

**AMENDMENT NO. 01**

to the Summary Plan Description of the  
**CITY OF RENTON EMPLOYEE HEALTH CARE PLAN**  
**Medical SPD**

The Summary Plan Description effective 1/01/2011 is amended effective 10/01/2011 as follows:

On **page 75** of the Summary Plan Description, within the **Prescription Drug Card Program**, revise the **Prescription Drug Preauthorization** provision as follows:

Delete:

- **Growth Hormones:** Medications used to promote or stimulate growth (e.g. Genotropin, Humatrope, Norditropin, Serostim). Limited to \$25,000.

**AMENDMENT NO. 2**

to the Summary Plan Descriptions of the  
**CITY OF RENTON EMPLOYEE HEALTH CARE PLAN**  
**CITY OF RENTON LEOFF I RETIREE HEALTH CARE PLAN**

**Medical, Dental, and LEOFF I Dental SPD's**

The Summary Plan Descriptions effective 01/01/11 are amended effective 01/01/12 as follows:

On Page 10 of the Medical Summary Plan Description, within the Schedule of Benefits, revise the Preferred Provider Organization as follows:

HMA Preferred  
800/700-7153  
OR  
[www.accesshma.com](http://www.accesshma.com)

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On page 51 of the Medical Summary Plan Description, within the Comprehensive Major Medical Benefits, under Chemical Dependency Treatment, replace the Inpatient Treatment with the following:

**Inpatient Treatment**

Inpatient treatment for chemical dependency is covered under the Plan.

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On page 61 of the Medical Summary Plan Description, within the Comprehensive Major Medical Benefits, under Mental Health Treatment, replace the Inpatient Treatment with the following:

**Inpatient Treatment**

Inpatient mental health treatment is covered under the Plan.

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On page 51 of the Medical Summary Plan Description, within the Comprehensive Major Medical Benefits, under Chemical Dependency Treatment exclusions, add the following:

Chemical Dependency treatment does not include:

- Wilderness or outdoor treatment programs.

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On page 62 of the Medical Summary Plan Description, within the Comprehensive Major Medical Benefits, under Mental Health Treatment, add the following:

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.
  - Wilderness or outdoor treatment programs.
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On page 51 of the **Medical Summary Plan Description**, within the **Comprehensive Major Medical Benefits**, under **Chemical Dependency Treatment**, add the following:

Coverage under this Plan includes treatment in an inpatient medical facility, residential treatment facility, including partial day treatment, and outpatient treatment. Inpatient and residential services are covered when medically necessary.

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On page 62 of the **Medical Summary Plan Description**, within the **Comprehensive Major Medical Benefits**, under **Mental Health Treatments**, revise the list of **Excluded Services** as follows:

- Services for residential treatment and services received at a residential treatment facility.
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On page 87 of the **Medical Summary Plan Description**, within the **General Definitions**, under **Medical Facility**, revise the last paragraph as follows:

The term "Hospital" or "Medical Facility" will not include an institution which is primarily: a place for rest or retirement; a residential treatment facility (except as provided under the Chemical Dependency Treatment benefit), a health resort; a place for the aged; a convalescent home; juvenile boot camps (e.g., Outward Bound, wilderness survival programs); or a nursing home.

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On Page 52 of the **Medical Summary Plan Description**, within the **Comprehensive Major Medical Benefits** section, add the following to the **Dental Services** benefit:

#### **DENTAL SERVICES**

Procedures performed by an oral surgeon to excise and/or biopsy suspected lesions, excise confirmed tumors or malignancies of the oral cavity, tongue, or jaw whether done in a dental office or a hospital.

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On Page 53 of the **Medical Summary Plan Description**, within the **Comprehensive Major Medical Benefits** section, revise the **Dietary Education**, as follows:

#### **DIETARY EDUCATION**

Dietary education is a covered benefit, if provided by a physician as defined under this Plan. Benefits will be provided for education, guidance, and nutritional therapy for individuals with illnesses or diseases that can be improved with diet, including, but not limited to diabetes, high blood pressure, and high cholesterol. The Plan Supervisor will be the final authority on which education programs will meet the criteria of eligibility.

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On page 72 of the **Medical Summary Plan Description**, within the **General Exclusions to the Medical Plan**, add the following:

**Cochlear implants and bone anchored hearing aid (BAHA) devices are not covered.**

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On page 89 of the Medical Summary Plan Description, within the General Definitions, add the following to the definition of Physician/Provider:

- Audiologist
- Certified Psychiatric/Mental Health Clinical Nurse
- Licensed Professional Counselor
- Licensed Speech Language Pathologist (S.L.P)
- Psychiatrist (M.D.)

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On page 96 of the Medical Summary Plan Description and on page 49 of the Dental Summary Plan Description, within the General Provisions, replace the Coordination of Benefits provisions with the following:

## **COORDINATION OF BENEFITS**

### **Definitions**

The term "allowable expense" shall mean the usual, customary and reasonable (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 that this Plan would have paid as primary Plan.

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

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 which does not include a Coordination of Benefits provision will be primary.
2. The plan covering the person as a retiree will be secondary.
3. The plan covering the person as the employee (or insured, member, or subscriber) of the policy will be primary.
4. This Plan will pay secondary to any individual policy.
5. 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.
6. 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 are 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.

- 7. Where 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 patient for the longer period of time.
- 8. Where the order of payment cannot be determined in accordance with (1), (2), (3), (4), (5), (6), or (7) 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.

On page 34 of the LEOFF I Dental Summary Plan Description, within the General Provisions, replace the Coordination of Benefits provisions with the following:

## **COORDINATION OF BENEFITS**

### **Definitions**

The term "allowable expense" shall mean the usual, customary and reasonable (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 that this Plan would have paid as primary Plan.

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

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 which does not include a Coordination of Benefits provision will be primary.
2. The plan covering the person as a retiree will be secondary.
3. The plan covering the person as the employee (or insured, member, or subscriber) of the policy will be primary.
4. This Plan will pay secondary to any individual policy.
5. 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.
6. Where 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 patient for the longer period of time.
7. Where the order of payment cannot be determined in accordance with (1), (2), (3), (4), (5), (6), or (7) 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.

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On pages 68-72 of the Medical Summary Plan Description, replace the General Exclusions to the Medical Plan with the following:

## GENERAL EXCLUSIONS TO THE MEDICAL PLAN

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This section of your booklet 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 Health Services 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 booklet, the Plan will not provide benefits for:

**Abortion** – Voluntary termination of pregnancy for dependent children.

**Adoption Expenses** – Adoption expenses or any expenses related to surrogate parenting.

**Alcohol/Drug/Chemical Dependency** – Except as provided under the Chemical Dependency Treatment 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.

**Alternative Medicine** – Services rendered by homeopath, herbalist, and acupressurist. Services for acupressure, rolfing, faith healing services, or reflexology.

**Appointments (Missed, Cancelled, Telephonic and Electronic)** – Missed or canceled appointments or for telephone and electronic consultations.

**Birth Control** – Except as provided under the Prescription Drug Card Program, legend oral contraceptives, nonprescription drugs, implants, injectables, devices, and supplies related to birth control. Examples of what is not covered include, but not limited to, the following: oral contraceptives; intrauterine devices (IUDs); intervaginal rings; diaphragms; condoms; sponges; contraceptive foam, jelly or other spermicidal item; and injections. Removal of IUD's, implants and other devices are not covered regardless of the reason for the removal. Please see the Prescription Drug Card Program for additional information.

**Breast Implants** -- Charges for breast implants except as provided herein.

**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 coinsurance provisions that apply for the mastectomy.

**Counseling, Education, or Training Services** -- Counseling, education, or training services, except as stated under the "Dietary Education" and "Chemical Dependency Treatment" benefits. This includes vocational assistance and outreach; job training such as work hardening programs; smoking cessation programs; family, marital, sexual, social, lifestyle, nutritional, and fitness counseling; and other services or supplies that are primarily educational in nature other than as defined herein.

**Court Ordered** -- 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.

**Custodial Care** -- Charges for 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 participants with no special medical skills or training. Such care includes, but is not limited to: helping a patient walk, getting in or out of bed, and taking normally self-administered medicine.

**Dental** -- Dental services including treatment of the mouth, gums, teeth, mouth tissues, jawbones or attached muscle, upper or lower jaw augmentation reduction procedures, orthodontic appliances, dentures and any service generally recognized as dental work. Hospital and Physician services rendered in connection with dental procedures are only covered 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 under the Dental Services Benefit and the TMJ Benefit.

**Driving Under the Influence (DUI)/Driving While Intoxicated (DWI)** -- Charges for any injury to a participant sustained while driving a vehicle that is involved in an accident where the participant is found guilty of Driving Under the Influence (DUI) or Driving While Intoxicated (DWI); guilt of driving under the influence of alcohol or illegal drugs.

**Environmental Services** -- Milieu therapy and any other treatment designed to provide a change in environment or a controlled environment.

**Experimental or Investigative** -- Services considered to be experimental, investigative (as defined in the Definition Section) or generally non-accepted medical practices at the time they are rendered.

**Felony** -- Charges that are a result of any injury or illness incurred by a participant while that participant is participating in the commission of a felony.

**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 (G.I.F.T.); fertility drugs (including but not limited to as Clomid, Pergonal or Serophene); or any other artificial means of conception.

**Gender Change** -- Charges for gender change or for procedures to change one's physical characteristics to those of the opposite gender.

**Government Facility** -- 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.

**Habilitative, Education, or Training Services** -- 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 and Mental Health benefits.

**Hospice Bereavement** -- Charges for hospice bereavement treatment.

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

**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; or impotency drugs whether or not they are the consequence of illness or injury.

**Jaw Augmentation/Reduction** -- The Plan does not cover congenital reconstructive or cosmetic upper or lower jaw augmentation or reduction procedures (orthognathic surgery).

**Licensed/Certified** -- Any services outside the scope of the provider's license, registration, or certification, or that is 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. Treatment or services provided by anyone other than a physician operating within the scope of their license, as defined herein.

**Mail Expenses** -- Mailing and/or shipping and handling expenses.

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

**Medical Records and Reports** -- Expenses for preparing medical reports, itemized bills, or claim forms, except as expressly requested by or on behalf of the Plan.

**Military Services** -- Charges for the treatment of a condition resulting from war or an act of war, declared or undeclared, or an injury sustained or illness contracted while on duty with any military service for any country.

**Neurodevelopmental Therapy** -- Charges for neurodevelopmental therapy treatment except as provided herein.

**No Charge** - Charges that the employee is not legally required to pay for or for charges which would not have been made in the absence of this coverage.

**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.

**Not Medically Necessary** -- Services and supplies not medically necessary (as defined in the Definition Section) for the diagnosis or treatment of an illness or injury, unless otherwise listed as covered.

**Obesity (and Morbid Obesity)** --Treatment for obesity (excessive weight and morbid obesity) including surgery or complications of such surgery, wiring of the jaw or procedures of similar nature, diet programs and/or other therapies, except as provided herein.

**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).

**Orthotics** -- Orthotics or other similar supportive devices for the feet, except as provided in the Orthotics benefits.

**Over-the-Counter** -- Over the counter drugs, supplies, food supplements, infant formulas, and vitamins.

**Personal Items** -- Services for the convenience of the individual, family, or physician. Personal comfort or service items while confined in a hospital, such as, but not limited to, radio, television, telephone, barber or beautician, and guest meals.

**Pregnancy (Dependent Children)** -- Services for pregnancy for dependent children, except as provided herein.

**Preventive Care** -- Charges from a non-PPO provider for any preventive care treatment services, including but not limited to gynecological exams, pap smears, and immunizations.

**Professional (and Semi-Professional) Athletics (Injury/Illness)** -- 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 semi-professional athletics, including practice.

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

**Relatives** -- 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.

**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.

**Reversal of Sterilization** -- Charges for reversal or attempted reversal of sterilization.

**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 stated under the "Medical Supplies," or "Orthotics," or "Prosthetic Appliances" benefits of the Plan.

**Routine Services** -- Services or supplies that are not directly related to an illness, injury, or distinct physical symptoms. Examples of routine services include, but not limited to, routine physical exams, diagnostic surgery, premarital exams and insurance exams. These exclusions do not apply to services and supplies specified under the Preventive Care Benefit, or to routine mammograms.

**Self-Help Programs** -- Non-medical, self-help programs such as "Outward Bound" or "Wilderness Survival," recreational or educational therapy.

**Smoking Cessation** - Treatment or classes to stop smoking.

**Third Party Liability** -- Benefits payable under the terms of any automobile medical, personal injury protection, automobile no fault, homeowner, commercial premises, or similar contract of insurance when such contract of 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.

**Training** -- Services or supplies for learning disabilities; vocational assistance and outreach; job training or other education or training services; except as provided herein.

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

**Travel Expenses** -- Travel, whether or not recommended by a physician, except as provided herein under the Ambulance benefits.

**Usual, Customary, and Reasonable (UCR)** -- Charges that are in excess of the usual, customary and reasonable (UCR) fees for the services or supplies provided.

**Vision Care** -- Eyeglasses, contact lenses, eye refractions or examinations for prescriptions or fitting of eyeglasses, contact lenses or charges for radial keratotomy, except as provided herein. Charges for vision.

analysis, therapy, or training relating to muscular imbalance of the eye, and orthoptics are not covered under the Plan.

**War** – Treatment made necessary as a result of war, declared or undeclared, or any act of war. An act of terrorism will not be considered an act of war, declared or undeclared.

**Worker's Compensation** – Services covered by or for which the employee is entitled to benefits under any Worker's Compensation or similar law.

Upon termination of this Plan, all expenses incurred prior to the termination of this Plan, but not submitted to the Plan Supervisor within 75 days of the effective date of termination of this Plan, will be excluded from any benefit consideration.

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On pages 38-39 of the Dental Summary Plan Description, replace the **General Exclusions to the Medical Plan** with the following:

## **EXCLUSIONS AND LIMITATIONS TO THE DENTAL PLAN**

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This section of your booklet explains circumstances in which all the dental benefits of this Plan are limited or in which no benefits are provided. Benefits may also be affected by 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 booklet, the Plan will not provide benefits for:

**Appointments (Missed, Cancelled, Telephonic and Electronic)** – Missed or canceled appointments or for telephone and electronic consultations.

**Changing Dentists** – Charges resulting from changing from one dentist to another while receiving treatment, or from receiving care from more than one dentist for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one dentist had performed all the required dental services.

**Congenital Malformation** – Charges for congenital malformation.

**Cosmetic Services** – Charges for services or supplies that are cosmetic in nature.

**Dental Records and Reports** – Expenses for preparing dental reports, itemized bills, or claim forms, except as expressly requested by or on behalf of the Plan.

**Diagnostic Casts and Study Models** – Charges for diagnostic casts and study models except as provided under the Orthodontia benefit.

**Experimental or Investigative** – Services considered to be experimental, investigative (as defined in the Definition Section) or generally non-accepted dental practices at the time they are rendered.

**Lost, Stolen or Missing Items** – Charges for the replacement of a lost, missing, or stolen prosthetic device.

**Missing Tooth Exclusion** – A partial or fully removable denture or fixed bridgework if involving replacement of one or more natural teeth extracted prior to the person becoming covered under the Plan, unless the denture or fixed bridgework also includes replacement of a natural tooth which:

1. Is extracted while the person is covered; the extraction of third molars (wisdom teeth) do not qualify under the above.

2. Was not an abutment to a partial denture or fixed bridge installed within the preceding five years.

**Nitrous oxide** – Charges for Nitrous oxide.

**Night Guards** – Charges for night guards, or other habit breaking appliances, except as provided under the Orthodontia benefit.

**Oral Hygiene Instruction** – Charges related to oral hygiene instruction.

**Precision Attachments** – Charges for precision or other elaborate attachments for any appliance.

**Prescriptions** – Prescriptions are not covered under the Dental Plan. Dental prescriptions are paid under your Prescription Drug Card Program.

**Procedures Began Prior to Effective Date of Coverage** – Any procedure which began before the date the covered participant's dental coverage started. X-rays and prophylaxis shall not be deemed to start a dental procedure.

**Providers Other Than Dentists** – Charges for treatment by other than a dentist except that scaling or cleaning of teeth and topical application of fluoride may be performed by a licensed dental hygienist or dental assistant if the treatment is rendered under the supervision or the direction of the dentist or is in accordance with state law.

**Provisional Splinting** – Charges for provisional splinting.

**Relatives** – 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.

**Services That Began Prior to Effective Date of Coverage** – A service which is:

1. An appliance, or modification of an appliance, for which an impression was made before such person became covered.
2. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered.
3. Root canal therapy, for which the pulp chamber was opened before such person became covered.

**Third Party Liability** – Benefits payable under the terms of any automobile medical, personal injury protection, automobile no fault, homeowner, commercial premises, or similar contract of insurance when such contract of 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.

**Usual, Customary and Reasonable (UCR)** – Charges that are in excess of the usual, customary and reasonable (UCR) fees for the services or supplies provided, or which exceed the UCR charges for the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.

**Vertical Dimension (Restoration of)** – Charges for dentures, crowns, inlays, onlays, bridgework, splinting, other appliances or service, for which the primary purpose is to increase vertical dimension or restore occlusion, except as specifically provided herein under the TMJ section or under orthodontia benefits.

**Worker's Compensation** – Services covered by or for which the employee is entitled to benefits under any Worker's Compensation or similar law.

## AMENDMENT NO. 3

to the Summary Plan Descriptions of the

### CITY OF RENTON EMPLOYEE HEALTH CARE PLAN CITY OF RENTON LEOFF I RETIREE HEALTH CARE PLAN

#### Medical, Dental, and LEOFF I Dental SPD's

The Summary Plan Description effective 01/01/11 is amended effective 01/01/12 as follows:

On page 10 of the **Medical** Summary Plan Description, within the **Schedule of Benefits** revise the **HMA Preferred Provider Network** as follows:

Effective 1/1/12, the HMA Preferred network has expanded to include access to Regence of Idaho, and Regence of Utah provider networks for members residing in Washington State and Oregon.

**Idaho/Oregon/Utah/Washington Participants:**

**HMA Preferred**

**800/700-7153**

**OR**

**[www.accesshma.com](http://www.accesshma.com)**

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The Summary Plan Descriptions effective 01/01/11 are amended effective 04/01/12 as follows:

On page 92 of the **Medical** Summary Plan Description, on page 30 of the **LEOFF I** Summary Plan Description and on page 45 of the **Dental** Summary Plan Description within the **General Provisions**, delete the **Appealing a Claim** provision, and on page 96 of the **Medical** Summary Plan Description, on page 34 of the **LEOFF I** Summary Plan Description, and on page 49 of the **Dental** Summary Plan Description, within the **General Provisions**, add **Claim for Benefits and Appealing a Claim** as follows:

#### **CLAIMS FOR BENEFITS AND APPEALING A CLAIM**

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

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

A call from a provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions.** Once treatment is rendered, a clean claim (a claim which includes all the information necessary to make a decision)

must be filed with the Plan (which will be considered a "Post-Service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A participant has the right to request a review of an adverse benefit determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a final adverse benefit determination. If the Participant receives notice of a final adverse benefit determination, then the Participant has the right to seek redress through the State or Federal Court Systems as applicable.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Plan participant, or to a provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

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

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

If the Plan does not require the participant to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. The participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

- Concurrent Claims. A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:
  - The Plan Administrator determines that the course of treatment should be reduced or terminated; or
  - The participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

If the Plan does not require the participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The participant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a post-service claim.

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

### **When Health Claims Must Be Filed**

Post-service health claims must be filed with the Plan Supervisor within one year from the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

A pre-service claim (including a concurrent claim that also is a pre-service claim) is considered to be filed when the request for approval of treatment or services is made and received by the Plan Supervisor in accordance with the Plan's procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the Plan. The Plan Supervisor will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Plan Supervisor within 45 days from receipt by the participant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

### Timing of Claim Decisions

The Plan Administrator shall notify the participant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of pre-service claims and concurrent claims, of decisions that a claim is payable in full) within the following timeframes:

- Pre-service Urgent Care Claims:
  - If the participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
  - If the participant has not provided all of the information needed to process the claim, then the participant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
  - The participant will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:
    - The Plan's receipt of the specified information; or
    - The end of the period afforded the participant to provide the information.
  - If there is an adverse benefit determination, a request for an expedited appeal may be submitted orally or in writing by the participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the participant may request an expedited review under the external review process.
- Pre-service Non-urgent Care Claims:
  - If the participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
  - If the participant has not provided all of the information needed to process the claim, then the participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the participant (if additional information was requested during the extension period).
- Concurrent Claims:

- Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The participant will be notified sufficiently in advance of the reduction or termination to allow the participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
- Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
- Request by Participant Involving Non-urgent Care. If the Plan Administrator receives a request from the participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).
- Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:
  - Notification to Participant - 30 days
  - Notification of adverse benefit determination on appeal - 30 days
- Post-service Claims:
  - If the participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
  - If the participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the participant will be notified of the determination by a date agreed to by the Plan Administrator and the participant.
- Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
- Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
- Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

### **Notification of an Adverse Benefit Determination**

The Plan Administrator shall provide a participant with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile or similar method, with written or electronic notice). The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the participant. The notice will contain the following information:

- Information sufficient to allow the participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- A reference to the specific portion(s) of the plan provisions upon which a denial is based;
- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- A description of any additional information necessary for the participant to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the participant's right to bring a civil action under State laws or section 502(a) of ERISA, as applicable, following an adverse benefit determination on final review;
- A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the participant's claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the participant, free of charge, upon request;
- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the participant, free of charge, upon request; and
- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes.
- In a claim involving urgent care, a description of the Plan's expedited review process.

## Appeal of Adverse Benefit Determination

### Full and Fair Review of All Claims

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

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

### Requirements for First Appeal

The participant must file the first appeal in writing using a Request for Review of Benefit Denial form (although oral appeals are permitted for pre-service urgent care claims) within 180 days following receipt of the notice of an adverse benefit determination. If the participant would like to authorize another individual to act on their

behalf in regards to the appeal, an Appointment of Authorized Representative form must be submitted with the appeal. A Request for Review of Benefit Denial form and an Appointment of Authorized Representative form can be obtained by calling HMA's Customer Service Department at 800/700-7153, at [www.accesshma.com](http://www.accesshma.com) or by logging onto your HealthX account at [www.healthx.com](http://www.healthx.com).

For pre-service urgent care claims, if the participant chooses to orally appeal, the participant may telephone:

Healthcare Management Administrators, Inc.  
425/462-1000 Seattle Area  
800/700-7153 All Other Areas

To file an appeal in writing, the participant's appeal must include a Request for Review of Benefit Denial form and be addressed and mailed or faxed as follows:

Healthcare Management Administrators, Inc.  
Attn: Appeals  
P.O. Box 85008  
Bellevue, Washington 98015-5008  
425/462-1000 - Seattle Area  
800/700-7153 - All Other Areas  
866/458-5488 - Fax

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

- A completed Request for Review of Benefit Denial form;
- The name of the employee/participant;
- The employee/participant's member ID number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the participant will lose the right to raise factual arguments and theories which support this claim if the participant fails to include them in the appeal;**
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the participant has which indicates that the participant is entitled to benefits under the Plan.

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

#### **Timing of Notification of Benefit Determination on First Review**

The Plan Administrator shall notify the participant of the Plan's benefit determination on first review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.

- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.
- Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time the first appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

### **Manner and Content of Notification of Adverse Benefit Determination on First Review**

The Plan Administrator shall provide a participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

- Information sufficient to allow the participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- A reference to the specific portion(s) of the plan provisions upon which a denial is based;
- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- A description of any additional information necessary for the participant to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the participant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final review;
- A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the participant, free of charge, upon request;
- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the participant, free of charge, upon request; and

- The following statement: “You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.”

### **Requirements for Second Appeal**

Upon receipt of notice of the Plan’s adverse benefit determination regarding the first appeal, the participant must submit a second appeal in writing using a Request for Review of Benefit Denial form (although oral appeals are permitted for pre-service urgent care claims) within 180 days. If the participant would like to authorize another individual to act on their behalf in regards to the second appeal, an Appointment of Authorized Representative form must be submitted with the appeal. A Request for Review of Benefit Denial form and an Appointment of Authorized Representative form can be obtained by calling HMA’s Customer Service Department at 800/700-7153, at [www.accesshma.com](http://www.accesshma.com) or by logging onto your HealthX account at [www.healthx.com](http://www.healthx.com).

As with the first appeal, the covered participant’s second appeal must be in writing and must include all of the items set forth in the section entitled “Requirements for First Appeal.”

### **Timing of Notification of Benefit Determination on Second Review**

The Plan Administrator shall notify the participant of the Plan’s benefit determination on second review within the following timeframes:

- Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal.
- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.
- Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

Calculating Time Periods. The period of time within which the Plan’s determination is required to be made shall begin at the time the first appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

### **Manner and Content of Notification of Adverse Benefit Determination on Second Review**

The same information must be included in the Plan’s response to a second appeal as a first appeal, except for:

- A description of any additional information necessary for the covered person to perfect the claim and an explanation of why such information is needed; and
- A description of the Plan’s review procedures and the time limits applicable to the procedures. See the section entitled “Manner and Content of Notification of Adverse Benefit Determination on First Appeal.”

### **Furnishing Documents in the Event of an Adverse Determination**

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to “Manner and Content of Notification of Adverse Benefit Determination on Review” as appropriate.

## Decision on Review

If, for any reason, the participant does not receive a written response to the appeal within the appropriate time period set forth above, the participant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted (first level and second level review) before any legal action is brought.**

The decision of the Plan on Second Review is the final level of appeal available to Plan Participants under the Plan. No further appeal rights are available. The Plan Participant has the right to bring civil action under either state law or under section 502(a) of ERISA once their appeal rights are exhausted.

**AMENDMENT NO. 4**

to the Summary Plan Descriptions of the  
**CITY OF RENTON EMPLOYEE HEALTH CARE PLAN**

**Medical SPD**

The Summary Plan Description effective 01/01/11 is amended effective 05/01/12 as follows:

On **Page 10** of the Summary Plan Description, within the **Schedule of Benefits**, add the following to the **Preferred Provider Organization** information:

**RETIRED Participants in all other States or when traveling:**

**PHCS Network**

**800/700-7153**

**OR**

**[www.accesshma.com](http://www.accesshma.com)**

Eligible expenses will be paid for covered retirees (this provision does not apply to active employees or their dependents) 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, where the medical facility and the primary surgeon are both preferred providers.
- You receive emergency services inside or outside the network area.

Retired participants who do not reside within the HMA Preferred PPO Network service area (WA, OR, ID, and UT) but travel to it must use a HMA Preferred PPO Network provider in order receive services covered at the preferred network level of benefit.

## AMENDMENT NO. 5

to the Summary Plan Descriptions of the

### CITY OF RENTON EMPLOYEE HEALTH CARE PLAN CITY OF RENTON LEOFF I RETIREE HEALTH CARE PLAN Medical, Dental, and LEOFF I Dental SPD's

The Summary Plan Descriptions effective 01/01/11 are amended effective 09/01/12 as follows:

On **Page 10** of the **Medical** Summary Plan Description, within the **Schedule of Benefits**, add/revise the following to the **Preferred Provider Organization** information:

**Participants in all other States or when traveling:**

**PHCS Network**

**800/700-7153**

**OR**

**[www.accesshma.com](http://www.accesshma.com)**

Eligible expenses 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, where the medical facility and the primary surgeon are both preferred providers.
- You receive emergency services inside or outside the network area.

Participants who do not reside within the HMA Preferred PPO Network service area but travel to it must use a HMA Preferred PPO Network provider in order receive services covered at the preferred network level of benefit.

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On **page 6** of the **Dental** Summary Plan Description, within the **Schedule of Benefits**, replace the **Dental Benefit** with the following:

### DENTAL SCHEDULE OF BENEFITS

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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-contracted dental providers. Benefits are payable at the preferred level by accessing your care through a Preferred Provider or a Participating Provider. Covered services received from Non-contracted providers will be paid at the out-of-network level of benefits. Your Dental Preferred Provider Organization is:

**HMA National Dental Network**

**800/700-7153 (HMA)**

**OR**

**[www.accesshma.com](http://www.accesshma.com)**

Eligible expenses will be paid at the preferred level when:

- The services are billed by a preferred or participating provider.

- You receive emergency services inside or outside the network area.

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

## DENTAL BENEFITS

	Participating & Preferred Network	Out Of Network
<b>INDIVIDUAL DEDUCTIBLE</b> Per calendar year.	None	None
<b>MAXIMUM PAYABLE</b> Per participant, per calendar year. Applicable to Type I, II, and III services.	\$1,600	\$1,600

Amounts credited to the maximum payable amount is applied to both the Preferred and Out-of-Network eligible expenses.

	Participating & Preferred Network	Out Of Network
<b>TYPE I - PREVENTIVE</b> Oral Exam, Cleaning, X-rays, Fluoride, Sealants.	100%	100%
Fluoride treatments are limited to 2 treatments per calendar year for individuals under the age of 19. Sealants are limited to children under the age of 19, for permanent teeth only.		
<b>TYPE II - BASIC AND RESTORATIVE</b> Fillings, Oral Surgery, Crowns, Endodontic Treatment, Periodontal Services, Pathology, Anesthesia, Injectables.	100%	100%
<b>TYPE III - MAJOR AND PROSTHETICS</b> Bridgework, Dentures, and their repairs, Relines and Rebases.	50%	50%
<b>TYPE IV* - ORTHODONTIA &amp; TMJ</b> <b>Orthodontia</b> Lifetime maximum \$1,250.	50%	50%
<b>Temporomandibular Joint Disorder (TMJ)</b> Not covered under dental benefit – see Medical benefit.	N/A	

\* Type IV benefits do not apply to the Dental Calendar Year Maximum.

On page 33 of the Dental Summary Plan Description, within the Dental Benefits, revise the Description of Benefits as follows:

## DESCRIPTION OF BENEFITS

The Plan pays for covered dental expenses that are incurred during a calendar year on behalf of a covered participant for preventive dental care, treatment of dental disease, failing dental restorations and for injury to teeth not otherwise covered under a medical benefit. Plan benefits are subject to the coinsurance percentage and payable up to the calendar year dental maximum shown in the Schedule of Benefits. The coinsurance is the percentage of the usual, customary, and reasonable (UCR) charge that the Plan will pay for non-participating providers, or the percentage of the negotiated rate for preferred providers and participating providers.

On page 6 of the LEOFF I Retiree Dental Summary Plan Description, within the Schedule of Benefits, replace the Dental Benefit with the following:

## DENTAL 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-contracted dental providers. Benefits are payable at the preferred level by accessing your care through a Preferred Provider or a Participating Provider. Covered services received from Non-contracted providers will be paid at the out-of-network level of benefits. Your Dental Preferred Provider Organization is:

**HMA National Dental Network**  
**800/700-7153 (HMA)**  
**OR**  
**[www.accesshma.com](http://www.accesshma.com)**

Eligible expenses will be paid at the preferred level when:

- The services are billed by a preferred or participating provider.
- You receive emergency services inside or outside the network area.

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

## DENTAL BENEFITS

	Participating & Preferred Network	Out Of Network
<b>INDIVIDUAL DEDUCTIBLE</b> Per calendar year.	None	None
<b>MAXIMUM PAYABLE</b> Per covered individual, per calendar year.	\$500	\$500

Amounts credited to the maximum payable amount is applied to both the Preferred and Out-of-Network eligible expenses.

<b>TYPE I - PREVENTIVE</b> Oral Exam, Cleaning, X-rays, Fluoride, Sealants.	50%	50%
<b>TYPE II - BASIC AND RESTORATIVE</b> Fillings, Oral Surgery, Endodontic Treatment, Periodontal Services, Pathology, Anesthesia, Injectables.	Not Covered	Not Covered
<b>TYPE III - MAJOR AND PROSTHETICS</b> Bridgework, Crowns, Dentures, and their repairs, Relines and Rebases.	Not Covered	Not Covered
<b>TYPE IV - ORTHODONTIA</b>	Not Covered	Not Covered

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On **page 20** of the **LEOFF I Retiree Dental Summary Plan Description**, within the **Dental Benefits**, revise the **Description of Benefits** as follows:

**DESCRIPTION OF BENEFITS**

The Plan pays for covered dental expenses that are incurred during a calendar year on behalf of a covered participant for preventive dental care, treatment of dental disease, failing dental restorations and for injury to teeth not otherwise covered under a medical benefit. Plan benefits are subject to the coinsurance percentage and payable up to the calendar year dental maximum shown in the Schedule of Benefits. The coinsurance is the percentage of the usual, customary, and reasonable (UCR) charge that the Plan will pay for non-participating providers, or the percentage of the negotiated rate for preferred providers and participating providers.

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**The Summary Plan Descriptions effective 01/01/11 are amended effective 10/01/12 as follows:**

On **page 74** of the **Medical Summary Plan Description**, within the **Prescription Drug Card Program**, add the following to the **Prescription Drug Preauthorization**:

- **Cymbalta:** Cymbalta, prescribed for the treatment of anxiety, depression, or pain.
- **Cialis:** Cialis, used in the treatment of erectile dysfunction. LEOFF I active and retired employees only.

## AMENDMENT NO. 6

to the Summary Plan Descriptions of the

### CITY OF RENTON EMPLOYEE HEALTH CARE PLAN CITY OF RENTON LEOFF I RETIREE HEALTH CARE PLAN Medical, Dental, and LEOFF I Dental SPD's

The Summary Plan Descriptions effective 01/01/11 are amended effective 01/01/13 as follows:

On **Page 52** of the **Medical** Summary Plan Description, within the **Comprehensive Major Medical Benefits** add **Contraceptive Services** benefit and on **page 68** of the **General Exclusions to the Medical Plan**, revise the **Birth Control** exclusion as follows:

*Comprehensive Major Medical Benefits:*

#### **CONTRACEPTIVE SERVICES**

Benefits will be provided for contraceptive intrauterine devices which require a prescription and have been approved by the United States Food and Drug Administration. Benefits will also be provided for the insertion and removal of implants and devices.

This benefit does not cover contraceptives that can be purchased without a prescription, such as condoms, sponges, or contraceptive foam or jelly.

*General Exclusions:*

**Birth Control** – Except as provided under the Prescription Drug Card Program and the Contraceptive Services Benefit, legend oral contraceptives, nonprescription drugs, implants, injectables, and supplies related to birth control. Examples of what is not covered include, but not limited to, the following: oral contraceptives; intervaginal rings; implants, transdermal contraceptives, emergency contraceptives, diaphragms; condoms; sponges; contraceptive foam, jelly or other spermicidal item; and injections. Please see the Prescription Drug Card Program for additional information.

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On **page 62** of the **Medical** Summary Plan Description, within the **Comprehensive Major Medical Benefits**, revise the **Orthotics** benefit as follows:

#### **ORTHOTICS**

Medically necessary orthotic foot devices prescribed by a physician to restore or improve function are covered at the coinsurance level indicated in the Schedule of Benefits.

Benefits are provided for medically necessary non-foot orthoses as follows: rigid and semi-rigid custom fabricated orthoses; semi-rigid prefabricated and flexible orthoses; rigid prefabricated orthoses.

Custom foot orthoses are only covered for participants with impaired peripheral sensation and/or altered peripheral circulation (e.g. diabetic neuropathy and peripheral vascular disease); when the foot orthosis is an integral part of the a brace and is necessary for the proper functioning of the brace; when the foot orthosis is for use as a replacement or substitute for missing parts of the foot (e.g. amputated toes) and is necessary for the alleviation or correction of injury, sickness, or congenital defect; or for participants with a neurological or neuromuscular condition (e.g. cerebral palsy, hemiplegia, spina bifida) producing spasticity, misalignment, or pathological positioning of the foot and there is a reasonable expectation of improvement.

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On **page 69** of the **Medical** Summary Plan Description, within the **General Exclusions to the Medical Plan**, add the following:

**Excess** – Charges that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the usual and customary amount, or are for services not deemed to be reasonable or medically necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document.

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On **page 84** of the **Medical** Summary Plan Description, within the **General Definitions**, add the following:

**ALLOWABLE EXPENSES** - Shall mean the usual and customary charge for any medically necessary, reasonable eligible item of expense, at least a portion of which is covered under this Plan. When some other plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had claim been duly made therefore.

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On **page 87** of the **Medical** Summary Plan Description, within the **General Definitions**, add the following:

**MAXIMUM AMOUNT AND/OR MAXIMUM ALLOWABLE CHARGE** - Shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of:

- The usual and customary amount;
- The allowable charge specified under the terms of the Plan;
- The negotiated rate established in a contractual arrangement with a provider; or
- The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the usual and customary amount. The Plan has the discretionary authority to decide if a charge is usual and customary and for a medically necessary and reasonable service.

The **Maximum Allowable Charge** will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

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On **page 90** of the **Medical** Summary Plan Description, within the **General Definitions**, add the following:

**REASONABLE AND/OR REASONABLENESS** - Shall mean in the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of illness or injury not caused by the treating provider. Determination that fee(s) or services are reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. Services, supplies, care and/or treatment that results from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are reasonable based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not reasonable.

Charge(s) and/or services are not considered to be reasonable, and as such are not eligible for payment (exceed the maximum allowable charge), when they result from provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not reasonable and therefore not eligible for payment by the Plan.

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On **page 91** of the **Medical Summary Plan Description**, within the **General Definitions**, replace the definition of **Usual, Customary, and Reasonable (UCR)** with the following:

**USUAL AND CUSTOMARY (U&C)** - Shall mean covered expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the provider most frequently charges the majority of patients for the service or supply, the cost to the provider for providing the services, the prevailing range of fees charged in the same "area" by providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a plan participant by a provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

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On **page 68** of the **Medical Summary Plan Description**, within the **General Exclusions to the Medical Plan**, revise the **Dental** exclusion as follows:

**Dental** -- Dental services including treatment of the mouth, gums, teeth, mouth tissues, jawbones or attached muscle, upper or lower jaw augmentation reduction procedures, orthodontic appliances, dentures and any service generally recognized as dental work. Hospital and Physician services rendered in connection with dental procedures are only covered 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 under the Dental Services for Accidental Injuries Benefit and the TMJ Benefit or if treatment is necessary due to a malignant tumor.

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On **page 96** of the **Medical** Summary Plan Description, on **page34** of the **LEOFF I Dental** Summary Plan Description, and on **page 49** of the **Dental** Summary Plan Description, within the **General Provisions**, throughout the **Claims For Benefits and Appealing a Claim** provisions, revise the address to send appeals to HMA as follows:

Healthcare Management Administrators, Inc.  
Attn: Appeals  
P.O. Box 85016  
Bellevue, Washington 98015-5016  
425/462-1000 - Seattle Area  
800/700-7153 - All Other Areas  
855/462-8875 - Fax