TO OUR VALUED EMPLOYEES

Welcome to the Everett School Employee Benefit Trust's Medical Benefit Plan!

We are pleased to provide you with this comprehensive program of medical, prescription drug and vision coverage.

With the exception of very large medical claims from which the Plan is protected by insurance, all Plan expenses are directly paid by the Everett School Employee Benefit Trust Medical Benefit Plan ("Plan"). The major portion of the Plan cost is provided by the Everett Public School District ("Employer") through the Everett School Employee Benefit Trust (the "Plan Administrator") and is supplemented by the Contributions you make to participate. This means that through careful use of the Plan, you, as a consumer of health care, can have a direct impact on the cost of our Plan, which will benefit both you and your Employer by allowing the Plan Administrator to continue to provide this high-quality level of benefits.

Please read this Plan Document carefully and particularly note the special requirements it recommends you follow prior to having a Surgical Procedure or being admitted to a Medical Facility—this is explained in the IMPORTANT INFORMATION section. Capitalized terms used in the document are defined in the GENERAL DEFINITIONS section at the end of the document.

We have contracted with Healthcare Management Administrators, Inc. (the "Plan Supervisor") and its Medical Management Department to help assure that you are receiving the best and most appropriate treatment when health care is needed. The Medical Management Department is your advocate to help improve the quality of your health care and to lower the cost of health care to you and the Plan.

If you have any questions regarding either your Plan's benefits or the procedures necessary to receive these benefits, please call the Plan Supervisor - Healthcare Management Administrators, Inc. at 425/974-3891. When calling from outside of Seattle, you may call the Plan Supervisor toll free at 888/486-7927.

We wish you the best of health.

Everett School Employee Benefit Trust Medical Benefit Plan

The Plan Administrator has the right to amend this Plan at any time for any reason. In most instances, you will receive a written notice 30 days before any Plan changes are made. For further information, see the section entitled "Amendment of the Plan Document" located in the "General Provisions" section.

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IMPORTANT INFORMATION–PLEASE READ

When contacting the Plan Supervisor's Customer Service Department, answers about benefits and eligibility will be provided to any Participant and to providers of service. The benefits quoted by the Plan Supervisor (HMA) are not a guarantee of claim payment. Claim payment will be dependent upon eligibility at the time of service and all terms and conditions of the Plan. This disclaimer will be provided to the caller when benefits are quoted over the telephone.

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

When the Utilization Review ("UR") Coordinator pre-authorizes any confinement, procedure, service or supply, it is only for the purpose of reviewing whether the service is determined to be Medically Necessary for the Treatment of Injury or Illness. Pre-authorization does not guarantee payment of benefits. All charges submitted for payment are subject to all other terms and conditions of the Plan, regardless of authorization by the Medical Management Department whether by telephone or in writing.

PREAUTHORIZATION OF INPATIENT MEDICAL FACILITY ADMISSIONS AND OUTPATIENT SURGERIES

At the time that your Physician recommends a Surgical Procedure or an Inpatient admission for you, it is recommended that you or your Physician contact the Plan's UR Coordinator to request preauthorization. It is recommended that all Inpatient and outpatient non-emergency surgeries and all non-emergency admissions (excluding normal vaginal deliveries where the length of stay is 48 hours or less and cesarean section deliveries where the length of stay is 96 hours or less) be preauthorized in advance. It is recommended that you call no later than **five days prior** to the Medical Facility admission or Surgical Procedure. Surgical Procedures performed in the Physician's own office do not need to be preauthorized. It is recommended that emergency Medical Facility admissions and emergency Surgical Procedures be authorized within 48 hours after the Medical Facility admission or Surgical Procedure, or by the next business day, if later.

Special Note Concerning Mothers and Newborns: It is recommended for Hospital stays that extend beyond 48 hours for a normal vaginal delivery, or beyond 96 hours for a cesarean section be preauthorized at the time your provider recommends the extended stay.

Preauthorization does not guarantee payment of benefits. The Medical Management Department should be contacted at the following numbers:

HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
425/974-3891 - Seattle
888/486-7927 - Other areas nationwide

CERTIFICATION OF ADDITIONAL DAYS

If your Physician is considering lengthening a stay, it is recommended that you, your Physician, the Hospital, or the Medical Facility call the Medical Management Department to request certification for additional days. Call no later than the last day previously certified. If Medically Necessary, additional days of confinement may be certified at that time.

STEPS TO TAKE

When an Inpatient admission or Surgical Procedure is determined Medically Necessary, it is recommended that the Patient, the Physician or a family member call the Medical Management Department at least five days prior to the admission or Surgical Procedure to obtain authorization. If an emergency admission or emergency surgery occurs, you or a family member should ask the attending Physician or the Medical Facility to contact the Medical Management Department within 48 hours of admission or surgery, or by the next business day, if later. Please be prepared to give the Medical Management Department the following information when you make the call for authorization:

- Name and age of patient.
- Employee's Social Security Number.
- Group number (020212).
- Medical Facility name and address.
- Name and phone number of admitting Physician.
- Admission date.
- Diagnosis.
- Procedure being performed.

The Medical Management Department will send written confirmation of the approved admission to the Participant once authorized.

CASE MANAGEMENT/ALTERNATE TREATMENT

In cases where a Participant's condition is expected to be or is of a serious nature, the Employer may arrange for review and/or case management services from a professional qualified to perform such services. The Medical Management Department shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost-effective result without a sacrifice to the quality of a Participant's care.

Alternate care will be determined on the merits of each individual case, and any care or Treatment provided will not be considered to be setting any precedent or creating any future liability, with respect to that Participant or any other Participant.

HOW TO FILE A CLAIM

- All providers should send bills to the address listed on your medical identification card.
- You must provide the provider of service with the information listed on your medical identification card. The provider must attach itemized bills to a claim form. An itemized bill is one that contains the provider's name, address, Federal Tax ID Number and the nature of the accident, Injury or Illness being treated.
- All claims for reimbursement must be submitted within one year of the date incurred.

CONTINUATION OF COVERAGE PROVISIONS (COBRA)

All Participants, both covered employees and Dependents, should take the time to read the Continuation of Coverage provisions found later in this document. Under certain circumstances, Participants may be eligible for a temporary extension of health coverage, at group rates, where coverage under the Plan would otherwise end. The information in this section is intended to inform you, in a summary fashion, of your rights and obligations under the Continuation of Coverage provisions. To find out more about your Continuation of Coverage rights, refer to the "Continuation of Coverage Rights Under COBRA" section of this document.

CONTACT FOR QUESTIONS ABOUT THE PLAN BENEFITS

Healthcare Management Administrators, Inc. (HMA) is the Plan Supervisor. You are encouraged to contact the Plan Supervisor with questions you have regarding this Plan. The Customer Service Department is available to answer questions about claims and how your benefits work. You may contact the Customer Service Department at:

HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
PO Box 85008
Bellevue, WA 98015-5008
425/974-3891 - Seattle
888/486-7927 - Other areas nationwide

SCHEDULE OF BENEFITS

The level of benefits received is based upon the Participant's decision at the time Treatment is needed to access care through either preferred or non-preferred providers. Benefits are payable at the preferred level by accessing your care through a Preferred Provider, Preferred Medical Facility or from a Preferred Hospital. Out-of-network charges will be paid at the out-of-network level of benefits. Your "Preferred Provider Organization" is:

Washington Employees:
HMA Preferred
800/700-7153
OR
www.wa.regence.com (in western Washington) and
www.asurisnorthwesthealth.com (in eastern Washington)

Charges will be paid at the preferred level when:

- The services are billed by a Preferred Provider, Hospital, or Medical Facility.
- The services are for a non-preferred assistant surgeon or anesthesiologist when the Medical Facility and the primary surgeon are both preferred providers.

If you live outside the area serviced by the Preferred Provider Organization (including eligible full-time students), if you are traveling or if you receive Medical emergency services inside or outside the network area, eligible expenses will be reimbursed at the preferred provider benefit level.

This Schedule of Benefits is a summary of the benefits provided under this Plan. **Please read the entire document for details on specific benefit limitations and maximums, Waiting Periods and exclusions.**

MEDICAL BENEFITS–DEDUCTIBLES/MAXIMUMS

	Plan I		Plan II		Plan III	
	Preferred Network	**Out of Network**	**Preferred Network**	**Out of Network**	**Preferred Network**	**Out of Network**
INDIVIDUAL DEDUCTIBLE Per calendar year.	$0/None	$0/None	$250	$250	$300	$300
FAMILY DEDUCTIBLE Per calendar year.	$0/None	$0/None	$750	$750	$900	$900
INDIVIDUAL MAXIMUM OUT-OF-POCKET EXPENSE Per calendar year.	$1,250	$1,250	$2,000	$2,000	$2,000	$2,000
FAMILY MAXIMUM OUT-OF-POCKET EXPENSE Per calendar year.	$3,750	$3,750	$6,000	$6,000	$6,000	$6,000

The out-of-pocket limit and maximums are combined for both the preferred provider and out-of-network eligible expenses.

Once the maximum out-of-pocket expense limit is reached, expenses are paid at 100% of allowable charges for the remainder of the calendar year. There are some benefits that are not payable at the 100% coinsurance rate. The following expenses do not count toward the out-of-pocket expense: (1) copays; (2) ineligible charges; (3) hearing aids and hearing aid batteries; (4) smoking cessation treatment; (5) neurodevelopmental therapy treatment; and (6) Temporomandibular Joint Disorder Treatment. When a copay is applicable, only one copay is to be taken per day for related outpatient services rendered.

PREAUTHORIZATION FOR MEDICAL FACILITY ADMISSIONS AND OUTPATIENT SURGERIES IS RECOMMENDED.

MEDICAL BENEFITS

	Plan I		Plan II		Plan III	
	Preferred Network	**Out of Network**	**Preferred Network**	**Out of Network**	**Preferred Network**	**Out of Network**
ALLERGY INJECTIONS/TESTING	100%	80%	90%	70%	80%	60%
ALTERNATIVE SERVICES Includes Acupuncture, Massage Therapy, and Naturopathy. Limited to $1,000 maximum per calendar year. Deductible waived for Plan II & Plan III.	$15 Copay then 100%	$15 Copay then 100%	$25 Copay then 100%	$25 Copay then 100%	$30 Copay then 100%	$30 Copay then 100%

MEDICAL BENEFITS

	Plan I		Plan II		Plan III	
	Preferred Network	**Out of Network**	**Preferred Network**	**Out of Network**	**Preferred Network**	**Out of Network**
ANESTHESIOLOGIST	100%	100%	100%	100%	100%	100%
AMBULANCE (AIR AND GROUND)	80%	80%	80%	80%	80%	80%
ASSISTANT SURGEON Limited to 20% of surgeon's fee.	100%	80%	90%	70%	80%	60%
CHEMICAL DEPENDENCY TREATMENT Limited to $14,500 every 24 months.	100%	80%	90%	70%	80%	60%
CHIROPRACTIC SERVICES AND X-RAYS Limited to $1,000 maximum per calendar year. Deductible waived for Plan II & Plan III.	$15 Copay then 100%	$15 Copay then 100%	$25 Copay then 100%	$25 Copay then 100%	$30 Copay then 100%	$30 Copay then 100%
CONTRACEPTION MANAGEMENT Deductible waived for Plan II & III.	$15 Copay then 100%	$25 Copay then 100%	$25 Copay then 100%	$35 Copay then 100%	$30 Copay then 100%	$40 Copay then 100%
DIAGNOSTIC X-RAY AND LABORATORY	100%	80%	90%	70%	80%	60%
DIETARY EDUCATION	100%	80%	90%	70%	80%	60%
DURABLE MEDICAL EQUIPMENT	100%	80%	90%	70%	80%	60%
EMERGENCY ROOM & SERVICES (deductible waived) Copay waived if admitted as an inpatient.	$100 Copay then 100%	$100 Copay then 80%	$100 Copay then 90%	$100 Copay then 70%	$100 Copay then 80%	$100 Copay then 60%
HEARING BENEFIT						
Hearing Exam Deductible waived for Plan II & III.	$15 Copay then 100%	$25 Copay then 100%	$25 Copay then 100%	$35 Copay then 100%	$30 Copay then 100%	$40 Copay then 100%
Hearing Aids Limited to $500 every three calendar years.	80%*	80%*	80%*	80%*	80%*	80%*
Hearing Aid Batteries Limited to $100 per calendar year.	80%*	80%*	80%*	80%*	80%*	80%*
HOME HEALTH CARE Limited to 130 visits per calendar year.	100%	80%	90%	70%	80%	60%

MEDICAL BENEFITS

	Plan I		Plan II		Plan III	
	Preferred Network	**Out of Network**	**Preferred Network**	**Out of Network**	**Preferred Network**	**Out of Network**
HOSPICE CARE Lifetime maximum of six months. Respite care is limited to 120 hours per three-month period.	100%	80%	90%	70%	80%	60%
INFUSION THERAPY Limited to $25,000 per calendar year.	100%	80%	90%	70%	80%	60%
INJECTIONS Deductible waived for Plan I & II.	100%	100%	100%	100%	100%	100%
INPATIENT PHYSICIAN VISIT	100%	80%	90%	70%	80%	60%
MAMMOGRAMS, PROSTATE EXAM, AND PROSTATE-SPECIFIC ANTIGEN (PSA) TESTS Deductible waived for Plan II & III. Limited to once per calendar year.	100%	100%	100%	100%	100%	100%
MATERNITY Copay for first visit of pregnancy only.	$15 Copay then 100%	$25 Copay then 80%	$25 Copay then 90%	$35 Copay then 70%	$30 Copay then 80%	$40 Copay then 60%
MEDICAL FACILITY SERVICES						
Inpatient (with $300 maximum per-admit copay for Plan I) Limited to the average semi-private room rate. Inpatient per-day copay is waived for newborns for Plan I.	$100/day Copay then 100%	$100/day Copay then 80%	90%	70%	80%	60%
Inpatient Prescription Drugs	100%	80%	90%	70%	80%	60%
Outpatient						
Ambulatory/surgical facility	100%	80%	90%	70%	80%	60%
Miscellaneous services	100%	80%	90%	70%	80%	60%
MENTAL AND NERVOUS TREATMENT						
Inpatient (with $300 maximum-per-admit copay for Plan I) Limited to 20 days maximum per calendar year.	$100/day Copay then 100%	$100/day Copay then 80%	90%	70%	80%	60%
Outpatient Limited to 20 visits per calendar year.	$15 Copay then 100%	$25 Copay then 100%	$25 Copay then 100%	$35 Copay then 100%	$30 Copay then 100%	$40 Copay then 100%

MEDICAL BENEFITS

	Plan I		Plan II		Plan III	
	Preferred Network	**Out of Network**	**Preferred Network**	**Out of Network**	**Preferred Network**	**Out of Network**
NEURODEVELOPMENTAL THERAPY Limited to $2,000 per calendar year, and combined with outpatient rehabilitation benefit limit. Limited to dependent children up to age seven.	100%*	80%*	90%*	70%*	80%*	60%*
OBESITY (MORBID)	100%	80%	90%	70%	80%	60%
OFFICE VISIT Deductible waived for Plan II & III.	$15 Copay then 100%	$25 Copay then 100%	$25 Copay then 100%	$35 Copay then 100%	$30 Copay then 100%	$40 Copay then 100%
ORTHOTICS Limited to one pair every 12 months.	100%	80%	90%	70%	80%	60%
PREADMISSION TESTING Must be within seven days of admission.	100%	100%	100%	100%	100%	100%
PRESCRIPTION BENEFITS						
Retail pharmacies–dispensing limit 31 days						
Generic drugs	$10	Not Covered	$10	Not Covered	$10	Not Covered
Preferred brand	$20	Not Covered	$30	Not Covered	$40	Not Covered
Non-preferred brand	$40	Not Covered	$50	Not Covered	$60	Not Covered
Mail order–Express-Scripts, Inc. Mail Order						
Dispensing limit 90 days						
Generic	$20	Not Covered	$20	Not Covered	$20	Not Covered
Preferred brand	$40	Not Covered	$60	Not Covered	$80	Not Covered
Non-preferred brand	$80	Not Covered	$100	Not Covered	$120	Not Covered
PREVENTIVE CARE 18 Years & older limited to one exam per calendar year. Deductible waived for Plan II & III.	$15 Copay then 100%	$25 Copay then 100%	$25 Copay then 100%	$35 Copay then 100%	$30 Copay then 100%	$40 Copay then 100%
WELL BABY CARE Up to age 18. Deductible waived for Plan II & III.	$15 Copay then 100%	$25 Copay then 100%	$25 Copay then 100%	$35 Copay then 100%	$30 Copay then 100%	$40 Copay then 100%

MEDICAL BENEFITS

	Plan I		Plan II		Plan III	
	Preferred Network	**Out of Network**	**Preferred Network**	**Out of Network**	**Preferred Network**	**Out of Network**
PREVENTIVE LAB, X-RAY, SCREENINGS AND IMMUNIZATIONS Billed with or without an office visit. Deductible waived for Plan II and III.	100%	100%	100%	100%	100%	100%
PROSTHETICS	100%	80%	90%	70%	80%	60%
REHABILITATION SERVICES						
Inpatient Limited to 120 days per calendar year.	100%	80%	90%	70%	80%	60%
Outpatient						
Physical, occupational, speech therapy Limited to $5,000 per calendar year.	100%	80%	90%	70%	80%	60%
SECOND SURGICAL OPINION	100%	100%	100%	100%	100%	100%
SKILLED NURSING FACILITY CARE Limited to 90 days per calendar year.	100%	80%	90%	70%	80%	60%
SMOKING CESSATION Lifetime maximum of $500.	100%*****	80%*****	90%*	70%*	80%*	60%*
SUPPLIES	100%	80%	90%	70%	80%	60%
SURGEON	100%	80%	90%	70%	80%	60%
TEMPOROMANDIBULAR JOINT DISORDER Lifetime maximum of $1,000.	50%*****	50%*****	50%*****	50%*****	50%*****	50%*****

MEDICAL BENEFITS

	Plan I		Plan II		Plan III	
	Preferred Network	**Out of Network**	**Preferred Network**	**Out of Network**	**Preferred Network**	**Out of Network**
TRANSPLANTS						
Must be enrolled in the Plan for 12 consecutive months or more for any transplant or transplant-related services. The 12-month transplant waiting period will not apply to children who have been continuously enrolled since birth. There is a $225,000 lifetime maximum on the combination of all transplant and transplant-related services.						
Transplants	100%	80%	90%	70%	80%	60%
Donor benefits	100%	80%	90%	70%	80%	60%
Limited to $25,000 per transplant.						
Transportation expenses (travel & lodging)	100%	80%	90%	70%	80%	60%
Available only when required to travel more than 30 miles or more outside the service area. Limited to $2,500 per transplant.						
URGENT CARE HOME SERVICES PROVIDED BY CARENA Deductible waived for Plan II & III.	$50 Copay then 100%	Not Applicable	$50 Copay then 100%	Not Applicable	$50 Copay then 100%	Not Applicable
OTHER MISCELLANEOUS ELIGIBLE CHARGES	100%	80%	90%	70%	80%	60%

*Remains at a constant coinsurance level and does not apply to the out-of-pocket maximum.

LIFETIME MAXIMUM BENEFITS–Plans I, II and III

Hospice care	six months
Smoking cessation	$500
Temporomandibular Joint Disorder	$1,000
Transplants	$225,000
Major medical	$1,000,000

VISION BENEFITS–Plans I, II and III

	Coinsurance
EXAMINATION Limited to one exam every 12 months. Deductible waived.	100%
HARDWARE Limited to $300 every 24 months. Deductible waived.	100%

ELIGIBILITY AND ENROLLMENT PROVISIONS

ELIGIBILITY

Employee Eligibility

Employees eligible for coverage under this Plan are all active full-time and part-time employees of the Everett Public School District.

Dependent Eligibility

Dependents eligible for coverage under this Plan are:

- An employee's legally married Spouse.
- An employee's unmarried dependent child(ren) under age 25.
- An employee's unmarried dependent child(ren) who is incapable of self-support because of mental retardation, mental Illness or physical incapacity that began prior to the date on which the child's eligibility would have terminated due to age. First proof of incapacity must be given (at your expense) within 31 days of the child's limiting birthday. Subsequent evidence of disability or dependency may be required as often as is reasonably needed to verify continued eligibility for benefits.
- An employee's unmarried dependent child(ren) whose coverage is required pursuant to a valid court or administrative order or a National Medical Child Support Notice.
- Adopted children are eligible under the same terms and conditions that apply to dependent, natural children of an employee covered under this Plan.
- Any individual who is covered as an employee can also be covered as a Dependent. Dependents can be covered as a dependent of more than one employee.
- A Domestic Partner.

Coverage is available to the dependent children of one or both Domestic Partners provided that the children are unmarried, are primarily dependent on the employee for support, live with the employee in a regular parent-child relationship and otherwise meet the requirements contained in the respective benefit.

Upon termination of a domestic partner relationship, an employee must submit a signed Affidavit of Termination of Domestic Partnership acknowledging that the relationship has ended. Coverage for Domestic Partners and their dependent children will cease on the last day of the month that the Domestic Partner relationship ends.

The term "dependent children" means any of the employee's natural children, legally adopted children, or children who have been placed for adoption with the employee prior to the age of 18, or stepchildren who depend on the employee for support, or children who have been placed under the legal guardianship of the employee or the employee's spouse by a court decree or placement by a state agency. Placement for adoption is defined as the assumption and retention of an obligation for total or partial support of a child in anticipation of adoption irrespective of whether the adoption has become final. The child's eligibility terminates upon termination of the legal obligation.

ENROLLMENT

Regular Enrollment

To apply for coverage under this Plan, the employee must complete and submit an enrollment form within 31 days of the date the individual first becomes eligible for coverage. The completed enrollment form should list all eligible dependents to be covered. Individuals not enrolled during the initial enrollment eligibility period will be required to wait until the next open enrollment period unless they become eligible to enroll as a result of a special enrollment period.

When the employee acquires an eligible Dependent (birth, marriage, adoption, etc.), the dependent child(ren) must be enrolled within the enrollment eligibility periods specified below:

- **Newly acquired Dependent**: A newly acquired Dependent (except a newborn child or a child placed for adoption) must be enrolled within 31 days of the date of acquisition.

- **Newborn child**: A newborn child will be covered from birth for a period of 21 days. Coverage will continue past 21 days if the child is enrolled within 60 days of the date of birth and the required retroactive contributions are made.

  The newborn child of any covered dependent daughter will be eligible for benefits for the first three (3) days after birth.

- **Adopted child**: A child placed for adoption may be covered from the date of placement provided the child is enrolled within 60 days of the date of placement.

Special Enrollment for Loss of Other Coverage

A special enrollment period is available for current employees and their Dependents who lose coverage under another group health plan or had other health insurance coverage if the following conditions are met:

- The employee or Dependent is eligible for coverage under the terms of the Plan, but not enrolled.

- Enrollment in the Plan was previously offered to the employee.

- The employee had declined the previously offered coverage under the Plan because, at the time, the employee and/or Dependent was covered by another group health plan or other health insurance coverage.

- The employee has declared in writing that the reason for the declination was the other coverage.

The current employee or Dependent may request special enrollment within 31 days of loss of other health coverage under the following circumstances:

- If the other group coverage is not COBRA continuation coverage, special enrollment can only be requested after losing eligibility for the other coverage due to a COBRA-qualifying event or after cessation of employer contributions for the other coverage. Loss of eligibility of other coverage does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause. COBRA continuation coverage does not have to be elected in order to preserve the right to a special enrollment period.

- If the other group coverage is COBRA continuation coverage, special enrollment can only be requested after exhausting COBRA continuation coverage.

- If the other individual or group coverage does not provide benefits to individuals who no longer reside, live, or work in a service area, and in the case of group coverage, no other benefit packages are available.

- If a claim is incurred that would meet or exceed a lifetime limit on all benefits under the other individual or group coverage.

- If the other plan no longer offers any benefits to the class of similarly situated individuals.

The effective date of coverage will be the first day of the first calendar month beginning after the date the special enrollment request is received by the Plan Administrator.

Special Enrollment for Loss of State Children's Health Insurance Program (SCHIP) or Medicaid

A special enrollment period is available for current employees and their dependents who are otherwise eligible for coverage under the Plan, if one of the following events occurs:

- The employee's or dependent's State Children's Health Insurance Plan coverage or Medicaid coverage is terminated due to a loss of eligibility.

- The employee or dependent becomes eligible for State Children's Health Insurance Plan or Medicaid premium assistance.

The current employee or dependent may request the special enrollment within 60 days from the date other coverage is lost or within 60 days from the date that premium assistance eligibility is determined.

Effective date of coverage will be the first of the month following the date the request is received by the Plan Administrator.

Special Enrollment for Loss of Eligibility Due to Reaching Lifetime Maximum Benefits

A special enrollment period is available for current employees and any Dependents if an individual incurs a claim that causes the individual to meet or exceed a lifetime limit on all benefits. The current employee or Dependent may request special enrollment within 30 days from the date that the claim putting the individual over the lifetime limit has been denied.

If the other coverage is COBRA continuation coverage, meeting or exceeding a lifetime limit on all benefits shall also result in the exhaustion of COBRA continuation coverage. Special enrollment must be requested within 30 days from the date the claim putting the individual over the lifetime limit has been incurred.

The effective date of coverage will be the first day of the first calendar month beginning after the date the Plan Administrator receives the request for special enrollment.

Special Enrollment for New Dependents

A special enrollment period is available for current employees who acquire a new Dependent by birth, marriage, adoption, placement for adoption or domestic partnership. This special enrollment period applies to the following events:

- When an employee marries or enters into a domestic partnership, a special enrollment period is available for the employee and newly acquired Dependents. As long as the proper enrollment material is received by the Plan Administrator within the 31 day special enrollment period, the effective date of coverage will be the first day of the first calendar month following enrollment.

- When an employee, Spouse, or Domestic Partner acquires a child through birth, adoption, or placement for adoption, a special enrollment period is available for the employee, the Spouse, the Domestic Partner and the dependent child. As long as the proper enrollment material is received by the Plan Administrator within the 60-day enrollment period, the effective date of coverage will be the date of the birth, adoption, or placement for adoption.

Special Enrollment for New Dependents Through a Medical Child Support Order

The Plan will honor the terms of a National Medical Child Support Notice or other judgment, order or decree requiring the Plan to provide coverage for a dependent child. If the order is not a National Medical Child Support Notice, it must be issued as part of a judgment, order or decree or a divorce settlement agreement related to child support, alimony or the division of marital property, issued pursuant to state law. Agreements made by the parties, but not formally approved by a court, are not acceptable. If the child is enrolled within 60 days of the court or state agency order, the Waiting Period and preexisting conditions exclusion period do not apply.

Open Enrollment

An open enrollment period is held once every 12 months to allow eligible employees to change their participation elections.

The Waiting Period for coverage of preexisting conditions for newly enrolled Participants will start on the date the coverage becomes effective. The preexisting conditions limitation for eligible employees enrolling during open enrollment will be three months from the date coverage begins, less any period of creditable coverage.

EFFECTIVE DATE OF COVERAGE

Employee Effective Date

The effective date of coverage for eligible employees is the first day of the first calendar month following the Waiting Period. The Waiting Period is the period that must pass before coverage for an employee or Dependent that is otherwise eligible to enroll under the terms of Plan can become effective. If an employee or Dependent enrolls as a late enrollee or special enrollee, any period before such late or special enrollment is not a Waiting Period. Periods of employment in an ineligible classification are not part of a Waiting Period.

The effective date of coverage for eligible employees is the first day of the first calendar month following the issuance of your first pay warrant.

Dependent Effective Date

If the employee elects coverage for eligible dependents during the first 31 days of eligibility, the dependents' effective date will be the same as the employee's effective date.

If the covered employee marries or enters a domestic partnership, the employee must add the newly acquired Dependents within 31 days of the date of marriage or Domestic Partnership, and the effective date of coverage will be effective on the first day of the month following enrollment.

If the covered employee acquires a child through birth, adoption or placement for adoption, the employee must add the child within 60 days of the date of birth, adoption or placement for adoption, and the effective date of coverage for the child is the date of birth, adoption, or placement for adoption.

TERMINATION OF COVERAGE

Except as provided in the Plan's Continuation of Coverage provisions, coverage will terminate on the earliest of the following occurrences:

Employee

- The date the Employer terminates the Plan and offers no other group health plan.
- The last day of the month for which Contributions have been made when the employee ceases to meet the eligibility requirements of the Plan.
- The last day of the month for which Contributions have been made when the employee's employment ends.
- The last day of the month for which Contributions have been made when the employee begins active service in the armed forces (please refer to "Military Leave of Absence" on page 22).
- The date the employee fails to make any required Contribution when coverage is contributory.
- The first day an employee fails to return to work following an approved leave of absence.
- The last day of the month for which Contributions have been made when the employee retires.

Dependent(s)

- The date the Employer terminates the Plan and offers no other group health plan.
- The last day of the month for which Contributions have been made when the employee's coverage terminates.
- The last day of the month for which Contributions have been made when the individual ceases to meet the eligibility requirements of the Plan.
- The last day of the month for which Contributions have been made when the Dependent becomes eligible as an employee.
- The last day of the month for which Contributions have been made on the Dependent's behalf.
- The last day of the month for which Contributions have been made when the Dependent becomes an active, full-time member of the armed forces of any country.
- The date Dependent coverage is discontinued under the Plan.

When coverage terminates, you will be provided with a certificate of Creditable Coverage.

APPROVED FAMILY AND MEDICAL LEAVE

If an employee is absent from work because of an approved leave of absence under the provisions of the Family and Medical Leave Act of 1993 ("FMLA"), coverage under the Plan shall be continued for the employee and covered Dependents as required under the law, provided the employee makes any required Contributions. The Employer may require employees who fail to return from FMLA Leave to repay any health plan premiums paid on their behalf during that leave. If the employee's leave extends more than the length of time allowed under FMLA, the employee will be eligible to continue coverage under the Plan's COBRA continuation coverage provisions.

EXTENDED MEDICAL CARE BENEFITS ON TERMINATION OF COVERAGE

If you are on an approved medical Disability leave of absence and have exhausted all of your available paid leave, you can continue your medical coverage up to 12 months. Medical coverage will continue for you and your covered dependents provided the following conditions are met:

- The medical care, services or supplies are given or received within 12 months from the date of disability;
- you remain Disabled from the same Injury or Illness;
- you do not become covered under another plan for such Injury or Illness;
- you are under a Physician's care; and
- you continue to pay your monthly Contribution.

You must notify the Employer when the Disability ends.

If you recover from your Disability, return to work on a full-time basis for less than six months and suffer recurrence of the same disabling condition, you will be able to continue your medical coverage for the remaining portion of your original 12-month maximum. If the subsequent Disability is not a recurrence of the same disability, it will be considered a new Disability and you will be eligible for a new 12-month maximum extension of benefits.

This extension will run concurrent with any COBRA continuation coverage period elected as outlined in this document.

CONTINUATION OF COVERAGE FOR SURVIVORS

In the event of your death, any covered dependent survivors will be allowed to continue coverage under the Plan for one year from the date of your death. Contributions are not required for this continued coverage. Coverage for survivors will be subject to all other provisions and limitation and will run concurrent with any COBRA continuation coverage period elected as outlined in this document.

If coverage can be continued for longer than one year under another Plan provision, Contributions for the first year of coverage under such other provision will be waived for any covered dependent survivor. However, any notification and enrollment requirements for continuation under the other Plan provision must be met to qualify for the waiver.

REINSTATEMENT OF COVERAGE

If an employee or Dependent who was covered under this Plan terminates employment or loses eligibility for coverage and is rehired or again becomes eligible for coverage, all Waiting Periods, deductibles and out-of-pocket expense limits must be resatisfied.

MILITARY LEAVE OF ABSENCE

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). These rights apply only to eligible employees and eligible Dependents covered under the Plan before leaving for military service ("Uniformed Service leave").

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

a. For elections made before December 10, 2004, the 18 month period beginning on the date that Uniformed Service leave commences; or
b. For elections made on or after December 10, 2004 ,the 24 month period beginning on the date that Uniformed Service leave commences; or
c. The period beginning on the date that Uniformed Service leave commences and ending on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

A person who elects to continue Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the employee's share, if any, for the coverage. Only the employee has the right to elect USERRA coverage, covered Dependents have no independent right to elect USERRA coverage.

A preexisting condition exclusion may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of Uniformed Service leave. However, Plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

Please contact the Plan Administrator for information concerning your eligibility for USERRA and any requirements of the Plan.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

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

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, ("COBRA"). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. **The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

In general, COBRA requires that a "qualified beneficiary" covered under an employer's group health plan who experiences a "qualifying event" be allowed to elect to continue that health coverage for a period of time. ***Qualified beneficiaries are employees and dependents who were covered by the Plan on the day before the qualifying event occurred.*** Coverage is elected on the election form provided by the Plan Administrator. Both employees and Dependents should take the time to read the Continuation of Coverage Rights under COBRA provisions.

The Plan has multiple group health components, Medical, Dental, Vision and Health FSA, and you may be enrolled in one or more of these components. COBRA (and the description of COBRA continuation coverage contained in this plan summary) applies only to the group health plan benefits offered under the Plan (the Medical, Dental, Vision and Health FSA components) and not to any other benefits offered under the Plan or by the Employer (such as life insurance, disability, or accidental death or dismemberment benefits). The Plan provides no greater COBRA rights than what COBRA requires—nothing in this Plan Document is intended to expand your rights beyond COBRA's requirements.

The Plan Administrator is:

Everett School Employee Benefit Trust
PO Box 2098
Everett, WA 98213
425/385-4100

The party responsible for administering COBRA continuation coverage ("COBRA Administrator") is:

Everett School Employee Benefit Trust
PO Box 2098
Everett, WA 98213
425/385-4100

WHAT IS COBRA COVERAGE?

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

After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your Spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (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.)

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

COBRA coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the component or components of the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights as if a current employee. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Additional information about the Medical, Dental, Vision and Health FSA components of the Plan is available in other portions of this plan summary.

COBRA COVERAGE UNDER THE HEALTH FSA COMPONENT

COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by reimbursements up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year.

COBRA coverage will consist of the Health FSA coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event). The use-it-or-lose-it rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year, and COBRA coverage under the Health FSA will terminate at the end of the plan year.

Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. However, each beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact the Plan Administrator for more information.

Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

WHO IS ENTITLED TO ELECT COBRA?

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

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

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

- your Spouse dies;
- your Spouse's hours of employment are reduced;
- your Spouse's employment ends for any reason other than his or her gross misconduct; or
- you become divorced or legally separated from your Spouse. Also, if your Spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

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

- your parent-employee dies;
- your parent-employee's hours of employment are reduced;
- your parent-employee's employment ends for any reason other than his or her gross misconduct; or
- you stop being eligible for coverage under the Plan as a "dependent child."

However, as discussed above in the section entitled "COBRA Coverage Under the Health FSA Component," COBRA coverage under the Health FSA will be offered only in limited circumstances.

If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee's spouse and dependent children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage within 18 months because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section below entitled "Length of COBRA Coverage.")

Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance ("TAA") or alternative trade adjustment assistance ("ATAA"). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible employee or former employee becomes eligible for TAA or ATAA, but only if the election is made within the six months immediately after the individual's group health plan coverage ended. If you are an employee or former employee and you qualify or may qualify for TAA or ATAA, contact the Plan Administrator using the Plan contact information provided below. **Contact**

the Plan Administrator promptly after qualifying for TAA or ATAA or you will lose the right to elect COBRA during a special second election period.

WHEN IS COBRA COVERAGE AVAILABLE?

When the qualifying event is the end of employment, reduction of hours of employment, or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the Plan Administrator of any of these three qualifying events.

For the other qualifying events (divorce or legal separation of the employee and Spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available to you only if you notify the Plan Administrator in writing within 60 days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

In providing this notice to the Plan Administrator, you must use the Plan's form entitled "Notice of Qualifying Event (Form & Notice Procedures)," and you must follow the procedures specified in the section below entitled "Notice Procedures for Notice of Qualifying Event." If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator on the required form during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA COVERAGE. **(You may obtain a copy of the Notice of Qualifying Event (Form & Notice Procedures) from the Plan Administrator.)**

ELECTING COBRA COVERAGE

To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and submit it the COBRA Plan Administrator. **(An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from the Plan Administrator.)**

Under federal law, you must have 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event to decide whether you want to elect COBRA under the Plan.

Mail or hand deliver the completed Election Form to:

Mailing Address

Everett School Employee Benefit Trust
Attn: Payroll Office
PO Box 2098
Everett, WA 98213
425/385-4100

Street Address

Everett School Employee Benefit Trust
Attn: Payroll Office
3715 Oakes Ave
Everett, WA 98201
425/385-4100

The Election Form must be completed in writing and mailed or hand delivered to the individual and address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA coverage rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail and faxed communications.

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

If you reject COBRA coverage before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

You do not have to send any payment with your Election Form when you elect COBRA coverage. Important additional information about payment for COBRA coverage is included in the section entitled, "Payment for COBRA Coverage."

Each qualified beneficiary will have an independent right to elect COBRA coverage. For example, the employee's spouse may elect COBRA coverage even if the employee does not. COBRA coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA coverage on behalf of all of the qualified beneficiaries, and parents may elect COBRA coverage on behalf of their children. **Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

When you complete the Election Form, you must notify the COBRA Administrator if any qualified beneficiary has become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the Election Form, immediately notify the COBRA Administrator of the date of your Medicare entitlement at the address specified above for delivery of the Election Form.

Qualified beneficiaries may be enrolled in one or more group health components of the Plan at the time of a qualifying event (the components are Medical, Dental, Vision and Health FSA). If a qualified beneficiary is entitled to a COBRA election as the result of a qualifying event, he or she may elect COBRA coverage under any or all of the group health components of the Plan under which he or she was covered on the day before the qualifying event. For example, if a qualified beneficiary was covered under the Medical and Dental components on the day before a qualifying event, he or she may elect COBRA coverage under the Dental component only, the Medical component only, or under both Medical and Dental. Such a qualified beneficiary could not elect COBRA coverage under the Health FSA component, because he or she was not covered under this component on the day before the qualifying event.

Qualified beneficiaries who are entitled to elect COBRA coverage may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied). See the section below entitled, "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA

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

LENGTH OF COBRA COVERAGE

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

When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months. However, COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred—see the section entitled "COBRA Coverage Under the Health FSA Component."

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan's Medical, Dental and Vision components for his Spouse and Dependents who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours. However, COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred—see the section entitled "COBRA Coverage Under the Health FSA Component."

Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months. However, COBRA coverage under the Health FSA component can last only until the end of the year in which the qualifying event occurred—see the section entitled "COBRA Coverage Under the Health FSA Component."

MAXIMUM COVERAGE PERIOD FOR HEALTH FSA COMPONENT

The maximum COBRA coverage period for the Health FSA component of the Plan ends on the last day of the plan year in which the qualifying event occurred—see the section entitled "COBRA Coverage Under the Health FSA Component."

EXTENSION OF MAXIMUM COVERAGE PERIOD (NOT APPLICABLE TO HEALTH FSA COMPONENT)

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

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

The disability extension is available only if you notify the COBRA Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

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

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

In providing this notice, you must use the Plan's form entitled "Notice of Disability (Form & Notice Procedures)," and you must follow the procedures specified in the section below entitled "Notice Procedures for Notice of Disability." If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE. (You may obtain a copy of the Notice of Disability (Form & Notice Procedures) from the COBRA Administrator.)

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours.

The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare.)

This extension due to a second qualifying event is available only if you notify the COBRA Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

In providing this notice, you must use the Plan's form entitled "Notice of Second Qualifying Event (Form & Notice Procedures)," and you must follow the procedures specified in the section below entitled "Notice Procedures for Notice of Second Qualifying Event." If these procedures are not followed or if the notice is not provided in writing to

the COBRA Administrator during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT. (You may obtain a copy of the Notice of Second Qualifying Event (Form & Notice Procedures) from the COBRA Administrator.)

TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD

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

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- the employer ceases to provide any group health plan for its employees; or
- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section entitled "Extension of Maximum Coverage Period (Not Applicable to Health FSA Component)."

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

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). You must use the Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures)," and you must follow the procedures specified below in the section entitled, "Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability." (You may obtain a copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures) from the COBRA Administrator.)

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary). The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the COBRA Administrator of Medicare entitlement or other group health plan coverage.

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

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled.

The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the COBRA Administrator that the disabled qualified beneficiary is no longer disabled. (For more information about the disability extension period, see the section entitled "Extension of Maximum Coverage Period (Not Applicable to Health FSA Component)."

COST OF COBRA COVERAGE

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

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation ("eligible individuals"). Under the new tax provisions, eligible individuals can take a tax credit equal to 65% of premiums paid for qualified health insurance, including COBRA coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

PAYMENT FOR COBRA COVERAGE

All COBRA premiums must be paid by check or money order.

Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to:

Mailing Address

Everett School Employee Benefit Trust
Attn: Payroll Office
PO Box 2098
Everett, WA 98213
425/385-4100

Street Address

Everett School Employee Benefit Trust
Attn: Payroll Office
3715 Oakes Avenue
Everett, WA 98201
425/385-4100

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

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

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. For example, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment

equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election. You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator using the contact information provided to confirm the correct amount of your first payment.

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

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

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

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

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

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

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

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

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act of 1974 ("ERISA"), including COBRA, the Health Insurance Portability and Accountability

Act ("HIPAA"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("EBSA") in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan and COBRA Administrator informed of any changes in the addresses of Relatives. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or COBRA Administrator.

PLAN CONTACT INFORMATION

You may request information about the Plan and COBRA coverage from:

Everett School Employee Benefit Trust
PO Box 2098
Everett, WA 98213
425/385-4100

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent plan summary (if you are not sure whether this is the Plan's most recent plan summary, you may request the most recent one from the Plan Administrator).

NOTICE PROCEDURES

Everett School Employee Benefit Trust Medical Benefit Plan (the Plan)

NOTICE PROCEDURES FOR NOTICE OF QUALIFYING EVENT

The deadline for providing this notice is 60 days after the later of (1) the qualifying event (i.e., a divorce or legal separation or a child's loss of dependent status); and (2) the date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the qualifying event.

You must mail or hand deliver this notice to the Plan Administrator at:

Mailing Address

Everett School Employee Benefit Trust
Attn: Payroll Office
PO Box 2098
Everett, WA 98213
425/385-4100

Street Address

Everett School Employee Benefit Trust
Attn: Payroll Office
3715 Oakes Avenue
Everett, WA 98201
425/385-4100

Your notice must be in writing (using the Plan's form described below) and must be mailed or hand delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand delivered, your notice must be received by the individual at the address specified above no later than the deadline described above.

You must use the Plan's form entitled, "Notice of Qualifying Event (Form & Notice Procedures)" to notify the Plan Administrator of a qualifying event (i.e., a divorce or legal separation or a child's loss of dependent status), and all of the applicable items on the form must be completed. (You may obtain a copy of the Notice of Qualifying Event (Form & Notice Procedures) from the Plan Administrator.)

Your notice must contain the following information:

- the name of the Plan (**Everett School Employee Benefit Trust Medical Benefit Plan**);
- the name and address of the employee or former employee who is or was covered under the Plan;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the qualifying event (divorce, legal separation, or child's loss of dependent status);
- the qualifying event (divorce, legal separation, or child's loss of dependent status);
- the date of the divorce, legal separation, or child's loss of dependent status; and
- the signature, name, and contact information of the individual sending the notice.

If you are notifying the Plan Administrator of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and you are notifying the Plan Administrator that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, you must provide notice within 60 days of the divorce or legal separation in accordance with these Notice Procedures for Notice of Qualifying Event and must in addition provide evidence satisfactory to the Plan Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

If you provide a written notice that does not contain all of the information and documentation required by these Notice Procedures for Notice of Qualifying Event, such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- the notice is mailed or hand delivered to the individual at the address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan;
- from the written notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies), the qualifying event (the divorce, legal separation, or child's loss of dependent status), and the date on which the qualifying event occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Qualifying Event) within 15 business days after a written or oral request from the Plan Administrator for more information (or, if later, by the deadline for the Notice of Qualifying Event described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be offered. If all of these conditions are met, the Plan Administrator will treat the notice as having been provided on the date that the Plan Administrator receives all of the required information and documentation but will accept the notice as timely.

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

If your notice was regarding a child's loss of dependent status, you must, if the Plan Administrator requests it, provide documentation of the date of the qualifying event that is satisfactory to the Plan Administrator (for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution). This will allow the Plan Administrator to determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the Plan Administrator that the child ceased to be a dependent on the date specified in your Notice of Qualifying Event, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have started. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

NOTICE PROCEDURES FOR NOTICE OF DISABILITY

The deadline for providing this notice is 60 days after the latest of (1) the date of the Social Security Administration's disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; and (3) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours. Your Notice of Disability must also be provided within 18 months after the covered employee's termination of employment or reduction of hours.

You must mail or hand deliver this notice to the COBRA Administrator at:

Mailing Address

Everett School Employee Benefit Trust
Attn: Payroll Office
PO Box 2098
Everett, WA 98213
(425) 385-4100

Street Address

Everett School Employee Benefit Trust
Attn: Payroll Office
3715 Oakes Ave
Everett, WA 98201
(425) 385-4100

Your notice must be in writing (using the Plan's form described below) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline described above.

You must use the Plan's form entitled, "Notice of Disability (Form & Notice Procedures)" to notify the COBRA Administrator of a qualified beneficiary's disability and all of the applicable items on the form must be completed. (You may obtain a copy of the Notice of Disability (Form & Notice Procedures) from the COBRA Administrator.)

Your notice must contain the following information:

- the name of the Plan **(Everett School Employee Benefit Trust Medical Benefit Plan)**
- the name and address of the employee or former employee who is or was covered under the Plan;
- the initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction of hours);
- the date that the covered employee's termination of employment or reduction of hours happened;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;
- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary became disabled;
- the date that the Social Security Administration made its determination of disability;
- a statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name, and contact information of the individual sending the notice.

Your Notice of Disability must include a copy of the Social Security Administration's determination of disability.

If you provide a written notice to the COBRA Administrator that does not contain all of the information and documentation required by these Notice Procedures for Notice of Disability, such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- the notice is mailed or hand-delivered to the individual and address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan and a qualified beneficiary's disability;
- from the written notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies) and the date on which the covered employee's termination of employment or reduction of hours occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Disability) within 15 business days after a written or oral request from the COBRA Plan Administrator for more information (or, if later, by the deadline for the Notice of Disability described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA coverage will not be extended. If all of these conditions are met, the Plan Administrator will treat the notice as having been provided on the date that the Plan Administrator receives all of the required information and documentation and will accept the notice as timely.

The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the covered employee's termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any

responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the disability reported in the notice.

NOTICE PROCEDURES FOR NOTICE OF SECOND QUALIFYING EVENT

The deadline for providing this notice is 60 days after the later of (1) the date of the second qualifying event (i.e., a divorce or legal separation, the covered employee's death, or a child's loss of dependent status); and (2) the date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the second qualifying event (if this event had occurred while the qualified beneficiary was still covered under the Plan).

You must mail or hand deliver this notice to the COBRA Administrator at:

Mailing Address	**Street Address**
Everett School Employee Benefit Trust **Attn: Payroll Office** **PO Box 2098** **Everett, WA 98213** **425/385-4100**	**Everett School Employee Benefit Trust** **Attn: Payroll Office** **3715 Oakes Avenue** **Everett, WA 98201** **425/385-4100**

Your notice must be in writing (using the Plan's form described below) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand-delivered, your notice must be received by the Plan Administrator at the address specified above no later than the deadline described above.

You must use the Plan's form entitled "Notice of Second Qualifying Event (Form & Notice Procedures)" to notify the COBRA Administrator of a second qualifying event (i.e., a divorce or legal separation, the covered employee's death, or a child's loss of dependent status), and all of the applicable items on the form must be completed. (You may obtain a copy of the Notice of Second Qualifying Event (Form & Notice Procedures) from the COBRA Administrator).

Your notice must contain the following information:

- the name of the Plan (**Everett School Employee Benefit Trust Medical Benefit Plan**);
- the name and address of the employee or former employee who is or was covered under the Plan;
- the initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction of hours);
- the date that the covered employee's termination of employment or reduction of hours happened;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;
- the second qualifying event (a divorce or legal separation, the covered employee's death, or a child's loss of dependent status);
- the date that the divorce or legal separation, the covered employee's death, or a child's loss of dependent status happened; and
- the signature, name, and contact information of the individual sending the notice.

If you are notifying the COBRA Administrator of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

If you provide a written notice to the COBRA Administrator that does not contain all of the information and documentation required by these Notice Procedures for Notice Second Qualifying Event, such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- the notice is mailed or hand-delivered to the individual at the address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, the COBRA Administrator is able to determine that the notice relates to the Plan;
- from the written notice provided, the COBRA Administrator is able to identify the covered employee and qualified beneficiary(ies), the first qualifying event (the covered employee's termination of employment or reduction of hours), the date on which the first qualifying event occurred, the second qualifying event, and the date on which the second qualifying event occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Second Qualifying Event) within 15 business days after a written or oral request from the COBRA Administrator for more information (or, if later, by the deadline for this Notice of Second Qualifying Event described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA coverage will not be extended. If all of these conditions are met, the Plan Administrator will treat the notice as having been provided on the date that the Plan Administrator receives all of the required information and documentation and will accept the notice as timely.

The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary who lost coverage due to the covered employee's termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the second qualifying event reported in the notice.

If your notice was regarding a child's loss of dependent status, you must, if the COBRA Administrator requests it, provide documentation of the date of the qualifying event that is satisfactory to the COBRA Administrator (for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution). This will allow the COBRA Administrator to determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the COBRA Administrator that the child ceased to be a dependent on the date specified in your Notice of Second Qualifying Event, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to loss of dependent status. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

If your notice was regarding the death of the covered employee, you must, if the COBRA Administrator requests it, provide documentation of the date of death that is satisfactory to the COBRA Administrator (for example, a death certificate or published obituary). This will allow the COBRA Administrator to determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the COBRA Administrator that the date of

death was the date specified in your Notice of Second Qualifying Event, the COBRA coverage of all qualified beneficiaries receiving an extension of COBRA coverage as a result of the covered employee's death may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to the covered employee's death. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

NOTICE PROCEDURES FOR NOTICE OF OTHER COVERAGE, MEDICARE ENTITLEMENT, OR CESSATION OF DISABILITY

If you are providing a Notice of Other Coverage (a notice that a qualified beneficiary has become covered, after electing COBRA coverage, under another group health plan), the deadline for this notice is 30 days after the other coverage becomes effective or, if later, 30 days after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary.

If you are providing a Notice of Medicare Entitlement (a notice that a qualified beneficiary has become entitled, after electing COBRA coverage, to Medicare Part A, Part B, or both), the deadline for this notice is 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).

If you are providing a Notice of Cessation of Disability (a notice that a disabled qualified beneficiary whose disability resulted in an extended COBRA coverage period is determined by the Social Security Administration to be no longer disabled), the deadline for this notice is 30 days after the date of the Social Security Administration's determination.

You must mail or hand deliver this notice to the COBRA Administrator at:

Mailing Address

Everett School Employee Benefit Trust
Attn: Payroll Office
PO Box 2098
Everett, WA 98213
425/385-4100

Street Address

Everett School Employee Benefit Trust
Attn: Payroll Office
3715 Oakes Avenue
Everett, WA 98201
425/385-4100

Your notice must be provided no later than the deadline described above.

You should use the Plan's form entitled, "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures)" to notify the COBRA Administrator of any of these events, and all of the applicable items on the form should be completed. (You may obtain a copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures) from the COBRA Administrator.)

Your notice should contain the following information:

- the name of the Plan (**Everett School Employee Benefit Trust Medical Benefit Plan**);
- the name and address of the employee or former employee who is or was covered under the Plan;
- the name(s) and address(es) of all qualified beneficiary(ies);
- the qualifying event that started your COBRA coverage;
- the date that the qualifying event happened; and
- the signature, name, and contact information of the individual sending the notice.

If you are providing a Notice of Other Coverage, your notice should include the name and address of the qualified beneficiary who obtained other coverage, the date that the other coverage became effective (and, if there were any preexisting condition exclusions applicable to the qualified beneficiary, the date that these were exhausted or satisfied), and evidence of the effective date of the other coverage (such as a copy of the insurance card or application for coverage).

If you are providing a Notice of Medicare Entitlement, your notice should include the name and address of the qualified beneficiary who became entitled to Medicare, the date that Medicare entitlement occurred, and a copy of the Medicare card showing the date of Medicare entitlement. If you are providing a Notice of Cessation of Disability, your notice must include the name and address of the disabled qualified beneficiary, the date of the Social Security Administration's determination that he or she is no longer disabled, and a copy of the Social Security Administration's determination.

The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the other coverage, Medicare entitlement, or cessation of disability reported in the notice.

If a qualified beneficiary first becomes covered by another group health plan after electing COBRA coverage, that qualified beneficiary's COBRA coverage will terminate (retroactively if applicable) as described above in the section entitled, "Termination of COBRA Coverage Before the End of the Maximum Coverage Period," regardless of whether or when a Notice of Other Coverage is provided.

If a qualified beneficiary first becomes entitled to Medicare Part A, Part B, or both after electing COBRA coverage, that qualified beneficiary's COBRA coverage will terminate (retroactively if applicable) as described above in the section entitled, "Termination of COBRA Coverage Before the End of the Maximum Coverage Period," regardless of whether or when a Notice of Medicare Entitlement is provided.

If a disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled, COBRA coverage for all qualified beneficiaries whose COBRA coverage is extended due to the disability will terminate (retroactively if applicable) as described above in the section entitled, "Termination of COBRA Coverage Before the End of the Maximum Coverage Period," regardless of whether or when a Notice of Cessation of Disability is provided.

PREEXISTING CONDITIONS LIMITATIONS

Preauthorization from the Plan's Medical Management Department does not constitute Plan liability for any preexisting condition charges during the preexisting condition waiting period.

If a claim is paid that was related to a preexisting condition, the payment will not constitute a waiver of this exclusion for that claim or any subsequent claim if it is later determined that the condition was preexisting.

When this Plan replaces another group health coverage program previously maintained by the Employer, the Waiting Periods will be credited for the time those employees and their eligible Dependents were enrolled under the prior coverage program.

PREEXISTING CONDITIONS

A preexisting condition, whether physical or mental, and regardless of the cause of the condition, is a condition for which medical advice, diagnosis, care or Treatment has been recommended or received within the three month period ending on the enrollment date. In order to be taken into account, the medical advice, diagnosis, care, or Treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under state law and who operates within the scope of practice authorized by the state law.

PREEXISTING CONDITIONS EXCLUSION

The exclusion period for preexisting conditions commences on your enrollment date and will be no longer than three months, less any period of Creditable Coverage.

The term "Enrollment Date" is the first day of coverage or, if there is a Waiting Period for coverage to begin under the Plan, the first day of the Waiting Period. "Waiting Period" means the period that must pass before coverage for an employee or dependent that is otherwise eligible to enroll under the terms of the Plan can become effective. If an employee or dependent enrolls as a late employee or special enrollee, any period before such late or special enrollment is not a Waiting Period. Periods of employment in an ineligible classification are not part of a Waiting Period. If an individual receiving benefits under a group health plan changes benefit packages, or if the Plan changes group health insurance issuers, the individual's Enrollment Date does not change.

The preexisting conditions exclusion does not apply to pregnancy or genetic information.

NEWBORNS AND ADOPTED CHILDREN

If a newborn child of a covered employee, a child under the age of 18 years of age who is placed for adoption with the covered employee, or a child who is actually adopted by a covered employee, is enrolled in the Plan within 60 days of birth, placement for adoption, or the date of actual adoption, the preexisting conditions exclusion period of the Plan will not apply. If the child was continuously covered under another Plan from birth, placement for adoption, or actual adoption prior to being covered under this Plan and such child becomes covered under this Plan without a break in coverage of 63 days or more, the preexisting conditions exclusion period of the Plan will not apply.

PLAN PAYMENT PROVISIONS

DEDUCTIBLES (Plans II & III)

Individual

The "deductible" is the amount of eligible medical expenses each Calendar Year that an employee or Dependent must incur before any benefits are payable by the Plan. The individual deductible amount is listed in the Schedule of Benefits.

Family

When the deductible amounts accumulated by all covered members of the family reach the family deductible shown in the Schedule of Benefits during one Calendar Year, no further deductibles will apply to any family member for the rest of that Calendar Year. **However, no single family member will be required to satisfy more than the individual deductible in a Calendar Year.**

DEDUCTIBLE CARRYOVER (Plans II & III)

Although a new medical deductible will apply each calendar year, expenses incurred during October, November and December which are applied against that year's deductible will also be applied toward the deductible for the next year and thus reduce or eliminate the next year's deductible. Any amounts that satisfy an individual deductible will count toward satisfying the family deductible.

AMOUNTS NOT CREDITED TOWARD THE DEDUCTIBLE (Plans II & III)

The following expenses will **not** be considered in satisfying the deductible requirement:

- Expenses for services or supplies not covered by this Plan.
- Charges in excess of the UCR charges.
- Copays.

COINSURANCE PERCENTAGE

The coinsurance is the percentage of the UCR charge that the Plan will pay for non-Preferred Providers, or the percentage of the negotiated rate for Preferred Providers. Once the deductible is satisfied, the Plan shall pay benefits for covered expenses incurred during the remainder of the Calendar Year at the applicable coinsurance as specified in the Schedule of Benefits. The Participant is responsible for paying the remaining percentage. The Participant's portion of the coinsurance represents their out-of-pocket expense.

The non-Preferred Provider of service may charge more than the UCR. The portion of the non-Preferred Provider's bill in excess of UCR is not a covered expense under this Plan and is the responsibility of the Participant.

COPAY

This is the amount paid by you the Participant each time treatment is received. Only one copay is to be taken per day for related outpatient services rendered.

MAXIMUM OUT-OF-POCKET

The amount of the coinsurance which is your responsibility is called your maximum out-of-pocket expense limit. When you (or your family's) out-of-pocket expense total reaches the out-of-pocket amount shown in the Schedule of Benefits during one Calendar Year, the Plan will pay 100% of allowable charges of the Participant's incurred eligible medical expenses for the remainder of the calendar year. Benefits stated at a constant coinsurance level do not count toward the out-of-pocket expense limit and are not payable at 100% when the out-of-pocket limit is reached.

The following expenses are not applied to the out-of-pocket:

- Copays.
- Expenses not covered under this Plan.
- Hearing aids and hearing aid batteries expenses.
- Smoking cessation expenses.
- Neurodevelopmental therapy expenses.
- TMJ expenses.

MAJOR MEDICAL LIFETIME MAXIMUM BENEFIT

The Major Medical Lifetime Maximum Benefit per Participant covered under the Everett School Employee Benefit Trust's Medical Plan is $1,000,000.

REINSTATEMENT OF LIFETIME MAXIMUM BENEFIT

The total benefits provided under this Plan for any participant for all Illnesses, accidental Injuries, and physical Disabilities combined during the Participant's lifetime shall not exceed a cumulative maximum cost of $1,000,000; provided however, that on January 1 of each Calendar Year the cost of benefits received by the patient under this Plan and charges against the Participant's Lifetime Maximum Benefit shall automatically be forgiven up to the amount of $200,000. This reinstatement does not apply to any benefit provision within the Plan that has a separate Lifetime maximum and will not apply to extended benefits.

COMPREHENSIVE MAJOR MEDICAL BENEFITS

ELIGIBLE EXPENSES

When Medically Necessary for the diagnosis or Treatment of an Illness or an Injury, the following services are eligible expenses for Participants covered under this Plan. Eligible expenses are payable as shown in the Schedule of Benefits and are limited by certain provisions listed in the General Exclusions. Major medical expenses are subject to all Plan conditions, exclusions, and limitations.

ALLERGY INJECTIONS/TESTING

Eligible charges for injections, testing, syringes and medication will be payable as shown in the Schedule of Benefits.

ALTERNATIVE SERVICES

The alternative medicine benefit consists of medically necessary services provided by naturopaths, acupuncturists, and massage therapists. Services are paid as shown in the Schedule of Benefits.

AMBULANCE (AIR AND GROUND)

Services of a licensed ambulance company are covered for transportation to the nearest Medical Facility where the required service is available, if other transportation would endanger the patient's health and the purpose of the transportation is not for personal or convenience reasons.

AMBULATORY SURGICAL CENTERS

An "Ambulatory Surgical Center" is a lawfully operated facility that is established, equipped, and operated to perform surgical procedures. Services rendered by an Ambulatory Surgical Center are covered when performed in connection with a covered Surgical Procedure.

CHEMICAL DEPENDENCY

Benefits will be provided for services of a Physician and/or an approved chemical dependency treatment facility for medically necessary inpatient and outpatient Treatment of chemical dependency, including detoxification and supportive services. "Chemical dependency" is defined as physical and/or emotional dependence on drugs, narcotics, alcohol, or other addictive substances to a debilitating degree. Eligible expenses for Treatment of chemical dependency shall be paid according to the limitations shown in the Schedule of Benefits.

Treatment for chemical dependency includes:

- Medical and psychiatric evaluations.
- Inpatient room and board (including detoxification).
- Psychotherapy (individual and group), counseling (individual and group), behavior therapy, and family therapy (individual and group) for the covered Participants.

- Prescription drugs prescribed by a Physician and administered while in an approved treatment facility.

- Supplies prescribed by an approved treatment facility, except for personal items.

Chemical dependency treatment does **not** include:

- Personal items.

- Items or Treatment not necessary to the care or recovery of the patient.

- Custodial care.

- Education or training.

Inpatient Treatment

When inpatient chemical dependency treatment is considered, it is recommended that the Participant first contact the Plan's Medical Management Department to preauthorize the admission. The following is required:

- Treatment must be ordered in writing by a Physician or certified by the Plan's Medical Management Department, for the entire length of time the Participant is confined.

- Under extenuating circumstances, such as emergency inpatient chemical dependency treatment, it is recommended that you obtain authorization within 48 hours of admission, or by the next business day, from the Plan Supervisor or Medical Management Department. Written explanation of the extenuating circumstances should be submitted to support the need for the emergency admission.

Outpatient Treatment

If treatment is provided on an outpatient basis, then treatment must be provided by a Physician as defined under this Plan.

No benefits will be provided for information and referral services, information schools, Alcoholics Anonymous, and similar chemical dependency programs; long-term care or custodial care; and tobacco cessation programs.

CHIROPRACTIC CARE

Covered chiropractic services include spinal manipulation, adjunctive therapy, vertebral alignment, subluxation, spinal column adjustments, and other chiropractic treatment of the spinal column, neck, extremities, or other joints, when performed by a physician as defined by the Plan. Examinations and x-rays in connection with chiropractic care are subject to the chiropractic limit shown in the Schedule of Benefits.

CONTRACEPTION MANAGEMENT

Benefits will be provided for injectable contraceptives, implantable contraceptives, devices and supplies related to birth control, including Norplant, Depo-Provera, and contraceptive devices. Injections and the insertion and removal of devices are covered. Legend oral contraceptives, injectable contraceptives and legend contraceptive devices are covered as described in the section entitled, "Prescription Drug Card Program."

DIAGNOSTIC X-RAY AND LABORATORY

Diagnostic X-ray and laboratory services are payable as shown in the Schedule of Benefits. Dental X-rays are excluded. Covered expenses include charges made by a blood bank for processing of blood and its derivatives, cross-matching, and other blood bank services; charges made for whole blood, blood components, and blood derivatives, to the extent not replaced by volunteer donors.

DIETARY EDUCATION

Dietary education is a covered benefit. In order for dietary education to be considered an eligible charge, the program must be provided by health care professionals as defined under the definition of Physician. This benefit includes diabetic counseling. The Plan Supervisor will be the final authority on which education programs meet the eligibility criteria.

DURABLE MEDICAL EQUIPMENT

Benefits are provided for rental or purchase (if more economical in the judgment of the Plan Supervisor) of Medically Necessary, Durable Medical Equipment. Durable Medical Equipment is equipment able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally used in the absence of Illness or Injury. Durable Medical Equipment must be prescribed by a Physician for therapeutic use, and documentation must include the length of time needed, the cost of rental, and cost of purchase prior to any benefits being paid. Examples include the following: crutches, wheelchairs, kidney dialysis equipment, hospital beds, traction equipment, and equipment for administration of oxygen. Repairs or replacement of eligible equipment shall be covered when necessary to meet the medical needs of the covered patient.

Benefits are **not** provided for certain equipment including, but not limited to, air conditioners, dehumidifiers, purifiers, heating pads, enuresis (bed-wetting) training equipment, exercise equipment, whirlpool baths, weights and hot tubs.

It is recommended that the purchase or rental of Durable Medical Equipment costing over $1,000 be reviewed by the Medical Management Department.

HEARING BENEFIT

The Plan will pay for a hearing exam and hearing aid device as outlined in the Schedule of Benefits.

In order to receive services through this hearing benefit, examination by a licensed Physician must be obtained before a hearing aid is received.

Services will be provided for:

- An otologic (ear) examination by a Physician.
- An audiologic (hearing) examination and hearing evaluation by a certified or licensed audiologist, including a follow-up consultation.
- The hearing aid (monaural or binaural) prescribed as a result of the examinations.
- Ear mold(s).
- The hearing aid instrument.
- The initial batteries, cords and other necessary ancillary equipment, as shown in the Schedule of Benefits.

- A follow-up consultation within 30 days following delivery of the hearing aid, with either the prescribing physician or audiologist.
- Repairs, servicing, and alteration of hearing aid equipment.

INFUSION THERAPY BENEFIT

Inpatient and outpatient services and supplies for infusion therapy are provided at the coinsurance level shown in the Schedule of Benefits. The attending Physician must submit, and periodically review, a written treatment plan that specifically describes the infusion therapy services and supplies to be provided. The treatment plan must be approved in advance by the Plan Supervisor or the Medical Management Department. Drugs and supplies used in conjunction with infusion therapy will be provided only under this benefit.

MATERNITY SERVICES

Benefits for maternity care and services are available to a covered employee, spouse, domestic partner, and dependent daughters. Pregnancy and complications of pregnancy will be covered as any other medical condition. Medical Facility, Surgical Procedure, and medical benefits are available on an Inpatient or outpatient basis for the following maternity services:

- Normal delivery.
- Cesarean delivery.
- Routine prenatal and postnatal care.
- Treatment for complications of pregnancy.
- Voluntary termination of pregnancy.

Newborns' and Mothers' Health Protection Act

The Plan will at all times comply with the terms of the Newborns' and Mothers' Health Protection Act of 1996. The Plan will not 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 normal vaginal delivery, or to less than 96 hours following a Cesarean section, or require that a provider obtain authorization from the Plan Supervisor for prescribing a length of stay for the mother or newborn child not in excess of the above periods.

Complications of Pregnancy

Benefits are available to a covered employee, Spouse, Domestic Partner or dependent child for services rendered to treat the following complications of pregnancy:

- Severe hemorrhage from any cause.
- Severe cardiac disease.
- Severe infection.
- Severe renal disease.
- Pulmonary edema and maternal CVA.

In no event shall the term "complication of pregnancy" include Cesarean section delivery as an alternative to vaginal delivery, false labor, occasional spotting, physician-prescribed rest, morning

sickness, hyperemesis gravidarum, pre-eclampsia or similar conditions associated with the management of a difficult pregnancy but not constituting a classifiably distinct complication of pregnancy.

MEDICAL FACILITY SERVICES

Inpatient Care

The following benefits will be provided for Inpatient care in an accredited Hospital or Medical Facility when the patient is under the care of a Physician:

- Room and board in a Semiprivate Room.
- Intensive care, cardiac care, isolation or other special-care unit.
- Private room accommodations, if Medically Necessary.
- Nursing care services.
- Prescribed drugs and medications administered in the Hospital or Medical Facility.
- Anesthesia and its administration.
- Oxygen and its administration.
- Dressings, supplies, casts, and splints.
- Diagnostic services.
- The use of Durable Medical Equipment.

Outpatient Care

Benefits will be provided for minor surgery and for emergency room treatment of an accidental Injury or a Medical Emergency.

Miscellaneous

All other charges made by a Hospital or the Medical Facility during an Inpatient confinement are eligible, except personal items, services not necessary for the treatment of an Illness or Injury, and services specifically excluded by the Plan.

ALTERNATIVES TO INPATIENT ADMISSIONS—SPECIAL PROVISIONS

Home health care, hospice care, skilled nursing facility care, and rehabilitation are provided in lieu of, and as an alternative to, Inpatient admissions.

- They are subject to the concurrent opinion of the attending Physician, the Plan Supervisor, or the Plan's Medical Management Department that they will be less costly than an Inpatient confinement that would have been required.
- Services are outlined in a written Approved Treatment Plan.
- The Approved Treatment Plan is to be developed and reviewed periodically by the attending Physician.

- The Approved Treatment Plan should include an estimate of the cost of services, length of stay and treatment, and supplies to be rendered.

- It is recommended that services for hospice and home health care be preauthorized by the Medical Management Department prior to services being rendered.

Home Health Care

Charges made by a home health care agency (approved by Medicare or state-certified) for the following services and supplies furnished to a Participant in his or her home for care in accordance with a home health care plan are included as covered medical expenses. Charges for home health care services described below will be applied to the home health care benefit and subject to the home health care maximum as shown in the Schedule of Benefits. This benefit is not intended to provide custodial care but is provided for care in lieu of Inpatient Hospital, Medical Facility or skilled nursing facility care for patients who are Homebound.

The following services will be considered eligible expenses:

- Part-time or intermittent nursing care by a registered nurse, a licensed vocational nurse, or a licensed practical nurse.

- Physical therapy services by a licensed, registered, or certified physical therapist.

- Speech therapy services by a licensed, registered, or certified speech therapist.

- Occupational therapy services by a registered, certified, or licensed occupational therapist.

- Nutritional guidance by a registered dietitian.

- Nutritional supplements such as diet substitutes administered intravenously or by enteral feeding.

- Respiratory therapy services by a certified inhalation therapist.

- Home health aide services by an aide who is providing intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, completing appropriate records and personal care or household services essential to achieve the medically desired result.

- Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services normally used by a patient in a skilled nursing facility, Medical Facility or Hospital, but only to the extent that they would have been covered under this Plan if the Participant had remained in the Hospital or Medical Facility.

Hospice Care

If a Participant is terminally ill, the services of an approved hospice will be covered for Medically Necessary treatment or palliative care (medical relief of pain and other symptoms) for the terminally ill Participant, subject to the conditions and limitations specified below. Services and supplies furnished by a licensed hospice (Medicare-approved or state-certified) for necessary Treatment of the Participant, pursuant to a written Approved Treatment Plan furnished by the attending Physician, will be eligible for payment as shown in the Schedule of Benefits.

The following services will be considered eligible expenses:

- Confinement in a hospice facility or at home.

- Ancillary services furnished by the hospice while the Participant is confined.

- Medical supplies and drugs prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition.

- Physician services and/or nursing care by a registered nurse, licensed practical nurse, master in social work or licensed vocational nurse.

- Home health aide services by an aide who is providing intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, completing appropriate records and personal care or household services essential to achieve the medically desired result.

- Nutritional advice by a registered dietitian, and nutritional supplements, such as diet substitutes, administered intravenously or through hyperalimentation.

- Physical therapy, speech therapy, occupational therapy, and respiratory therapy.

With respect to hospice care, a treatment plan must include:

- A description of the Medically Necessary care to be provided to a terminally ill patient for palliative care or Medically Necessary Treatment of an Illness or Injury but not for curative care.

- A provision that care will be reviewed and approved by the Physician at least every 60 days.

- A prognosis of six months or less to live.

Limitations to Hospice Care

- Respite care in which no skilled care is required will be limited to a total of 120 hours per three-month period. Respite care is continuous care of the patient to provide temporary relief to family members or friends from the duties of caring for the patient.

- Any expenses for hospice care that qualify both under this benefit and under any other benefit of this Plan will be covered only under the benefit the Plan Supervisor determines to be the most appropriate.

- If the participant exhausts the above benefit limits, the participant may apply to the Plan Supervisor for an extension of benefits. Limited extensions will be granted by the Plan Supervisor if it determines the treatment to be Medically Necessary.

- When the Participant is confined as an Inpatient in an approved hospice that is not a Hospital or skilled nursing facility, the same benefits that are available in the participant's home will be available to the Participant as an Inpatient. In addition, a Semiprivate Room allowance will be provided.

If the Participant requires end-of-life care beyond six months, the Plan will approve additional hospice care benefits on receipt of an Approved Treatment Plan documenting the continued need for the services.

Exclusions to Home Health Care and Hospice Care

- Non-medical or custodial services except as specifically included as an eligible expense.
- Meals on Wheels or similar home-delivered food services, clothing, housing and transportation.
- Services performed by a member of the patient's family or household.
- Services not included in the Approved Treatment Plan.
- Supportive environmental materials such as handrails, ramps, telephones, air-conditioners and similar appliances or devices.
- Hospice bereavement services, financial or legal counseling services and funeral expenses.

Skilled Nursing Facility Care

Charges for daily room and board up to the maximum shown in the Schedule of Benefits when in lieu of hospitalization are covered, if:

- Ordered by an attending Physician.
- The Illness or Injury requires skilled nursing care on a continuing basis.
- Care is not primarily custodial or principally for senile deterioration, mental retardation, mental deficiency or a Mental Health Condition.

Rehabilitation Benefit

Rehabilitative services are covered when Medically Necessary to restore and improve bodily function that was previously normal, but was lost due to Illness or Injury, including function lost as a result of congenital anomalies.

The Plan covers charges for you on an Inpatient or outpatient basis in a rehabilitation center. All Medically Necessary services and supplies are covered during the confinement.

Services provided for occupational, massage, physical and speech therapy in the office, Medical Facility or Hospital will be paid under the rehabilitation benefit when provided by a licensed Physician as defined in the "Definitions" section as shown in the Schedule of Benefits. Continuing, measurable progress must be demonstrated at regular intervals.

Occupational Therapy - Charges of a registered, certified, or licensed occupational therapist are covered when necessary to restore a bodily function lost or impeded due to Illness or Injury. It is recommended that a treatment plan be submitted to and approved in advance by the Plan Supervisor or Medical Management Department for any Inpatient rehabilitative care.

Physical Therapy - Charges of a registered, certified, or licensed physical therapist are covered when necessary to restore a bodily function lost or impeded due to Illness or Injury. It is recommended that a treatment plan be submitted to and approved in advance by the Plan Supervisor or Medical Management Department for any Inpatient rehabilitative care.

Speech Therapy - Charges are covered when prescribed by a Physician and when Medically Necessary to restore a bodily function lost or impeded due to Illness or Injury. It is recommended that a treatment plan be submitted to and approved in advance by the Plan Supervisor or Medical Management Department for any Inpatient rehabilitative care. Excluded are speech therapy services that are educational in nature or due to tongue thrust, stuttering, lisping, abnormal speech development, changing an accent, dyslexia, and hearing loss that is not medically documented.

The eligible expenses at a rehabilitation center and a skilled nursing facility are payable as shown in the Schedule of Benefits for the following services and supplies furnished while the patient requires 24-hour care and is under continuous care of the attending Physician:

- Room, board and other services and supplies furnished by the facility for necessary care (other than personal items and professional services).
- Use of special treatment rooms.
- X-ray and laboratory examinations.
- Occupational, physical and speech therapy.
- Oxygen and other gas therapy.

No benefits will be provided for custodial care; maintenance, non-medical self-help, recreational, educational, or vocational therapy; psychiatric care; treatment of learning disabilities or developmental delay; chemical dependency rehabilitative treatment; and gym or swim therapy.

MAMMOGRAPHY, PROSTATE EXAM, AND PROSTATE-SPECIFIC ANTIGEN (PSA) TESTING BENEFIT

Routine screening mammograms, prostate exams, and prostate-specific antigen (PSA) tests are covered by the Plan. Services are payable as shown in the Schedule of Benefits. Non-routine mammograms and prostate-specific antigen (PSA) tests are covered when Medically Necessary if prescribed by your Physician.

MEDICAL SUPPLIES

When prescribed by a Physician and Medically Necessary, the following medical supplies are covered, including but not limited to: braces; surgical and orthopedic appliances; colostomy bags and supplies required for their use; catheters; dressings for surgical wounds, cancer, burns or diabetic ulcers; oxygen; back braces; cervical collars; and medical compression stockings limited to six stockings (three pairs) per Calendar Year.

MENTAL AND NERVOUS TREATMENT

Benefits will be provided for mental health care when treatment is rendered by a physician as defined herein. Mental health is defined as and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions and psychiatric conditions. This includes but is not limited to the following conditions: psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, attention deficit disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD) and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems.

Inpatient Treatment

When Inpatient mental disorder treatment is recommended, it is advised that the patient first contact the Plan's Medical Management Department to preauthorize admission.

In addition to preauthorization, the following is required:

- Treatment must be ordered in writing by a Physician or certified by the Plan's Medical Management Department, for the entire length of time the patient is confined.
- Under extenuating circumstances, such as emergency Inpatient mental disorder treatment, it is recommended that you obtain authorization within 48 hours of admission, or by the next business day, from the Medical Management Department.
- The patient must complete the approved course of Treatment in a Hospital or Medical Facility.

Outpatient Treatment

If treatment is provided on an outpatient basis, then Treatment must be provided by a Physician.

Mental Health treatment does not include:

- Personal items.
- Items or treatment not necessary to the care or recovery of the patient.
- Custodial care.
- Education or training.
- Residential treatment facility.
- Wilderness or outdoor treatment programs.
- Marital, family or sexual counseling.

NEURODEVELOPMENTAL THERAPY SERVICES

Benefits will be provided for Medically Necessary neurodevelopmental therapy treatment to restore and improve bodily function for children up to age seven. This benefit includes maintenance services if significant deterioration of the patient's condition would result without the service. "Neurodevelopmental therapy" means therapy designed to treat structural or functional abnormalities of the central or peripheral nervous system. Its purpose is to restore, maintain, or develop age-appropriate functions in a child.

Such therapy includes occupational therapy, physical therapy, and speech therapy. The services of a physician, physical therapist, speech therapist, or occupational therapist will be provided in the office, medical facility, or hospital outpatient department. Inpatient hospital, medical facility, or skilled nursing facility expenses will be eligible when care cannot be safely provided on an outpatient basis. The physician must submit a treatment plan to the Medical Management Department for prior approval and must periodically review the treatment plan.

Benefits are payable at the coinsurance level indicated in the Schedule of Benefits. Benefits for rehabilitative services or other treatment programs will not be available for the same condition.

NEWBORN NURSERY CARE BENEFIT

Medical Facility charges incurred by a well newborn during the first 48 hours following a normal delivery, or 96 hours following a Cesarean delivery, will be covered as charges of the baby unless a shorter stay is requested by the mother and her health care provider. In addition, a circumcision performed in an outpatient setting within 31 days of the birth of the baby will be covered under these benefits.

- Medical facility nursery expenses for a healthy newborn.
- Routine pediatric care for a healthy newborn child while confined in a Hospital or Medical Facility immediately following birth.
- Phenylketonuria ("PKU") testing within the first seven days of life.

The benefits of this Plan will be provided for routine care, Illness, accidental Injury or physical disability, including congenital anomalies, for the newborn child for up to 21 days after birth if the mother is enrolled in this Plan, with benefits applying to the mother's coverage (e.g., deductible and out-of-pocket expenses). No benefits will be provided after day 21 unless the newborn is enrolled in this Plan.

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

Charges for preventive care (routine immunizations and examinations) will be considered eligible expenses only to the extent specified in the Schedule of Benefits.
The newborn child of any covered dependent daughter will be eligible for benefits for the first three days after birth.

OBESITY TREATMENT

If a Participant is morbidly obese, the Plan covers doctor's office visits and related laboratory tests for the treatment of obesity. Treatment must be provided by a Physician on an outpatient basis according to a written treatment plan. The benefit is limited to one course of Treatment. A course of Treatment begins and ends as specified in the Approved Treatment Plan, or sooner if the Participant discontinues Treatment. "Morbidly obese" means that, for at least five years, the Participant's weight is 100 pounds over the ideal weight for his or her age, body type, and height as given in standard height/weight tables. This must be documented by objective evidence provided by the Physician who is treating the Participant.

Medical Necessity must be documented in order for benefits to be allowed for surgical correction of morbid obesity. The following requirements must be met by the patient and documented as indicated below:

- The patient must be twice the ideal weight, or greater than 80 pounds overweight for a woman or 100 pounds for a man (owing to different average height).
- The patient must demonstrate inability to control weight through diet over a minimum period of five years. This must be documented by medical records or details of treatment over a five-year period, as related by attending Physician(s).
- The patient must suffer from a documented separate condition that is aggravated by obesity (e.g., severe diabetes mellitus, hypertension, alveolar hypoventilation, a chronic back condition, varicose veins, etc.). This must be documented by objective evidence provided by the Physician who is treating the patient for the condition that is aggravated by obesity.

- The patient must be psychiatrically stable. This must be documented by a recent psychiatric evaluation indicating no psychiatric problems.

It is recommended that the surgery be preauthorized by the Medical Management Department prior to services being rendered. When all the above information has been accumulated, the information should be referred to the Medical Management Department.

The Plan does not pay for anything not included in the written Approved Treatment Plan. In addition, the Plan does not pay for appetite or weight control drugs, dietary supplements, special foods or food supplements, health and weight control centers or resorts, health club memberships or exercise equipment.

ORTHOTICS

Benefits are payable at the coinsurance level indicated in the Schedule of Benefits. Covered orthotic appliances include, but are not limited to, foot supports, supplies, devices, and corrective shoes.

PHENYLKETONURIA (PKU) DIETARY FORMULA

Dietary formula that is Medically Necessary for the treatment of phenylketonuria is covered by the Plan.

PHYSICIAN SERVICES

Physician's fees for medical and surgical services are covered.

POSTMASTECTOMY

Benefits will are payable for an external and the first permanent internal breast prosthesis following a mastectomy. Benefits are not provided for cosmetic prostheses except as stated in the Women's Health and Cancer Rights Act:

- 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 complication at all stages of mastectomy, including lymphedemas.

Breast prostheses adhesive and two post-mastectomy holding bras are covered per Calendar Year.

A prosthesis ordered before your effective date of coverage will not be covered. A prosthesis ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be covered.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

PREADMISSION TESTING

The plan will cover charges for laboratory and X-ray examinations to determine if the Participant is suitable for surgery prior to admission.

PRESCRIPTION DRUGS

Inpatient drugs are covered when administered to an individual for the Treatment of a covered Illness or Injury, while confined. Inpatient prescription drugs will be paid as shown in the Schedule of Benefits, Medical Facility Services, Inpatient, and are subject to the deductible.

Outpatient prescription drugs are reimbursable through your Prescription Drug Card Program.

PREVENTIVE CARE

This benefit covers routine Physician services and related diagnostic tests that are regularly performed without the presence of symptoms. Services are payable as shown in the Schedule of Benefits.

Eye exams and hearing exams are not covered under this benefit.

PROSTHETIC APPLIANCES

Benefits are provided for artificial limbs and eyes. Repair or replacement of prostheses due to normal use or growth of a child will be covered.

A prosthesis ordered before your effective date of coverage will not be covered. A prosthesis ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be covered.

RADIATION THERAPY AND CHEMOTHERAPY

X-ray therapy, radium therapy, radioactive isotope therapy, and chemotherapy are covered expenses under this Plan.

SECOND SURGICAL OPINION

A second surgical opinion is not normally required but may be requested by the patient. This benefit is paid as shown in the Schedule of Benefits.

Please note: it is recommended that all non-emergency Surgical Procedures other than surgery done in the doctor's office be preauthorized by the Plan's Medical Management Department. When requested, the Plan will pay the UCR accepted fee for a second surgical opinion, and for a third and final opinion in case of conflict between the first two opinions.

Second or third opinion: Must be an opinion of an independent second or third surgeon acting on a consulting basis. A surgeon in association or practice with a prior surgical consultant will not be accepted.

STERILIZATION—ELECTIVE

The Plan pays for elective sterilization procedures such as tubal ligations and vasectomies. These procedures shall be paid under the Major Medical benefits for covered employees and Spouses.

Eligible expenses under this Plan shall not include reversal or attempted reversal of these procedures.

SURGERY AND RELATED SERVICES

Benefits are provided for the following Inpatient or outpatient services:

- Surgeon's charges.
- Assistant surgeon's charges.
- Anesthesia.

If two or more Surgical Procedures are performed through the same incision during an operation, full benefits are provided only for the primary procedure, and one-half benefits are provided for the secondary procedure.

TEMPOROMANDIBULAR JOINT DISORDER

This Plan covers Medically Necessary Treatment of Temporomandibular Joint Disorders (TMJ) when provided by a participating Physician, approved Medical Facility, licensed physical therapist, or licensed oral surgeon. Oral surgeons will be covered only for the surgical treatment of TMJ disorders under this benefit. TMJ benefits will be paid as outlined in the Schedule of Benefits.

TRANSPLANTS

Benefits are payable for charges for organ or tissue transplant services incurred while the recipient is covered by this Plan. Such covered charges must be due to an accidental Injury or Illness covered by this Plan.

It is recommended that you contact the Medical Management Department prior to any testing that may occur, to determine whether you are a transplant candidate. A written treatment plan must be submitted in order to obtain preauthorization.

Also remember that preauthorization is required before any Medical Facility admission. See "Preauthorization of Inpatient Medical Facility Admissions And Outpatient Surgeries" in the "Important Information" section.

Organ or tissue transplant services include the following Medically Necessary services and supplies:

- Organ or tissue procurement. These consist of removing, preserving, and transporting the donated part.
- Compatibility testing undertaken prior to procurement is covered if medically necessary. This includes costs related to the search for, typing and testing, and identification of a bone marrow or stem cell donor for allogeneic transplant up to the maximum amount shown in the Schedule of Benefits. These expenses will be charged against the transplant benefit maximum as shown in the Schedule of Benefits.

- Medical facility or Hospital room and board, and medical supplies.
- Diagnosis, treatment, and surgery by a Physician.
- The rental of wheelchairs, hospital-type beds, and mechanical equipment required to treat respiratory impairment.
- Local ambulance services, medications, X-rays and other diagnostic services, laboratory tests and oxygen.
- Rehabilitative therapy consisting of speech therapy (not for voice training or lisp), audio therapy, visual therapy, occupational therapy, and physiotherapy. Any of these must be in direct respect to rehabilitation from the covered transplant procedure.
- Surgical dressing and supplies.
- Transportation and lodging, as shown in the Schedule of Benefits.
- Other services approved by the Medical Management Department.

Benefits for a donor are payable only in the absence of other coverage and shall not exceed the benefit limitation as shown in the Schedule of Benefits. Donor expenses are payable only when the organ recipient is covered under this Plan and are considered expenses of the recipient.

No benefits will be provided for the following:

- Transplant services or supplies received during the first 12 months of coverage under this Plan. The 12-month transplant waiting period will not apply to children who have been continuously enrolled since birth. The eligible participant will be allowed a credit toward this transplant waiting period for any period of time he or she was continuously covered under another medical plan with the Employer, immediately preceding the time the eligible participant's coverage under this Plan began. Coverage under the other plan must have ended when this Plan began. Other than described herein, this 12-month waiting period will not be waived or credited for any reason.
- Any procedure that has not been proven effective, is Experimental or Investigative, or is not a standard of care in the community.
- When donor benefits are available through other group coverage.
- When government funding of any kind is available.
- When the recipient is not covered under this Plan.
- Private nursing care by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.).
- Meals associated with travel.

URGENT CARE HOME VISITS

Urgent Care Home Visits ***provided by Carena*** are paid in full after a $50 copay. For urgent, but not-life threatening health conditions, members may be eligible for a Carena Urgent Care home visit in lieu of an emergency room visit and/or if their Primary Care Physician is not available. This service is NOT intended to treat life-threatening emergencies - members should dial 911 if they think they are having a true medical emergency. Members must be within the Carena service area to be eligible for a home visit. Deductible waived for Plans II and III.

WIGS

Hair replacement devices such as wigs are covered when medically necessary; typically used when undergoing chemotherapy. Benefits for any provider (in or out of network) will be payable at the preferred network level and limited to a maximum of $450 per condition.

GENERAL EXCLUSIONS TO THE MEDICAL PLAN

This section of your document explains circumstances in which all the medical benefits of this Plan are limited or in which no benefits are provided. Benefits may also be affected by the Medical Management provisions of the Plan. Your eligibility and expenses are subject to all Plan conditions, exclusions, and limitations, including Medical Necessity. In addition, some benefits have their own limitations.

In addition to the specific limitations stated elsewhere in this document, the Plan will not provide benefits for:

- Services and supplies that are not Medically Necessary (as defined in the "General Definitions" section) for the diagnosis or treatment of an Illness or Injury, unless otherwise listed as covered.

- Cosmetic and Reconstructive Surgery -- Cosmetic surgery or related medical facility admission, unless made necessary:

    1. When related to an Illness or Injury.

    2. Except as specifically excluded by this plan, for correction of congenital deformity. To be covered, the surgery must be done within 18 years of the date of birth.

    3. A member receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will also receive coverage for:

        - Reconstruction of the breast on which the mastectomy has been performed

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

        - Prostheses

        - Treatment of physical complications of all stages of mastectomy, including lymphedemas

        This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

- Dental services including treatment of the mouth, gums, teeth, mouth tissues, jawbones or attached muscle, orthodontic appliances, dentures and any service generally recognized as dental work. Hospital and Physician services rendered in connection with dental procedures are covered only if adequate Treatment cannot be rendered without the use of Hospital facilities, and if you have a medical condition (besides the one requiring dental care), that makes Hospital care Medically Necessary. The only exceptions to this exclusion are the services and supplies covered due to accidental injury to teeth and as described by the "TMJ Benefit."

- Services covered by or for which the Participant is entitled to benefits under any workers' compensation or similar law.

- Charges by a facility owned or operated by the United States or any state or local government unless the Participant is legally obligated to pay. This does not apply to covered expenses rendered by a Medical Facility owned or operated by the United States Veteran's Administration when the services are provided to a participant for a non-service-related Illness or Injury. The exclusion also does not apply to covered expenses rendered by a United States military Medical Facility to Participants who are not on active military duty.

- Charges that the employee is not legally required to pay, and charges that would not have been made in the absence of this coverage.

- Charges that are in excess of UCR fees, or that are not generally accepted medical procedures for the Treatment of the diagnosed Illness or Injury.

- Charges that are reimbursed, or that are eligible to be reimbursed, by any public program except as otherwise required by law.

- Preexisting conditions. Coverage will be provided for covered services and supplies for preexisting conditions after the preexisting-condition exclusion period ends.

- Except as provided under the "Chemical Dependency" section, any medical Treatment required because of the use of narcotics or the use of hallucinogens in any form, unless the Treatment is prescribed by a Physician.

- Treatment made necessary as a result of war or an act of war, whether declared or undeclared. An act of terrorism will not be considered an act of war.

- Charges for the Treatment of a condition resulting from war or an act of war, whether declared or undeclared, or an Injury sustained or Illness contracted while on duty with any military service for any country.

- Eyeglasses, contact lenses, eye refractions, or examinations for prescriptions or fitting of eyeglasses, contact lenses (except the first pair after cataract surgery) or charges for radial keratotomy or lasik surgery, except as provided in the "Vision Benefits."

- Routine services such as, but not limited to, premarital exams and insurance exams.

- Air travel, whether or not recommended by a physician, except as provided herein under the "Ambulance Benefit."

- Rest Home – Any services rendered by an institution, which is primarily a place of rest, a place for the aged, a nursing home, sanitarium, or a convalescent home.

- Custodial care, except as specifically provided herein. Custodial care is care whose primary purpose is to meet personal rather than medical needs and which is provided by individuals with no special medical skills or training. Such care includes, but is not limited to, helping a patient walk, get in or out of bed, and take normally self-administered medicine.

- Licensed/Certified – Any services outside the scope of the provider's license, registration or certification; furnished by a provider that is not licensed, registered or certified to provide the service or supply by the state in which the services or supplies are furnished; or provided by anyone other than a Physician operating within the scope of his or her license, as defined herein.

- Services considered to be experimental, investigational, or generally unaccepted medical practices at the time they are rendered.

- Services of a chiropractor, except as provided herein.

- Medical Facility services performed in a facility other than a Medical Facility as defined herein.

- Services or supplies that are primarily educational in nature, except as provided herein.

- Charges for reversal or attempted reversal of sterilization.

- Charges for sex change or for procedures to change one's physical characteristics to those of the opposite sex.

- Charges for breast implants, except as provided herein.

- Charges for any illegal treatment or treatment listed by the American Medical Association (AMA) as having no medical value.

- Charges for vision analysis, therapy, or training relating to muscular imbalance of the eye, or for orthoptics.

- Routine Foot Care – Services for routine or palliative foot care, including hygienic care; impression casting for prosthetics or appliances and prescriptions thereof; fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses and toenails (except for ingrown toenail surgery); and other asymptomatic complaints of the foot. This includes foot-support supplies, devices, and shoes, except as provided under the "Medical Supplies," or "Orthotics," and "Prosthetic Appliances" sections of the Plan.

- Services or supplies for learning disabilities; marital, sexual, or family counseling outreach; job training or other education or training services; treatment or classes to stop smoking; and Treatment for eating disorders, except as provided herein.

- Impotency – Charges associated with impotency and erectile dysfunction, and procedures to restore potency, including but not limited to: corrective or reconstructive surgery, hormone injections, penile implants, and impotency drugs whether or not they are the consequence of Illness or Injury, except as covered under the Prescription Drug Card Program.

- Fertility and Infertility – Charges in association with infertility, and procedures to restore fertility or to induce pregnancy, including but not limited to: corrective or reconstructive surgery; hormone injections; in-vitro fertilization; embryo transfer; artificial insemination, gamma intra-fallopian transfer; fertility drugs (including but not limited to Clomid, Pergonal and Serophene); and any other artificial means of conception, (except necessary care and supplies needed to diagnose infertility).

- Charges in connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semiprofessional athletics, including practice.

- Milieu therapy (a treatment designed to provide a change in environment or a controlled environment).

- Transportation by private automobiles, taxi service or other ground transportation, except as specifically provided herein.

- Treatment for obesity (excessive weight), including Surgical Procedures or complications of such surgery, wiring of the jaw or procedures of a similar nature, except Treatment of morbid obesity as provided in the medical benefits.

- Charges incurred for Treatment or care by any provider if he or she is a Relative, or Treatment or care provided by any individual who ordinarily resides with the Participant.

- Missed or canceled appointments or telephone consultations.

- Personal comfort or service items while confined in a hospital, such as, but not limited to, radio, television, telephone, and guest meals.

- Mailing and/or shipping and handling expenses.

- Blood or plasma when a refund or credit is made for those items.

- Expenses for preparing medical reports, itemized bills, or claim forms.

- Charges for biofeedback therapy.

- Charges for hospice bereavement Treatment.

- Non-Covered Services–Services or supplies directly related to any condition, service or supply that is not covered by this Plan. This includes any complications arising from any treatment, services or supplies not covered by this Plan.

- Charges for transplant services or supplies received during the first 12 months of coverage under this Plan. The 12-month waiting period will not apply to children who have been continuously enrolled since birth. The eligible Participant will be allowed a credit toward this transplant waiting period for any period of time he or she was continuously covered under another medical plan with the Employer, immediately preceding the time the eligible participant's coverage under this Plan began. Coverage under the other plan must have ended when this Plan began. Other than described herein, this 12-month transplant waiting period will not be waived or credited for any reason.

- Adoption expenses or any expenses related to surrogate parenting.

- Services and supplies that are court-ordered or are related to deferred prosecution, deferred or suspended sentencing or driving rights, if those services are not deemed Medically Necessary under the Plan.

- Habilitative, 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 therefore, except as provided herein under the "Neurodevelopmental Therapy Services" and "Mental and Nervous Treatment" sections.

- Over-the-counter drugs, supplies, food supplements, infant formulas, and vitamins, except as provided under the Prescription Drug Card Program.

- Self-Help Programs – Non-medical self-help programs such as Outward Bound or wilderness survival, and recreational or educational therapy.

- Third-Party Liability – Benefits payable under the terms of any automobile medical, personal injury protection, automobile no-fault, homeowner, commercial premises or similar contract or insurance when such contract or insurance is issued to, or makes benefits available to, the covered Participant. This also includes Treatment of Illness or Injury for which the third party is liable.

- Off Label Drug Use - Expenses related to Off-Label Drug Use, unless medically necessary; would otherwise be a covered expense under the Plan; and the use meets the definition of Off-Label Drug Use, (as defined in the General Definition section).

PRESCRIPTION DRUG CARD PROGRAM

"Legend" drugs are those drugs which cannot be purchased without a prescription written by a Physician or dentist.

GENERIC SUBSTITUTION

Over 400 commonly prescribed drug products are now available in a generic form at an average cost of 50% less than the brand-name products. This Plan encourages the use of generic prescription drugs. By law, generic and brand-name drugs must meet the same standards of safety, purity, strength, and effectiveness. At the same time, brand name drugs are often two to three times more expensive than Generic Drugs. Use of Generic Drugs with this benefit will save you money, and we encourage you to ask your Physician to prescribe them whenever possible.

PAYMENT SCHEDULE

A copay is payable for each prescription filled according to the amounts shown in the Schedule of Benefits.

BRAND NAME PREFERRED DRUGS

An important element of your Express-Scripts, Inc. Prescription Drug Card Program is the opportunity to select drugs from the "Preferred Drug List." The Preferred Drug List is a guide to the best values within select therapeutic categories which helps the provider identify products that will provide optimal clinical results at a lower cost. The Preferred Drug List undergoes a thorough review and/or revision annually. Interim changes could occur to reflect changes in the market. These changes could include entry of new products or other events that alter the clinical or economic value of the products on the Preferred Drug List. Please see your Human Resources Department for a copy of the Preferred Drug List, or visit the Express-Scripts, Inc. Web site at www.express-scripts.com.

"Other brand-name drugs" are any brand-name drugs covered through the Express-Scripts, Inc. Prescription Drug Card Program, but not listed on the Preferred Drug List.

DRUGS COVERED

- Legend drugs.
- Insulin.
- All diabetic supplies, including syringes, needles, devices, pump supplies, swabs, blood monitors and kits, test strips, blood glucose calibration solutions, urine tests, lancets and lancet devices.
- Disposable needles and syringes.
- Respiratory supplies.
- Tretinoin, all dosage forms (e.g., Retin-A), for individuals through age 35.
- Compounded medication of which at least one ingredient is a legend drug.

- Any other drug that, under the applicable state law, may be dispensed only upon the written prescription of a Physician or other lawful prescriber.

- Legend oral and injectable contraceptives.

- Legend prenatal vitamins.

- Smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms except oral inhalers (e.g., Nicorette, Nicoderm, etc.). Legend Zyban (bupropion) and nicotine transdermal patches for smoking cessation are limited to one 12-week course per calendar year.

DRUGS EXCLUDED AND LIMITED

- Anorectics (any drug used for the purpose of weight loss).

- Dietary supplements.

- Drugs used for cosmetic purposes (e.g., Botox).

- Drugs used for the treatment of hair loss (e.g., Propecia®, Rogaine®).

- Drugs used for the treatment of impotency unless needed as a direct result of surgery or invasive procedure for unrelated conditions. Prior authorization is required.

- Immunization agents, biological sera, blood, or blood plasma.

- Infertility medications.

- Contraceptive implants, devices and IUDs.

- Nicotine oral inhalers (e.g., Nicotrol).

- Non-legend drugs other than insulin (over the counter products).

- Growth hormone drugs or medicines, unless authorized in advance.

- Pigmenting and depigmenting agents, unless authorized in advance.

- Tretinoin, all dosage forms (e.g., Retin-A), for individuals 36 years of age or older, unless authorized in advance.

- Vitamins, singly or in combination, except legend prenatal vitamins.

- Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, except those listed above.

- Charges for the administration or injection of any drug.

- Prescriptions that an eligible individual is entitled to receive without charge under any workers' compensation laws.

- Drugs labeled "Caution—limited by federal law to investigational use," or experimental drugs, even if a charge is made to the individual.

- Medication that 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 Medical Facility, rest home, sanitarium, extended care facility, convalescent medical facility, 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 specified by the Physician, or any refill dispensed after one year from the Physician's original order.

PRIOR AUTHORIZATION

Prior authorization is the process of obtaining a certification of authorization from the pharmacy benefit manager for specified medications or specified quantities of medications. This process often involves appropriateness review against established criteria. Failure to obtain prior authorization often results in a financial penalty to the Participant. Prior authorization is especially valuable for drug therapy that can be prescribed either for uses that are covered by a benefit or for uses that are not. Prior authorizations is the means by which uses covered by a benefit can be discerned from uses not covered by the benefit.

Please keep in mind that some drugs may also require prior authorization before the pharmacy can fill your prescription. These drugs require additional information from your Physician such as drugs tried and drugs failed, diagnosis, current medication, etc. to ensure safety and Medical Necessity. Your Physician will need to complete a prior authorization form, which will then be reviewed for Medical Necessity. A prior authorization form may be obtained by calling Express-Scripts, Inc. Customer Service at 888/676-7902.

DISPENSING LIMITATIONS

The amount normally prescribed by a Physician, but not to exceed a 31-day supply.

COORDINATION OF BENEFITS

Coordination of Benefits does not apply to outpatient prescription drug card programs.

BENEFIT LIMITATIONS

If the prescription card is not used by the Participant at the time of the prescription purchase or if the prescription is purchased at a nonparticipating pharmacy, you must file a claim directly with the drug card service agency using its claim form.

When you do not use the prescription card, the benefit is less because the prescription drugs cost more. When you submit a prescription claim to the drug card service agency, the charges will include: (1) the copay you would normally pay; (2) the difference between the pharmacy retail price and the amount the pharmacy would have charged if the prescription card was used; and (3) a handling fee will be deducted from your total reimbursement.

BENEFITS FOR EMPLOYEES AND DEPENDENTS WITHOUT A CARD

Prescription drugs that are reimbursed by the Prescription Drug Card Program can be submitted to Express-Scripts, Inc. prior to the receipt of the card. To claim this benefit, a receipt for the paid prescription with an Express-Scripts, Inc. claim form must be submitted to Express-Scripts, Inc. Express-Scripts, Inc. will reimburse eligible claims as if the card had been used (100% reimbursement following the applicable copay).

CUSTOMER SERVICE

For questions regarding the Prescription Drug Card Program, please contact Express-Scripts, Inc. at 888/676-7902, Monday through Friday (excluding holidays) 5:30 a.m. to 7:00 p.m., Saturdays 6:00 a.m. to 5:00 p.m., and Sundays 9:00 a.m. to 3:00 p.m. Pacific Time.

MAIL ORDER PRESCRIPTION DRUG PROGRAM

Express-Scripts, Inc.

GENERIC SUBSTITUTION

Over 400 commonly prescribed drug products are now available in a Generic Drug form at an average cost of 50% less than the brand name products. This Plan encourages the use of generic prescription drugs. By law, generic and brand name drugs must meet the same standards of safety, purity, strength, and effectiveness. At the same time, brand-name drugs are often two to three times more expensive than Generic Drugs. Use of Generic Drugs with this benefit will save you money, and we encourage you to ask your physician to prescribe them whenever possible.

PAYMENT SCHEDULE

A copay is payable for each prescription filled according to the amounts shown in the Schedule of Benefits.

This Plan requires the pharmacist to fill the prescription with a Generic Drug product whenever it is available, unless the prescription is written as "Dispense as Written."

DISPENSING LIMITATIONS

The amount normally prescribed by a Physician, but not to exceed a 90-day supply.

ORDERING INFORMATION

For your first order, complete the Express-Scripts Inc. Mail Order form and submit with your new prescription. The Physician can also phone or fax in refill prescriptions to save time. Refills can be ordered over the telephone with a credit card by calling 888/676-7902 or via the web at www.express-scripts.com.

Express-Scripts, Inc. Mail Order Pharmacy maintains a quick turnaround time. Orders that do not require a conversation with either the Participant or the Physician, prior to dispensing will be filled and mailed within three to five days. Prescriptions that require communication with either the Participant or the Physician will not be filled until all questions have been answered.

BENEFIT LIMITATIONS

Continue to have non-maintenance prescriptions (prescribed for urgent illness or injury) filled at the local pharmacy. However, if you are ordering maintenance medications (those taken on a regular or long-term basis, such as heart, allergy, diabetes, or blood pressure medications), use the Express-Scripts, Inc. Mail Order program and have the medications delivered directly to your home.

VISION BENEFITS

COVERED SERVICES

An eye examination consists of the inspection of internal and external appearance of the eye, eye movement, visual acuity, visual field, color vision, glaucoma, and a refraction test, to assess whether glasses or contact lenses are necessary.

An eye examination must be completed by an optometrist or ophthalmologist.

Covered vision hardware includes:

- Single, bifocal, and trifocal lenses.
- Frames.
- Contact lenses.

VISION BENEFITS AFTER TERMINATION OF COVERAGE

Expenses incurred for lenses and/or frames within 30 days of termination of the Participant's coverage under the benefit will be considered to be covered vision care expenses, but only if a complete eye examination, including refraction, was performed during the 30-day period immediately preceding the termination of coverage and while coverage was in force, and if the examination resulted in lenses being prescribed for the first time or new lenses required because of a change in prescription.

EXCLUSIONS

To ensure coverage at a reasonable cost, and to prevent unnecessary use of services, the following are not covered:

- Charges for special procedures, such as orthoptics or vision training, or for special supplies, such as non-prescription sunglasses and subnormal vision aids.
- Drugs or medications of any kind.
- Charges for services or supplies that are received while the Participant is not covered.
- Charges for vision care services or supplies for which benefits are provided under any worker's compensation law or any other law of similar purpose, whether benefits are payable as to all or only part of the charges.
- Charges for any eye examination required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement, or which is required by any law or government.
- Charges for refractive eye surgery, including radial keratotomy and LASIK surgery.

GENERAL PROVISIONS

ADMINISTRATION OF THE GROUP MEDICAL PLAN

The Plan is administered through the Plan Administrator. The Plan Administrator has retained the services of an independent Plan Supervisor experienced in claims processing. The Plan Administrator has the right to determine eligibility for benefits and to construe the terms of the Plan. The Plan Administrator has given the Plan Supervisor the authority to carry out its decisions.

Legal notices may be filed with, and legal process served upon, the Plan Administrator.

AMENDMENT OF PLAN DOCUMENT

The Plan Administrator may terminate, modify, or amend the Plan in its sole discretion upon 30 days written notice unless exigent circumstances exist. The Plan Administrator must notify the Plan Supervisor in writing to request an amendment to the Plan. The Plan Supervisor will prepare an amendment to be signed by the Plan Administrator. Once the Plan Administrator has signed the amendment, such termination, amendment or modification which affects covered employees and their dependents will be communicated to the employees in the manner of a new Plan Document or Employer communication. The Plan, as amended, shall be the controlling legal document for determining all Plan payments for all expenses incurred on or after the effective date of such amendment. Plan payments made under the Plan prior to amendment shall continue to be included as Plan payments in determining the total benefits remaining toward satisfaction of any benefit maximums calculated on a Plan Year, calendar year or lifetime basis.

APPEALING A CLAIM

Claims Procedure

As required by state law, the Plan has adopted a written claims administration program. The details of the current claims administration program are detailed below. The claims administration program may be amended in the future. If it is, you will receive written notification of the changes 30 days before they become effective, unless exigent circumstances are present.

Benefits under the Plan will be paid only if the Trustees of the Everett School Employer Benefit Trust ("Trust") or their delegate decide, in their discretion, that Participants and their Dependents are entitled to such benefits. HMA has been delegated the responsibility for administering and determining initial claims and reviewing and reconsidering benefit, enrollment and eligibility denials if appealed. All final appeals will be decided by the Trustees of the Trust. HMA will generally make decisions on a claim within the time frames outlined below. If your claim for benefits is denied in whole or in part, you will be notified of the decision in writing.

Initiating Claim

To initiate a claim, whether for prior authorization or for payment for services received, contact your HMA Customer Service Team. Prior authorization is recommended for certain services. See "Preauthorization of Inpatient Medical Facility Admissions and Outpatient Surgeries" in the "Important Information" section for information on how to obtain prior authorization. If you receive a bill from a provider for which you want payment, send it to Healthcare Management Administrators, Inc., PO Box 85008, Bellevue, Washington 98015-5008. The period of time within which your claim will be processed depends upon whether it is a Pre-Service claim or a Post-Service claim and whether or not it is an Urgent Pre-Service claim.

- Urgent Pre-Service Claim. You will be notified as soon as possible but not later than 72 hours after receipt of the claim unless you or your physician provide insufficient information.

- Other Pre-Service Claims. You will be notified not later than 15 days after receipt of the claim by HMA.

- Post-Service Claims. You will be notified not later than 30 days after receipt of the claim by HMA.

Urgent Care Claims are defined as claims that involve a decision that, if treated as non-urgent, could seriously jeopardize the patient's life, health, or ability to regain maximum function; or would, according to a physician, subject the patient to severe pain.

Post-Service Claim

If your claim is denied in whole or in part, you will receive an Explanation of Benefits showing the calculation of the total amount payable, charges not payable, the reason for the determination, and if applicable, a description of any additional information needed. If additional information is needed, you may be requested to provide the information prior to payment of your claim.

First Level: You may request a review of the initial claim denial **within 180 days** by filing a written appeal with the Plan Supervisor. The written appeal must clearly state that it is an appeal and clearly state the reason for appeal. You must supply any additional information you wish considered to support your appeal reason. The Plan Supervisor will make a decision on appeal **within 30 days**. This decision will be delivered to you in writing setting forth specific references to the pertinent Plan provision, rule, protocol, or guidelines upon which the decision is based. You will also be given a description of any additional information that will aid in making a determination. The review will be conducted by someone other than the individual who made the initial decision and who is not a subordinate of that individual. If you are dissatisfied with the result of the first-level review, you may request a second-level review.

Second Level: You may request a review of the first-level appeal denial **within 180 days** by filing a written request for a second-level appeal with the Plan Supervisor. The written appeal must clearly state that it is an appeal and clearly state the reason for appeal. You must supply any additional information you wish considered to support your appeal reason. The Plan Supervisor will make a decision on appeal **within 30 days**. This decision will be delivered to you in writing setting forth specific references to the pertinent Plan provision, rule, protocol, or guidelines upon which the decision is based. You will also be given a description of any additional information that will aid in making a determination. The review will be conducted by someone other than the individual who made the initial decision on your claim and the adverse decision at the first-level review. The person or committee conducting the second level review will not be subordinate to the person making the initial claim decision or the first-level review.

Subsequent Action: Upon exhaustion of the full participant appeals process, you may appeal to the Trust within 180 days of notification of your second level appeal denial. Please contact the Trust for an appeal form, which you must use to submit your final appeal to the Trust.

Pre-Service Claim

If your Pre-Service (or Pre-Authorization) claim is denied in whole or in part, you will receive written notification of the decision, the reason for the determination and, if applicable, a description of any additional information needed. If additional information is needed, you may be requested to provide the information prior to payment of your claim.

First Level: You may request a review of the initial claim denial **within 180 days** by filing a written appeal with the Plan Supervisor. The written appeal must clearly state that it is an appeal and clearly state the reason for appeal. You must supply any additional information you wish considered to support your appeal reason. The Plan Supervisor will make a decision on appeal **within 15 days**.

This decision will be delivered to you in writing setting forth specific references to the pertinent Plan provision, rule, protocol, or guidelines upon which the decision is based. You will also be given a description of any additional information that will aid in making a determination. The person who conducts the review will not the individual who made the initial decision and will not be a subordinate of that individual. If you are dissatisfied with the result of the first level review, you may request a second-level review.

Second Level: You may request a review of the first-level appeal denial **within 180 days** by filing a written request for a second appeal with the Plan Supervisor. The written appeal must clearly state that it is an appeal and clearly state the reason for appeal. You must supply any additional information you wish considered to support your appeal reason. The Plan Supervisor will make a decision on appeal **within 15 days**. This decision will be delivered to you in writing setting forth specific references to the pertinent Plan provision, rule, protocol, or guidelines upon which the decision is based. You will also be given a description of any additional information that will aid in making a determination. The review will be conducted by someone other than the individual who made the initial decision on your claim and the adverse decision at the first level review. The person or committee conducting the second level review will not be subordinate to the person who made the initial claim decision or the first-level review.

Subsequent Action: Upon exhaustion of the full appeals process, you may appeal to the Trust within 180 days of notification of your appeal denial. Please contact the Trust for an appeal form, which you must use to submit your final appeal to the Trust.

Urgent Pre-Service Claim

"Urgent Care Claims" are defined as claims that involve a decision that, if treated as non-urgent, could seriously jeopardize the claimant's life, health, or ability to regain maximum function; or would, according to a physician, subject the claimant to severe pain. If your Urgent Pre-Service (or Pre-Authorization) claim is denied in whole or in part, you will receive verbal and written notification of the decision, and the reason for the determination, and if applicable, a description of any additional information needed. If additional information is needed, you may be requested to provide the information prior to payment of your claim.

First and Second Level: You may request a review **within 180 days** by filing a written appeal with the Plan Supervisor. The appeal must clearly state that it is an appeal and clearly state the reason for appeal. It is also recommended that you supply any additional information you wish considered to support your appeal reason. The Plan Supervisor will make a decision **within 72 hours** to include both the first- and second level appeals. This decision will be delivered to you verbally and in writing setting forth specific references to the pertinent Plan provision, rule, protocol, or guidelines upon which the decision is based. You will also be given a description of any additional information needed to overturn the decision. The person who conducts the first-level review will not be the individual who made the initial decision who and will not be a subordinate of that individual. The second-level review will be conducted by someone other than the individual who made the initial decision and the individual or individuals who conducted the first-level review. The person or committee conducting the second level review will not be subordinate to the person who made the initial claim decision or the first level review.

Subsequent Action: Upon exhaustion of the above appeals process, you may appeal to the Trust within 180 days of notification of your appeal denial. Please contact the Trust for an appeal form, which you must use to submit your final appeal to the Trust.

APPLICABLE LAW

This Plan is a governmental (sponsored) plan and as such is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a federal law regulating employee welfare and pension plans. Your rights as a Participant in the Plan are governed by the Plan Documents and applicable state law and regulations. This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations.

APPLICATION AND IDENTIFICATION CARD

To obtain coverage and enroll as a Participant, an eligible employee must complete and deliver to the Plan Administrator an application on the enrollment form supplied by the Plan Supervisor.

Acceptance of this application by the Plan Supervisor to the Plan Administrator will be evidenced by the delivery of an identification card showing the employee's name and names of any covered Dependents.

ASSIGNMENT OF PAYMENT

The Plan will pay any benefits accruing under this Plan to the Participant unless the Participant assigns benefits to a Medical Facility, Physician or other provider of service furnishing the services for which benefits are provided herein. No assignment, however, shall be binding on the Plan unless the Plan Supervisor is notified in writing of such assignment prior to payment. Preferred Providers normally bill the Plan directly. If service has been received from a Preferred Provider, benefits are automatically paid to that provider. Any balance due after the Plan payment will then be billed to the Participant by the Preferred Provider.

AUDIT AND CASE MANAGEMENT FEES

Reasonable charges made by an audit and/or case management firm when the services are requested by the Plan Supervisor and approved by the Plan Administrator shall be payable.

CANCELLATION OR TERMINATION

No person shall acquire a vested right to receive benefits after the date this Plan is terminated.

In the event of the termination of this Plan, or the termination of the Employer's participation in the Plan, all employees' and Dependents' coverage shall cease upon a 30 day written notice unless exigent circumstances are present. Employees and Dependents shall not be entitled to further coverage or benefits, whether or not any medical condition was covered by the Plan prior to termination or cancellation.

The Plan may be canceled or terminated at any time for any reason.

CONDITIONS PRECEDENT TO THE PAYMENT OF BENEFITS

The Participant or covered Dependent shall present the Plan identification card to the provider of service upon admission to a Medical Facility or upon receiving service from a Physician.

Written proof of the nature and extent of service performed by a Physician or other provider of service shall be furnished to the Plan Supervisor within one year after the service was rendered. Claim forms are available through the Plan Supervisor, and are required along with an itemized statement with a diagnosis, the employee's name, the patient's name and Social Security number and the name of the Plan Administrator or the Employer.

The employee and all covered Dependents agree that in order to receive benefits, any physician, nurse, medical facility or other provider of service, having rendered service or being in possession of information or records relating thereto, is authorized and directed to furnish the Plan Supervisor, at any time, upon request, any and all such information and records, or copies thereof.

The Plan Supervisor shall have the right to review these records with the Employer and with any medical consultant or with the Medical Management Department as needed to determine the Medical Necessity of the Treatment being rendered.

COORDINATION OF BENEFITS

Definitions

The term "allowable expense" shall mean the UCR expense, at least a portion of which is paid under at least one of any multiple plans covering the Participant for whom the claim is made. In no event will more than 100% of total allowable expenses be paid between all plans, nor will total payment by this Plan exceed the amount which this Plan would have paid as primary plan.

Coordination of Benefits does not apply to the outpatient Prescription Drug Card Program or the Mail Order Prescription Drug Program.

The term "order of benefits determination" shall mean the method for ascertaining the order in which the Plan renders payment. The principle applies when another plan has a Coordination of Benefits provision.

Application

Under the order of benefits determination method, the plan that is obligated to pay its benefits first is known as the "primary plan." The plan that is obligated to pay additional benefits for allowable expenses not paid by the primary plan is known as the "secondary plan." When a Participant is enrolled under two or more plans (policies), an order of benefits determination will be made regarding which plan will pay first. The order of benefit determination is as follows:

1. The plan that does not include a Coordination of Benefits provision will be primary.

2. The plan covering the person as the employee (or insured, member, subscriber or retiree) of the Employer will be primary.

3. This Plan will pay secondary to any individual policy.

4. If this Plan is covering the Participant as a COBRA participant or a participant of continuation coverage pursuant to state law, this Plan is secondary to the Participant's other plan.

5. When a dependent child is covered under more than one plan, the following rules apply. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

   (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      (i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

      (ii) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

   (b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

      (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;

      (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits; or

      (iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child is as follows:

         I. The plan covering the custodial parent;

         II. The plan covering the custodial parent's spouse;

         III. The plan covering the non-custodial parent; and then

         IV. The plan covering the non-custodial parent's spouse.

   For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

6. If the order of payment cannot be determined in accordance with (1), (2), (3), (4), or (5) above, the primary plan shall be deemed to be the plan which has covered the patient for the longer period of time.

7. If the order of payment cannot be determined in accordance with (1), (2), (3), (4), (5), or (6) above, the primary plan shall be deemed to be the plan which has covered the employee for the longest time.

Coordination of benefits with Medicare is governed by the Medicare Secondary Payer rules.

Coordination of Benefits with Medicaid

In all cases, benefits available through a state or Federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

CREDIT FOR PRIOR GROUP COVERAGE

This Plan amends and replaces the prior Plan. Employees and Dependents who were covered under the prior plan sponsored by the Employer immediately prior to the time this Plan became effective shall not lose their eligibility or benefits due to the change in plans. If a Participant is disabled on the date a Plan change is to take effect that increases the benefit, the disabled Participant will remain at the old benefit level until he or she is no longer disabled. All charges incurred on or after the effective date of this Plan will be subject to the benefits available under this Plan and not the prior plan. Credit will be given for time enrolled under the prior plan in meeting the preexisting condition waiting periods and for payments toward coinsurance and deductibles.

EFFECT OF TERMINATION OF THE PLAN

Upon complete or partial termination of the Plan, the Plan Administrator may, after the payment or provision for payment of all benefits to each Participant who has incurred covered expenses and charges properly payable, including all expenses incurred and to be incurred in the liquidation and distribution of the related Trust Fund or separate account, direct the disposition of all assets held in the Trust Fund or separate account to the participating Employer, subject to any applicable requirement of an accompanying Trust Document or applicable law or regulation.

FACILITY OF PAYMENT

If, in the opinion of the Plan Supervisor, a valid release cannot be rendered for the payment of any benefit payable under this Plan, the Plan Supervisor may, at its option, make such payment to the individuals who have, in the Plan Supervisor's opinion, assumed the care and principal support of the covered person and are therefore equitably entitled thereto. In the event of the death of the covered person prior to such time as all benefit payments due him/her have been made, the Plan Supervisor may, at its sole discretion and option, honor benefit assignments, if any, made prior to the death of such Participant.

Any payment made by the Plan Supervisor from liability in accordance with the above provisions shall fully discharge the Plan and the Plan Supervisor to the extent of such payment.

FREE CHOICE OF PHYSICIAN

Participants shall have free choice of any licensed Physician or surgeon, and the physician-patient relationship shall be maintained. Please refer to the Schedule of Benefits for the appropriate coinsurance reimbursement level.

Nothing contained herein shall confer upon a Participant any claim, right or cause of action, either at law or in equity, against the Plan for the acts of any medical facility in which he/she receives care, for the acts of any physician from whom he/she receives service under this Plan or for the acts of the Medical Management Department in performing their duties under this Plan.

Use and Disclosure of Protected Health Information

Under the HIPAA privacy rules **effective April 14, 2004**, the Plan Sponsor must establish the permitted and required uses of Protected Health Information (PHI).

Plan Sponsor's Certification of Compliance

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose PHI to the Employer ("Plan Sponsor") unless the Plan Sponsor certifies its compliance with 45 Code of Federal Regulations §164.504(f)(2) (collectively referred to as the "Privacy Rule") as set forth in this section, and agrees to abide by any revisions to the Privacy Rule.

Restrictions on Disclosure of Protected Health Information to Plan Sponsor

The Plan and any health insurance issuer or business associate servicing the Plan will disclose PHI Information to the Plan Sponsor only to permit the Plan Sponsor to carry out Plan administration functions for the Plan consistent with the requirements of the Privacy Rule. Any disclosure to and use by the Plan Sponsor of PHI will be subject to and consistent with the provisions of paragraphs on "Plan Sponsor Obligations Regarding Protecting Health Information" and "Adequate Separation Between the Plan Sponsor and the Plan" below.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose PHI to the Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to the Plan's eligible employees.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose PHI for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Plan Sponsor Obligations Regarding Protected Health Information

The Plan Sponsor will:

- Neither use nor further disclose PHI, except as permitted or required by the Plan Document, as amended, or required by law.
- Ensure that any agent, including any subcontractor, to whom it provides PHI, agrees to the restrictions and conditions of the Plan Document, including this "HIPAA Privacy" section, with respect to PHI.
- Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
- Report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures allowed under this Section, promptly upon learning of such inconsistent use or disclosure.
- Make PHI available to the Plan's participant who is the subject of the information, in accordance with 45 Code of Federal Regulations §164.524.
- Make PHI available for amendment, and will on notice amend PHI, in accordance with 45 Code of Federal Regulations §164.526.
- Track disclosures it may make of PHI so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations §164.528.

- Make available its internal practices, books, and records, relating to its use and disclosure of PHI, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.

- If feasible, return or destroy all PHI, in whatever form or medium (including in any electronic medium under the Plan Sponsor's custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any employee who is the subject of the PHI, when the PHI is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all PHI, the Employer (Plan Sponsor) will limit the use or disclosure of any PHI it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Adequate Separation Between the Plan Sponsor and the Plan

The following classes of employees and other workforce members under the control of the Plan Sponsor may be given access to PHI received from the Plan or a health insurance issuer or business associate servicing the Plan:

- Board of Trustees.

- Human Resources staff.

- IT staff.

This list includes every class of employees and other workforce members under the control of the Plan Sponsor who may receive PHI relating to payment under, health care operations of or other matters pertaining to the Plan in the ordinary course of business. The identified classes of employees and other workforce members will have access to PHI only to perform the Plan administration functions that the Plan Sponsor provides for the Plan.

The identified classes of employees and other workforce members will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Plan Sponsor, for any use or disclosure of PHI in breach or violation of or noncompliance with the provisions of this "HIPAA Privacy" section of the Plan Document. The Plan Sponsor will promptly report such breach, violation or noncompliance to the Plan, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance; and to mitigate any deleterious effect of the breach, violation or noncompliance on any participant in the Plan, the privacy of whose PHI may have been compromised by the breach, violation or noncompliance.

Employer (Plan Sponsor) Obligations Regarding Electronic Protected Health Information

Effective April 21, 2005, the Employer (Plan Sponsor) will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

- Ensure that the adequate separation between the Plan and Plan Sponsor with respect to electronic PHI is supported by reasonable and appropriate security measures.

- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect the electronic PHI.

- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

INADVERTENT ERROR

Inadvertent error by the Plan Administrator in the transmission of employee's applications shall not deprive any employee or dependent of benefits otherwise due, provided that such inadvertent error be corrected by the Plan Administrator within one hundred and eighty (180) days after it was made.

MEDICARE

Medicare - As used in this section, "Medicare" means Title XVIII (Health Insurance for the Aged) of the United States Social Security Act, as added to by the Social Security Amendments of 1965, the Tax Equity and Fiscal Responsibility Act of 1982, or as later amended.

Person - As used in this section means a person who is eligible for benefits as an employee in an eligible class of this Plan and who is or could be covered by Medicare Parts A and B, whether or not actually enrolled.

Eligible Expenses - As used in this section with respect to services, supplies and treatment shall mean the same benefits, limits, and exclusions as defined in this Plan Document. However, if the provider accepts Medicare assignment as payment in full, then Eligible Expenses shall mean the lesser of the total amount of charges allowable by Medicare, whether enrolled or not, and the total eligible expenses allowable under this Plan exclusive of coinsurance and deductible.

Order of Benefits Determination - As used in this section shall mean the order in which Medicare benefits are paid, in relation to the benefits of this Plan.

Total benefits of this Plan shall be determined as follows:

Active Employees - For active employees and/or nonworking spouses of active employees age 65 or over: This Plan will be primary and Medicare will be secondary.

Disabled Employees with Medicare (Except Those with End-Stage Renal Disease) - For persons eligible for Medicare by reason of disability: This Plan will be primary and Medicare will be secondary. The Employer will remain the primary payor of medical benefits until the earliest of the following events occurs: (1) the group coverage ends for all employees, or (2) the group coverage as an active individual ends.

Disabled Employees with End-Stage Renal Disease ("ESRD")

This Plan shall be primary for ESRD Medicare beneficiaries during the initial 30 months of Medicare coverage, in addition to the usual three month waiting period, or a maximum of 33 months. ESRD Medicare entitlement usually begins on the fourth month of renal dialysis, but can start as early as the first month of dialysis for individuals who take a course in self-dialysis training during the three-month waiting period.

MISREPRESENTATION

Any material misrepresentation on the part of the Plan Administrator or the employee in making application for coverage, or any application for reclassification thereof, or application for service thereunder shall render the coverage null and void.

NOTICE

Any notice given under this Plan shall be sufficient, if given to the Plan Administrator when addressed to it at its office; if given to the Plan Supervisor, when addressed to it at its office; or if given to a participant, when addressed to the participant at his or her address as it appears on the records of the Plan Supervisor on the Participant's enrollment form and any corrections made to it.

PHOTOCOPIES

Reasonable charges made by a provider for photocopies of medical records when the copies are requested by the Plan Supervisor shall be payable.

PLAN DOCUMENT

This document is the Plan Document.

Everett School Employee Benefit Trust, of Everett, Washington, has established this Plan for the payment of certain expenses for the benefit of its eligible employees.

Everett School Employee Benefit Trust assures covered eligible employees that during the continuance of the Plan, all benefits herein described shall be paid to or on behalf of the Employer's employees in the event they become eligible for benefits and enroll as participants in the Plan.

The Plan is subject to all the terms, provisions and conditions recited on the preceding pages hereof.

This Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

PLAN IS NOT A CONTRACT OF EMPLOYMENT

The Plan shall not be deemed to constitute a contract of employment between the Plan Administrator or the Employer and any employee or to be a consideration for or an inducement to or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Plan Administrator or the Employer, or to interfere with the right of the Plan Administrator or the Employer to discharge any employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements that may be made by the Plan Administrator or the Employer with the bargaining representative of any employees.

PLAN SUPERVISOR IS NOT A FIDUCIARY

The Plan Supervisor is not a fiduciary with respect to this Plan and shall not exercise any discretionary authority or control over the management or administration of the Plan, or the management or disposition of the Plan's assets. The Plan Supervisor shall limit its activities to carrying out ministerial acts of notifying Plan Participants and making benefit payments as required by the Plan. Any matters for which discretion is required shall be referred by Plan Supervisor to the Plan Administrator, and the Plan Supervisor shall take direction from the Plan Administrator in all such matters. The Plan Supervisor shall not be responsible for advising the Employer or Plan Administrator with respect to their fiduciary responsibilities under the Plan or for making any recommendations with respect to the investment of Plan assets. The Plan Supervisor may rely on all information provided to it by the Employer, Plan Administrator, and Trustees. The Plan Supervisor shall not be responsible for determining the existence of Plan assets.

RIGHT OF RECOVERY

Whenever payments have been made (or benefits have been quoted) by the Plan Supervisor in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Plan, the Plan Supervisor shall have the right to recover such payment (or avoid making such payment), to the extent of such excess, from among one or more of the following as the Plan Supervisor shall determine: any individuals and/or any insurance companies and other organizations to or for, or with respect to whom, such payments were made.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT—THE PLAN'S RIGHT TO RESTITUTION

The Plan does not provide benefits for any accident, Injury or Illness for which you or your eligible Dependents have, or may have, any claim for damages or entitlement to recover from another party or parties arising from the acts or omissions of such third party (for example, an auto accident). In the event that another party fails or refuses to make prompt payment for the medical expenses incurred by you or your eligible Dependents, which expenses arise from an accident, Injury or Illness, subject to the terms of the Plan, the Plan may conditionally advance the payment of the eligible medical benefits.

Benefits Conditional upon Cooperation

The Plan's payment of eligible benefits is conditional upon:

- The cooperation of you and eligible Dependents, or your respective agent(s) (including your attorneys) or guardian (of a minor or incapacitated individual) working on your behalf to recover damages from another party. You may be asked to complete, sign, and return a questionnaire and possibly a restitution agreement.

If you or your eligible Dependents, or your agent(s) or guardian (of a minor or incapacitated individual), refuse to sign and return a restitution agreement, or to cooperate with the Plan or its assignee, such refusal and non-cooperation may be grounds to deny payment of any medical benefits.

By participating in the Plan, you and your eligible Dependents acknowledge and agree to the terms of the Plan's equitable or other rights to full restitution. You will take no action to prejudice the Plan's rights to restitution. You and your eligible Dependents agree that you are required to cooperate in providing and obtaining all applicable documents requested by the Plan Administrator or the Employer, including the signing of any documents or agreements necessary for the Plan to obtain full restitution.

You and your eligible Dependents are also required to:

- Notify the Plan Supervisor at 800/700-7153 as soon as possible, that the Plan may have a right to obtain restitution of any and all benefits paid by the Plan. You will later be contacted by HMA, and you must provide the information requested. If you retain legal counsel, your counsel must also contact HMA;

- Inform HMA in advance of any settlement proposals advanced or agreed to by another party or another party's insurer;

- Provide the Plan Administrator with all information requested by the Plan Administrator regarding an action against another party, including an insurance carrier; this includes responding to letters

from the Plan Supervisor (and other parties designated by the Plan Administrator acting on behalf of the Plan) on a timely basis;

- Not settle, without the prior written consent of the Plan Administrator or its designee, any claim that you or your eligible dependents may have against another party, including an insurance carrier; and

- Take all other action as may be necessary to protect the interests of the Plan.

In the event you or your eligible Dependents do not comply with the requirements of this section, the Plan may deny benefits to you or your eligible dependents or take such other action as the Plan Administrator deems appropriate.

Right of Full Restitution

If you or your eligible Dependents are eligible to receive benefits from the Plan for injuries caused by another party or as a result of any accident or personal Injury, or if you or your eligible dependents receive an overpayment of benefits from the Plan, the Plan has the right to obtain full restitution of the benefits paid by the Plan from:

- Any full or partial payment which an insurance carrier makes (or is obligated or liable to make) to you or your eligible dependents; and

- You or your eligible dependents, if any full or partial payments are made to you or your eligible Dependents by any party, including an insurance carrier, in connection with, but not limited to, your or another party's:

    - Uninsured motorist coverage;

    - Underinsured motorist coverage;

    - Other medical coverage;

    - No-fault coverage;

    - Workers' compensation coverage;

    - Personal injury coverage;

    - Homeowner's coverage; or

    - Any other insurance coverage available.

This means that, with respect to benefits which the Plan pays in connection with an injury or accident, the Plan has the right to full restitution from any payment, settlement or recovery received by you or your eligible dependents from any other party, regardless of whether the payment, recovery or settlement terms state that there is a separate allocation of an amount for the restitution of medical expenses or the types of expenses covered by the Plan or the benefits provided under the Plan.

Payment Recovery to Be Held in Trust

You, your eligible Dependents, your agents (including your attorneys) and/or the legal guardian of a minor or incapacitated person agree, by request for and acceptance of the Plan's payment of eligible medical benefits, to maintain 100% of the Plan's payment of benefits or the full extent of any payment from any one or combination of any of the sources listed above in trust and without dissipation except for reimbursement to the Plan or its assignee.

Any payment or settlement from another party received by you or your eligible Dependents must be used first to provide restitution to the Plan to the full extent of the benefits paid by or payable under the Plan. The balance of any payment by another party must, first, be applied to reduce the amount of benefits which are paid by the Plan for benefits after the payment and, second, be retained by you or your eligible dependents. You and your eligible dependents are responsible for all expenses incurred to obtain payment from any other parties, including attorneys' fees and costs or other lien holders, which amounts will not reduce the amount due to the Plan as restitution.

The Plan is entitled to obtain restitution of any amounts owed to it from funds received by you or your eligible dependents from other parties, regardless of whether you or your eligible Dependents have been fully indemnified for losses sustained at the hands of the other party. A Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Plan's equitable (or other) right to obtain full restitution.

TAXES

Local, state, and federal taxes associated with supplies or services covered under this Plan will also be considered covered expenses under this Plan.

GENERAL DEFINITIONS

ACCIDENT/ACCIDENTAL INJURY
- A personal bodily injury to the employee or Dependent, effected solely through external, violent and unintentional means. All injuries sustained in connection with one accident will be considered one Accidental Injury. Accidental Injury does not include ptomaine poisoning, disease, or infection (except pyogenic infection occurring through an accidental cut or wound).

AMBULATORY SURGICAL CENTER
- A licensed surgical facility, surgical suite, or medical facility surgical center in which a surgery is performed and the patient is not admitted for an overnight stay.

APPROVED CHEMICAL DEPENDENCY TREATMENT FACILITY
- For the purpose of Treatment of chemical dependency, the definition of the term "facility" includes any public or private treatment facility providing services for the treatment of chemical dependency that has been licensed or approved as a chemical dependency treatment facility by the state in which it is located.

APPROVED TREATMENT PLAN
- A written outline of proposed Treatment that is submitted by the attending Physician to the Plan Supervisor for review and approval.

BIOFEEDBACK THERAPY
- An electronic method that allows the patient to monitor the functioning of the body's autonomic systems (e.g., body temperature, heart rate) that were previously thought to be involuntary.

CALENDAR YEAR
- The 12 months beginning January 1 and ending December 31 of the same year.

COBRA
- Consolidated Omnibus Budget Reconciliation Act of 1985

CONTRIBUTIONS/CONTRIBUTORY
- The employee is required to pay a portion of the cost to be eligible to participate in the Plan.

COVERED INDIVIDUAL OR PARTICIPANT
- An employee, spouse, domestic partner, child, or participating COBRA beneficiary meeting the eligibility requirements for coverage as specified in the Plan, and properly enrolled in the Plan.

CREDITABLE COVERAGE
- The period of prior medical coverage that an individual had from any of the following sources, and that is not followed by a Significant Break in Coverage: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the U.S. uniformed services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan (meaning any plan established or maintained by a state, the U.S. government, a foreign country or any political subdivision of a state, the U.S. government or a foreign country that provides health coverage to individuals who are enrolled in the Plan), a health benefit plan under the Peace Corps Act, or a State Children's Health Insurance Program. Creditable Coverage does not include coverage for liability, dental, vision, specified disease and/or other supplemental-type benefits.

CUSTODIAL CARE
- Care or service that is not Medically Necessary and is designed essentially to assist a Participant in the activities of daily living. Such care includes, but is not limited to, bathing; feeding; preparation of special diets; assistance in walking, dressing and getting into or out of bed, and supervision of taking of medication that can normally be self-administered.

DEDUCTIBLE
- The amount of eligible expenses each Calendar Year that an employee or Dependent must incur before any benefits are payable by the Plan. The individual deductible amount is listed in the Schedule of Benefits.

DEPENDENT
- Any individual who is or may become eligible for coverage under the terms of the Plan because of a relationship to a covered employee.

DISABLED AND DISABILITY
- The terms "disability" and "disabled" mean:

- For employees - their inability to engage, as a result of Accident or Illness, in their normal occupation with the Employer on a full-time basis.

- For Dependents - their inability to perform the usual and customary duties or activities of a Participant in good health and of the same age.

DOMESTIC PARTNER
– Domestic partners are defined as two adults, of the same or opposite sex, engaged in a spouse-like relationship and who have lived together for a period of not less than six (6) months. To qualify for domestic partner coverage, both individuals must meet the following qualifications:

1. Individuals are at least 18 years of age;

2. Individuals are each other's sole domestic partner, have been so for a period of at least six months, and intend to remain so indefinitely; *and* have lived together in the same residence for at least six months;

3. Individuals are not married to or legally separated from anyone else;

4. Individuals are not related by blood to a degree that would prohibit legal marriage in the state in which they reside;

5. Individuals are engaged in a committed relationship and are jointly responsible for each other's common welfare and living expenses;

6. Individuals are not in the relationship solely for the purpose of obtaining coverage;

7. Individuals must sign an Affidavit of Domestic Partnership certifying that the relationship exists, and provide sufficient documentation of a domestic partnership, as defined. In addition to the Affidavit of Domestic Partnership, examples of acceptable proof of domestic partnership include the following, when dated at least six months ago:

    a. Tax returns with the same address.
    b. Bank statements showing the same address.
    c. Driver's licenses showing the same address.

DONOR
- The individual who provides the organ for the recipient in connection with organ transplant surgery. A donor may or may not be an employee or covered under the provisions of this Plan.

DURABLE MEDICAL EQUIPMENT
- Equipment prescribed by the attending Physician that meets all of the following requirements:

- Is Medically Necessary;
- Is designed for prolonged and repeated use;
- Is for a specific purpose in the treatment of an Illness or Injury;
- Would have been covered if provided in a Medical Facility; and
- Is appropriate for use in the home.

EFFECTIVE DATE
– As to the Plan, it is the first day this Plan was in effect as shown in the Plan Specifications. As to a Participant, it is the first day the benefits under this Plan would be in effect, after satisfaction of the Waiting Period and any other provisions or limitations contained herein.

EMPLOYER
- The Everett School District.

ENROLLMENT DATE
- The first day of coverage or, if there is a Waiting Period for coverage to begin under the Plan, the first day of the Waiting Period. If an individual receiving benefits under the Plan changes benefit packages, or if the Plan changes group health insurance issuers, the individual's Enrollment Date does not change.

EXPERIMENTAL OR INVESTIGATIVE
- For the purpose of determining eligible expenses under this Plan (other than off-label drug use, see definition for "Off-Label Drug Use"), a treatment will be considered by the Plan to be experimental or investigative if:

1. The treatment is governed by the United States Food and Drug Administration ("FDA") or another United States governmental agency and the FDA or the other United States governmental agency has **not** approved the treatment for the particular condition at the time the treatment is provided; or
2. The treatment is the subject of ongoing Phase I, II or III clinical trials as defined by the National Institute of Health, National Cancer Institute or the FDA; or
3. There is documentation in published U.S. peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine the safety, toxicity, or efficacy of the treatment.

FMLA
- A leave of absence granted to an eligible participant by the Employer in accordance with Public Law 103-3 for the birth or adoption of the participant's child; placement in the participant's care of a foster child; the serious health condition of the participant's spouse, child or parent; the participant's own disabling serious health condition; the participant's spouse, son, daughter, or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation and this results in a qualifying exigency (as determined by the Secretary of Labor); or the participant is the spouse, son, daughter, parent, or next of kin of a member of the Armed Forces who suffered a serious injury or illness in the line of duty while on active-duty.

GENERAL ANESTHESIA
- A drug/gas which produces unconsciousness and insensitivity to pain.

GENERIC DRUG
- A drug that is generally equivalent to a higher-priced brand name drug and meets all FDA bioequivalence availability standards.

HIPAA
- Health Insurance Portability and Accountability Act of 1996. This Plan is subject to and complies with applicable HIPAA rules and regulations. The Plan is the "Covered Entity" as defined in HIPAA (§160.103).

HOMEBOUND
- A participant is "homebound" when leaving the home could be harmful and involves a considerable and taxing effort, and the Participant is unable to use transportation without the assistance of another person.

ILLNESS
- An illness causing loss to the Participant whose illness is the basis of the claim. For the purposes of this Plan only, "Illness" shall also be deemed to include disability caused or contributed to by pregnancy of the covered employee or spouse, including miscarriage, childbirth, and recovery therefrom. "Illness" shall mean only illness or disease that requires Treatment by a Physician.

INCURRED CHARGE
- The charge for a service or supply is considered to be "incurred" on the date it is furnished or delivered. In the absence of proof to the contrary, when a single charge is made for a series of services, each service will be considered to bear a pro rata share of the charge.

INJURY
- Bodily injury caused by an Accident while the Plan is in force as to the Participant whose injury is the basis of the claim. "Injury" shall mean only those injuries that require Treatment by a Physician.

INPATIENT
- Anyone treated as a registered bed patient in a Medical Facility or other institutional facility.

LIFE-ENDANGERING
- An Injury or Illness is "life-endangering" if it requires immediate medical attention, without which death or serious impairment to a Participant's bodily functions could occur.

LIFETIME
- Wherever this word appears in this Plan Document in reference to benefit maximums and limitations, it refers to the time a Participant is covered under this Plan or any other Employer plan. Under no circumstances does "lifetime" mean during the physical lifetime of the covered person.

MEDICAL EMERGENCY
- An Illness or Injury that is life threatening or one that must be treated promptly to avoid serious adverse health consequences to the Participant.

MEDICAL FACILITY OR HOSPITAL
- An institution that is accredited by the Joint Commission on Accreditation of Healthcare Organizations and that receives compensation from its patients for services rendered. On an inpatient basis, it is primarily engaged in providing all of the following:

- Diagnostic and therapeutic facilities for the surgical and medical diagnosis, Treatment and care of injured and ill Participants.

- Services performed by or under the supervision of a staff of Physicians who are duly licensed to practice medicine.

- Continuous 24-hour-a-day nursing services by registered graduate nurses.

It is not, other than incidentally, a place for rest or for the aged.

For the services covered under this Plan and for no other purpose, Inpatient Treatment of mental illness or chemical dependency, provided by any psychiatric medical facility licensed by the appropriate State Board of Health or the Department of Mental Health, will be considered services rendered in a Medical Facility as defined, subject to the limitations shown herein.

MEDICAL MANAGEMENT DEPARTMENT
- The individual or organization designated by the Plan Administrator to authorize Medical Facility admissions and Surgical Procedures and to determine the Medical Necessity of Treatment for which Plan benefits are claimed.

MEDICALLY NECESSARY
- Medical services and/or supplies that are absolutely needed and essential to diagnose or treat an Illness or Injury of a Participant while covered by this Plan. The Treatment must be:

- Consistent with the symptoms or diagnosis and treatment of the Participant's condition.

- Appropriate with regard to standards of good medical practice.

- Not solely for the convenience of the Participant, family members or a provider of services or supplies.

- The least costly of the alternative supplies or levels of service which can be safely provided to the Participant. When specifically applied to a Medical Facility Inpatient, it further means that the service or supplies cannot be safely provided in other than a Medical Facility Inpatient setting without adversely affecting the Participant's condition or the quality of medical care rendered.

MEDICARE
- The programs established by Title XVIII of the U.S. Social Security Act as amended and as may be amended, entitled Health Insurance for the Aged Act, which includes Part A - Hospital Insurance Benefits for the Aged, and Part B - Supplementary Medical Insurance Benefits for the Aged.

NONEMERGENCY ADMISSIONS
- A Medical Facility admission (including normal childbirth) that may be scheduled at the convenience of a Participant without endangering the Participant's life or without causing serious impairment to the Participant's bodily functions.

OFF LABEL DRUG USE
- The use of a drug for a purpose other than that for which it was approved by the FDA. For purposes of determining whether off-label use for a FDA approved drug is eligible for coverage under the Plan versus investigative, the following will apply:

1. Medically necessary off-label drug use will be accepted if the drug is otherwise covered by the Plan and if one of the following criteria are met:

   A. Drug Compendia: One of the following drug compendia indicates that the drug is recognized as effective for the indication:
      - The American Hospital Formulary Service Drug Information;
      - Drug Facts and Comparison;
      - The U.S. Pharmacopoeia Dispensing Information;
      - American Medical Association Drug Evaluation;
      - National Cancer Care Network;
      - National Cancer Institute; or

- Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services.

B. Scientific Evidence/Substantially Accepted Peer-Reviewed Medical Literature: The majority of the scientific evidence indicates that the drug is effective for the off-label indication. The evidence must:

1. Consist of an adequate number of well-designed studies with sufficient numbers of patients in relation to the incidence of the disease;
2. Be published in peer reviewed journals. The studies must be printed in journals or other publications that publish original manuscripts only after the manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy, validity, and reliability;
3. There must be enough information in the peer-reviewed literature to allow judgment of the safety and efficacy;
4. Demonstrate consistent results throughout all studies; and
5. Document positive health outcomes and demonstrate:
   i. That the drug is as effective as or more effective than established alternatives; and
   ii. Improvements that are attainable outside the investigational setting.

C. Recognized as effective for treatment of such indication by the Federal Secretary of Health and Human Services.

ORDER OF BENEFITS DETERMINATION
- The method for ascertaining the order in which the Plan renders payment. The principle applies when another plan covering a Participant has a Coordination of Benefits provision.

ORTHOTICS/ORTHOSIS
- An orthopedic appliance or apparatus used to support, align, prevent, or correct deformities or to improve function of movable parts of the body.

PHYSICIAN
- A doctor of medicine (M.D.), doctor of osteopathy (D.O.) or physician's assistant (P.A.) who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. For services covered by this Plan and for no other purpose, doctors of dental surgery, Doctors of dental medicine, doctors of podiatry, optometrists, chiropractors and licensed health service providers in psychology are deemed to be physicians when acting within the scope of their licenses for services covered by this Plan.

Registered physical therapists, licensed speech therapists and certified occupational therapists who are registered, licensed or certified by the state.

Registered nurses (R.N.), licensed vocational nurses (L.V.N.) and licensed practical nurses (L.P.N.) will be covered under this definition.

A licensed masters of social work (M.S.W.), licensed masters of arts (M.A.), licensed masters of education (M.Ed.) or licensed master of counseling (M.C.) who is licensed or certified by the state.

A licensed midwife or nurse practitioner who is licensed by the state to perform services for which benefits are provided under the Plan, and who acts within the scope of such license, is included in the term "physician."

Licensed Acupuncturists (L.Ac.), Licensed Massage Therapists (L.M.P.), and Licensed Naturopathic Physicians (N.D.) will be covered under this definition.

PLAN
- The Everett School Employee Benefit Trust Medical Benefit Plan.

PLAN ADMINISTRATOR
- The individual, group, or organization responsible for the day-to-day functions and management of the Plan; *i.e.,* the Trustees of the Everett School Employee Benefit Trust. The Plan Administrator may employ individuals or firms to process claims and perform other Plan-connected services.

PLAN DOCUMENT
- The term "Plan Document" whenever used herein shall, without qualification, mean this document, which contains the complete details of the benefits provided by this Plan.

PLAN SPONSOR
– The Everett School Employee Benefit Trust.

PLAN SUPERVISOR
- The individual or group providing administrative services to the Plan Administrator, currently Healthcare Management Administrators, Inc. (HMA), in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it by the Plan Administrator.

PLAN YEAR
- An annual period beginning on the effective date of this Plan and ending 12 calendar months thereafter or upon termination of the Plan, whichever occurs earliest.

PREFERRED PROVIDER
- A provider who is part of a network of providers contracted to accept a negotiated rate as payment in full for services rendered.

PROTECTED HEALTH INFORMATION (PHI)
– Individually Identifiable Health Information, as defined in HIPAA §164.501 (see §164.514(2)(b)(i) for individual identifiers), whether it is in electronic, paper or oral form that is created or received by or on behalf of the Plan Administrator or the Plan Supervisor.

RECIPIENT
- The "recipient" is the participant who receives the organ for transplant from the organ donor. The recipient shall be an employee or dependent covered under the provisions of this Plan. Only those organ transplants not considered experimental in nature and specifically covered herein are eligible for coverage under this Plan.

RELATIVE
- When used in this document shall mean a husband, wife, domestic partner, son, daughter, mother, father, sister or brother of the employee, or any other person related to the employee through blood, marriage, domestic partnership or adoption.

ROOM AND BOARD CHARGES
- The institution's charges for room and board and its charges for other Medically Necessary institutional services and supplies, made regularly at a daily or weekly rate as a condition of occupancy of the type of accommodations occupied.

SEMI-PRIVATE ROOM
- The daily room and board charge that an institution applies to the greatest number of beds in its semiprivate rooms containing two or more beds. If the institution has no semiprivate rooms, the semiprivate rate will be the daily room and board rate most commonly charged for semiprivate rooms with two or more beds by similar institutions in the area. The term "area" means a city, county, or any greater geographic area necessary to obtain a representative cross-section of similar institutions.

SIGNIFICANT BREAK IN COVERAGE
- Any period of 63 consecutive days during each of which an individual does not have any Creditable Coverage. Periods of no coverage during an HMO affiliation period, a Waiting Period, or for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period, shall not be taken into account for purposes of determining whether a Significant Break in Coverage has occurred.

SKILLED NURSING/REHABILITATION FACILITY
- An institution or a distinct part of an institution, meeting all of the following tests:

- It is licensed to provide and is engaged in providing, on an inpatient basis, for participants convalescing from injury or disease, professional nursing services rendered by a registered graduate nurse (R.N.), licensed vocational nurse (L.V.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered graduate nurse, physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.

- Its services are provided for compensation from its patients and patients are under the full-time supervision of a Physician or registered graduate nurse (R.N.).

- It provides 24-hour-per-day nursing services by a licensed nurse, under the direction of a full-time registered graduate nurse (R.N.).

- It maintains a complete medical record on each patient.

- It has an effective utilization review plan.

- It is not, other than incidentally, a place for rest for the aged, drug addicts, alcoholics, the mentally handicapped, custodial, or educational care, or care of mental disorders.

SPOUSE
- The employee's lawfully wed spouse, which is legally recognized in the jurisdiction in which the employee has his/her principle residence, not including a common-law marriage.

SURGICAL PROCEDURE
- A "surgical procedure" is defined as:

- A cutting operation.

- Treatment of a fracture.

- Reduction of a dislocation.

- Radiotherapy if used in lieu of a cutting operation for removal of a tumor.

- Electrocauterization.

- Diagnostic and therapeutic endoscopic procedures.

- Injection treatment of hemorrhoids and varicose veins.

TEMPOROMANDIBULAR JOINTS
- The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

TREATMENT
- Administration or application of remedies to a patient for a disease or injury; medicinal or surgical management or therapy.

UCR
- A usual, customary, and reasonable fee that is commonly accepted as payment for a given service by Physicians or suppliers of services in a particular geographic area.

WAITING PERIOD
- The period that must pass before coverage for an employee or Dependent that is otherwise eligible to enroll under the terms of the Plan can become effective. If an employee or Dependent enrolls as a late employee or special enrollee, any period before such late or special enrollment is not a Waiting Period. Periods of employment in an ineligible classification are not part of a Waiting Period.

PLAN ACCEPTANCE

Everett School Employee Benefit Trust, of Everett, Washington, has established this Plan for the payment of certain expenses for the benefit of the Employer's eligible employees.

Everett School Employee Benefit Trust assures covered employees that during the continuance of the Plan, all benefits herein described shall be paid to or on behalf of employees in the event they become eligible for benefits.

The Plan is subject to all the terms, provisions and conditions recited on the preceding pages hereof.

This Plan is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

Everett School Employee Benefit Trust has caused this Plan to be amended and restated. This Plan, as amended and restated, will take effect as of 12:01 a.m. on January 1, 2009 at Everett, Washington.

Everett School Employee Benefit Trust

_____
Authorized Signature

_____
Printed Name and Title

_____
Date

Plan Amended and Restated January 1, 2009

Claim Administration By:

HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
PO Box 85008
Bellevue, WA 98015-5008

425/462-1000 Seattle Area
800/700-7153 All Other Areas