordered. This also includes places of service, such as inpatient Hospital.

- Care rendered by any non-preferred medical facility that is owned or operated by a government agency, except when:

  - The Plan refers you to the facility;
  - The facility's covered services are to treat a medical emergency or an accidental injury that occurs on the day of, or within two days following, the date of the accident; or
  - The Plan is required by law to provide available benefits for covered services rendered by the facility.

- Habitative, education, or training services or supplies for dyslexia, for attention deficit disorders and for disorders or delays in the development of a child's language, cognitive, motor, or social skills, including evaluations thereof. However, this exclusion does not apply to treatment of neurodevelopmental disabilities in children under age seven.

- Cosmetic services and supplies (including drugs) and any direct or indirect complications and aftereffects thereof, except that benefits will be provided for:

  - Repair of a defect that is the direct result of an accidental injury, provided such repair is performed within 12 months of the date of the accident.
  - Repair of a dependent child's congenital anomaly.
  - Reconstructive breast surgery in connection with a mastectomy.
  - Correction of functional disorders upon our review and approval.

- Treatment of obesity, including surgery, and any direct or indirect complications and aftereffects thereof; services and supplies connected with weight loss or weight control. This exclusion applies even if you also have an illness or accidental injury that might be helped by weight loss.

- Diagnosis and treatment of sexual disorders and defects, whether or not they are the consequence of illness or accidental injury, including any direct or indirect complications and aftereffects thereof. Examples are impotence, frigidity and infertility.

- Treatment of tobacco dependence, except as specified under the Tobacco Cessation benefit.

- Any illness, condition or injury arising out of, or in the course of, employment, for which you or your dependent is entitled to receive benefits, whether or not a proper and timely claim for such benefits has been made under:

  - Occupational coverage required of, or voluntarily obtained by, the employer;
  - State or federal workers' compensation acts; or
  - Any legislative act providing compensation for work-related illness or injury.

- Services and supplies that are not directly related to a covered illness, accidental injury or distinct physical symptoms.

- Diagnostic screenings. However, this exclusion does not apply to services and supplies specified under the Maternity Benefit and the Preventive Care Benefit, or to routine mammography screening.

- Routine vision examinations, hearing examinations and diagnostic screenings; any type of appliance (and its fittings) used to improve visual or hearing sharpness, including glasses, contact lenses and hearing aids. Vision therapy, eye exercise, any type of training to correct muscular imbalance of the eye (orthoptics); and pleoptics. Treatment or surgeries to improve the refractive character of the cornea, including the treatment of any results of such treatment.

- Dental care for teeth and gums except when all of the following requirements are met:

    - The services are necessitated as a direct result of an accidental injury;
    - The services are within the scope of the provider's license;
    - The injury is not caused by biting or chewing;
    - The services are received within 12 months of the accident causing the injury; and
    - In reference to injury to a tooth, the tooth must be a natural tooth, free from decay and otherwise functionally sound at the time of the injury.

- Experimental or investigational and unproven services.

- Services which are not Medically Necessary for the diagnosis, treatment or prevention of injury or illness, even though such services are not specifically listed as exclusions.

- Non-covered services and complications arising from non-covered services.

- Custodial Care

- Hearing aids

The Plan sponsor continues to reserve its discretion to exclude other procedures relating to charges for any condition, disease, ailment or illness which is not deemed to be Medically Necessary, reasonable or otherwise covered. Thus no inference should be drawn from the inclusion or exclusion of any specific condition, disease, ailment or illness or its related treatment, diagnosis or care in this section or otherwise.

Claims and Appeals

To submit or appeal a claim for benefits from the Plan, follow the procedures for filing claims and appealing claims.

Filing Claims

If you receive services from a provider who offers First Choice discounts, your provider should submit the claim for reimbursement on your behalf. If you receive services from a provider who does not offer First Choice discounts, you must file your own claim. If you need to file your own form, it's a good idea to take the form along with you when you see your provider. You can obtain a member claim form by contacting First Choice Customer Service at 1-800-517-4078 or by logging in to www.myFirstChoice.fchn.com.

When you need to file a claim for benefits, complete the appropriate forms and mail them with all required documentation to the Claims Administrator at:

First Choice
Post Office Box 12659
Seattle, WA 98111

NOTE: When services are rendered by a provider who offers First Choice discounts, claims should be submitted by the provider to the address denoted on your First Choice identification card.

IMPORTANT! Claims should be submitted as soon as possible. Claims submitted more than twelve months from the date of service will not be honored. Previous Plan year claims will be applied against your previous Plan year HIA balance (if applicable), Deductible amounts, and coinsurance maximums.

Generally, the Trust has delegated its claims administration authority for the Plan to First Choice. As the Claims Administrator, First Choice is responsible for reviewing and processing certain claims.

Additional Information That May Be Required to Process Claims

In order to process claims correctly, the Claims Administrator will sometimes require more information than is provided with the claim. Failure to receive this additional information may result in a delay in processing or the denial of the claim. Some of the information, such as other insurance coverage and full-time student status, can be handled prior to receiving claims by filling out the appropriate forms in advance. These forms are available from the Trust Office.

If you receive a letter from the Claims Administrator requesting additional information, you should fill out the request in full, sign and date the letter, and return to the address listed as soon as possible.

Here are examples of some of the additional information that may be required:

Other Insurance Coverage

The Plan requires verification of other insurance coverage every 12 months. The forms are available through the Trust Office.

Accident Information

If you are involved in any type of accident, the Claims Administrator will require the accident information to process a claim. Because this Plan has a provision concerning third-party liability, the accident information is required to determine whether a third party (or parties) may be liable. If you are involved in a motor vehicle accident, the Claims Administrator will require the accident report and the name, address and telephone number of the auto insurance carrier(s) involved.

Full-Time Student Status

This Plan requires that any covered dependent children ages 19 through 24 must be either a full-time student or be disabled in order to remain on the Plan. If your child is 19 years of age or older, the Plan may verify at the beginning of every semester whether the child is a full-time student, and every 12 months whether the child is disabled.

Benefit Determinations

There are four types of Plan claims: Pre-Service, Concurrent Care, Urgent Care Claims and Post Service Claims.

- **Pre-Service Claim**: A claim for health care where prior approval for any part of the care is a condition to receiving the care. For example, the Plan requires that you pre-certify Hospital admissions.
- **Concurrent Care Claim**: A previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments.
- **Post-Service Claim**: A claim for care that has already been received, and any claim for which the Plan does not require pre-authorization.
- **Urgent Care Claim*:*** A Pre-Service or Concurrent Care Claim becomes an Urgent Care Claim when the normal time frame for making a determination would:

    - seriously jeopardize the life of the claimant (in the view of a prudent layperson acting on behalf of the Plan who possesses an average knowledge of health and medicine, or a physician with knowledge of the claimant's medical condition) or
    - subject the claimant to severe pain that cannot be adequately managed without treatment (in the view of a physician with knowledge of the claimant's condition).

Claims Review and Appeals Procedures

Generally, the following steps describe your appeal procedures (regardless of the type of claim—pre-service, concurrent care, etc.):

Step 1: *Notice is received from Claims Administrator.* If your claim is denied, you will receive written notice from the Claims Administrator that your claim is denied (in the case of urgent claims, notice may be verbal). The time frame in which you will receive this notice is described in the chart below and will vary depending on the type of claim. In addition, the Claims Administrator may obtain an extension of time in which to review your claim, if necessary for reasons beyond the Claims Administrator's control. If the reason for the extension is that you need to provide additional information, you will be given a certain amount of time in which to obtain the requested information (it

will vary depending on the type of claim). The time period during which the Claims Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the applicable information-gathering period.

Step 2: *Review your notice carefully*. Once you have received your notice from the Claims Administrator, review it carefully. The notice will contain:

- the reason(s) for the denial and the Plan provisions on which the denial is based;
- a description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information;
- a description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following a denial of your appeal;
- a statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and that a copy of that rule, guideline or protocol will be provided free of charge upon request;
- if the denial is based on a medical necessity, experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request; and
- if the claim was an Urgent Care Claim, a description of the expedited appeal process. The notice may be provided to you verbally; however, a written or electronic notification will be sent to you not later than three days after the verbal notification.

Step 3: *If you disagree with the decision, file a 1st Level Appeal with the Claims Administrator.* If you do not agree with the decision of the Claims Administrator, you may file a written appeal with the Claims Administrator within 180 days of receipt of the Claims Administrator's letter (or verbal notice if an urgent care claim) referenced in Step 1. If the claim involves Urgent Care, your appeal may be made verbally. In addition, you should submit all information identified as necessary to perfect your claim as referenced in the Notice described in Step 2 with your appeal. You should also gather and submit any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim. Your request for appeal must include the following:

- **the patient's name and identification number**
- **the date of the medical service**
- **the provider's name**
- **the reason you believe the claim should be paid, and**
- **any documentation or other written information to support your request for claim payment.**

All appeals will be processed as described below.

All appeals should be sent to:

First Choice
Attention: Appeals
600 University Street, Suite 1400
Seattle, WA 98102

Step 4: *1st Level Appeal notice is received from Claims Administrator.* If the claim is again denied, you will be notified by the Claims Administrator within the time period described in the chart below depending on the type of claim.

Step 5: *Review your notice carefully.* You should take the same action that you take in Step 2 described above. The notice will contain the same type of information that is provided in the first notice of denial provided by the Claims Administrator.

Step 6: *If you still disagree with the Claims Administrator's decision, file a 2nd Level Appeal with the Claims Fiduciary.* If you still do not agree with the Claims Administrator's decision, you may file a written appeal to the Claims Fiduciary (the Board of Trustees) within 60 days after receiving the first-level appeal denial notice from the Claims Administrator. You should gather any additional information that is identified in the notice as necessary to perfect your claim as well as any other information that you believe will support your claim. The appeal should be sent to

Board of Trustees of the
Washington State Auto Dealers Insurance Trust
P. O. Box 52848
Bellevue, WA 98015-2848
Attention: Claims Appeals Department

When acting as Claims Fiduciary the Board of Trustees has all the power, right, authority and discretion described under "Plan Administration" on page 64.

If the Claims Fiduciary denies your 2nd Level Appeal, you will receive notice within the time period described in the chart below, depending on the type of claim. The notice will contain the same type of information that was referenced in Step 1 above.

Important Information

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e. the same person(s) or subordinate(s) of the same person(s) involved in a prior level of appeal will not be involved in the appeal);
- On each level of appeal, the claims reviewer will review relevant information that you submit, even if it is new information;
- If an appeal involves medical judgment, then the Claims Administrator and the Claims Fiduciary will consult during the 1st and 2nd level appeals with an independent health care professional who has expertise in the specific area involving medical judgment.
- While it is your option to appeal, you cannot file suit in federal court until you have exhausted these appeals procedures.

Time Limitation for Filing Legal Action; Venue

All suits or legal proceedings against First Choice, the Plan, the Trust, or the Board of Trustees by you or by anyone claiming any right under or with respect to this Plan must be filed:

- in the case of a claim for benefits, within 12 months of the date First Choice or the Board of Trustees, as the case may be, have finally decided, or are deemed to have finally decided, an appeal of an adverse benefit determination;
- in the case of any other claim, and except to the extent governed by any applicable statutes of limitations, within 12 months of the act or failure to act that affects you or another claimant;
- in a court of competent jurisdiction in King County, Washington.

Timetable for Processing and Notification of Appeal Procedures	
Type of Review	**Appeal (Benefit Determination on Review & Notification to Claimant)**
Urgent Care Claim	72 hours No extensions from Claimant
Pre-Service Claim	Reasonable period = 30 days No extension from Claimant
Concurrent Care Claim	Decision before treatment ends or is reduced
Post-Service Claim	Reasonable period = 60 days No extensions from claimant

Third Party Liability

In certain situations your benefits under the Plan will be coordinated with other benefits. Refer to the sections below for additional information:

- Coordination of Benefits (COB)
- Integrating Benefits with Medicare
- Trustees' Right to Subrogation, Reimbursement and Recoupment

Coordination of Benefits (COB)

If you are eligible for benefits under another group health care plan, such as your spouse's plan or another employer's plan, the two plans will coordinate their benefit payments so the combined payments do not exceed your actual expenses. This provision is called coordination of benefits (COB). The Plan uses a COB method called "non-duplication of benefits."

For more information on COB, see:

- How COB Works
- COB "Birthday Rule"
- Right to Recover

How COB Works

Under COB provisions, one group plan has "primary" responsibility and pays first. The other group plan has "secondary" responsibility and considers any additional benefits not covered by the primary carrier. Therefore, if the Plan is:

- *primary* – it pays expenses as if no other insurance were involved
- *secondary* – it pays benefits only if you have not already received the full amount the Plan would pay if it were primary

if the benefit is for …	Then …
You	The Plan is primary for you, as an employee
You as a COBRA participant continuing benefits under another plan	COBRA coverage will be primary for limits and exclusions under the other plan
Your spouse	The Plan is always the secondary payer if he or she is covered through another employer's plan
Your dependent children	The primary plan for your dependent children is determined by the COB "Birthday Rule" except where child is covered as an employee under another employer plan. In that case, the Plan covering the dependent as an employee will be primary (without regard to the Birthday Rule).

If the other group Benefit Plan does not have a COB provision, these rules will not apply. In that case, the other group plan is automatically primary.

You should always file a claim with the primary plan first and then submit a copy of what the primary plan has paid or denied (along with copies of the same itemized expenses) to the secondary

plan. This will avoid delays in claims processing and will ensure that you are reimbursed for the full amount to which you are entitled.

COB "Birthday Rule"

Under this rule, primary coverage for your dependent children will be the Plan of the parent whose *birthday* occurs first in the calendar year. For example, if your spouse's birthday is in March and your birthday is in October, your spouse's plan will provide primary coverage for your children. If a decision cannot be made based on the birthday rule, the Plan that has covered the individual the longest will be primary.

Primary coverage for a dependent child whose parents are separated or divorced will be determined in the following order, without regard to the birthday rule:

- The plan of the parent with custody of the child.
- The plan of the stepparent whose spouse has custody of the child – if the parent with custody has remarried.
- The plan of the parent not having custody of the child.

NOTE: If a court decree declares one parent responsible for a child's health care expenses, payment will be made first under that parent's plan.

Right to Recover

If the Plan makes larger payments than are necessary under this COB provision or under any other provision, the Trustees have the right to recover the excess payments from any insurance company, any organization, and/or any persons for whom those payments were made.

The Claims Administrator also may pay another organization an amount that it determines is warranted, if the other organization or group plan pays benefits that should have been paid under the Plan.

The Plan also has the right to receive and release necessary information to determine whether coordination of benefits or any similar provisions apply to a claim. By participating in this Plan option, you agree to furnish any information that the Claims Administrator, Claims Fiduciary or Trustees require in order to administer or enforce these provisions.

Integrating Benefits with Medicare

As a general rule, if you or your covered dependent becomes eligible for Medicare benefits, there are rules that determine whether the Plan pays benefits first (pays "primary"), or whether Medicare pays primary.

When the Plan Pays Primary (Medicare Pays Secondary)

Working Aged. Except as provided under *Exception for Working Aged of a Small Employer* below, this Plan pays primary (Medicare pays secondary) for you or your spouse when age 65 or older when you are actively employed by your Dealer or have current employment status with your Dealer. "Current employment status" is defined in Medicare regulations.

Disability. The Plan pays primary (Medicare pays secondary) for you or your dependent under age 65 when you, he or she is entitled to Medicare on the basis of your disability and you are actively employed by your Dealer or have current employment status with your Dealer.

End Stage Renal Disease (ESRD). The Plan pays primary (Medicare pays secondary) for you or your dependent when you, he or she is eligible for, or entitled to, Medicare benefits based on ESRD during the first 30 months of eligibility or entitlement.

During the time the Plan pays benefits primary, you should submit a claim for any remaining expenses not covered by the Plan to Medicare. (Incidentally, you should apply for Social Security disability income benefits during the fifth month of disability to make sure you have no gaps in income protection.) During the time Medicare pays benefits first, you should first submit claims to Medicare for payment.

When the Plan Pays Secondary (Medicare Pays or Would Pay Primary)

In all other cases Medicare pays primary and this Plan pays secondary. The benefits otherwise payable or considered payable by this Plan are reduced so that the sum of benefits paid under this Plan and Medicare do not exceed what the Plan would pay if the Plan were solely responsible for paying the benefits.

In addition, the Plan will pay benefits as if Medicare paid primary if you or your dependent is actually eligible for Medicare Parts A or B, but has not enrolled in Medicare, or has failed to take any other action required by Medicare to qualify for benefits, or would have received benefits payable by Medicare had you or your dependent received services in a facility to which Medicare would have paid benefits. In the event you or your dependent enters into a private contract with a physician in accordance with Medicare private contracting arrangements, this Plan shall not coordinate benefits or assume a primary payer position for you, him or her.

Exception for Working Aged of a Small Employer

The rules applicable to Working Aged above do not apply for you or your spouse when:

- Your Dealer is a Small Employer; and
- The Centers for Medicare and Medicaid Services have approved the Plan's request for an exception from the Medicare secondary payer rules for the Covered Person.

A Dealer is a Small Employer only if:

- The Dealer does not have 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year; and
- The Dealer did not have 20 or more employees for each working day in each of 20 or more calendar weeks in the preceding calendar year.

The Plan will notify each affected party in writing of the date Medicare will become the primary payer and when the Plan will pay secondary to Medicare.

Trustees' Rights to Subrogation, Reimbursement and Recoupment

By your and your dependents' enrollment in this Plan, you and your dependents, and any other Covered Person, agree to the provisions of this section, Trustees' Rights to Subrogation, Reimbursement and Recoupment as a condition to you and your dependents receiving benefits under this Plan. If any Covered Person fails to comply with the requirements of this section, the Trust may reduce, deny or eliminate benefits otherwise available under this Plan.

Definition

For purposes of this section, the following terms are defined:

- "Benefit Payments" means benefit payments under the Plan to you or your dependent, or to others on behalf of you or your dependent, for services or supplies for a Covered Injury or Illness.
- "Covered Injury or Illness" means an injury or illness to or of you or your dependent that, in the judgment of the Trustees, is or appears to be the responsibility of one or more persons, and for which payment is or may be made by a third party (including, but not limited to, an individual, a corporation or other entity, automobile liability, uninsured or underinsured motorist; business or commercial liability; homeowners' liability and umbrella liability insurance; and medical payments for PIP coverage, regardless who maintains the insurance or coverage).
- "Covered Person" means you and your dependent, and any person who is acting for you, him or her or on your, his or her behalf, including a parent, child, spouse, representative, attorney, guardian or trustee.
- "Recovery" means the proceeds of any recovery by a Covered Person (including proceeds from a settlement or a judgment, or a payment by a person responsible or liable for payment of medical expenses), related to the Covered Injury or Illness regardless of the source of the recovery, and regardless how a Covered Person or any other party characterizes the recovery or source of recovery. "Recovery" includes the proceeds from:
    - payments made by any person or persons whom the Trustees consider responsible for the Covered Injury or Illness, or their insurers (whether pursuant to a judgment, settlement or otherwise);
    - payments made under any auto or recreational vehicle insurance, including, but not limited to, uninsured/underinsured motorist coverage, in connection with or relating to the Covered Injury or Illness; or
    - payments made under any business or homeowners' medical liability insurance in conncection with or relating to the Covered Injury or Illness; or
    - attorney's fees or award paid in connection with any claim, demand, lawsuit or other proceeding by a Covered Person against any third party in connection with or relating to the Covered Injury or Illness.
- "Reimbursement and Subrogation Agreement" means a written agreement, in form and content acceptable to the Trustees, signed by you, your dependent and any other Covered Person , in which the Covered Persons acknowledge and agree to the Trustees' rights and the Covered Persons' obligations as set forth in this section *Trustees' Right to Subrogation, Reimbursement and Recoupment."*

You Must Sign a Reimbursement and Subrogation Agreement Before Benefit Payments Are Made

Wherever there is evidence of Covered Injury or Illness, the Trustees will make Benefit Payments only if you, your dependent and any other Covered Person first fully sign a Reimbursement and Subrogation Agreement.

Until the Trustees receive the fully signed Reimbursement and Subrogation Agreement, your or your dependent's claims for supplies or services for a Covered Injury or Illness will not be considered filed and the Trustees will not make Benefit Payments. A claim will be untimely and will not be paid if the period for filing claims passes before the Trustees receive your Reimbursement and Subrogation Agreement. However, Benefit Payments made before, or without, obtaining a fully signed Reimbursement and Subrogation Agreement shall not operate as a waiver of the Trustees' rights under this section, *Trustees' Rights to Subrogation, Reimbursement and Recoupment*.

Trustees' Equitable Lien by Agreement

Once the Trust makes, or is obligated to make, Benefit Payments, the Trustees have, and the Covered Parties consent to, an equitable lien by agreement and a constructive trust to the extent of the Benefit Payments made or to be made to secure repayment of the Benefit Payments to the Trustees, and the Covered Party is deemed to hold any Recovery in trust for the benefit of the Trustees until 100% of the Benefit Payments are repaid to the Trustees.

The Trustees' right to equitable lien and constructive trust applies notwithstanding any anti-subrogation, "made whole," "common fund" or similar statute, regulation, prior court decision or common law theory. The Trustees may recover up to 100% of the Benefit Payments made or to be made, even if you or your dependent is not "made whole" or is not paid for all of your, his or her claim for damages.

Trustees' Right to Require Payments into Trust Account

At the request of the Trustees, the Covered Persons shall cause the Recovery, up to 100% of the Benefit Payments to be paid into a trust account for the benefit of the Trustees and held there until the Trustees' claim is resolved by mutual agreement or court order. The individual or entity that will hold the funds in trust must be identified to the Trustees. The obligation to place the Recovery in a trust account is independent of the obligation to reimburse the Trustees. If the Recovery, up to the 100% of the Benefit Payments, is not placed in a trust account, the Covered Persons shall be personally liable for any loss the Trust suffers as a result. If there are multiple parties or Recoveries, the Covered Persons shall cause payments to be made from each successive Recovery until 100% of the Benefit Payments has been paid into the trust.

Trustees' Right to Subrogation

Trustees are subrogated for 100% of Benefit Payments made or to be made to any and all rights of recovery and causes of action that a Covered Party may have against a third party, whether by suit, settlement or otherwise, in connection with or relating to the Covered Injury or Illness, including rights to recovery and causes of action:

- against the person or persons whom the Trustees consider responsible for the Covered Injury or Illness, or their insurers (whether pursuant to a judgment, settlement or otherwise) — regardless whether the payment is designated as payment for damages including, but not limited, to pain and/or suffering, loss of income, medical benefits or any other specified damages;

- against any auto or recreational vehicle insurance, including, but not limited to, uninsured/underinsured motorist coverage, in connection with or relating to the Covered Injury or Illness; or
- against any business or homeowners' medical liability insurance in connection with or relating to the Covered Injury or Illness; or
- for attorney's fees paid or to be paid in connection with any claim, demand, lawsuit or other proceeding by a Covered Person against any third party in connection with or relating to the Covered Injury or Illness.

Under their right of subrogation the Trustees may use any Covered Person's right to recover money from a third party. Thus, among other things, the Trustees have the right:

- to commence an action against a third party in the name of a Covered Person to effect the Trustees' right of subrogation; and
- to join as a party in any action (including a lawsuit, an arbitration or other means of dispute resolution) against a third party that you or your dependent commences.

The Trustees' right to subrogation applies notwithstanding any anti-subrogation, "made whole," "common fund" or similar statute, regulation, prior court decision or common law theory. Covered Persons must pay, and the Trustees may recover, up to 100% of the Benefit Payments made or to be made, even if you or your dependent is not "made whole" or is not paid for all of your, his or her claim for damages.

Trustees' Right to Reduce or Deny Benefits (Recoupment)

The Trustees have the right to reduce or deny benefits they otherwise would pay or provide to or on behalf of you or your dependent under the Plan to the extent of any and all:

- payments made, to be made or that should be made by any person or persons whom the Trustees consider responsible for the Covered Injury or Illness, or their insurers (whether pursuant to a judgment, settlement or otherwise) — regardless whether the payment is designated as payment for damages including, but not limited, to pain and/or suffering, loss of income, medical benefits or any other specified damages;
- payments made, to be made or that should be made under any auto or recreational vehicle insurance, including, but not limited to, uninsured/underinsured motorist coverage, in connection with or relating to the Covered Injury or Illness; or
- payments made, to be made or that should be made under any business or homeowners medical liability insurance in connection with or relating to the Covered Injury or Illness; or
- attorney's fees paid, to be paid or that should be paid in connection with any claim, demand, lawsuit or other proceeding by you or your dependent against any third party in connection with or relating to the Covered Injury or Illness.

The benefits the Trustees have a right to reduce or deny are not limited to the benefits with respect to an injury or illness for which a person is responsible. The Trustees have the right to reduce or deny benefits until the amount of benefits they would otherwise pay or provide to or on behalf of you or your dependent under the Plan exceeds 100% the Benefit Payments.

The Trustees right to reduce or deny benefits applies notwithstanding any anti-subrogation, "made whole," "common fund" or similar statute, regulation, prior court decision or common law theory. The Trustees may reduce or deny benefits, even if you or your dependent is not "made whole" or is not paid for all of your, his or her claim for damages.

Trustees' Right to Reimbursement

The Trustees are entitled, in first priority, to the Recovery of 100% of the Benefit Payments made or to be made.

The Trustees' right to the Recovery and reimbursement applies notwithstanding any anti-subrogation, "made whole," "common fund" or similar statute, regulation, prior court decision or common law theory. The Trustees have the right to be reimbursed for or recover 100% of the Benefit Payments, even if you or your dependent is not "made whole" or is not paid for all of your, his or her claim for damages.

Covered Person's Obligations

Each Covered Person must cooperate with the Trustees in protecting and enforcing their rights under this section *Trustees' Right to Subrogation, Reimbursement and Recoupment* and do nothing to impair those rights.

If a Covered Person makes or files a claim, demand, lawsuit or other proceeding against any third party, in connection with or relating to an illness or injury of or to you or your dependent, with respect to which the Trustees have advanced benefits under this section*, Trustees' Right to Subrogation, Reimbursement and Recoupment*, the Covered Person must (1) as part of such claim, demand, lawsuit or other proceeding, and on behalf of the Trustees, seek payment or reimbursement for the Amount Advanced; and (2) promptly notify the Trustees in writing (A) of the claim, demand, lawsuit or other proceeding, when made or filed; (B) of any settlement the Covered Person intends to make of the claim, demand, lawsuit or other proceeding, before you make the settlement; (C) of any request or motion for any judgment or award against a third party, when the Covered Person makes the request or motion; and (D) of any judgment or award against a third party or payment by or on behalf of a third party, when the judgment, award or payment is entered or made.

A Covered Person must promptly notify the Trustees of the existence of any right to indemnification with respect to any injury or illness to you or your dependent, when the Covered Person first knows of that right.

The Covered Person must pay the Covered Person's attorney's fees. The Trustees do not pay for, and are not responsible for, your or your dependent's attorney's fees. The Covered Person's attorney's fees do not reduce the amounts that the Trustees may recover, be reimbursed for or by which the Trustees may reduce or deny benefits they would otherwise pay or provide, unless the Trustees in their discretion otherwise agree in writing. Benefit Payments must be repaid in full, in first priority, notwithstanding any anti-subrogation, "made whole," "common fund" or similar statute, regulation, prior court decision or common law theory unless a reduction or compromise settlement is agreed to in writing by the Trustees in their discretion or is required pursuant to a court order.

Amendment and Termination

The Board of Trustees may amend, change, or modify the Plan.

The Board of Trustees may terminate the Plan.

Plan Administration

The Trustees have the exclusive authority to control and manage the operation and administration of the Plan. The Trustees may designate other persons to carry out any duty or power that would otherwise be a responsibility of the Trustees under the Plan; and to retain such actuaries, accountants, consultants, third-party administration service providers, legal counsel, or other specialists as the Trustees may deem appropriate and necessary for the Plan's administration. The Trustees also have such further authority to allocate or delegate their responsibilities as may be provided in the Trust Agreement.

The Trustees have the exclusive power, right and authority, in their discretion:

- to determine whether you are eligible to participate in this Plan, except that the Trustees shall have no power, right, authority or obligation to determine your eligibility when your Dealer has determined that you are not eligible, and the Trustees are bound by that determination;
- to determine whether any individual is an eligible dependent whom you may cover under this Plan;
- to interpret the Plan, and any other writings that affect the establishment or operation of the Plan, both as to legal import and as to the application of the provisions of any such documents to the facts of a particular claim for benefits;
- to decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions; and
- to make factual findings and decide conclusively all questions regarding any claim for benefits under the Plan.

All determinations by the Trustees with respect to any matter relating to the Plan are conclusive and binding on all persons.

Only the Board of Trustees is authorized to interpret the provisions of the Plan, and will do so only in writing. You should not rely on any representation - whether verbal or in writing - that anyone else may make concerning Plan provisions.

Notice Regarding Cost Sharing and Certain Discounts

Some of the contracts with medical, dental, and vision providers may allow discounts, allowance, incentives, adjustments and settlements. These amounts are for the sole benefit of the Plan and the Plan will retain any such payments. Claims submitted to the Plan may have copayment and the Deductible amounts calculated according to the provider’s charge for covered expenses without regard to the applicable discounts, allowances, or incentives.

Definitions

Definitions included here will help you understand your Plan benefits.

Benefits Election Worksheet

The Benefits Election Worksheet is the paperwork required by the Trust to enroll you in the Benefit Plan. You may obtain this paperwork from your Dealer or from the Trust Office.

Benefits Plan (or Plan)

This Washington State Auto Dealers Insurance Trust Basic Plan, also known as the Basic Plan.

Board of Trustees

Board of Trustees of the Washington State Auto Dealers Insurance Trust.

Case Management

Case Management is a program whereby a case manager monitors patient care and explores and discusses coordinated and/or alternative types of appropriate Medically Necessary care.

Chemical Dependency

An illness characterized by a physiological or psychological dependence, or both, on a controlled substance regulated under Chapter 69.50 RCW and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent that the user:

- Exhibits a loss of self-control over the amount and circumstances of use.
- Develops symptoms of tolerance or psychological and/or physiological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued.
- Substantially impairs or endangers his or her health or substantially disrupts his or her social or economic function.

Claims Administrator

The Claims Administrator provides administrative services on the Plan under an administrative services agreement with the Board of Trustees. The Claims Administrator is:

First Choice
Post Office Box 12659
Seattle, WA 98111

Claims Fiduciary

The Claims Fiduciary is:

Board of Trustees
of the Washington State Auto Dealers Insurance Trust
P O. Box 52848
Bellevue, WA 98015-2848

COBRA

COBRA stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. COBRA is a federal law that enables you or your enrolled spouse or dependent children to continue group health plan coverage in the event that you or they lose coverage as the result of certain qualifying events.

Custodial Care

Care that consists of services and supplies used to assist an individual in the activities of daily living, whether or not the person is disabled. These services and supplies are considered Custodial Care, regardless of who prescribes, recommends or performs them. However, when room and board and skilled nursing services must be combined with other therapeutic methods to establish a program of medical treatment, they are not considered custodial if:

- they are provided in an institution covered by the Plan
- this care can be reasonably expected to substantially improve the patient's medical condition

Dealer

Any sole proprietorship, corporation, trust, or other business entity that is an active member of the Washington State Auto Dealers Association, satisfies the requirements for participation in the Trust under the Trust Agreement, and has a currently effective Trust Participation Agreement with the Trustees. Also, for purposes of the Plan, the Washington State Auto Dealers Association and the Trust are considered Dealers.

Deductible

Your Deductible is the amount in each Plan year that you pay out-of-pocket before Traditional Health Coverage begins to play claims. You can offset the Deductible by earning money in your HIA through participation in the Health and Well-Being Assessment.

Durable Medical Equipment (DME)

Medical equipment which can withstand repeated use, is not disposable, is used to serve a Medically Necessary therapeutic purpose, is generally not useful to a person in the absence of a sickness or injury, and is appropriate for use in the home.

ERISA

ERISA stands for the Employee Retirement Income Security Act of 1974, as amended.

Experimental or Investigational Services

Experimental or investigational services include a treatment, procedure, equipment, drug, drug usage, medical device, or supply that meets one or more of the following criteria as determined by the Trustees:

- A drug or device that cannot be lawfully marketed without the approval of the United States Food and Drug Administration, and has not been granted such approval on the date the service is provided.
- The service is subject to oversight by an Institutional Review Board.
- Reliable evidence does not demonstrate efficacy of the service, nor does it define a specific role for the service in clinical evaluation, management, or treatment.
- The service is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety, or efficacy.
- Evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Family Medical Leave Act (FMLA)

A federal law that provides unpaid leaves of absence with job protection for as long as 12 workweeks, for birth of a child, newborn care, adoption or foster care placement, or the serious health condition of an employee, or an employee's spouse, child, or parent.

Full-Time Student

An eligible dependent child who regularly attends an accredited school on a full-time basis as defined by the school (usually 12 hours for undergraduate or nine hours for graduate work on a semester system) and who normally resides with you in a parent-child relationship except while away at school.

Home Health Care Agency and/or Services

A Hospital or a nonprofit or public agency which:

- Primarily provides skilled nursing services and other therapeutic services under the supervision of a physician or a registered graduate nurse
- Is run according to rules established by a group of medical professionals
- Maintains clinical records on all patients
- Does not primarily provide Custodial Care or care and treatment of the mentally ill
- Is licensed and runs according to the laws of the appropriate state, county and/or legally authorized agency

Hospice

Hospice is a health care program providing a coordinated set of services rendered at home, in outpatient settings, or in institutional settings for covered persons suffering from a condition that has a terminal prognosis.

To be covered, the hospice program must be licensed and the attending physician must certify that the terminally ill covered person has a life expectancy of six months or less. Charges incurred during periods of remission are not eligible under the provision of this Plan.

Hospital

A legally constituted Hospital that offers 24-hour resident service for patients. Hospitals have professional staff, nursing services and physical equipment that satisfy the legal requirements of the state, province, county, city or community in which they are established.

Inpatient Rehabilitation

Most people who are admitted for inpatient are recovering from injuries or illnesses that severely impair their physical functioning or understanding. These include strokes, spinal cord injuries, traumatic brain injuries, chronic pulmonary problems, neurological disorders and other debilitating conditions.

Administered by treatment teams, individual patient programs can include these services:

- Behavioral medicine
- Case Management
- Dialysis
- Nutrition services
- Neuropsychology
- Occupational therapy (OT)
- On-site orthotic and prosthetic services
- Physical therapy (PT)
- Psychology

- Recreation therapy
- Rehabilitation engineering and technology
- Rehabilitation nursing
- Social work
- Speech and language therapy
- Vocational and community re-entry services

Medically Necessary

Medically Necessary means covered services and supplies that are, in the judgment of the Trustees, determined to meet all of the following requirements:

- Essential to the diagnosis or the treatment of an illness, accidental injury, or condition harmful or threatening to your or your dependent's life or health, unless provided for preventive services when specified as covered under this Plan.
- Appropriate for the medical condition as specified in accordance with authoritative medical or scientific literature.
- Medically effective treatment of the diagnosis as demonstrated by:
- Sufficient evidence existing from which to draw conclusions about the effect of the health intervention on health outcome;
- Evidence demonstrating that the health intervention can be expected to produce its intended effects on health outcomes; and
- Expected beneficial effects of the health intervention on health outcomes outweigh its expected harmful effects.
- Cost effective as determined by being the least costly of the alternative supplies or levels of service which are medically effective and can safely be provided to you or your dependent. A health intervention is cost effective if there is no other available health intervention that offers a clinically appropriate benefit at a lower cost.
- Not primarily for research or data accumulation.
- Not primarily for the convenience of you or your dependent, or your or your dependent's family, physician, or other provider.

The Trustees have the right to require proof of that a service or supply is Medically Necessary from you or your provider when you are receiving benefits under this Plan. No benefits will be available under this Plan if the proof is not provided or not acceptable to the Trustees.

Organ and Bone Marrow Transplant Services

The medical, surgical, and Hospital services, and immunosuppressive medications, required to perform any of the following human-to-human organ or tissue transplants: kidney, bone marrow, lung, liver, partial liver, islet or pancreas.

Plan Year

The Plan Year is the time frame in which the Plan runs; for this Plan, the Plan Year begins May 1 and ends April 30.

Qualified Change in Status/Qualifying Event

An event that permits changing insurance coverage.

Qualified Medical Child Support Order (QMCSO)

A QMSCO is a court order, which requires the Plan to provide health care coverage to the dependent child named in the order. It is not the equivalent of a divorce settlement requiring a named parent to provide health care insurance.

Reasonable and Customary (R&C) Charge

A Reasonable and Customary (R&C) charge is the charge for a particular service or procedure that is customarily charged by doctors in the community in which the service or procedure is performed. In determining the Reasonable and Customary charge, the Claims Administrator and Claims Fiduciary:

- review charges published by Ingenix (as updated semi-annually)
- take into account the physician's or surgeon's degree of specialized knowledge and skill
- consider the nature and severity of the patient's condition, and that unusual circumstances or medical complications may require additional time, skill and experience in connection with a particular service or procedure

NOTE: The charge for the same service or procedure may vary from one community to another, and even within a community.

Important! Reasonable and Customary charges are determined by the Claims Administrator and Claims Fiduciary in accordance with generally accepted principles and applied by the Claims Administrator and Claims Fiduciary on a uniform and consistent basis where there is not a Reasonable and Customary rate published by Ingenix for such charges.

Semi-Private Room Rate

The room and board rate of any institution for Semi-Private rooms. "Semi-private rooms" are accommodations with two or more beds that are classified by the institution as Semi-Private. If the institution does not have Semi-Private rooms, then that institution's "Semi-Private room rate" will be deemed to be the most common daily room and board rate for Semi-Private rooms in similar institutions in the area. The term "area" means a city, county or any greater area necessary to obtain a representative cross-section of similar institutions.

Skilled Care Services

Services may include skilled nursing and skilled rehabilitation services which meet all of the following criteria: (1) must be delivered or directly supervised by licensed professional medical personnel in order to obtain the specific medical outcome; (2) are ordered by a physician; and (3) are Medically Necessary for the treatment of the sickness, injury or medical condition.

Determination of benefits for Skilled Care Services is based on both the skilled nature of the specific service and the medical necessity of physician-directed medical management. The absence of a caregiver to perform an unskilled service does not cause the service to become "skilled."

Skilled Nursing Facility

A qualified facility designated by FCHA which has the staff and equipment to provide skilled care services as well as other related services.

Trust

The Washington State Auto Dealers Insurance Trust.

Trust Agreement

The Trust Agreement of the Washington State Auto Dealers Insurance Trust, as amended from time to time.

Trustees

See "Board of Trustees."

Urgent Care

Conditions requiring immediate attention from a doctor or nurse, but which are not critical or life-threatening.

General Provisions

Protection of your Health Information

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that, in part, requires group health plans to protect the privacy and security of your confidential health information. As a multiple employee welfare Benefit Plan under ERISA, the Plan is subject to the HIPAA privacy rules. This means that the Plan will not use or disclose your protected health information without your authorization, except for purposes of treatment, payment, health care operation, or Plan administration, or as required or permitted by law. For a description of the Plan's uses and disclosures of your protected health information and your rights and protections under the HIPAA privacy rules, see Appendix A, Plan's Notice of Privacy Practices. You may obtain a copy of the Plan's Notice of Privacy Practices by contacting:

Trust Manager
Washington State Auto Dealers Insurance Trust Insurance Trust
P O. Box 52848
Bellevue, WA 98015-2848

Limitations of Liability

Neither the Trustees, the Trust nor the Plan are liable for any of the following:

- Situations such as epidemics, disasters, or other causes or conditions beyond their control that prevent you or your dependents from obtaining the benefits of this Plan.
- The quality of services or supplies you or your dependents receive, or the regulation of the amounts charged by any provider.
- Harm that comes to you or your dependents while in a provider's care.
- Amounts in excess of the actual cost of services and supplies.
- Amounts in excess of this Plan's maximums. This includes recovery under any claim of breach.
- General or special damages including, without limitation, alleged pain, suffering, or mental anguish or consequential damages.
- Descriptive materials written, created, designed or printed by any third party when such descriptive materials are used without the Trust's prior review and written approval.

Right to and Payment of Benefits

All rights to the benefits of this Plan are available only to you and your dependents. The Trustees will not honor any attempted assignment, garnishment, attachment or transfer of any right under this Plan.

At their option, the Trustees may pay benefits under this Plan to you, a provider, or other party legally entitled to such payment under federal or state medical child-support laws, or jointly to any of these. Such payment will discharge the Trustees' obligation to the extent of the amount paid so that the Trustees will not be liable to anyone aggrieved by their choice of payee.

Payment Due to Incompetency

If a person entitled to receive benefits under the Plan is legally, physically or mentally incapable of receiving benefits, the Trustees may make payment to another person or institution determined to maintain or have custody of the individual.

Employment Rights

By adopting and maintaining this benefit program, no employment contract with any employee has been entered into. Nothing in the Plan Document or the Summary Plan Description gives any employee the right to be employed by participating Dealer or to interfere with the Dealer's right to discharge any employee at any time. If you quit or are discharged or laid off, this Plan does not give you a right to any benefit or interest in the Plan except as specifically provided in the Plan Document.

You and Your Dependents Must Cooperate

You and your dependents must cooperate in a timely and appropriate manner with the Trustees in the administration of benefits or in the event of a lawsuit.

False or Misleading Statements

If the Trustees pay benefits in error due to any false or misleading statements, the Trustees are entitled to recover these amounts. Furthermore, if you make any false or misleading statements on the Benefit Election Worksheets that affect your or your dependent's eligibility for coverage, the Trustees may rescind coverage for you or your dependents from the effective date or prospectively, recover any overpayments, deny you or your dependents' claims for benefits, or reduce the amount of benefits provided for you or your dependent's claim.

Right of Recovery or Deduction for Overpayments

The Trustees have the right to recover amounts they paid (whether to or on behalf of you or your dependent) that exceed the amount they must pay under the Plan. The Trustees may recover these amounts from you, your dependent or any other payee, including a provider. Or, the Trustees may deduct these amounts from you or your dependent's future benefits (even if the original payment was not made on your, his or her behalf) when the future benefits would otherwise have been paid directly to you, your dependents or to a provider.

Time Limitation for Filing Legal Action; Venue

All suits or legal proceedings against the Plan, the Trust, the Trustees or First Choice by you or by anyone claiming any right under or with respect to this Plan must be filed:

- in the case of a claim for benefits, within 12 months of the date First Choices or the Trustees, as the case may be, have finally decided, or are deemed to have finally decided, an appeal of an adverse benefit determination;
- in the case of any other claim and except to the extent governed by any applicable statute limitations, within 12 months of the act or failure to act that affects you or another claimant; and
- in a court of competent jurisdiction in King County, Washington.

No Modifications to Plan

You and your dependents may not rely on any verbal statement, whether by a Trustee, an employee of the Trustees (the Trust Office), First Choice or an employee of First Choice including, but not limited to, a customer service representative to:

- Modify or otherwise affect the benefits, Services, Supplies, and Medical Expenses Not Covered, or other provisions of this Plan;
- Increase, reduce, waive or void any coverage or benefits under this Plan.

In addition, such verbal statement shall not be used in the prosecution or defense of a claim under this Plan.

Any written or verbal verification received from the Trust Office or First Choice is based upon eligibility information that the Trust Office or First Choice then has and the benefits in this Plan, which are subject to change. No verification should be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to you or your dependent.

Important Notices

Women's Health and Cancer Rights Act

Reconstructive Surgery Following Mastectomy

The Women's Health and Cancer Rights Act requires group health plans that provide coverage for mastectomies to also provide coverage for reconstructive surgery and prostheses following mastectomies. As required under law, we are providing this notice to inform you about it.

The law mandates that a participant or eligible beneficiary who is receiving benefits, on or after the law's effective date, for a covered mastectomy and who elects breast reconstruction in connection with the mastectomy, will also receive coverage for:

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

This coverage will be provided in consultation with the patient and the patient's attending physician and will be subject to the same annual Deductible, coinsurance, and/or co-payment provisions otherwise applicable under the Plan.

If you have questions about coverage for mastectomies and post-operative reconstructive surgery, please contact the Trust Manager of the Washington State Auto Dealers Insurance Trust.

Newborns and Mothers Health Protection Act

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

Appendix A
Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Plan Washington State Auto Dealers (WSAD) Insurance Trust Benefit Plan

Privacy Contact Trust Manager
WSAD Insurance Trust
PO Box 52848, Bellevue, WA 98015-2848.

Telephone 425-451-9866

If you have any questions about this notice, please contact the Privacy Contact.

This notice describes how the WSAD Insurance Trust Benefit Plan, and any third party that assists in the administration of the Plan, may use or disclose your protected health information with respect to the Plan's group health plan benefits (medical, dental, vision and prescription drug benefits). Protected health information that is created by the WASD Insurance Trust solely in connection with non-group health plan benefits is not subject to this notice. Protected health information is medical information that identifies you, as defined in privacy regulations of the U.S. Department of Health and Human Services under the federal Health Insurance Portability and Accountability Act (the "Privacy Regulations").

We understand that your protected health information is personal. We are committed to protecting your protected health information. We create a record of the health care claims reimbursed under the Plan for Plan administrative purposes. This notice applies to all of the medical records we maintain in connection with the Plan's group health plan benefits. Your personal doctor or health care provider may have different policies or notices regarding the doctor's use and disclosure of your protected health information created in the doctor's office or clinic. An insurer that insures group health plan benefits of the Plan may have different policies or notices regarding the insurer's use and disclosure of your protected health information created in the insurer.

This notice will tell you about the ways in which we may use and disclose protected health information about you. It also describes our obligations and your rights regarding the use and disclosure of your protected health information.

We are legally required to:

- Make sure that your protected health information is kept private;
- Give you this notice of our legal duties and privacy practices with respect to your protected health information; and
- Follow the terms of the Plan's notice of privacy practices that are currently in effect.

The following categories describe different ways that we use and disclose protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of these categories.

For Treatment (as described in the Privacy Regulations). We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose

your protected health information to providers, including doctors, nurses, technicians, medical students, or other Hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if a pending prescription is contraindicative with prior prescriptions.

For Payment (as described in the Privacy Regulations). We may use and disclose your protected health information to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or Medically Necessary or to determine whether the Plan will cover the treatment. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another plan to coordinate benefit payments.

For Health Care Operations (as described in the Privacy Regulations). We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use your protected health information in connection with: conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

Business Associates. The Plan contracts with service providers – called business associates – to perform various functions on its behalf. For example, the Plan contracts with a service provider to perform the administrative functions necessary to pay your claims under its self-insured medical, dental or vision benefits. To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose protected health information, but only after the Plan and the business associate agree in writing to contract terms requiring the business associate to appropriately safeguard your protected health information.

Organized Health Care Arrangement. The Plan and the insurers of its group health plan benefits are an organized health care arrangement within the meaning of the Privacy Regulations. The Plan and the insurer of a group health plan benefit may share your protected health information with each other to carry out payment and health care activities.

Other Covered Entities. The Plan may use or disclose your protected health information to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain health care operations. For example, the Plan may disclose your protected health information to a health care provider when needed by the provider to render treatment to you, and the Plan may disclose protected health information to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing, or credentialing. This also means that the Plan may disclose or share your protected health information with other health care programs or insurance carriers in order to coordinate benefits, if you or your family members have other health insurance or coverage.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by a court order in a litigation proceeding such as a malpractice action.

To Avert a Serious Threat to Health or Safety. We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

Special Situations

Disclosure to Health Plan Sponsor. Your protected health information may be disclosed to the Board of Trustees of the WSAD Insurance Trust or Trust personnel solely for the purpose of administering benefits under the Plan.

Organ and Tissue Donation. If you are an organ donor, we may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. We may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose your protected health information for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release your protected health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons, or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;

- About criminal conduct at a Hospital, clinic, or treatment facility;
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors. We may release your protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release your protected health information to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. We may release your protected health information to authorized federal officials for intelligence, counterintelligence, or other national security activities authorized by law, and for the protection of the President, other authorized persons, or heads of state.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your protected health information to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Others Involved in Your Health Care. The Plan may disclose your protected health information to a friend or family member that is involved in your health care, unless you object or request a restriction (in accordance with the process described below under "Right to Request Restrictions"). The Plan also may disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your protected health information, then, using professional judgment, the Plan may determine whether the disclosure is in your best interest.

Disclosures to the Secretary of the U.S. Department of Health and Human Services. The Plan is required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the Privacy Regulations.

Disclosures to You or Your Personal Representative. The Plan is required to disclose to you or your personal representative most of your protected health information when you request access to this information. The Plan will disclose your protected health information to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant law. Prior to such a disclosure, however, the Plan must be given written documentation that supports and establishes the basis for the personal representation. The Plan may elect not to treat the person as your personal representative if it has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; treating such person as your personal representative could endanger you; or the Plan determines, in the exercise of its professional judgment, that it is not in your best interest to treat the person as your personal representative.

Your Rights Regarding Your Protected Health Information

You have the following rights regarding protected health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy protected health information that may be used to make decisions about your plan benefits. To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to the Privacy Contact. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to protected health information, you may request that the denial be reviewed.

Right to Amend. If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Privacy Contact. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by or for the Plan;
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the information which you would be permitted to inspect or copy; or
- Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of certain disclosures the Plan has made of your protected health information.

To request an accounting of disclosures, you must submit your request in writing to the Privacy Contact. Your request must state the time period that may not be longer than six years and may not include disclosures made before April 14, 2003. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a twelve-month period will be free. For additional accountings, we may charge you for the costs of providing the accountings. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the protected health information we disclose to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had.

We are not required to agree to your request.

To request restrictions, you must make your request in writing to the Privacy Contact. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the Privacy Contact. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how and where you wish to be contacted.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

You may obtain an electronic copy of this notice on our website, www.wsadit.org.

To obtain a paper copy of this notice, you must request it in writing from the Privacy Contact.

Changes to This Notice

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for protected health information we already have about you as well as any information we receive in the future. We will post a copy of the current notice on the Plan website. The notice will state the effective date on the first page, in the top right hand corner.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Trust or with the Secretary of the Department of Health and Human Services. File your complaint with the Privacy Contact at its address above. All complaints must be submitted in writing.

You will not be penalized for filing a complaint.

Other Uses of Protected Health Information

Other uses and disclosures of protected health information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose protected health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected health information about you for the reason covered by your written authorization. You understand that we are unable to rescind any disclosures we have already made with your permission, and that we are required to retain our records of the care that we provided to you.

Effective Date
This Notice of Privacy Practices becomes effective on April 14, 2003.
* * * *

Appendix B
Continuation of Group Health Plan Coverage — USERRA

Under the Uniformed Services Employment and Re-employment Rights Act of 1994 (USERRA), if you or your dependent will lose coverage under the Plan because you leave employment with your Dealer to perform Service in the Uniformed Services, you may elect to continue Plan coverage for yourself and your eligible dependents for up to 24 consecutive months.

"Uniformed Services" means: the United States Armed Forces; the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty; commissioned corps of the Public Health Service; and any other category of persons designated by the President in time of war or emergency.

"Service in the Uniformed Service" or "**Service"** means: the performance of duty on a voluntary or involuntary basis in the Uniformed Services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full time National Guard duty, a period for which a person is absent from employment for the purpose of an examination to determine the fitness of the person to perform this duty, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster-response personnel of the National Disaster Medical System.

USERRA coverage for you and your dependent will end before the 24-month period expires if one of the following events takes place:

- a premium payment is not made within the required time;
- you fail to return to work with your Dealer within the time required under USERRA (see "Returning to Work" below) following the completion of your Service in the Uniformed Services;
- you lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA;
- you become covered under the Plan as an active employee of a Dealer.

Coverage for your eligible dependent also will end as provided in "When Coverage Ends," above.

Returning to Work. Your right to continue coverage under USERRA will end if you do not notify your Dealer of your intent to return to work within the time required under USERRA following the completion of your Service by either reporting to work (if your Service was for less than 31 days) or applying for reemployment (if your Service was for more than 30 days). The time for returning to work depends on the period of Service, as follows:

Period of Service	Return-to-Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your Service, after allowing for safe travel home and an eight-hour rest period; or, if that is unreasonable or impossible through no fault of your own, as soon as is possible.
More than 30 days but less than 181 days	Within 14 days after completion of your Service; or, if that is unreasonable or impossible through no fault of your own, the first day on which it is possible to do so.
More than 180 days	Within 90 days after completion of your Service.
Any period if for purposes of an examination for fitness to perform Uniformed Service	The beginning of the first regularly scheduled work period on the day following the completion of your Service, after allowing for safe travel home and an eight-hour rest period; or if that is unreasonable or impossible through no fault of your own, as soon as is possible.
Any period if you were Hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your Service	Same as above (depending on length of Service period), except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your Service. Maximum period for recovering is limited to two years, but the two-year period may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods.

COBRA Coverage and USERRA Coverage. Your (and your spouse's or dependent child's) loss of Plan coverage because you leave employment with your Dealer to perform Service is a "qualifying event" for purposes of COBRA continuation coverage. See "Appendix C — Continuation of Group Health Plan Coverage — COBRA." Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you (or your covered spouse or dependent children) different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described in Appendix C (for example, the procedures for how to elect COBRA coverage and for paying premiums for COBRA coverage) also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

COBRA and USERRA coverage are concurrent. This means that COBRA coverage and USERRA coverage begin at the same time. However, COBRA coverage can continue for up to 18 months (it may continue for a longer period and is subject to early termination, as described in Appendix C). In contrast, USERRA coverage can continue for up to 24 months, as described above.

Premium Payments. If you elect to continue your health coverage (or your spouse or dependent children's coverage) pursuant to USERRA, you will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA). However, if your period of Service is less than 31 days, you are not required to pay more than the amount that you pay as an active employee for that coverage.

Appendix C
Continuation of Group Health Plan Coverage — COBRA

Introduction

This Appendix C — Continuation of Group Health Plan Coverage — COBRA applies to the following program of the Washington State Auto Dealers Insurance Trust Benefit Plan:

- Basic Plan

For purposes of this Appendix C, each program is called the “Plan.”

Under federal law (known as "COBRA"), you, your spouse and your dependent children are entitled to elect a temporary extension of medical, dental and/or vision benefit coverage (called "continuation coverage" or "COBRA coverage") in certain instances where coverage would otherwise end. You, your spouse or your dependent child do not have to show that you, he or she is insurable to elect continuation coverage. However, you will have to pay the entire premium for continuation coverage.

This Continuation of Group Health Plan Coverage - COBRA provision is intended only to summarize, as best possible, your rights and obligations under federal law. The Plan offers no greater COBRA rights than what the COBRA statute requires, and the Trustees construe this Continuation of Group Health Plan Coverage - COBRA provision accordingly.

For purposes of this Continuation of Group Health Plan Coverage - COBRA provision, "coverage" refers to medical, dental or vision benefit coverage under the Plan. Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights. The Trustees, as Plan Administrator, are responsible for administering COBRA continuation coverage.

Benefits that are paid under COBRA continuation coverage during any period when COBRA does not require coverage are treated as benefit overpayments, even if the premium for the period has been paid.

Events That Can Trigger the Right to Elect COBRA Continuation Coverage

You have a right to elect continuation coverage only if you will lose coverage under the Plan because of one of the following three triggering events:

- Termination (for reasons other than your gross misconduct) of your employment with your Dealer.
- Reduction in the hours of your employment with your Dealer.
- (If you are an eligible retiree covered by the Basic PPO Plan) a proceeding in bankruptcy under Title 11 of the United States Code with respect to the Dealer from whose employment you retired. For purposes of this event, "lose coverage" also means any substantial elimination of coverage under the Plan that occurs within 12 months before or

after the date the bankruptcy proceeding commences, provided that you retired on or before the date of the substantial elimination of coverage.

Your spouse has the right to elect continuation coverage if he or she will lose coverage because of one of the following six triggering events:

- You die.
- Termination (for reasons other than your gross misconduct) of your employment with your Dealer.
- Reduction in the hours of your employment with your Dealer.
- Divorce or legal separation from you, subject to notice to the Trust Office, described below. (Also, if you eliminate or reduce coverage for your spouse in anticipation of a divorce or legal separation, and the divorce or legal separation later occurs, then your former spouse may be entitled to elect COBRA coverage for the period after the divorce or legal separation. In order to elect COBRA coverage under these circumstances, you or your former spouse must notify the Trust Office, must establish that you eliminated or reduced his or her coverage earlier in anticipation of divorce or legal separation, and there is no intervening COBRA triggering event on which spouse would have elected coverage).
- You become entitled to Medicare benefits.
- (If you are an eligible retiree covered by the Basic PPO Plan, or were covered by the Plan but have died) a proceeding in bankruptcy under Title 11 of the United States Code with respect to the Dealer from whose employment you retired. For purposes of this event, "lose coverage" also means any substantial elimination of coverage under the Plan that occurs within 12 months before or after the date the bankruptcy proceeding commences, provided that your spouse, on the day before the bankruptcy, is a beneficiary under the Plan. For purposes of this event, "spouse" includes your surviving spouse who is covered under the Plan.

Your ***dependent child*** has the right to elect continuation coverage if he or she will lose coverage because of any of the following seven triggering events:

- You die.
- The termination (for reasons other than your gross misconduct) of your employment with your Dealer.
- The reduction in your hours of employment with your Dealer.
- Your divorce or legal separation (subject to notice to the Trust Office, described below).
- You become entitled to Medicare benefits.
- Your child ceases to be an eligible child under the Plan (subject to notice to the Trust Office, described below).
- (If you are an eligible retiree covered by the Basic PPO Plan) a proceeding in bankruptcy under Title 11 of the United States Code with respect to the Dealer from whose employment you retired. For purposes of this event, "lose coverage" also means any substantial elimination of coverage under the Plan that occurs within 12 months before or after the date the bankruptcy proceeding commences, provided that your child, on the day before the bankruptcy, is a beneficiary under the Plan.

Qualified Beneficiary and Qualifying Event

If you, your spouse or your dependent child will lose coverage due to a triggering event described above, you, he or she is called a "qualified beneficiary." Certain newborns, newly adopted children and alternate recipients under qualified medical child support orders ("QMCSOs") may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below. A qualified

beneficiary's loss of coverage due to one of the triggering events described above is a "qualifying event."

Notice of Qualifying Event to the Trust Office

The Trust offers a qualified beneficiary the opportunity to elect COBRA continuation coverage only after the Trust Office has been properly notified that a qualifying event has happened.

Notice from your Dealer

When the qualifying event is a loss of coverage because of:

- The end of your employment or reduction of your hours of employment,
- Your death, or
- A proceeding in bankruptcy under Title 11 of the United States Code,

your Dealer must notify the Trust Office of that qualifying event within 30 days after that triggering event occurs.

Notice from You or Your Dependent - Important!

When the qualifying event is a loss of coverage because of:

- Your divorce or legal separation from your spouse, or
- Your child's losing eligibility for coverage as a dependent child,
- you, or your spouse or dependent child, must notify the Trust Office within 60 days after that triggering event occurs (for example, the date a divorce decree is entered or the date a dependent child attains age 19).

Also, if you eliminated your spouse's coverage in anticipation that you will divorce or legally separate, and the divorce or legal separation happens, you or your spouse must notify the Trust Office within 60 days after the divorce or legal separation,

You, your spouse or dependent child must notify the Trust Office in writing and mail your notification to the Trust Office. See *How to Provide Notice to the Trust Office*, below. No other method of providing notice will be accepted (for example, telephone, fax or e-mail are **NOT ACCEPTABLE** methods of notification).

The notice must contain the following:

- The name of the Plan ("Washington State Auto Dealers Insurance Trust Benefit Plan");
- Your name;
- The name(s) of the qualified beneficiary(ies);
- The triggering event (divorce, legal separation or child's loss of dependent status);
- The date on which the triggering event occurred; and
- The name and contact information for the individual sending the notice.

If the spouse has become divorced or legally separated, provide a copy of the decree of divorce or legal separation. If a child has lost dependent status because he or she married or attained age 19 or age 25 (while attending an educational institution), provide a copy of the child's birth certificate or

marriage certificate. However, if you cannot provide the decree or certificate by the 60-day deadline above, file the notice with the Trust Office by the deadline and submit the decree or certificate within 14 days after filing the notice. Your notice will be timely. COBRA continuation coverage, however, will not become effective, and no claims will be paid, until after the decree or certificate is received, reviewed and accepted.

You may, but are not required to, use the *Notice of COBRA Qualifying Event* form at the end of this Appendix C.

If the notice:

- Is not in writing,
- Is not mailed to the Trust Office,
- Is not postmarked within the 60-day period,
- Does not contain the required content described above, or
- Does not include the decree or divorce or legal separation, birth certificate or marriage certificate (by the 14-day deadline),

then the right to elect COBRA continuation coverage is lost; the Trust will not offer the qualified beneficiary the opportunity to elect COBRA continuation coverage, and coverage for the qualified beneficiary will end with end of regular Plan coverage.

Further, if any claims are paid mistakenly for expenses incurred after the last day of the month of the divorce, legal separation, or a child losing dependent status, then you and your family members for whom claims are paid must reimburse the Trustees for those payments.

Trust Administration Office's Election Notice to Qualified Beneficiary(ies)

After the Trust Office receives the appropriate qualifying event notice (see above), the Trust Office will notify each qualified beneficiary of his or her right to elect COBRA continuation coverage (but only to the extent that the Trust Office has been notified in writing of the affected family member's current mailing address). The election notice will include information regarding rights and obligations under COBRA continuation coverage, including cost for the coverage, payment procedures and plan requirements, and an election form. If you receive election information at your address, but your spouse or other eligible dependent does not live with you at the address, you must notify the Trust Office immediately of the names of the dependents and their current addresses.

Electing COBRA Continuation Coverage

COBRA continuation coverage is not automatic. You (or your eligible dependent) must elect COBRA continuation coverage.

How to Elect; Election Deadline

You or your eligible dependent must elect COBRA continuation coverage on the election form included with the Trust Office's election notice.

To elect COBRA continuation coverage, the completed election form must be mailed to the Trust Office (and postmarked) within 60 days after the date the Trust Administration Office sent the

election notice, or, if later, within 60 days after regular Plan coverage ended. See How to Provide Notice to Trust Office, below.

If the election form is not mailed to the Trust Office (and postmarked) within the 60-day election period, the right to elect COBRA continuation coverage is lost and no COBRA continuation coverage will be provided.

A qualified beneficiary may elect COBRA continuation coverage only on the Trust's election form, which must be mailed to the Trust Office. No other method of election (for example, by telephone, fax or e-mail) will be accepted.

You (the employee) or your qualifying family member must elect continuation coverage within 60 days after Plan coverage ends, or, if later, 60 days after the Trust Office provides you or your family member notice of the right to elect continuation coverage. *If you or your qualifying family member does not elect continuation coverage within this 60-day election period, you will lose your right to elect continuation coverage.* Your (or your qualifying family member's) election is effective on the day of the postmark.

Who May Elect

You or your spouse may elect continuation coverage for all qualifying family members. You or your spouse may elect COBRA continuation coverage only for your dependent children. *You, your spouse and your dependent children each have an independent right to elect continuation coverage. Thus, your spouse or your dependent child may elect continuation coverage even if you do not (or are not deemed to) elect it.*

You, your spouse or dependent child can elect continuation coverage even if you, he or she, at the time you, he or she elects continuation coverage, is covered under another employer-sponsored group health plan or entitled to Medicare.

You, your spouse, and other eligible dependents should read the information the Trust Office sends concerning COBRA continuation coverage election rights.

Consequences of Electing or Not Electing COBRA Continuation Coverage

In considering whether to elect continuation coverage, a qualified beneficiary should take into account that a failure to continue group health coverage will affect his or her future rights under federal law.

First, the qualified beneficiary can lose the right to avoid having pre-existing condition exclusions applied to him or her by other group health plans. If the qualified beneficiary has more than a 63-day gap between the last day of coverage under this Plan and the first day of coverage under another plan, the other plan may be able to exclude coverage for his or her pre-existing conditions. However, electing and continuing COBRA continuation coverage under this Plan may help the qualified beneficiary to avoid having such a gap.

Second, the qualified beneficiary will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if he or she does not elect and continue COBRA continuation coverage for the maximum period of coverage available.

Third, a qualified beneficiary also should take into account that he or she has special enrollment rights under federal law. A qualified beneficiary has the right to request special enrollment if coverage is available under another group health plan for which he or she is otherwise eligible (such as a plan sponsored by the qualified beneficiary's employer) within 30 days after his or her group health coverage ends because of a qualifying event. If the qualified beneficiary elects and

continues COBRA continuation coverage under this Plan for the maximum coverage period available, he or she will also have the same special enrollment right at the end of the maximum COBRA continuation coverage period.

What is COBRA Continuation Coverage?

Ordinarily, you, your spouse or dependent child will be offered COBRA coverage that is the same coverage that you, he or she had on the day before the qualifying event. Therefore, if you, your spouse or your dependent child have no coverage on the day before the qualifying event, you, he or she are generally not entitled to COBRA coverage (except, for example, where there is no coverage because it was eliminated in anticipation of a qualifying event like divorce). If the coverage for similarly situated employees or their family members is modified, COBRA coverage will be modified the same way.

Special Rule for HRA Plan

A qualified beneficiary may continue the level of coverage in effect under the HRA Plan immediately preceding the qualifying event for the remainder of the Plan year, even if the qualified beneficiary elects a lower tier of coverage. When a subsequent Plan year begins, the qualified beneficiary, family unit (or, if no family unit, the single qualified beneficiary) will be entitled to any unused amounts from the previous Plan year plus an increase in the HRA coverage level up to the potential amount that can be earned in the HRA applicable to the coverage tier elected by the qualified beneficiary.

Example. Employee A and spouse B are covered by the HRA Plan. On July 31, employee A and spouse B have $100 available in the HRA. On August 1, employee A dies. Spouse B elects employee-only level coverage and the HRA Plan. Under the HRA, Spouse B may continue the $100 HRA through the remainder of the year (reduced by expenses paid from the HRA through the end of the year). On the following May 1, Spouse B will be entitled to any unused amount from the previous year and an increase in HRA coverage up to the potential amount that can be earned in the HRA for employee-only coverage.

Payment for COBRA Continuation Coverage

First Payment

COBRA continuation coverage becomes effective only after (1) COBRA continuation coverage is properly elected within the 60-day election period and (2) first payment for COBRA continuation coverage is received within 45 days after the election is made. If the first payment is not made in the 45-day period, COBRA continuation coverage never becomes effective. No benefits are paid for any period of COBRA continuation coverage for which the payment has not been received.

The first payment must cover the cost of COBRA continuation coverage from the time regular coverage under the Plan would have otherwise terminated through the last month before the month in which you make your first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the Trust Office to confirm the correct amount of your first payment.

Example. Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her first payment is due on or before December 30, the 45th day after the date of her COBRA election. If Sue pays her first payment in December, the amount of the first payment is the sum of the premiums for October and November.

Monthly Payments

After the first payment is made, payments are due on the first of the month for that month's COBRA continuation coverage. If you make the monthly payment on or before the first of the month, your COBRA continuation coverage will continue for that month without any break.

Grace Periods for Monthly Payments

Although monthly payments are due on the first of the month, there is a 30-day grace period. If payment is not received by the first of the month, COBRA continuation coverage is suspended for nonpayment. If a monthly payment is received after the first of the month, but during the 30-day grace period, COBRA continuation coverage is suspended as of the due date and then retroactively reinstated (back to the payment due date). This means that any claim for benefits expenses incurred on or after the first of the month while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you or your dependent fails to make a monthly payment before the end of the 30-day grace period for that payment, COBRA continuation coverage automatically ends as of the last day of the month for which timely payment was made.

The Trust may send monthly COBRA premium reminders notices as a courtesy. COBRA premiums, however, must be paid on time whether or not you receive a reminder notice.

How to Make Payments

Mail your payments to the Trust Office at:

Washington State Auto Dealers Insurance Trust
PO Box 52848
Bellevue, WA 98015-2848

Payment by Check or Money Order

Make your payment by check or money order. The Trust Office will not accept cash payments. A check that is returned for insufficient funds (sometimes called an "NSF check") is not a payment.

For more information about the COBRA continuation coverage and the current premium rates, contact the Trust Office.

Maximum COBRA Continuation Coverage Periods

36 Months. If your spouse or dependent child loses coverage because of your death, divorce, legal separation, Medicare entitlement, or because the child loses his or her status as an eligible child under the Plan, the maximum continuation coverage period (for your spouse and dependent child) is three years from the last day of the month in which the qualifying event occurs.

18 Months. If you, your spouse or your child loses group health coverage because of termination of your employment (for reasons other than your gross misconduct) or reduction in your hours of employment, the maximum continuation coverage period (for you, you spouse and your dependent child) is 18 months from the last day of the month in which the termination or reduction in hours occurs. There are three ways in which this 18-month period of COBRA continuation coverage can be extended:

- 11-month extension for disability of qualified beneficiary. COBRA continuation coverage is extended for up to an additional 11 months, for a total maximum of up to 29 months, if all the following conditions are satisfied:
- You, your spouse or dependent child is a qualified beneficiary and is determined by the Social Security Administration (SSA) to be disabled at any time during the first 60 days of COBRA continuation coverage (running from the date of termination of employment or reduction in hours).

- You or other qualified beneficiary notify the Trust Office within 60 days after the date of the SSA's determination and before the end of the 18-month period of COBRA continuation coverage; and
- The notice satisfies the requirements below.

This extension is available only if you or your spouse or dependent child notifies the Trust Office of the event in a timely fashion. You must notify the Trust Office in writing, and mail the notice to the Trust Office. See How to Provide Notice to Trust Administration Office. No other method of providing notice (for example, by telephone, fax or e-mail) will be accepted.

The notice must contain the following:

- The name of the Plan ("Washington State Auto Dealers Insurance Trust Benefit Plan");
- The covered employee's name;
- The name of the disabled qualified beneficiary;
- The date on which the qualified beneficiary was determined to be disabled; and
- The name and contact information for the individual sending the notice.

Required Documentation: Provide a copy of the Social Security Administration's determination. However, if you cannot provide the determination by the deadline above, complete and provide the notice to the Trust Office by the deadlines, and submit the determination within 14 days after filing the notice. Your notice will be timely. Continuation coverage, however, will not be extended, and no claims will be paid, until a copy of the determination has been received, reviewed and accepted.

You may, but are not required to, use the *Notice of COBRA Second Qualifying Event (Divorce, Legal Separation, Death or Loss of Dependent Status) or SSA Disability Determination* form at the end of this Appendix C.

If the notice:

- Is not in writing,
- Is not mailed to the Trust Administration Office,
- Is not postmarked within the 60-day period and before the end of the 18-month period,
- Does not contain the required content described above, or
- Does not include the Social Security Administration's determination (by the 14-day deadline),

then the right to an extension of COBRA continuation coverage beyond the 18-month period is lost.

If the qualified beneficiary is determined by the SSA to no longer be disabled, you, he or she must notify the Trust Office of that fact by mailing a written notice within 30 days of the SSA's determination. See *How to Provide Notice to Trust Office*. COBRA coverage for all qualified beneficiaries will terminate as of the first day of the month that is more than 30 days after the SSA's determination that the qualified beneficiary is no longer disabled. The Plan reserves the right to retroactively cancel COBRA coverage and will require reimbursement of all benefits paid after the first day of the month that is more than 30 days after the SSA's determination that the qualified beneficiary is no longer disabled.

Second qualifying event extension of 18-month period of continuation coverage. If any of the following events happen during the 18-month period while your spouse or dependent child is receiving COBRA continuation coverage:

- You die,
- You divorce or become legally separated, or

- Your child loses eligibility under the Plan as a dependent,

the spouse (only in the case of death or divorce) and dependent child can get up to an additional 18 months of COBRA continuation coverage, for a total maximum of 36 months.

This extension is available only if you or your spouse or dependent child notifies the Trust Office of the event in a timely fashion. You must notify the Trust Office in writing and mail the notice to the Trust Office within 60 days of the date of the event. See *How to Provide Notice to Trust Office.* No other method of providing notice (for example, by telephone, fax or e-mail) will be accepted.

The notice must contain the following:

- The name of the Plan ("Washington State Auto Dealers Insurance Trust Benefit Plan");
- The covered employee's name;
- The name of the affected qualified beneficiar(y)(ies);
- The event (death, divorce, legal separation or child's loss of status);
- The date the event occurred (for example, date a child attained age 19); and
- The name and contact information for the individual sending the notice.

Required Documentation. If the spouse has become divorced or legally separated, provide a copy of the decree of divorce or legal separation. If a child has lost dependent status because he or she attained age 19 (or age 25 while attending an educational institution) or married, provide a copy of the child's birth certificate or marriage certificate. If the covered employee has died, provide a copy of the death certificate. If a qualified beneficiary has been determined to be disabled, provide a copy of the Social Security Administration's determination. However, if you cannot provide the decree, certificate or determination by the deadline above, complete and provide the notice to the Trust Office by the deadline and submit the decree, certificate or determination within 14 days after filing the notice. Your notice will be timely. Continuation coverage, however, will not be extended, and no claims will be paid, until a copy of the decree, certificate or determination has been received, reviewed and accepted.

You may, but are not required to, use the *Notice of COBRA Second Qualifying Event (Divorce, Legal Separation, Death or Loss of Dependent Status) or SSA Disability Determination* form at the end of this Appendix C.

If the notice:

- Is not in writing,
- Is not mailed to the Trust Office,
- Is not postmarked within the 60-day period,
- Does not contain the required content described above, or
- Does not include the decree of divorce or legal separation, marriage certificate or birth certificate, as applicable (by the 14-day deadline)

then COBRA continuation coverage will not be extended beyond the 18-month period.

Extension for spouse or dependent child due to your earlier entitlement to Medicare. If you become entitled to Medicare benefits during the 18-month period that ends on the date of your qualifying event (end of your employment or reduction of hours), then the COBRA continuation coverage period for your spouse and dependent child is extended beyond the 18-month period. Their COBRA continuation coverage period ends 36 months after the date you became entitled to Medicare benefits.

Special Periods for Bankruptcy of Dealer Qualifying Event. In the case of a qualifying event that is the bankruptcy of the Dealer from whose employment you retired, the maximum

coverage period for you ends when you die. The maximum coverage period for your spouse, surviving spouse, or dependent child ends on the earlier of (a) when he or she dies or (b) 36 months after you die.

Children Born to, or Placed for Adoption with You After the Qualifying Event

Your newborn child or child placed with you for adoption can be a qualified beneficiary, with the rights of a qualified beneficiary, if all of the following requirements are satisfied:

- You are (1) a former employee and covered under COBRA continuation coverage, or (2) an active employee and covered under the Plan, and your former spouse is covered under COBRA continuation coverage from this Plan.
- The child is born to you or placed for adoption with you during the period of your (or, in the case of your divorce, your former spouse's) COBRA continuation coverage.
- If you are an active employee who is covered under the Plan, the child is not eligible to be covered as your dependent.
- The child is enrolled in the Plan during the period of COBRA continuation coverage.

As a qualified beneficiary, your child has rights that a qualified beneficiary's newly enrolled dependent (say, a qualified beneficiary's new spouse) would not have.

Example. Assume you lose coverage under the Plan (because your employment ended or your work hours were reduced). You elect COBRA continuation coverage. Shortly after COBRA continuation coverage begins, you marry. During the 13th month of your COBRA continuation coverage you and your spouse have a newborn child. You die during the 17th month of your COBRA continuation coverage. Coverage for your spouse terminates at the end of the month in which you die. Your spouse timely notifies the Trust Office of this second qualifying event. Coverage for your child - but not for your spouse - is extended for up to an additional 18 months beyond the first 18 months of your COBRA continuation coverage period.

Alternate Recipients Under QMCSOs

If your child is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Plan Administrator during your period of employment with the Dealer, he or she is entitled to the same rights under COBRA as your dependent child, regardless of whether he or she would otherwise be considered your dependent.

Open Enrollment Rights and HIPAA Special Enrollment Rights

Qualified beneficiaries who have elected COBRA will be given the same opportunity to change their coverage option or add or drop dependents at Open Enrollment as the Dealer's similarly situated active employees. In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA. HIPAA, a federal law, gives a person who is already receiving COBRA continuation coverage certain rights to add dependents if that person acquires a new dependent (through marriage, birth, adoption or placement for adoption), or if an eligible dependent declines coverage because of other coverage and later loses such coverage due to certain qualifying reasons. Except for certain children described above under "Children Born To, or Placed for Adoption with You After the Qualifying Event," dependents who are added under HIPAA's special enrollment rights do not become qualified beneficiaries; their coverage will end at the same time coverage ends for the person who elected COBRA continuation coverage and later added them.

Termination of COBRA Before the End of Maximum Coverage Period

Continuation coverage for you, your spouse and/or dependent child will automatically terminate before the end of the maximum coverage period when any one of the following six events occurs:

- Your Dealer no longer provides coverage under the Plan to any of its employees. (Coverage under this Plan ends for all qualified beneficiaries.) If the Dealer is making coverage under another group health plan available to (or is contributing to another group health plan with respect to) a class of the Dealer's employees that was formerly covered under this Plan, COBRA coverage continues under that group health plan.)
- The premium for the qualified beneficiary's COBRA coverage is not timely paid. (Coverage ends on the last day of the month for which premium was timely paid, Coverage ends for that qualified beneficiary.)
- After electing COBRA, the qualified beneficiary becomes covered under another employer-sponsored group health plan (as an employee or otherwise) that has no exclusion or limitation with respect to any pre-existing condition that you have. Coverage ends on the first day of coverage under the other plan. If the other plan has applicable exclusions or limitations, COBRA coverage will terminate after the exclusion or limitation no longer applies (for example, after a 12-month pre-existing condition waiting period expires). This rule applies only to the qualified beneficiary who becomes covered by another employer-sponsored group health plan. (Note that under HIPAA, a federal law, an exclusion or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other group health plan.)
- After electing COBRA coverage, you, your spouse or your dependent child becomes entitled to Medicare benefits. Coverage ends on the date of Medicare entitlement. This applies only to the person who becomes entitled to Medicare.
- If a qualified beneficiary is entitled to 29 months of continuation coverage on account of his or her disability or the disability of another qualified beneficiary under the same qualifying event, but it is later determined by the SSA that the formerly-disabled qualified beneficiary is no longer disabled, then coverage for all qualified beneficiaries will end with the first of the month that begins more than 30 days after the SSA determination, or, if later, at the end of the 18 months of continuation coverage.
- Occurrence of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered employees or their spouses or dependent children who have coverage under the Plan for a reason other than the COBRA coverage requirements of federal law.

How to Provide Notice to Trust Office

All notices must be mailed to the Trust Office at the following address:

Washington State Auto Dealers Insurance Trust
PO Box 52848
Bellevue, WA 98015-2848

Keep a copy of notices and documents mailed to the Trust Office for your records.

If You Have Questions

If you have questions about COBRA continuation coverage you should contact the Trust Office. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone number of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

Keep the Trust Office Informed of Address Changes

In order to protect your and your family's rights to elect COBRA continuation coverage, you should keep the Trust Office informed of any changes in the addresses of family members. It is your responsibility to keep current your (and your dependents') addresses on file with the Trust Office.

Washington State Auto Dealers Insurance Trust

NOTICE OF COBRA QUALIFYING EVENT

When to Use this Notice: Use this Notice to notify the Trust Office when (1) there is a divorce or legal separation or (2) a child ceases to be an eligible dependent under the terms of the Plan.

Instructions: Complete, date, sign and mail this Notice to the Trust Office within 30 days after the date of the divorce or legal separation or the date the child ceases to be a dependent. If the Notice is postmarked after this date, no COBRA coverage will be offered to the spouse or child and coverage for the spouse or child will cease at the date provided in the plan.

Required Documentation: If the spouse has become divorced or legally separated, provide a copy of the decree of divorce or legal separation. If a child has lost dependent status because he or she married or attained age 19 (or age 25 while attending an educational institution), provide a copy of the child's marriage certificate or birth certificate. However, if you cannot provide the decree or certificate by the 60-day deadline above, complete and provide this Notice to the Trust Office by the deadline and submit the decree or certificate within 14 days after you file the Notice. Your Notice will be timely. COBRA continuation coverage, however, will not become effective, and no claims will be paid, until after the decree or certificate is received, reviewed and accepted.

1. Event Description (Check one and complete):

☐ **Employee and spouse divorced or legally separated.**

Name of Spouse: _____

Address of Spouse: _____

Date of Divorce or Legal Separation: _____

Is a copy of decree of divorce or legal separation enclosed? ☐ Yes ☐ No

☐ **Employee's child ceased to be an eligible dependent under the terms of the Plan**

Name of Child: _____

Address of Child: _____

Reason child ceased to be eligible dependent: ☐ married ☐ attained age 19 ☐ attained age 25

☐ no longer a full-time student attending an accredited educational institution ☐ other

(see dependent eligibility rules - describe) _____

Date child ceased to be a dependent: _____

Is a copy of the child's birth or marriage certificate enclosed? ☐ Yes ☐ No ☐ N/A

2. Status, Signature, Date and Telephone Number:
I am the ☐ employee ☐ spouse or former spouse of employee ☐ former dependent child

Signature	Print Name
Date	Telephone

Address of Trust Office
Washington State Auto Dealers Insurance Trust, PO Box 52848, Bellevue, WA 98015

For Plan Use Only

Date Notice received: _____ If mailed, date of postmark: _____

Decree of divorce or legal separation enclosed?	☐Yes	☐No	☐N/A
Child's birth or marriage certificate received?	☐Yes	☐No	☐N/A

Washington State Auto Dealers Insurance Trust

NOTICE OF COBRA SECOND QUALIFYING EVENT (Divorce, Legal Separation, Death or Loss of Dependent Status) or SSA DISABILITY DETERMINATION

[This Notice is 2 pages]

When to Use this Notice: Use this Notice only when you or your family member is already receiving COBRA coverage, to extend the maximum period of COBRA coverage to:

- a total of 36 months when (a) the covered employee and spouse divorce or become legally separated; (b) a child ceases to be a dependent under the terms of the Plan, or (c) the covered employee dies; or
- a total of 29 months when the Social Security Administration (SSA) has determined that a qualified beneficiary was disabled on any day of the first 60 days after the covered employee's termination of employment or reduction in hours.

Instructions: Complete, date, sign and mail this Notice to the Trust Office by the deadline below. If the Notice is postmarked after the deadline, COBRA coverage will not be extended past the original 18-month period.

Deadline If you are notifying the Trust Office of divorce or legal separation, employee's death or child's loss of eligibility as a dependent, mail, fax or deliver the completed Notice within 60 days after the divorce, death or date the child ceased to be a dependent (for example, the date the child attained age 19 or married). If you are notifying the Trust Office of a disability determination by SSA, mail, fax or deliver the Notice (a) 60 days after the date of Social Security Administration's disability determination and (b) before the initial 18-month COBRA coverage period ends.

Required Documentation: If the spouse has become divorced or legally separated, provide a copy of the decree of divorce or legal separation. If a child has lost dependent status because he or she attained age 19 (or age 25 while attending an educational institution) or married, provide a copy of the child's birth certificate or marriage certificate. If the covered employee has died, provide a copy of the death certificate. If a qualified beneficiary has been determined to be disabled, provide a copy of the Security Administration's determination. However, if you cannot provide the decree, certificate or determination by the deadline above, complete and provide this Notice to the Trust Office by the deadline and submit the decree, certificate or determination within 14 days after filing the notice. Your Notice will be timely. Continuation coverage, however, will not be extended, and no claims will be paid, until a copy of the decree, certificate or determination has been received, reviewed and accepted.

1. Identify the Employee;

Print name of employee:_____

Address of employee_____

2. Event Description (Check one and complete):

☐ **Employee and spouse have become divorced or legally separated**

Print name of spouse:_____

Address of spouse: _____

Date of divorce or legal separation: _____

Print name(s) of dependent child(ren) receiving continuation coverage_____

_____

Address of spouse and dependent child(ren): ☐same as employee's address ☐different address (provide address)_____

Is a copy of the decree of divorce or legal separation enclosed? ☐Yes ☐No

☐ **Employee's child ceased to be an eligible dependent under the terms of the Plan**

Name of Child:_____

Address of Child:_____

Reason child ceased to be eligible dependent: ☐married ☐attained age 19 ☐attained age 25

☐no longer a full-time student attending an accredited educational institution ☐other

(see dependent eligibility rules - describe)_____

Date child ceased to be a dependent:_____

Is a copy of the child's birth or marriage certificate enclosed? ☐Yes ☐No ☐N/A

☐ **Covered employee has died**

Date of employee's death:_____

Print name of spouse receiving continuation coverage: _____

Print name(s) of dependent child(ren) receiving continuation coverage:

_____

Address of spouse and dependent child(ren):_____

Is a copy of the death certificate enclosed? ☐Yes ☐No

☐ **Social Security Administration has determined qualified beneficiary to be disabled**

Print name of disabled qualified beneficiary:_____

Address of disabled qualified beneficiary:_____

Date disability began (as determined by the Social Security Administration):_____

Date of Social Security Administration's determination:_____

Is a copy of the Social Security Administration's determination enclosed? ☐Yes ☐No

3. Status, Signature, Date and Telephone Number:

I am the ☐employee ☐spouse or former spouse of employee ☐former dependent child

Signature	Print Name
Date	Telephone

Address of Trust Office
Washington State Auto Dealers Insurance Trust, PO Box 52848, Bellevue, WA 98015

For Plan Use Only

Date Notice received: _____ If mailed, date of postmark:_____

Decree of divorce or legal separation enclosed?	☐Yes	☐No	☐N/A
SSA determination enclosed?	☐Yes	☐No	☐N/A
Child's birth or marriage certificate received?	☐Yes	☐No	☐N/A
Covered employee's death certificate received?	☐Yes	☐No	☐N/A

Appendix D
Medicare Creditable Coverage Disclosure Notice

Important Notice from The WSAD Insurance Trust
About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the WSAD Insurance Trust and prescription drug coverage available for people with Medicare. It also explains the options you have under Medicare prescription drug coverage and can help you decide whether or not you want to enroll. At the end of this notice is information about where you can get help to make decisions about your prescription drug coverage.

Medicare prescription drug coverage became available in 2006 to everyone with Medicare through Medicare prescription drug plans and Medicare Advantage Plans that offer prescription drug coverage. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.

The WSAD Insurance Trust has determined that the prescription drug coverage offered by the WSAD Insurance Trust is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay and is considered Creditable Coverage.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare prescription drug coverage.

Individuals can enroll in a Medicare prescription drug plan when they first become eligible for Medicare and each year from November 15th through December 31st. Beneficiaries leaving employer/union coverage may be eligible for a Special Enrollment Period to sign up for a Medicare prescription drug plan.

You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

If you do decide to enroll in a Medicare prescription drug plan and drop your WSAD Insurance Trust prescription drug coverage, be aware that you and your dependents may not be able to get this coverage back.

Please contact us for more information about what happens to your coverage if you enroll in a Medicare prescription drug plan.

Options that may be available when you or your dependent are Medicare Part D eligible include:
you can retain your existing coverage and choose to not enroll in a Part D plan; or
you can enroll in a Part D plan as a supplement to your existing coverage.

Your current coverage pays for other health expenses in addition to prescription drugs. If you enroll in a Medicare prescription drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits.

You should also know that if you drop or lose your coverage with The WSAD Insurance Trust and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more (a penalty) to enroll in Medicare prescription drug coverage later.

If you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up at least 1% per month for every month that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to enroll.

For more information about this notice or your current prescription drug coverage…

Contact the Trust administration office for further information at 800-544-9420. NOTE: You will receive this notice annually and at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage through the WSAD Insurance Trust changes. You also may request a copy.

For more information about your options under Medicare prescription drug coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. For more information about Medicare prescription drug plans:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number) for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for Medicare prescription drug coverage is available. Information about this extra help is available from the Social Security Administration (SSA) online at www.socialsecurity.gov, or you call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the new plans approved by Medicare which offer prescription drug coverage, you may be required to provide a copy of this notice when you join to show that you are not required to pay a higher premium amount.