AMENDMENT NO. 1

to the Summary Plan Descriptions of the

WHATCOM COUNTY EMPLOYEE HEALTH CARE PLAN
CAP 2000, CONTRIBUTORY CAP, CAP HDHP, AND LEOFF I SPD'S

The Summary Plan Descriptions effective 01/01/17 are amended effective 01/01/18 as follows:

Within **all Summary Plan Descriptions**, in the **Important Information** provisions, add **Section 1557 Non-Discrimination Statement** as follows:

SECTION 1557 NON-DISCRIMINATION STATEMENT

This Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. This Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

This Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats (large print, audio, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, contact the Plan Administrator as listed in this document.

If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: The Civil Rights Coordinator, at the address and phone number listed in this document. You can file a grievance in person or by mail. If you need help filing a grievance, The Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW., Room 509F, HHH Building, Washington, D.C. 20201, 800/368-1019, 800/537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Within **all Summary Plan Descriptions**, in the **Schedule of Benefits**, revise the **Assistant Surgeon** benefit as follows:

ASSISTANT SURGEON
Remove:
- Limited to 20% of surgeon's fee.

Add:
Paid based upon the primary surgeon's allowed amount, whether contracted or usual and customary.

Within **all Summary Plan Descriptions**, in the **General Provisions,** under **Coordination of Benefits,** add the following:

A credit savings may be established if this Plan is secondary. A credit savings is the difference between the benefits this Plan would pay if you had no other coverage and the benefits this Plan actually paid. Credit savings may be used to provide 100% payment rather than partial payment of allowable expenses that you incur within the same calendar year.

Within **all Summary Plan Descriptions**, in the **Comprehensive Major Medical Benefits,** add **Palliative Care** as follows:

PALLIATIVE CARE

Palliative care is covered if you have a serious illness and your provider has assessed that you are in need of palliative services. Covered services include counseling, symptom management, and treatment within scope of palliation concurrently with disease-directed therapies.

Palliative Care focuses on providing you with relief from the symptoms, pain and stress of a serious illness, regardless of the diagnosis. The goal is to improve quality of life for both you and your family. It is appropriate at any age and at any stage of a serious illness and can be provided along with curative treatment. Typically, the palliative care interdisciplinary team is composed of a physician board-certified in hospice and palliative medicine, an advanced practice nurse, a social worker and a chaplain. This benefit is available in conjunction with or without hospice benefits.

Within **all Summary Plan Descriptions**, in the **General Definitions,** add **Palliative Care** as follows:

Palliative Care - Palliative care means services received from a provider specialized in palliative care which can be provided in a home, inpatient or outpatient setting.

Within the **CAP2000, Contributory CAP, and CAP HDHP Summary Plan Descriptions**, throughout the **Continuation of Coverage Under COBRA** provisions, revise the **COBRA Administrator Contact Information** as follows:

Mailing Address:

HMA, Inc.
P.O. Box 53168
Bellevue, WA 98015-5016
Attn: COBRA Unit
800/869-7093 (phone)
425/285-3662 (fax)
COBRARequest@accesstpa.com

Street Address:

HMA, Inc.
220 120th Ave NE
Bellevue, WA 98005
Attn: COBRA Unit
800/869-7093 (phone)
425/285-3662 (fax)
COBRARequest@accesstpa.com

Within the **CAP2000, Contributory CAP, and CAP HDHP Summary Plan Descriptions**, in the **Continuation of Coverage Under COBRA** provisions, under **Electing COBRA Coverage,** revise the **third paragraph** as follows:

You must complete the Election Form in writing and mail, fax, e-mail, or hand deliver to the individual and address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about your COBRA coverage.

Within the **CAP2000, Contributory CAP, and CAP HDHP Summary Plan Descriptions**, in the **Continuation of Coverage Under COBRA** provisions, under **Notice Procedures** revise the **second paragraph** as follows:

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

Within the **CAP2000, Contributory CAP, and CAP HDHP Summary Plan Descriptions**, in the **Continuation of Coverage Under COBRA** provisions, under **Notice Procedures for Notice of Disability,** revise the **second paragraph** as follows:

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

Within the **CAP2000, Contributory CAP, and CAP HDHP Summary Plan Descriptions**, in the **Continuation of Coverage Under COBRA** provisions, under **Notice Procedures for Notice of Second Qualifying Event,** revise the **second paragraph** as follows:

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

Within the **CAP2000, Contributory CAP, and CAP HDHP Summary Plan Descriptions**, in the **Important Information** provisions, under the **Pre-authorization of Inpatient Medical Facility Admissions and Outpatient Surgeries** replace the **Additional Services Requiring Pre-Authorization** provision with the following:

Please see the Care Management provisions of this SPD for additional services which require pre-authorization. Failure to obtain pre-authorization from the HMA Care Management Department prior to the receipt of these services will result in the denial of your claim and the expenses will not apply towards the out-of-pocket maximum.

Within **all Summary Plan Descriptions**, in the **Important Information** provisions, replace the **Case Management/Alternative Treatment** provision with **Care Management** as follows:

CARE MANAGEMENT

Care Management services are provided for you if you are receiving acute or on-going care that is considered serious, high dollar or complex in nature. Acute or catastrophic events, high dollar claims and other unique or complex conditions will be monitored by Care Management. The following services are always reviewed for medical necessity and other conditions of the Plan; claims received without pre-authorization are evaluated prior to payment to ensure all benefit terms are met:

- Inpatient admissions and Outpatient surgeries.
- Home Health and Hospice Care.
- Radiation therapy (other than conformal).

- DME and Prosthetics that exceed $2,000.
- Infusions, Injections and Chemotherapy.
- Inpatient Acute Rehabilitation and Skilled Nursing Facility admissions.
- Residential, Partial Hospital Programs, and Intensive Outpatient Programs.
- Kidney Dialysis.
- Blood/Marrow and Solid Organ Transplants.

Assessment tools and evidenced based guidelines are used by Care Management for all case determinations. This SPD is the primary source for specific benefit language and is the default directive for any potential subsequent referenced guideline(s). Please see the Evidence Based Medicine provisions within the General Plan Provisions section of this SPD for information regarding guidelines and compendia used by this Plan for medical necessity and length of stay determinations.

Care Management will work with you to ensure that the right care at the right time is delivered and to lower the cost of health care to you and the Plan. The Care Manager 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 your care and when a higher level care would be the reasonable outcome if lower level provisions of the Plan are not available. In order to qualify for alternative treatment, medical necessity criteria must be met for the higher cost service line that would be a reasonable expectation without access to the proposed lower cost alternative. Reasonable outcomes and expectations are determined by Care Management and/or Medical Director assessment.

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

Within **all Summary Plan Descriptions**, in the **Comprehensive Major Medical Benefits,** revise the **Ambulance** benefit as follows:

AMBULANCE (AIR AND GROUND)

Services of a licensed ambulance company for transportation to the nearest medical facility where the required service is available, if other transportation would endanger your health and the purpose of the transportation is not for personal or convenience reasons.

Cabulance

The Plan will cover ground cabulance services for non-emergent transport if you are a medically stable patient who cannot otherwise use private transportation without endangering your safety. You will be eligible for ground cabulance services when:

- You are medically stable and require a wheelchair with portable oxygen, a non-active IV, hep lock, Foley catheter or NG tube.
- You are medically stable, non-ambulatory and you require movement by wheelchair, or you are ambulatory but you require assistance to transfer.

Within **all Summary Plan Descriptions**, in the **Comprehensive Major Medical Benefits,** revise the **Prosthetics** benefit as follows:

PROSTHETIC APPLIANCES

Benefits are provided for artificial devices which are medically necessary to replace a missing or defective body part, including (but not limited to) artificial limbs, eyes, breasts, cochlear implant, BAHA, and artificial shoulder, knee or hip. Benefits will also be payable for an external and permanent internal breast prosthesis following a mastectomy

and as required by the Women's Health and Cancer Rights Act. Benefits are available for a testicular prosthesis if related to orchiectomy for testicular cancer. 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. Repair or replacement of prostheses due to normal use or due to normal growth of your child will be covered. Benefits are not provided for cosmetic prostheses except as stated in the Women's Health and Cancer Rights Act. Additional services may be authorized based upon medical necessity review by Care Management services.

Purchase of a prosthetic that is over $2,000 may/must be reviewed by Plan Supervisor's Care Management Department. Failure to pre-authorize services may result in the denial of the claim.

Within **all Summary Plan Descriptions**, in the **Comprehensive Major Medical Benefits,** add the **Self-Administered Medication Benefit** as follows:

SELF-ADMINISTERED MEDICATION BENEFIT

Coverage for topical, oral drugs, and the injectable medications listed below are exclusively provided through the pharmacy benefits of the Plan. Please see the Prescription Drug Card Program provisions of this SPD for information regarding the Pharmacy Benefit Manager (PBM). Pre-authorization from the PBM may be required. (See the Infusion Therapy Benefit for infusion services provided under the medical benefits of the Plan.)

Please contact the Pharmacy Benefit Manager for details on coverage of the following self-injectable medications:

- Avonex
- Betaseron
- Cimzia
- Copaxone
- Cosentyx
- Enbrel
- Extavia
- Genotropin
- Humatrope
- Humira
- Kineret
- Kynamro
- Norditropin
- Nutropin
- Omnitrope
- Peg-Intron
- Plegridy
- Praluent
- Rebif
- Repatha
- Saizen
- Simponi

- Stelara
- Taltz

If you are unable or unwilling to self-administer an injectable medication as noted above or if the prescription drug plan does not cover the medication or it isn't included on the formulary drug list, your attending physician must submit a written pre-authorization request to administer the injectable medication under the medical benefits of the Plan. Drugs must meet the Plan's Off Label Drug Use and Medical Necessity language criteria to be considered for pre-authorization. The request must be pre-authorized in advance by the Plan Supervisor's Care Management Department. Failure to pre-authorize the administration or purchase and administration of the injectable medication may result in the denial of your claim. Specialty benefit criteria will be waived for payment of the first dose under the major medical benefit, to allow for adequate time to transition the prescription to your pharmacy benefit manager.

Within the **CAP2000, Contributory CAP, and CAP HDHP Summary Plan Descriptions**, in the **Comprehensive Major Medical Benefits**, replace the **Preventive Care** language with the following:

PREVENTIVE CARE

This benefit covers routine physician/provider services and related diagnostic tests that are regularly performed without the presence of symptoms, including school or sports examinations, and examinations required by the Department of Transportation. Benefits will be covered under this Preventive Care benefit if services are in accordance with age and frequency guidelines according to, and as recommended by, the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices or the Health Resources and Services Administration (HRSA). In the event any of these bodies adopts a new or revised recommendation, this Plan has up to one year before coverage of the related services must be available and effective under this benefit. Services are payable as shown in the Schedule of Benefits.

Within the **LEOFF I Summary Plan Description**, in the **Comprehensive Major Medical Benefits**, replace the **Preventive Care** language with the following:

PREVENTIVE CARE

This benefit covers routine physician/provider services and related diagnostic tests that are regularly performed without the presence of symptoms, including school or sports examinations, and examinations required by the Department of Transportation. Services are payable as shown in the Schedule of Benefits.

Within **all Summary Plan Descriptions**, in the **General Exclusions to the Medical Plan**, replace the **Routine Services** exclusion with the following:

Routine Services - Services or supplies that are not directly related to an illness, injury, or distinct physical symptoms. Routine services include health examinations required:

- By a third party, including examinations and treatments required to obtain or maintain employment (excluding exams required by the Department of Transportation), or which
- An employer is required to provide under a labor agreement;
- For securing insurance, school admissions or professional or other licenses;
- For administrative purposes;
- As a premarital requirement;
- To travel;
- To attend a camp, or sporting event or to participate in other recreational activities;

- Any special medical reports not directly related to treatment except when provided as part of a covered service.

This exclusion does not apply to services and supplies specified under the Preventive Care Benefit, or to routine mammograms.

Throughout the **LEOFF I, CAP 2000, and Contributory CAP Summary Plan Descriptions,** revise the **Pharmacy Benefit Manager** as follows:

Remove:
Express-Scripts, Inc.
www.expressscripts.com
800/282-2881 Customer Service

Add:
CVS Caremark
www.caremark.com
866/885-4944