

TO OUR VALUED RETIREES

Welcome to the City of Renton LEOFF I Retiree Health Care Plan!

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

With the exception of very large medical claims from which the Plan is protected by insurance, all Plan expenses are directly paid by the City of Renton LEOFF I Retiree Health Care Plan. This means that through careful use of the Plan, you, as a consumer of health care, can have a direct impact on the cost of our Plan which will benefit both you and the City by allowing us to continue to provide this high-quality level of benefits.

Please read this booklet carefully and particularly note the special requirements you must follow prior to being admitted to a medical facility - this is explained in the IMPORTANT INFORMATION section.

We have contracted for Care Management to help assure that you are receiving the best and most appropriate treatment when health care is needed. The Care Management team are your advocates to help improve the quality of your health care and to lower the cost of health care to you and the Plan.

If you have any questions regarding either your Plan's benefits or the procedures necessary to receive these benefits, please call the Plan Supervisor - Healthcare Management Administrators, Inc. (HMA) at 425/462-1000. When calling from outside of Seattle, you may call HMA toll free at 800/869-7093.

We wish you the best of health.

City of Renton LEOFF I Retiree Health Care Plan

TABLE OF CONTENTS

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION	6
INTRODUCTION AND PURPOSE	6
GENERAL PLAN INFORMATION	6
LEGAL ENTITY; SERVICE OF PROCESS	7
NOT A CONTRACT	7
MENTAL HEALTH PARITY	7
APPLICABLE LAW	7
DISCRETIONARY AUTHORITY	8
PLAN SUPERVISOR NOT A FIDUCIARY	8
IMPORTANT INFORMATION - PLEASE READ	9
WHAT'S MOST IMPORTANT WHEN IT COMES TO HEALTH CARE?	9
CLAIMS AND BENEFIT INFORMATION	9
NO SURPRISES ACT	9
PRE-AUTHORIZATION OF INPATIENT MEDICAL FACILITY ADMISSIONS	11
CERTIFICATION OF ADDITIONAL DAYS	11
STEPS TO TAKE	12
CARE MANAGEMENT	12
CONTINUITY OF CARE	13
HOW TO FILE A CLAIM	14
PREFERRED NETWORK AND OUT-OF-NETWORK PROVIDER ARRANGEMENT	14
CONTACT FOR QUESTIONS ABOUT THE PLAN BENEFITS	15
SCHEDULE OF BENEFITS	16
MEDICAL BENEFITS	18
PRESCRIPTION BENEFITS	22
VISION BENEFITS	23
DENTAL SCHEDULE OF BENEFITS	24
DENTAL BENEFITS	25
ELIGIBILITY AND ENROLLMENT PROVISIONS	26
ELIGIBILITY	26
ENROLLMENT AND EFFECTIVE DATE OF COVERAGE	26
TERMINATION OF COVERAGE	26
PLAN PAYMENT PROVISIONS	27
COINSURANCE PERCENTAGE	27
COMPREHENSIVE MAJOR MEDICAL BENEFITS	28
ELIGIBLE EXPENSES	28
ALLERGY INJECTIONS/TESTING	28
ALTERNATIVE SERVICES	28
AMBULANCE (AIR AND GROUND)	28
BIOFEEDBACK	28
BLOOD BANK	28
CHIROPRACTIC CARE	29
CLINICAL TRIALS BENEFIT	29
CONTRACEPTIVE SERVICES	29
CT SCAN	29
DENTAL SERVICES	29
DIAGNOSTIC X-RAY AND LABORATORY	30
DIETARY EDUCATION	30
DURABLE MEDICAL EQUIPMENT	30
EMERGENCY ROOM & SERVICES	31
GENDER AFFIRMATION SERVICES	31
GENETIC TESTING	31
HEARING BENEFIT	31

HOME HEALTH CARE	32
HOSPICE CARE	33
IMMUNIZATIONS.....	34
INFUSION THERAPY BENEFIT	34
KIDNEY DIALYSIS (OUTPATIENT SERVICES).....	34
LAP BAND PROCEDURE.....	35
MAGNETIC RESONANCE IMAGING (MRI)	36
MEDICAL FACILITY SERVICES	36
MEDICAL SUPPLIES.....	36
MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES	36
ORTHOTICS.....	37
OUTPATIENT SURGICAL FACILITY.....	37
PALLIATIVE CARE	37
PHENYLKETONURIA (PKU) DIETARY FORMULA	38
PHYSICIAN SERVICES.....	38
PRE-ADMISSION TESTING	38
PRESCRIPTION DRUGS	38
PREVENTIVE CARE.....	38
PREVENTIVE MAMMOGRAPHY	38
PROSTHETIC APPLIANCES.....	38
RADIATION THERAPY AND CHEMOTHERAPY	39
REHABILITATION BENEFIT.....	39
SECOND SURGICAL OPINION	40
SELF-ADMINISTERED MEDICATION BENEFIT.....	40
SKILLED NURSING FACILITY CARE	41
STERILIZATION - ELECTIVE	41
SURGERY AND RELATED SERVICES	41
TELEHEALTH MDLIVE.....	41
TELEMEDICINE.....	42
TEMPOROMANDIBULAR JOINT DISORDER (TMJ)	42
TRANSPLANTS	42
GENERAL EXCLUSIONS TO THE MEDICAL PLAN	44
PRESCRIPTION DRUG CARD PROGRAMS.....	51
GENERIC SUBSTITUTION.....	51
BRAND NAME FORMULARY DRUGS	51
PAYMENT SCHEDULE	51
DRUGS COVERED.....	51
DRUGS EXCLUDED AND LIMITED	52
PRESCRIPTION DRUG PREAUTHORIZATION	52
SPECIALTY PHARMACY	53
PRESCRIPTION REFILLS.....	53
RETAIL PRESCRIPTION DRUG PROGRAM.....	53
MAIL ORDER PRESCRIPTION DRUG PROGRAM	54
DENTAL BENEFITS	56
OPTIONAL PREDETERMINATION OF BENEFITS.....	56
DESCRIPTION OF BENEFITS	56
CALENDAR YEAR MAXIMUM.....	56
COVERED DENTAL EXPENSES	56
ALTERNATE TREATMENT	57
TYPE I - PREVENTIVE	57
TYPE II - BASIC AND RESTORATIVE	57
TYPE III - MAJOR AND PROSTHETICS	58
PROSTHESIS REPLACEMENT RULE	58
TYPE IV - ORTHODONTIA.....	59
EXCLUSIONS AND LIMITATIONS TO THE DENTAL PLAN	60
VISION BENEFITS	63
COVERED SERVICES	63
VISION BENEFITS AFTER TERMINATION OF COVERAGE	63

EXCLUSIONS TO THE VISION PLAN.....	63
GENERAL DEFINITIONS	65
GENERAL PROVISIONS	77
ADMINISTRATION OF THE GROUP MEDICAL PLAN	77
AMENDMENT OF PLAN DOCUMENT	77
APPLICATION AND IDENTIFICATION CARD	77
ASSIGNMENT OF BENEFITS	77
AUDIT AND REVIEW FEES	78
AUDIT INCENTIVES.....	78
BALANCE BILLING.....	78
CANCELLATION.....	79
CLAIMS FOR BENEFITS AND APPEALING A CLAIM.....	79
CONDITIONS PRECEDENT TO THE PAYMENT OF BENEFITS.....	87
COORDINATION OF BENEFITS.....	88
CREDIT FOR PRIOR GROUP COVERAGE.....	89
EFFECT OF TERMINATION OF THE PLAN	89
EVIDENCE BASED MEDICINE	89
FACILITY OF PAYMENT	90
FIDUCIARY OPERATION.....	90
FREE CHOICE OF PHYSICIAN	90
FUNDING.....	90
HIPAA PRIVACY AND SECURITY	91
INADVERTENT ERROR.....	93
MEDICARE	93
LEOFF I RETIREES WITH MEDICARE.....	94
MISREPRESENTATION	94
NOTICE.....	94
PHOTOCOPIES.....	94
PLAN ADMINISTRATION	94
RIGHT OF RECOVERY OF PAYMENTS	95
RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION	95
STATE AND FEDERAL EMERGENCY OR EXECUTIVE ORDER	95
STATUTE OF LIMITATIONS CLAUSE	95
SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT - THE PLAN'S RIGHT TO RESTITUTION	96
SUMMARY PLAN DESCRIPTION	101
TAXES	101
SPECIAL RIGHTS TO EMPLOYEES IN THE PLAN.....	102
STATUTE OF LIMITATIONS CLAUSE	102

The Plan Administrator has the right to amend this Plan at any time. The Plan Administrator will make a good faith effort to communicate to you all Plan amendments on a timely basis. For further information, see the section titled Amendment of Plan Document located in the General Provisions section of this Plan.

ESTABLISHMENT OF THE PLAN; ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

This Plan Document and Summary Plan Description, made by City of Renton (the "City" or the "Plan Sponsor") as of January 1, 2023 hereby **amends and restates** City of Renton LEOFF I Retiree Health Care Plan (the "Plan"), which was originally adopted by the City, effective January 1, 1985.

Effective Date

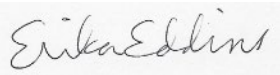
The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein.

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

City of Renton

By:  _____

Name: Erika Eddins _____

Date: June 8, 2023 _____

Title: HR Benefits Manager _____

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

INTRODUCTION AND PURPOSE

The Plan Sponsor has established the Plan for the benefit of eligible Employees, such as yourself, in accordance with the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from you and/or the Plan Sponsor, or may be funded solely from the general assets of the Plan Sponsor. As a participant in the Plan, you may be required to contribute toward Plan benefits.

The Plan Sponsor's purpose in establishing the Plan is to help offset, for yourself, the economic effects arising from certain health expenses. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for medical, prescription drug, dental, and vision charges. The Plan Document is maintained by City of Renton and may be inspected by you at any time during normal working hours.

GENERAL PLAN INFORMATION

NAME OF PLAN	City of Renton LEOFF I Retiree Health Care Plan
NAME & ADDRESS OF EMPLOYER	City of Renton 1055 S. Grady Way Renton, WA 98057 425/430-7650
EMPLOYER IDENTIFICATION NUMBER	91-6001271
TYPE OF PLAN	Employee Health Care Benefits Plan providing Medical, Dental, Prescription, and Vision
TYPE OF PLAN ADMINISTRATION	Contract Administration
ACA PLAN STATUS	Grandfathered
BUNDLED OR UNBUNDLED	Medical coverage is bundled with prescription drug coverage. Dental is unbundled from medical. Vision is unbundled from medical.
ORIGINAL PLAN EFFECTIVE DATE	January 1, 1985
LAST AMENDED DATE	January 1, 2023
PLAN YEAR	January 1st - December 31st
PLAN ADMINISTRATOR PLAN SPONSOR NAMED FIDUCIARY DESIGNATED LEGAL AGENT	City of Renton 1055 S. Grady Way Renton, WA 98057 425/430-7650

EMPLOYEES	You will be considered an eligible employee of City of Renton, when you meet the eligibility requirements described herein.
GROUP NUMBER	5034
CONTRIBUTION REQUIRED	Retiree Coverage - No
PLAN SUPERVISOR	Healthcare Management Administrators, Inc. PO Box 85008 Bellevue, Washington 98015-5008 425/462-1000 Seattle Area 800/869-7093 All Other Areas

The Plan shall take effect for each Participating Employer on the Effective Date unless a different date is set forth above opposite such Participating Employer's name.

LEGAL ENTITY; SERVICE OF PROCESS

The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

NOT A CONTRACT

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between yourself and the City or to be consideration for, or an inducement or condition of your employment. Nothing in this Plan Document shall be deemed to give you the right to be retained in the service of the City or to interfere with the right of the City to discharge you at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the City with bargaining representatives.

MENTAL HEALTH PARITY

As a governmental Self-Funded Health Plan, the City of Renton has the authority to exempt this Plan from certain requirements of title XXVII of the Public Health Services Act. Accordingly, this Plan is exempt from the requirements against having benefits for mental health and substance use disorders be subject to more restrictions than apply to medical and surgical benefits covered by the Plan. This exemption also applies to requirements under the Mental Health Parity and Addiction Equity Act of 2008. This Plan does not enforce parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

APPLICABLE LAW

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

DISCRETIONARY AUTHORITY

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regard to issues relating to eligibility for benefits; to decide disputes that may arise relative to your rights; and to determine all questions of fact and law arising under the Plan.

PLAN SUPERVISOR NOT A FIDUCIARY

The Plan Supervisor is not a fiduciary with respect to this engagement and shall not exercise any discretionary authority or control over the management or administration of the Plan, or the management or disposition of the Plan's Assets. The Plan Supervisor shall limit activities to carrying out ministerial acts of notifying Plan Participants, such as yourself, and making benefit payments as required by the Plan. Any matters for which discretion is required shall be referred by the Plan Supervisor to the Plan Administrator, and the Plan Supervisor shall take direction from Plan Administrator in all such matters. The Plan Supervisor shall not be responsible for advising the City or Plan Administrator with respect to fiduciary responsibilities under the Plan nor for making any recommendations with respect to the investment of Plan Assets. The Plan Supervisor may rely on all information provided to it by the City, Plan Administrator, and the Trustees, as well as the Plan's other vendors. The Plan Supervisor shall not be responsible for determining the existence of Plan Assets.

City of Renton of Renton, WA hereby establishes this Plan for the payment of certain expenses for your benefit to be known as City of Renton LEOFF I Retiree Health Care Plan.

City of Renton assures you that during the continuance of the Plan, all benefits herein described shall be paid to you or on your behalf in the event you become eligible for benefits.

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

This Plan is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

IMPORTANT INFORMATION - PLEASE READ

This group health plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status to non-grandfathered health plan status can be directed to the Plan Administrator at 425/430-7650.

WHAT'S MOST IMPORTANT WHEN IT COMES TO HEALTH CARE?

For some people, the doctor-patient relationship is the top priority; for others, it's having reliable, quality care nearby. Please review this health care booklet to discover what the Plan has to offer and then decide what would work best for you. There are two choices, the Preferred Network of Providers or Out-of-Network. The Plan pays according to "point of service," which means it's flexible - you have an option in selecting wherever you access care, it's your choice.

CLAIMS AND BENEFIT INFORMATION

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

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

When the HMA Care Management Department pre-authorizes any confinement, procedure, service or supply, it is only for the purpose of reviewing whether the service is determined to be medically necessary for the care or the treatment of an illness. Pre-authorization does not guarantee payment of benefits. All charges submitted for payment are subject to all other terms and conditions of the Plan, regardless of authorization by the HMA Care Management Department whether by telephone or in writing.

NO SURPRISES ACT

The No Surprises Act is a federal law that establishes standards to protect you from balance billing if you receive emergency care at an Out-of-Network facility, if you receive treatment for certain ancillary services provided by an Out-of-Network provider but received them at a Preferred Network hospital or outpatient surgical facility, or if you receive Out-of-Network air ambulance services.

Under this Plan, you are responsible for certain cost-sharing amounts. This includes copayments, coinsurance and deductibles. You may have additional costs or be responsible for the entire bill if you see a provider or go to a facility that is not in your Plan's Preferred Provider Network.

Some providers and facilities have not signed a contract with your Preferred Provider Network. They are called Out-of-Network providers. Out-of-Network providers can bill you the difference between what this Plan pays and the amount your Out-of-Network provider bills. This is called balance billing.

The No Surprises Act will protect you from surprise medical bills in cases where you have limited control in choosing a Preferred Network or Out-of-Network provider. For Out-of-Network claims subject to the No Surprises Act, your cost-sharing will be the same amount as would be applied if the claim was provided by a Preferred Network provider and will be calculated as if the Plan's allowable expense was the recognized amount, regardless of the Plan's actual maximum allowable charge and the provider's billed charge for applicable services. This law does not apply if you choose or consent to receive services from an Out-of-Network provider.

Benefits for claims subject to the No Surprises Act will be denied or paid within 30 days of receipt of an initial claim, and if approved will be paid directly to the Provider.

When you CANNOT be balance billed:

a) Emergency Services

The most you can be billed for emergency services is your plan's Preferred Network cost-sharing amount, even if you receive services at an Out-of-Network hospital or from an Out-of-Network provider that works at the hospital. The amounts paid will be applied to your Preferred Network deductible and out-of-pocket maximum. The provider and facility cannot balance bill you for emergency services.

b) Certain services at an In-Network Health Care Facility

When you receive surgery, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeons, intensivists, or hospitalist services from an Out-of-Network provider while you are at a Preferred Network health care facility, the most you can be billed is your Preferred Network cost-sharing amount. The amounts paid will be applied to your Preferred Network deductible and out-of-pocket maximum. These providers cannot balance bill you.

c) Air Ambulance Services

When you receive air ambulance services, you are only required to pay the Preferred Network cost sharing amount even if the air ambulance company is Out-of-Network. The amounts paid will be applied to your Preferred Network deductible and out-of-pocket maximum. The air ambulance provider cannot balance bill you for the remaining amount. **Note:** This does not apply to ground ambulance services.

When you CAN still be balance billed:

If you receive services from an Out-of-Network provider, hospital or facility in any situation OTHER than those listed in paragraphs a), b), or c) above, you may still be balance billed, or you may be responsible for the entire bill. If you knowingly and voluntarily choose an Out-of-Network provider or sign a consent to receive services from an Out-of-Network provider, the Plan's Out-of-Network reimbursement rates will apply and you may be subject to balance billing.

In these instances, the Out-of-Network provider should notify you of their Out-of-Network status within 72 hours before services (or at the time of service if 72 hours advanced notice is not possible) are received. The notice should also include a good faith estimate of the cost for services and identify in-network options for obtaining services.

Independent Dispute Resolution (IDR)

The Plan has 30 days to make a benefit determination and either pay the Out-of-Network claim at the Out-of-Network rate directly to your provider or deny the claim. If your provider is not satisfied with our initial offering, they may request negotiation. If an agreement isn't reached during the negotiation period, your provider may initiate the Independent Dispute Resolution process. The Plan and your Out-of-Network provider will come to a negotiated agreement regarding full payment for services rendered within 30 days, starting on the day after your provider receives payment or the claim denial. If an agreement cannot be made, 4 days following the 30-day negotiation period, either the Plan or your provider may request

arbitration, referred to as Independent Dispute Resolution (IDR). The IDR process will be administered by an independent, unbiased entity with no affiliation to the provider or the Plan. Once the IDR entity has made a determination, the arbitration process is final and binding.

PRE-AUTHORIZATION OF INPATIENT MEDICAL FACILITY ADMISSIONS

This Plan requires pre-authorization of all inpatient medical facility admissions. To avoid a penalty, pre-authorization is required for all scheduled admissions. Failure to call for pre-authorization 2 days **prior** to an admission into a medical facility or, in the case of an emergency admission, failure to obtain authorization either within 48 hours after the emergency admission or on the next business day, if later, will result in the following reductions and losses:

- The amount of the payment due will be reduced by a \$100 penalty on the facility charges; and
- The penalty will not apply towards the out-of-pocket maximum.

At the time that your doctor recommends an inpatient admission for you, you or your doctor should contact the HMA Care Management Department to request pre-authorization. All non-emergency admissions (excluding normal vaginal deliveries where the length of stay is 48 hours or less and cesarean section deliveries where the length of stay is 96 hours or less) must be pre-authorized in advance. You must call no later than 2 business days prior to the medical facility admission. Surgeries performed in the doctor's own office do not need to be pre-authorized. Emergency medical facility admissions must be authorized within 48 hours after the medical facility admission, or by the next business day, if later. Pre-authorization is not required for services related to the treatment of COVID-19.

Special Note Concerning Mothers and Newborns: Hospital stays that extend beyond 48 hours for a normal vaginal delivery or beyond 96 hours for a cesarean section must be pre-authorized at the time your provider recommends the extended stay.

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 may result in the denial of your claim and the expenses will not apply towards the out-of-pocket maximum.

Pre-authorization does not guarantee payment of benefits. The Care Management Department should be contacted at the following numbers:

**HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
425/462-1000 - SEATTLE
800/869-7093 - OTHER AREAS NATIONWIDE**

CERTIFICATION OF ADDITIONAL DAYS

If your physician/provider is considering lengthening a stay, you, your physician/provider, the hospital, or the medical facility must call HMA's Care Management Department to request certification for additional days. Call no later than the last day previously certified. If medically necessary, additional days of confinement may be certified at that time.

STEPS TO TAKE

When an inpatient admission is recommended, you, the physician/provider or a member of your family must call HMA's Care Management Department at least 2 days prior to the admission to obtain authorization. If an emergency admission occurs, you or a member of your family should ask the attending physician/provider or the medical facility to contact HMA's Care Management Department within 48 hours of admission, or by the next business day, if later. Please be prepared to give HMA's Care Management Department the following information when you make the call for authorization:

- Your name and your age.
- Your subscriber identification number.
- Your group number (5034).
- Your medical facility name and address.
- The name and phone number of your admitting physician/provider.
- Your admission date.
- Your diagnosis.
- The procedure being performed.

The Care Management Department will send written confirmation of the approved admission to you once authorized.

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 may be evaluated prior to payment to assess whether all benefit terms are met:

- Inpatient admissions and Outpatient Services
- Home Health and Hospice Care.
- Radiation therapy (other than conformal).
- Durable Medical Equipment 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.
- Formula for PKU or other inborn errors of metabolism.
- Non-urgent ambulance or cabulance services.
- Genetic testing.

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 of 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.

CONTINUITY OF CARE

If you are receiving treatment for certain services, and your health care provider or facility was a contracted Preferred Network provider, but is no longer contracted, you may be able to continue to see that provider temporarily, on an in-network basis.

To qualify under this continuity of care provision, you must be:

- Undergoing a course of treatment for a serious and complex condition from the provider or facility;
- Undergoing a course of institutional or inpatient care from the provider or facility;
- Scheduled to undergo non-elective surgery from the provider (including postoperative care following surgery);
- Pregnant and undergoing a course of treatment for pregnancy from the provider; or
- Determined to be terminally ill and is receiving treatment for such illness from the provider or facility.

If you qualify for continued benefits, the Plan will provide you 90 days of continued in-network coverage if your treating in-network provider leaves the network beginning on the date of the Plan's notice of termination is provided to you (or the date you are no longer receiving qualified continued treatment, whichever is earlier). This provision does not apply if the contract with the provider or facility was terminated due to a failure to meet quality standards or for fraud.

You must continue to be enrolled on this plan and you must elect continuation in writing (preferred) or verbally to be eligible for any continuity of care benefit. The Plan will notify you of the termination and that you have the right to receive continued transitional care from the provider or facility. You will also be given an opportunity to request a need for continued care. Coverage under this continuity of care provision will be provided on the same terms and conditions as any other in-network provider.

If you are receiving benefits under this continuity of care provision, your health care provider or facility must continue to adhere to all policies, procedures, and quality standards imposed by the network contract as if the termination had not occurred. During this continuation, Plan benefits will be processed as if the termination had not occurred, however, the Provider may be free to pursue you for any amounts above the Plan's benefit amount.

When continuity of care ends, you may continue to receive services from this same provider, however, the plan will pay benefits at the out-of-network benefit level. Please see the Schedule of Benefits for more information. If we deny your request for continuity of care, you may appeal the denial. Please see Claim for Benefits and Appealing a Claim provisions for further information.

HOW TO FILE A CLAIM

All providers should send bills to the address listed on your medical identification card.

- You must provide the provider of service with the information listed on your medical identification card. Your provider must attach itemized bills to a claim form. An itemized bill is one that contains your provider's name, address, Federal Tax ID Number, and the nature of the accident or illness being treated.
- In the event that your provider does not submit the claim on your behalf, you may mail your claim form to the Plan Supervisor's address listed on the back of your identification card.

All claims for reimbursement must be submitted within one year of the date incurred.

COORDINATION OF BENEFITS

This Plan is designed to help the covered individual meet the cost of illness or injury and not intended to provide benefits greater than actual expenses. Therefore, the Plan will take into account and coordinate with the benefits of any other plan that provides medical benefits so that the combined benefits of the plans do not exceed 100% of the allowable expenses incurred. Details regarding how the coordination of benefits work are contained in General Provisions section of this booklet.

PREFERRED NETWORK AND OUT-OF-NETWORK PROVIDER ARRANGEMENT

Your Plan contracts with provider networks to access discounted fees for your services. Hospitals, physicians and other providers who have contracted with the provider networks are called Preferred Network Providers or Participating Network Providers. Those who have not contracted with the networks are referred to in this Plan as Out-of-Network Providers. This arrangement results in the following benefits to you:

1. The Plan provides different levels of benefits based on whether you use a Preferred Network, Participating Network, or Out-of-Network-Provider provider. If you elect to receive medical care from an Out-of-Network Provider, the benefits payable are generally lower than those payable when you use a Preferred Network provider, unless an exception applies as outlined in the Schedule of Benefits.
2. Except as outlined in the No Surprises Act provision above, if the charge billed by an Out-of-Network provider for any covered service is higher than the maximum allowable charge determined by the Plan, you are responsible for the excess unless the provider accepts assignment of benefits as consideration in full for services rendered. Since Preferred Network providers have agreed to accept a negotiated discounted fee as full payment for their services, you are not responsible for any billed amount that exceeds that fee. The Plan Administrator reserves the right to revoke any previously-given assignment of benefits or to proactively prohibit assignment of benefits to anyone, including any provider, at its discretion.
3. To receive benefit consideration, you may need to submit claims for services provided by Out-of-Network Providers to the Plan Supervisor. Preferred Network providers have agreed to bill the Plan directly, so you do not have to submit claims yourself.
4. Benefits available to Preferred Network providers are limited such that if a Preferred Network provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a clean claim and review by the Plan Administrator, will be eligible for payment.

If you receive information with respect to an item or service from the Plan, its representative, or a database maintained by the Plan or its representative indicating that a particular provider is a Preferred Network Provider and you receive such item or service in reliance on that information, your coinsurance, copayment, deductible, and out-of-pocket maximum will be calculated as if your provider had been Preferred Network despite that information proving inaccurate.

CONTACT FOR QUESTIONS ABOUT THE PLAN BENEFITS

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

**HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
P.O. Box 85008, Bellevue, WA 98015-5008
425/462-1000 - Seattle
800/869-7093 - Other Areas Nationwide**

SCHEDULE OF BENEFITS

This Plan does not require the designation of a primary care provider or to obtain a referral for services received from a specialist. You shall have the free choice to obtain services from any licensed physician/provider or surgeon, acting within the license's scope. The level of benefits received is based upon your decision at the time treatment is needed to access care through either Preferred or non-preferred providers. Benefits are payable at the Preferred level by accessing your care through a Preferred Provider, Preferred Medical Facility or from a Preferred Hospital. Out-of-Network charges will be paid at the Out-of-Network level of benefits.

If you are receiving treatment for certain services, and your health care provider or facility is no longer contracted as a Preferred Network provider, you may be able to continue to see that provider temporarily, on an in-network basis. Please see the Continuity of Care provision within the Important Information section for more information.

Important Out-of-Network Benefit Notice: The maximum allowable charge for Out-of-Network services is based upon 100% of billed charges (including deductible, out-of-pocket maximum, and coinsurance as applicable), unless otherwise indicated under a specific benefit in the Schedule of Benefits.

Patients who utilize covered services received from Out-of-Network providers, may be subject to balance billing, even if the benefit shows Out-of-Network coverage at 100%. In this instance, the Plan will pay 100% of the maximum allowable amount, and not 100% of the charges billed by the provider. Charges over the maximum allowable amount that are billed by the provider are not covered by this Plan and you may be billed for the balance of the charges.

For example, if you are charged \$100 but the maximum allowable amount for that service is \$80:

- With Out-of-Network coverage at 100%, the Plan will pay \$80 (minus any applicable copayment or deductible). This is 100% of the maximum allowable amount. You may still be responsible for the amount billed by the Out-of-Network provider that is over the maximum allowable amount, in this example, \$20. The Out-of-Network provider may balance bill you for the remaining \$20.***
- With Out-of-Network coverage at 50%, the Plan will pay \$40 (minus any applicable copayment or deductible). This is 50% of the maximum allowable amount. You may still be responsible for the amount billed by the Out-of-Network provider that is over the maximum allowable amount, in this example, \$60. The Out-of-Network provider may balance bill you for the remaining \$60.***

Your Preferred Provider Organization is:

**If you live in Idaho/Oregon/Utah/Washington:
HMA Preferred Provider Network**

800/869-7093

OR

Log in to the myHMA member portal at www.accesshma.com

If you live outside of WA, OR, ID, or UT:

PHCS Network

800/869-7093

OR

Log in to the myHMA member portal at www.accesshma.com

If you live in WA, OR, ID, or UT but are temporarily outside of your home state:

PHCS Network for Out-of-Area Access

800/869-7093

OR

Log in to the myHMA member portal at www.accesshma.com

You can access a directory of Preferred Network providers and facilities at any time on our online portal at www.accesshma.com. This directory is updated at least every 90 days. While we strive to provide accurate provider network status, the listings can change. We recommend you verify with your provider for the most up to date network contract status prior to receiving services.

Eligible expenses will be paid at the Preferred level when (any of the following apply):

- The services are billed by a Preferred provider, hospital or medical facility.
- The services are for non-emergent care provided by a non-preferred Assistant Surgeon or Anesthesiologist, where the medical facility and the primary surgeon are both Preferred providers.
- You live outside the area serviced by the Preferred provider organization.
- You receive emergency services (includes Ambulance, Anesthesiologist, Assistant Surgeon, Emergency Room Services, Primary Surgeon, and Urgent Care) inside or outside the network area.
- The services are for Durable Medical Equipment (DME) distributed by a Preferred provider but the DME company is non-preferred.
- The services are for non-preferred diagnostic testing, lab and imaging services, where the physician/provider who ordered the services is a Preferred provider.

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

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.**

MEDICAL BENEFITS

	Preferred Network	Participating/Out-of-Network
INDIVIDUAL DEDUCTIBLE Per calendar year.	None	None
FAMILY DEDUCTIBLE Per calendar year.	None	None
INDIVIDUAL OUT-OF-POCKET MAXIMUM Per calendar year.	None	None
FAMILY OUT-OF-POCKET MAXIMUM Per calendar year.	None	None

Your benefit maximums (calendar year) are combined for Preferred, Participating, and Out-of-Network eligible expenses.

PRE-AUTHORIZATION FOR INPATIENT MEDICAL FACILITY ADMISSIONS is required for full benefits. Failure to pre-authorize will result in the following: a \$100 penalty.

	Preferred Network	Participating/Out-of-Network
ALLERGY INJECTIONS/TESTING	100%	100%
ALTERNATIVE SERVICES Limited to 25 visits per calendar year. Includes acupuncture and massage therapy.	100%	100%
AMBULANCE (AIR AND GROUND)	100%	100%
ANESTHESIOLOGIST	100%	100%
ASSISTANT SURGEON Paid based upon the primary surgeon's allowed amount, whether contracted or maximum allowable charge.	100%	100%
BIOFEEDBACK	100%	100%
BREAST PUMPS	100%	100%
CHIROPRACTIC SERVICES AND X-RAYS	100%	100%
CLINICAL TRIALS	Paid the same as any other condition	Paid the same as any other condition
CONTRACEPTIVE SERVICES	100%	100%
COVID-19 BENEFIT		
Diagnostic Testing and Laboratory Includes all related tests received the same day and includes services received in an emergency room, urgent care facility, physician's office, or other diagnostic testing facility or laboratory. Payment for services received from an Out-of-Network provider will be reimbursed based upon billed charges. Over the counter (OTC) tests are not covered under the medical benefits of the Plan. Please see the Pharmacy Benefits for details regarding the purchase of OTC tests.	100%	100%
COVID-19 Vaccine Payment for services received from an Out-of-Network provider will be reimbursed based upon billed charges.	100%	100%
COVID-19 Office Visits/Treatment Payment for services received from an Out-of-Network provider will be reimbursed based upon billed charges.	100%	100%
DENTAL ACCIDENT	Paid the same as any other condition	Paid the same as any other condition
DIAGNOSTIC X-RAY, IMAGING AND LABORATORY	100%	100%
DIETARY EDUCATION	100%	100%

	Preferred Network	Participating/Out-of-Network
DURABLE MEDICAL EQUIPMENT	100%	100%
EMERGENCY ROOM & SERVICES	100%	100%
FLU SHOTS	100%	100%
GENETIC TESTING	100%	100%
HEARING BENEFIT - Exams Limited to one exam per calendar year.	100%	100%
HEARING BENEFIT - Hearing Aids Limited to \$5,600 every three years. Batteries are eligible for reimbursement, subject to the benefit maximum. Payment for services received from an Out-of-Network provider and hearing aids from a Preferred Network provider will be reimbursed based upon billed charges.	100%	100%
HOME HEALTH CARE	100%	100%
HOSPICE CARE	100%	100%
IMMUNIZATIONS	100%	100%
INFUSION THERAPY	100%	100%
INJECTIONS	100%	100%
KIDNEY DIALYSIS (OUTPATIENT SERVICES)	100%	100%
LAP BAND BENEFIT	100%	100%
MEDICAL FACILITY SERVICES		
Inpatient	100%	100%
Outpatient Surgical Facility	100%	100%
Miscellaneous Services	100%	100%
MEDICAL SUPPLIES	100%	100%
MENTAL HEALTH SERVICES		
Inpatient	100%	100%
Residential Treatment Services received from a Participating provider are paid at 100%.	100%	Not Covered
Outpatient	100%	100%
MRI, CT, AND PET SCANS	100%	100%
NATUROPATHIC SERVICES	100%	100%
ORTHOTICS	100%	100%
PHYSICIAN SERVICES		
Inpatient Services	100%	100%
Office Visits	100%	100%

	Preferred Network	Participating/Out-of-Network
PRE-ADMISSION TESTING	100%	100%
PREVENTIVE CARE	100%	100%
PREVENTIVE MAMMOGRAPHY	100%	100%
PROSTHETICS	100%	100%
RADIATION AND CHEMOTHERAPY	100%	100%
REHABILITATION SERVICES		
Inpatient	100%	100%
Outpatient	100%	100%
SECOND SURGICAL OPINION	100%	100%
SKILLED NURSING FACILITY CARE	100%	100%
STERILIZATION (ELECTIVE)	100%	100%
SUBSTANCE USE DISORDER SERVICES		
Inpatient	100%	100%
Outpatient	100%	100%
SURGEON FEES	100%	100%
TELEHEALTH MDLIVE	100%	Not Covered
TELEMEDICINE	Paid the same as any other condition	Paid the same as any other condition
TEMPOROMANDIBULAR JOINT DISORDER	Paid the same as any other condition	Paid the same as any other condition
TRANSPLANTS		
Transplants	100%	100%
Donor Benefits	100%	100%
URGENT CARE FACILITY	100%	100%
WIGS	100%	100%
OTHER MISCELLANEOUS ELIGIBLE CHARGES	100%	100%

Benefit maximums described herein are combined for the Preferred Network, Participating Network, and Out-of-Network.

A 5-day grace period will be allowed in determining whether or not an annual or monthly benefit limitation has been satisfied.

PRESCRIPTION BENEFITS

Costco Health Solutions - Retail Pharmacies

Generic Drugs	\$0 Copay
Brand Name Drugs	\$0 Copay
Dispensing limit	90 days

Costco Health Solutions - Mail Order Prescriptions

Generic Drugs	\$0 Copay
Brand Name Drugs	\$0 Copay
Dispensing limit	90 days

If you would like to know more information about the drug coverage policies under this program, or if you have a question or concern about your pharmacy benefit, please contact Costco Health Solutions at 877/908-6024.

This Plan requires your pharmacist to fill the prescription with a generic product whenever it is available. If the prescription is filled with a name brand prescription at the request of either your provider or yourself, then the copay **plus** the difference between the ingredient cost of the generic drug and the brand name drug will be charged.

Over the Counter COVID-19 Tests

Over the Counter (OTC) COVID-19 Tests can be purchased point-of-sale at retail pharmacy locations, and are eligible for coverage under the pharmacy benefits of this Plan with no up-front out-of-pocket cost to you. Coverage will be limited to 8 tests per person every 30 days, based upon the purchase date of the test. If you paid up front for an OTC Covid-19 test and need to submit for reimbursement you must contact the PBM for claim submission instructions.

VISION BENEFITS

Coinsurance

EXAMINATION, HARDWARE & LASER SURGERY*

Examination

Limited to one exam per calendar year.

100%

Hardware & Laser Surgery

Combined Hardware/Laser Eye Surgery maximum of \$450 every 2 calendar years.

100%

If a **Preferred Provider** is used for the examination, a PPO discount will be applied and your overall benefit will be maximized as the cost of the examination will have been reduced. Please contact Healthcare Management Customer Care if you have questions regarding this benefit.

*Vision benefit limit of \$450 for a two year period, **plus** one eye exam each year.

The benefit works as follows: The benefit of \$450 is based upon a 24-month period beginning the first of January of even years and ending the end of December of odd years. For example, employees are eligible for one benefit amount of \$450 in 2016/2017, one benefit of \$450 in 2018/2019, and so on. Any benefits not used during the applicable benefit period is forfeited.

DENTAL SCHEDULE OF BENEFITS

The level of benefits received is based upon your decision at the time treatment is needed to access care through either preferred or non-preferred dental providers. Benefits are payable at the preferred level by accessing your care through a Preferred Provider or a Participating Provider. Out-of-Network charges will be paid at the Out-of-Network level of benefits. Your Dental Preferred Provider Organization is:

HMA National Dental Network

800/869-7093

OR

Log in to the myHMA member portal at 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
INDIVIDUAL DEDUCTIBLE Per calendar year.	None	None
MAXIMUM PAYABLE Per Participant, per calendar year. Applies to Type II and Type III services.	\$2,000	\$2,000

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

	Participating & Preferred Network	Out-of- Network
TYPE I - PREVENTIVE Oral Exam, Cleaning, Night Guards, and X-rays. Preventive oral examinations, limited to two treatments per calendar year.	100%	80%
TYPE II - BASIC AND RESTORATIVE Fillings, Oral Surgery, Endodontic Treatment, Crowns, Periodontal Services, Pathology, Anesthesia, and Injectables.	100%	80%
TYPE III - MAJOR AND PROSTHETICS Bridgework, Dentures, Relines, Rebases, Repairs, Adjustments, Tissue Conditioning, Addition of Teeth, and Implants.	80%	50%
TYPE IV - ORTHODONTIA* Lifetime maximum \$2,000.	50%	50%

***Type I and IV benefits do not apply to Maximum Payable under Dental.**

ELIGIBILITY AND ENROLLMENT PROVISIONS

ELIGIBILITY

LEOFF I Retired Employees

All retirees and disabled who are eligible for the LEOFF I Pension system will be eligible for medical, dental, and vision benefits under this Plan. LEOFF I persons will have any deductibles, coinsurance or copays waived.

Dependent Eligibility

Dependents are not eligible for coverage under this Plan.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

All retirees and disabled individuals who are eligible for the LEOFF I Pension system will be automatically enrolled for benefits under this Plan upon retirement. Coverage will become effective on the first of the month following the retirement date.

TERMINATION OF COVERAGE

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

- The date the City terminates the Plan and offers no other group health plan.
- The last day of the month in which you cease to meet the eligibility requirements of the Plan.

Your employer has the right to rescind your coverage for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under this Plan. Your employer may either void coverage for you for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide you at least 30 days advance written notice of such action. Your employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. Your employer reserves the right to collect additional monies if claims are paid in excess of your paid contributions.

If you commit fraud, make an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, or you fail to notify the Plan Administrator that you have become ineligible for coverage, then your employer may either void coverage for you for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide you at least 30 days advance written notice of such action.

PLAN PAYMENT PROVISIONS

COINSURANCE PERCENTAGE

The coinsurance is the percentage of the maximum allowable charge that the Plan will pay for non-participating providers, or the percentage of the negotiated rate for preferred providers and participating providers. Once your deductible is satisfied, the Plan shall pay benefits for covered expenses incurred during the remainder of the calendar year at the applicable coinsurance as specified in the Schedule of Benefits. You are responsible for paying the remaining percentage. Your portion of the coinsurance represents your out-of-pocket expense.

The non-participating provider of service may charge more than the maximum allowable charge. The portion of the non-participating provider's bill in excess of the maximum allowable charge is not a covered expense under this Plan and is your responsibility.

COMPREHENSIVE MAJOR MEDICAL BENEFITS

ELIGIBLE EXPENSES

When medically necessary for the diagnosis or treatment of an illness or an accident, the following services are eligible expenses for yourself covered under this Plan. Eligible expenses are payable as shown in the Schedule of Benefits and are limited by certain provisions listed in the General Exclusions. Major Medical expenses are subject to all Plan conditions, exclusions, and limitations.

ALLERGY INJECTIONS/TESTING

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

ALTERNATIVE SERVICES

The alternative medicine benefit consists of services for acupuncture and massage therapy when performed by a provider acting with the scope of their license.

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 charges of a licensed ground cabulance service for non-emergent medical 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.

To be eligible for coverage, cabulance services must be provided to you by a licensed cabulance company. Cabulance staff are ADA certified and the vehicle is ADA compliant.

BIOFEEDBACK

Biofeedback therapy is an electronic method which allows you to monitor the functioning of the body's autonomic systems (e.g. body temperature, heart rate, etc.) and is payable under this Plan.

BLOOD BANK

Eligible charges made by a blood bank for processing of blood and its derivatives, cross-matching and other blood bank services; charges made for whole blood, blood components, and blood derivatives to the extent not replaced by volunteer donors will be covered by the Plan. Storage of any blood and its derivatives are not covered under the Plan.

CHIROPRACTIC CARE

Covered chiropractic services include spinal manipulation, adjunctive therapy, vertebral alignment, subluxation, spinal column adjustments and other chiropractic treatment of the spinal column, neck, extremities or other joints, provided for as defined under the definition of physician/provider. Examinations and x-rays in connection with chiropractic care are subject to the chiropractic limit shown in the Schedule of Benefits.

CLINICAL TRIALS BENEFIT

Expenses incurred as part of a Phase II and III clinical trial may be considered covered under this plan of benefits if all of the following criteria are met:

1. The Treatment was provided as part of an ongoing Phase II or III clinical trial sponsored by the National Cancer Institute, National Institute of Health or the FDA;
2. The Treatment provided by the clinical trial is covered by Your Plan;
3. Funding is not available for the routine costs of the clinical trial from the National Cancer Institute, the National Institute of Health, the FDA or any other entity. "Routine costs" shall have the meaning attributed to it by the Centers for Medicare and Medicaid Services in its Coverage Issues Manual for clinical trials; and
4. The clinical trial has been approved by an institutional review board. An "institutional review board" shall mean a committee of physicians, statisticians, researchers, community advocates, and others that ensures that a clinical trial is ethical and that the rights of trial Participants are protected.

CONTRACEPTIVE SERVICES

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

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

CT SCAN

CT Scan services are payable as shown in the Schedule of Benefits.

DENTAL SERVICES

Dental services provided by a dentist, oral surgeon, or physician/provider, including all related medical facility inpatient or outpatient charges, including an outpatient surgical center, for only the following:

- Treatment for accidental injuries to natural teeth. Treatment for up to 12 months from the date of the accident for accidental injuries is provided under this Plan. Injuries caused by biting or chewing are not covered under the medical plan.
- Treatment performed by an oral surgeon to excise and/or biopsy suspected lesions, excised confirmed tumors or malignancies of the oral cavity, tongue, or jaw; whether done in a dental office or hospital.

- Benefits for anesthesia for dental services are covered the same as relevant services listed on your Schedule of Benefits. Services must be prior authorized by the Plan and are only provided for Participants with complicating medical conditions. Examples of these conditions include, but are not limited to:
 - Mental handicaps.
 - Physical disabilities.
 - A combination of medical conditions or disabilities that cannot be managed safely and efficiently in a dental office.
 - Emotionally unstable, uncooperative, combative Participants where treatment is extensive and impossible to accomplish in the office.

All other dental services are excluded.

DIAGNOSTIC X-RAY AND LABORATORY

Benefits will be provided for medical services, administration, and interpretation of diagnostic X-ray, pathology, and laboratory tests. Dental x-rays, the storage of blood, and donor replacement of blood are excluded. 3D mammograms are covered.

DIETARY EDUCATION

Dietary education is a covered benefit, if provided by a physician/provider 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 will be the final authority on which education programs will meet the criteria of eligibility.

DURABLE MEDICAL EQUIPMENT

Benefits are provided for rental or purchase (if more economical in the judgment of the Plan Supervisor's Care Management Department) of medically necessary durable medical equipment. Durable medical equipment is equipment able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally used in the absence of illness or injury. The durable medical equipment must be prescribed by a physician/provider for therapeutic use, and include the length of time needed, the cost of rental and cost of purchase prior to any benefits being paid. Examples of durable medical equipment include: crutches; wheelchairs; kidney dialysis equipment; beds and mattresses; traction equipment; footwear (corrective shoes, diabetic shoes and orthopedic shoes); keyboard language or assistive communication devices; non-invasive positive pressure ventilation systems (CPAP, BiPAP) and equipment for administration of oxygen. Repairs or replacement of eligible equipment shall be covered when necessary to meet your medical needs and when necessary to make the equipment serviceable, but not where repairs suggest malicious damage or culpable neglect.

Benefits are not provided for certain equipment including, but not limited to, air conditioners, humidifiers, over-the-counter arch supports, orthopedic chairs, personal hygiene items, purifiers, heating pads, enuresis (bed-wetting) training equipment, exercise equipment, whirlpool baths, weights, or hot tubs. The fact that an item may serve a useful medical purpose will not ensure that benefits will be provided. Please see the sections covering Medical Supplies, Orthotics, and Prosthetics for further information.

Services for manual and electronic breastfeeding equipment or supplies will be covered under the Breast Pump benefit as outlined in the Schedule of Benefits. Hospital grade equipment is covered under the Durable Medical Equipment benefit and is subject to all applicable plan provisions.

Purchase or rental of durable medical equipment that is over \$2,000 must be reviewed by Plan Supervisor's Care Management Department. Failure to pre-authorize services may result in the denial of the claim.

EMERGENCY ROOM & SERVICES

Benefits will be provided for emergency room treatment of an accidental injury or a medical emergency. Benefits are paid at the level shown in the Schedule of Benefits. All eligible services provided in an emergency room (physician/provider services and facility fees) will be covered at the level shown in the Schedule of Benefits.

GENDER AFFIRMATION SERVICES

Medically necessary medical and surgical services for gender affirmation, including related mental health services and prescription drugs, are covered by the Plan. Services must be pre-authorized by the Plan Supervisor's Care Management Department. Surgeries or other treatments that are cosmetic in nature or are deemed experimental or investigative based upon current medical policy are not covered by the Plan. Such services and coverage determination shall be made using approved industry standard medical criteria and Evidence Based Compendia used by this Plan, which may be informed in part, but is not limited to guidelines and recommendations put forth by World Professional Association for Transgender Health (WPATH).

The Plan does not cover any related services which are not medically necessary nor does it cover travel expenses, unless the Plan includes a separate Medical Travel benefit.

GENETIC TESTING

This Plan covers charges for medically necessary genetic testing and genetic counseling when received by a provider acting within the scope of their license.

Charges are covered for the examination of blood or other tissue for changes in genes (DNA or RNA) that may indicate an increased risk for developing a specific disease or disorder or to provide information to guide the selection of treatment of certain diseases, including cancer.

Covered services includes genetic counseling when provided in conjunction with medically necessary genetic testing and when performed by a provider with specialized education in genetics (including genetic counselors, physician geneticists, and physicians with advanced training in genetics).

Genetic counseling includes counseling about the benefits and risk of potential genetic testing and interpretation of genetic testing results to guide further health care decisions.

Charges for genetic testing must be pre-authorized in advance by the Plan Supervisor's Care Management Department. Failure to pre-authorize services may result in the denial of the claim.

Genetic testing services are subject to standard pre-authorization requirements. Services deemed preventive by the U.S. Preventive Services Task Force will be paid under the Plan's Preventive Care benefit.

HEARING BENEFIT

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

In order to receive services through this hearing benefit, examination by a licensed physician/provider, as defined under the definition of physician/provider, must be obtained before a hearing aid is received.

Services will be provided for:

- Otologic (ear) examination by a physician/provider.
- Audiologic (hearing) examination and hearing evaluation by a certified or licensed audiologist, including a follow-up consultation.
- The hearing aid (monaural or binaural) prescribed as a result of the examinations.
- Ear mold(s).
- The hearing aid instrument.
- The initial batteries, cords, and other necessary ancillary equipment.
- A follow-up consultation within 30 days following delivery of the hearing aid with either the prescribing physician/provider or audiologist.
- Repairs, servicing, and alteration of hearing aid equipment.
- Batteries as necessary.

HOME HEALTH CARE

Services for Home Health Care must be ordered by a physician/provider, include a treatment plan, and must be pre-authorized by the Care Management Department prior to services being rendered. Failure to pre-authorize services may result in the denial of the claim.

Charges made by a home health care agency (approved by Medicare or state certified) for the following services and supplies furnished to you in your home for care in accordance with a home health care treatment plan are included as covered medical expenses. Charges for home health care services described below will be applied to the home health care benefit and subject to the home health care maximum as shown in the Schedule of Benefits. Outpatient rehabilitation provided in a home setting are covered under the Rehabilitation Services benefit when medically appropriate for the patient. This benefit is not intended to provide custodial care but is provided for care in lieu of inpatient hospital, medical facility or skilled nursing facility care for you if you are homebound.

The following services will be considered eligible expenses:

- Part-time or intermittent nursing care by a registered nurse, a licensed vocational nurse, or by a licensed practical nurse.
- Physical therapy by a licensed, registered, or certified physical therapist.
- Speech therapy services by a licensed, registered, or certified speech therapist.
- Occupational therapy services by a registered, certified, or licensed occupational therapist.
- Nutritional guidance by a registered dietitian.
- Nutritional supplements such as diet substitutes administered intravenously or by enteral feeding.
- Respiratory therapy services by a certified inhalation therapist.
- Home health aide services by an aide who is providing intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, completing appropriate records.

- Medical supplies, drugs and medicines prescribed by a physician/provider, and laboratory services normally used by you in a skilled nursing facility, medical facility or hospital, but only to the extent that they would have been covered under this Plan if you had remained in the hospital or medical facility.
- Assessment by a Masters of Social Work (M.S.W.).

Exclusions to Home Health Care

- Non-medical or custodial services except as specifically included as an eligible expense.
- Meals on Wheels or similar home delivered food services.
- Services performed by a member of your family or household.
- Services not included in the approved treatment plan.
- Supportive environmental materials such as handrails, ramps, telephones, air conditioners or similar appliances or devices.

HOSPICE CARE

Services for Hospice Care must be ordered by a physician/provider, include a treatment plan, and must be pre-authorized by the Plan Supervisor's Care Management Department prior to services being rendered. Failure to pre-authorize services may result in the denial of the claim.

If you are terminally ill, the services of an approved hospice will be covered for medically necessary treatment or palliative care (medical relief of pain and other symptoms), subject to the conditions and limitations specified below. Services and supplies furnished by a licensed hospice (Medicare approved or state certified) for necessary treatment will be eligible for payment as shown in the Schedule of Benefits. The following services will be considered eligible expenses:

- Confinement in a hospice facility or at home.
- Ancillary charges furnished by the hospice while you are confined.
- Medical supplies and drugs prescribed by your attending physician/provider, but only to the extent such items are necessary for pain control and management of the terminal condition.
- Physician/provider services and/or nursing care by a registered nurse, licensed practical nurse, master in social work, or a licensed vocational nurse.
- Home health aide services and home health care.
- Nutritional advice by a registered dietitian, nutritional supplements, such as diet substitutes, administered intravenously or through hyperalimentation.
- Physical therapy, speech therapy, occupational therapy, respiratory therapy.
- Respite care for a minimum of four or more hours per day (continuous care of the patient to provide temporary caring for the patient). Respite care up to a maximum of 120 hours in each three-month period of hospice care, to relieve anyone who lives with and cares for you if you are terminally ill. The first three-month respite care period begins on your first day of covered hospice care.

When you are confined as an inpatient in an approved hospice status that is not an approved hospital or skilled nursing facility, the same benefits that are available in your home will be available to you as an inpatient. In addition, a semiprivate room benefit will be provided.

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

- A description of the medically necessary care to be provided to you if terminally ill for palliative care or medically necessary treatment of an illness or injury but not for curative care.

- A provision that care will be reviewed and approved by your physician/provider at least every 60 days.
- A prognosis of six months or less to live.

Exclusions to Hospice Care

- Non-medical or custodial services except as specifically included as an eligible expense.
- Meals on Wheels or similar home delivered food services.
- Services performed by a member of your family or household.
- Services not included in your approved treatment plan.
- Supportive environmental materials such as handrails, ramps, telephones, air conditioners or similar appliances or devices.
- Hospice bereavement services.

IMMUNIZATIONS

Immunizations for routine use adults if ordered by your physician/provider and are medically necessary or are recommended by the Federal Drug Administration (FDA) or Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) and listed on the Immunization Schedules of the CDC for adults are covered as shown in the Schedule of Benefits. Covered services do not include immunizations for the purpose of travel, occupation or residence in a foreign country.

INFUSION THERAPY BENEFIT

Inpatient and outpatient services and supplies for infusion therapy are provided at the coinsurance level shown in the Schedule of Benefits. Your attending physician/provider must submit, and periodically review, a written treatment plan that specifically describes the infusion therapy services and supplies to be provided. The treatment plan must be approved in advance by the Plan Supervisor's Care Management Department. Failure to pre-authorize services may result in denial of the claim. Drugs and supplies used in conjunction with infusion therapy will be provided only under this benefit.

To ensure clinically appropriate delivery of treatment, lower overall cost of care and increase patient satisfaction and quality of life, the Plan has partnered with the Plan Supervisor's Care Management Department to offer an infusion/specialty drug program. This Plan recommends utilization of an optimal site of care for infusion administration. Optimal sites of care include a physician's office, a pharmacy, an outpatient infusion center, or a home-based setting. The Care Management Department will work with you and your treating provider to ensure that the infusion services and any high cost specialty oral drugs are delivered through the most cost effective and medically appropriate channels. Site of care review criteria will be waived for payment of the first dose of a medication, to allow for adequate transition time to an approved site of care for subsequent infusions. The Plan may recommend use of a specialty drug vendor who has contracted with the Plan or with the Plan Supervisor to manage this benefit

KIDNEY DIALYSIS (OUTPATIENT SERVICES)

Charges for professional treatment, supplies, medications, labs, and facility fees related to outpatient kidney dialysis are covered services under the Plan. When kidney dialysis is recommended, you must first contact the Plan Supervisor's Care Management Department to pre-authorize the treatment. Failure to pre-authorize services may result in denial of the claim. Eligible services will be covered as shown in the Schedule of Benefits and will be paid in accordance with the applicable provider network agreements, or in accordance with other Out-of-Network payment methodologies.

Eligible services include, but are not limited to, hemodialysis, peritoneal dialysis, and hemofiltration. Coverage is subject to your annual deductible and coinsurance up to the Out-of-Pocket Maximum amount offered under the Plan for Preferred Network, Participating Network, or Out-of-Network coverage. You may elect to enroll in Medicare coverage as a secondary insurance and the Plan will coordinate benefits as primary payer during the applicable Medicare coordination period.

The Plan Supervisor's assigned Care Manager will work with you to understand how the benefit works.

Notwithstanding the above, upon the conclusion of the coordination period as required under Federal Medicare regulations, this Plan will take a secondary position to Medicare as permitted pursuant to Medicare Secondary Payer regulations. Accordingly, in the event that your provider accepts Medicare assignment as payment in full, then eligible expenses shall mean the lesser of the total amount of charges allowable by Medicare, whether you are enrolled for Medicare coverage or not, and the total eligible expenses allowable under this Plan exclusive of coinsurance.

LAP BAND PROCEDURE

The Plan will pay for the Lap Band Procedure, plus related consultation, pre and post requirements, complications and emergency room visits for LEOFF I retirees only. All services provided under this benefit must meet Medical Necessity criteria. Benefits are payable as shown in the Schedule of Benefits.

PRE-AUTHORIZATION FOR THE LAP BAND PROCEDURE

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

- The patient must demonstrate that attempts at weight control have been ineffective.
- The patient must be greater than 100 pounds overweight or have a Body Mass Index greater than 40kg/m² or greater than 35kg/m² with a significant comorbidity. The comorbidity must be documented by objective evidence provided by the physician who is treating the patient, the condition must be aggravated by obesity, and be covered by our benefit plan (e.g., severe diabetes mellitus, hypertension, alveolar hypoventilation, varicose veins, heart attacks, strokes, dyslipidemia, Pickwickian syndrome, asthma, low back and disk disease, weight bearing osteoarthritis of the hips, knees, ankles and feet, thrombophlebitis and pulmonary emboli, intertriginous dermatitis, urinary stress incontinence, gastroesophageal reflux disease, gallstones, and cirrhosis and carcinoma of the liver).
- Prior to surgery the patient must be seen by a Dietician.
- The Surgeon may also require the patient to see a Psychotherapist if he/she deems it necessary.

The surgery must be pre-authorized by the Plan Supervisor's Care Manager prior to services being rendered. When all the above information has been accumulated, the information should be referred to the Care Manager.

No coverage is available for complications arising directly from a bariatric (obesity) surgery that was previously denied under this Plan. This does not apply to complications arising from a bariatric (obesity) surgery covered by this Plan. Complications arising from a surgery obtained prior to enrollment under this Plan will be covered.

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

MAGNETIC RESONANCE IMAGING (MRI)

Magnetic Resonance Imaging or MRI services are payable as shown in the Schedule of Benefits.

MEDICAL FACILITY SERVICES

Inpatient Care

The following benefits will be provided for inpatient care in an accredited hospital or medical facility when you are under the care of a physician/provider:

- Room and board in a semi-private room.
- Intensive care, cardiac care, isolation or other special care unit.
- Private room accommodations, if medically necessary.
- Nursing care services.
- Prescribed drugs and medications administered in the hospital or the medical facility.
- Anesthesia and its administration.
- Oxygen and its administration.
- Dressings, supplies, casts, and splints.
- Diagnostic services, including but not limited to x-ray, laboratory, and radiological services.
- The use of durable medical equipment.

Outpatient Care

Benefits will be provided for minor surgery, including x-ray, laboratory, and radiological services, and for emergency room treatment of an accidental injury or a medical emergency.

Miscellaneous

All other charges made by a hospital or the medical facility during an inpatient confinement are eligible, exclusive of: personal items; services not necessary for the treatment of an illness or injury; or services specifically excluded by the plan.

MEDICAL SUPPLIES

When prescribed by your physician/provider, and medically necessary, the following medical supplies are covered; including but not limited to: braces; surgical and orthopedic appliances; colostomy bags and supplies required for use; catheters; syringes and needles necessary for diabetes or allergic conditions; dressings for surgical wounds, cancer, burns, or diabetic ulcers; oxygen; back brace; and cervical collars.

MENTAL HEALTH AND SUBSTANCE USE DISORDER SERVICES

Benefits are available for inpatient or outpatient care for mental health and substance use disorder conditions, including individual and group psychotherapy, psychiatric tests, and expenses related to the diagnosis when rendered by a covered provider. Covered services also include neurobiological disorders as **defined in General Definitions**, and treatment of eating disorders (such as anorexia nervosa, bulimia, or any similar condition) when medically necessary.

Benefits are available for in-network residential treatment facility, partial hospitalization, and intensive outpatient services.

Mental Health and Substance Use Disorder Services benefits include those received by you on an inpatient or intermediate care basis in a hospital or an alternate facility, and those received on an outpatient basis in your provider's office, alternate facility or home setting.

When inpatient or intermediate treatment (including Residential Treatment, Partial Hospital Program or Intensive Outpatient Program) for Mental Health Services, including neurobiological disorders, are recommended, you or your provider must first contact the Plan Supervisor's Care Management Department to pre-authorize the requested services.

Neurobiological Disorders - Autism Spectrum Disorder Services

Psychiatric services for Autism Spectrum Disorders that are both of the following are covered:

- Provided by or under the direction of a psychiatrist and/or a licensed psychiatric provider.
- Focused on treating maladaptive/stereotypic behaviors that are posing a danger to self, others and property, and impairment in daily functioning.

This section describes only the psychiatric component of treatment for Autism Spectrum Disorders. Medical treatment of Autism Spectrum Disorders is a covered condition under the Plan and is paid under the applicable benefit for the service being provided.

ORTHOTICS

Medically necessary orthotic foot devices prescribed by a physician/provider 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 you if you have 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 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 if you have 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.

OUTPATIENT SURGICAL FACILITY

An outpatient surgical facility refers to a lawfully operated facility that is established, equipped, and operated to perform surgical procedures. Services rendered by an outpatient surgical facility are covered when performed in connection with a covered surgery.

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.

PHENYLKETONURIA (PKU) DIETARY FORMULA

This Plan covers tube feeding or orally administered formula which is medically necessary for the treatment of phenylketonuria (PKU) and other inborn errors of metabolism, based on medical evaluation and under the supervision of a Physician. Services must be pre-authorized by the Plan Supervisor's Care Management Department. Failure to pre-authorize services may result in denial of your claim. This benefit does not cover foods related to dietary restrictions or gluten free diets.

PHYSICIAN SERVICES

Physician's fees for medical and surgical services are covered. Office visits for school or sports examinations will be covered under this benefit.

PRE-ADMISSION TESTING

Charges for laboratory and x-ray examinations to determine if you are suitable for surgery prior to admission are covered as shown in the Schedule of Benefits.

PRESCRIPTION DRUGS

Inpatient drugs are covered when administered to you for the treatment of a covered illness or accident, while confined. Inpatient prescription drugs will be paid as shown in the Schedule of Benefits.

Outpatient prescription drugs are reimbursable through your prescription drug card plan.

PREVENTIVE CARE

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

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

WELLNESS BENEFIT

Benefits will be provided for preventive care for adults as shown in the Schedule of Benefits through the Preferred Provider Network only. There is no out-of-network benefit.

WELL ADULT PREVENTIVE CARE

Routine preventive care is covered for individuals age 18 and older, will be provided as shown in the Schedule of Benefits. Services include routine physical examinations, associated x-ray, and laboratory, and flu shots.

PREVENTIVE MAMMOGRAPHY

Preventive routine screening mammograms, including 3D mammograms, are covered by the Plan. Services are payable as shown in the Schedule of Benefits. Mammograms, other than routine screening mammograms, are covered when medically necessary if prescribed by your physician/provider and payable at the Diagnostic, X-Ray and Laboratory Benefit as shown in the Schedule of Benefits.

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, 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 a medically necessary orchiectomy. 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 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 must be reviewed by Plan Supervisor's Care Management Department. Failure to pre-authorize services may result in the denial of the claim.

RADIATION THERAPY AND CHEMOTHERAPY

X-ray, radium, radioactive isotope therapy, and chemotherapy are covered expenses under this Plan. Services must be pre-authorized by the Care Management Department prior to services being rendered. Failure to pre-authorize services may result in the denial of the claim.

REHABILITATION BENEFIT

The Plan covers charges for you on an inpatient or outpatient basis in a rehabilitation center. Services for inpatient rehabilitation must be ordered by a physician, include a treatment plan and must be pre-authorized by the Plan Supervisor's Care Management Department. Failure to pre-authorize services may result in the denial of the claim. All services specified below will be provided if continued measurable progress is demonstrated at regular intervals.

Rehabilitative services are provided when medically necessary to restore and improve bodily function previously normal, but lost due to illness or injury, including function lost as a result of congenital anomalies.

Occupational, physical, respiratory, speech therapy, pulmonary rehabilitation, neurodevelopmental therapy, and cardiac rehabilitation in the office, medical facility, or hospital will be paid under the rehabilitation benefit as shown in the Schedule of Benefits. Services may be provided in the home setting when medically appropriate for the patient.

Cardiac Rehabilitation Therapy - Benefits for an approved hospital-based cardiac rehabilitation program will be provided, when necessary to restore a bodily function lost or impeded due to illness or injury and such services are recommended by provider.

Neurodevelopmental Therapy - Benefits will be provided for medically necessary neurodevelopmental therapy treatment to restore and improve bodily function. This benefit includes maintenance services where significant deterioration of your condition would result without the service. Neurodevelopmental therapy means therapy designed to treat structural or functional abnormalities of the central or peripheral nervous system. Its purpose is to restore, maintain, or develop age appropriate functions. Covered therapy includes, but is not limited to, occupational therapy, physical therapy, speech therapy, and feeding therapy (the goal of feeding therapy is to help patients develop normal, effective feeding patterns and behaviors). This neurodevelopmental therapy benefit is not intended to cover enteral feeding, please see the Home Health Care benefit for additional information.

Occupational Therapy - Charges of a registered, certified, or licensed occupational therapist are covered when necessary to restore a bodily function lost or impeded due to illness or injury.

Physical Therapy - Charges of a registered, certified, or licensed physical therapist are covered when necessary to restore a bodily function lost or impeded due to illness or injury. Covered services include aquatic/swim therapy if medically necessary and included as part of a treatment plan.

Pulmonary Rehabilitation Therapy - Benefits for an approved hospital-based pulmonary rehabilitation program will be provided, when necessary to restore a bodily function lost or impeded due to illness or injury and such services are recommended by your provider.

Respiratory Therapy - Charges of a registered, certified, or licensed respiratory therapist are covered when necessary to restore a bodily function lost or impeded due to illness or injury.

Speech Therapy - Charges are covered when prescribed by your physician/provider and when necessary to restore a bodily function lost or impeded due to illness or injury. Excluded are speech therapy services that are educational in nature or due to: tongue thrust; stuttering; lisping; abnormal speech development; changing an accent; dyslexia; and hearing loss which is not medically documented.

Inpatient Treatment

The eligible expenses for inpatient rehabilitation are payable as shown in the Schedule of Benefits for the following services and supplies furnished while you require 24-hour care and are under continuous care of your attending physician/provider:

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

No benefits will be provided for the following inpatient or outpatient services:

- Custodial care.
- Maintenance, non-medical self-help, recreational, educational, or vocational therapy.
- Psychiatric care.
- Learning disabilities or developmental delay, except as may be provided under coverage for neurodevelopmental therapy.
- Chemical dependency/substance use rehabilitative treatment.
- Gym therapy.

SECOND SURGICAL OPINION

A second surgical opinion is not normally required but may be requested by you or by the Plan Supervisor's Care Management Department. This benefit is paid as shown in the Schedule of Benefits.

Please note that all non-emergency surgery other than surgery done in your doctor's own office must be pre-authorized by the Plan Supervisor's Care Management Department. When requested, the Plan will pay the maximum allowable fee for a second surgical opinion, and for a third and final opinion in case of conflict between the first two opinions.

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

SELF-ADMINISTERED MEDICATION BENEFIT

Coverage for self-administered medications 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 your PBM to determine if your medication can be self-administered and how it will be covered.

If you are unable or unwilling to self-administer an injectable medication, or the prescription drug plan does not carry the medication on its formulary, 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 of the injectable medication may result in the denial of your claim. Self-administered benefit criteria may be waived for reimbursement purposes for the initial dose of the medication when multiple administrations are required and allow coverage under the major medical benefit if all terms and conditions are met, to allow for adequate transitioning of the prescription to your pharmacy benefit manager.

SKILLED NURSING FACILITY CARE

Services for Skilled Nursing Facility Care must be ordered by your physician/provider, include a treatment plan, and must be pre-authorized by the Care Management Department prior to services being rendered. Failure to pre-authorize services may result in the denial of the claim.

This Plan will pay benefits for confinement in a Skilled Nursing Facility, as specified in the Schedule of Benefits, provided such confinement is not for Custodial Care.

Charges for medically necessary services and supplies furnished by a licensed Skilled Nursing Facility will be applied to the Skilled Nursing Facility benefit and subject to the Skilled Nursing Facility maximum as shown in the Schedule of Benefits.

STERILIZATION - ELECTIVE

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

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

SURGERY AND RELATED SERVICES

Benefits are provided for the following inpatient or outpatient services:

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

If two or more surgical procedures are performed through the same incision during an operation, full benefits are only provided for the primary procedure and one half for the lesser procedure.

TELEHEALTH MDLIVE

The Plan covers Telehealth services provided by MDLive. MDLive has a national network of board certified physicians and licensed therapists to consult, treat and prescribe for routine medical conditions. You can connect with an MDLive provider via phone at 877/596-0967, online via the myHMA portal found on the

HMA website at www.accesshma.com, or direct via MDlive.com, or through the MDLive mobile app 24 hours per day and 365 days per year. Services are covered as outlined in the Schedule of Benefits.

TELEMEDICINE

This telemedicine benefit covers medically necessary healthcare services between you and your physician to consult, treat, and prescribe for medical conditions. This benefit includes audio and video communication services, such as video conferencing and scheduled telephone visits. Telemedicine visits must be initiated at the request of you or your authorized provider and replace the need for an in-person office visit. Scheduling and record-keeping standards that apply to in-person visits also apply to telemedicine visits.

TEMPOROMANDIBULAR JOINT DISORDER (TMJ)

This Plan covers medically necessary surgical and non-surgical treatment of Temporomandibular Joint Disorders (TMJ) when provided by your physician/provider, approved medical facilities, licensed physical therapist or licensed oral surgeon. Oral surgeons will be covered only for the surgical treatment of TMJ disorders under this benefit.

TRANSPLANTS

Benefits are payable for charges for organ or tissue transplant services which are incurred while you are covered by this Plan. Such covered charges must be due to an accidental injury or sickness covered by this Plan.

You must contact the Plan Supervisor's Care Management Department prior to any testing that may occur to determine whether you are a transplant candidate. A written treatment plan must be submitted in order to obtain pre-authorization.

Also remember that pre-authorization is required before any medical facility admission. See Pre-Authorization of Inpatient Medical Facility Admissions in the Important Information Section.

Organ or tissue transplant services include the following medically necessary services and supplies:

- Organ or tissue procurement. These consist of removing, preserving, and transporting the donated part.
- Compatibility testing undertaken prior to procurement is covered if medically necessary. This includes costs related to the search for, typing and testing, and identification of a bone marrow or stem cell donor for allogeneic transplant.
- Medical facility or Hospital room and board and medical supplies.
- Diagnosis, treatment, and surgery by a doctor.
- Private nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).
- The rental of wheelchairs, hospital-type beds, and mechanical equipment required to treat respiratory impairment.
- Local ambulance services, medications, x-rays and other diagnostic services, laboratory tests, and oxygen.
- Rehabilitative therapy consisting of: speech therapy (not for voice training or lisp), audio therapy, visual therapy, occupational therapy, and physiotherapy. Any of these must be in direct respect to rehabilitation from the covered transplant procedure.
- Surgical dressing and supplies.
- Other services approved by the Plan Supervisor's Care Management Department.

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

No benefits will be provided for the following:

- Any procedure that has not been proven effective, is experimental or investigative, or is not standard of care for the community. **(See definition of Experimental and Investigative.)**
- When donor benefits are available through other group coverage.
- When government funding of any kind is available.
- When the recipient is not covered under this Plan.
- Transportation, lodging, and meals.

Special Transplant Benefit

In addition to any standard transplant benefit set forth in this booklet, a Special Transplant Benefit may be available when you participate in the Special Transplant Program. The Special Transplant Benefit provides enhanced transplant benefits and participation in the Program is voluntary. Additional information regarding the Special Transplant Program may be obtained through Healthcare Management Administrators, Inc.

The Special Transplant Benefit provides the following benefits in addition to any transplant benefits available under this Plan:

1. Access to Centers of Excellence Transplant Facilities throughout the United States;
2. Reimbursement, up to a total of \$5,000, for expenses incurred by you and one companion, or both parents if the member is your minor child:
 - a) For travel to and from the Centers of Excellence facility when that travel is related to the actual transplant occurrence; and
 - b) For lodging expenses related to such travel and occurring prior to and following the actual transplant occurrence.
3. Waiver of the member's deductible and co-payments up to \$1,500 during the year in which the transplant occurs.

The Special Transplant Benefit is only available when you participate in the Special Transplant Program and you satisfy all of the following requirements:

1. Notification of the transplant procedure must be provided to Healthcare Management Administrators in accordance with its guidelines;
2. You, your physician or your authorized representative must call Healthcare Management Administrators, Inc. at 800/869-7093 as soon as you are identified as a potential transplant candidate to notify the Special Transplant Program of the impending transplant; and
3. All transplant services must be rendered at a Centers of Excellence Transplant Facility which participates in this Program for the specific organ or tissue transplant required. A current list of participating Centers of Excellence facilities for each type of transplant is available from Healthcare Management Administrators, Inc.

GENERAL EXCLUSIONS TO THE MEDICAL PLAN

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 Care Management provisions of the Plan. Your eligibility and expenses are subject to all Plan conditions, exclusions, and limitations, including medical necessity. In addition, some limitations may apply to benefits.

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

Abuse of Substances, Drugs, or Other Medications - Services, supplies, care or medical treatment for injury or sickness resulting from taking of or being under the influence of any substance, drug, hallucinogen or narcotic not administered on the advice of your physician/provider, except as provided under the Substance Use Disorder Benefit. Expenses will be covered for injured covered Participants, such as yourself, except the person who took or was under the influence of substances, and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the injury resulted from being the victim of an act of domestic violence or a documented medical (including both physical and mental health) condition, or for treatment that is medically necessary due to an overdose.

Adoption Expenses - Adoption expenses or any expenses related to surrogate parenting, except as provided herein.

After the Termination Date - Charges arising from care, supplies, treatment, and/or services that are Incurred Charges by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Alcohol - Services, supplies, care or treatment you receive for an injury or sickness which occurred as a result of your illegal use of alcohol, based upon a court conviction or other documented court finding. Expenses will be covered for injured covered Participants, such as yourself, except the person illegally using alcohol, and expenses will be covered for substance abuse treatment as specified in this Plan. This exclusion does not apply if the injury resulted from being the victim of an act of domestic violence or a documented medical (including both physical and mental health) condition.

Alternative Medicine - Services for acupuncture, Rolting, faith healing services, or reflexology.

Appointments (Missed, Cancelled, Telephonic and Electronic) - Missed or cancelled appointments or for telephone and electronic consultations, except as provided herein.

Birth Control - Except as provided under the Prescription Drug Card Program and the Contraceptive Services benefit, nonprescription drugs, and supplies related to birth control. Examples of what is not covered include, but not limited to, the following: oral contraceptives; consultations; implants; emergency contraceptives; transdermal contraceptives; condoms; sponges; contraceptive foam, jelly or other spermicidal item.

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

Broken Appointments - Charges arising from care, supplies, treatment, and/or services that are charged solely due to the Participant's having failed to honor an appointment.

Clinical Trials - Except as provided herein, costs incurred due to the participation in a phase I, II, or III clinical trial, including but not limited to, the costs of the investigative item, device, or service; the costs of items and services provided solely to satisfy data collection and analysis, and the cost for a service that is inconsistent with commonly accepted and established standard of care for the diagnosis. However, routine

medical expenses associated with an approved clinical trial (phase I, II, III, or IV) (see definition of Approved Clinical Trials) will be covered under the Plan if medically necessary.

Cochlear Implants and Bone Anchored Hearing Aids (BAHA) - Charges or supplies with regard to cochlear implants and BAHA devices.

Cosmetic and Reconstructive Surgery - Cosmetic surgery or related medical facility admissions are excluded, unless made necessary due to one or more of the following:

1. When authorized for an illness or injury that is a covered benefit under this Plan, except as excluded herein.
2. Except as specifically excluded by this Plan, for correction of congenital anomalies when medically necessary.
3. If you are receiving benefits for a medically necessary mastectomy and elect breast reconstruction after the mastectomy, you 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
 - Areola tattooing if performed in a surgeon's office and billed by a surgeon

This reconstructive surgery coverage will be provided in consultation with your attending physician/provider and yourself, and will be subject to the same coinsurance provisions that apply for the mastectomy.

Counseling or Training Services - Charges for counseling or training services. This includes vocational assistance and outreach; job training such as work hardening programs; religious counseling; treatment by a pastoral or financial counselor; 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 individuals with no special medical skills or training. Such care includes, but is not limited to: helping you 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, 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 Accident Benefit and TMJ Benefit or if treatment is necessary due to a malignant tumor.

Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) - Charges for any injury you sustained while driving a vehicle that is involved in an accident where you are 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.

Excess - Charges arising from care, supplies, treatment, and/or services that exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

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.

Facility Charges - Facility charges for care, services or supplies provided in:

- Rest homes;
- Assisted living facilities;
- Similar institutions serving as an individual's primary residence or providing primarily custodial or rest care;
- Health resorts;
- Spas, sanitariums;
- Infirmaries at schools, colleges, or camps;
- Boarding schools, academies or other institutions providing academic and scholastic services; or
- Wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

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

Fertility and Infertility - Charges in association with infertility testing, 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 Clomid, Pergonal or Serophene); or any other artificial means of conception. Expenses related to fertility preservation are not covered.

Gene Therapy - Charges for gene therapy or adoptive cellular therapy.

Government Facility - Except for charges related to the testing and treatment of COVID-19, charges by a facility owned or operated by the United States or any state or local government unless you are 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 you 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 you if you are not on active military duty.

Habilitative, Education, or Training Services - Habilitative, education, or training services or supplies 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 Services benefits.

Hospice Bereavement - Charges for hospice bereavement treatment.

Illegal Treatment - Charges for any illegal treatment under the laws of the state where the care is rendered and 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; medications specific for treatment of sexual dysfunction; penile implants; or impotency drugs whether or not a consequence of illness or injury. This exclusion does not apply to medically necessary hormones.

Incurred by Other Persons - Charges arising from care, supplies, treatment, and/or services that are expenses actually incurred charges by other persons.

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/provider 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.

Medical Tourism - Expenses for any care, services, drugs, or supplies incurred outside of the United States if you traveled to such a location for the purpose of obtaining the care, services, drugs, or supplies.

Mental Health and Substance Use Disorder Services - Charges are not covered for the following:

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
2. Tuition for or services that are school-based for children and adolescents under the Individuals with Disabilities Education Act.
3. Learning, motor skills, and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
4. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Plan.
5. All unspecified disorders in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
6. Educational or correctional services or sheltered living provided by a school or halfway house, including any academic component of treatment; however, you may receive covered outpatient services while living temporarily in a sheltered living situation.
7. A court-required screening interview or treatment program unless determined to be medically necessary.
8. Support groups, including Alcoholics Anonymous or similar programs.
9. Personal items.
10. Custodial care or long-term care.
11. Investigational therapies, including wilderness or outdoor treatment programs.
12. Tobacco cessation programs.
13. Educational services that are focused on primarily building skills and capabilities in communication, social interaction and learning.

The Plan may consult with professional clinical consultants, peer review committees or other appropriate sources for recommendations and information regarding whether a service or supply meets any of these criteria.

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.

Negligence - Charges arising from care, supplies, treatment, and/or services that are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, institution, or provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

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

No Coverage - Charges arising from care, supplies, treatment, and/or services that are incurred charges at a time when no coverage is in force for you.

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.

Non-U.S. Providers - Expenses are not covered for any care, services, drugs, or supplies incurred outside of the United States. This exclusion does not apply to emergency care received outside of the United States.

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).

Other than Attending Physician - Charges arising from care, supplies, treatment, and/or services that are other than those certified by your attending physician, as being required for the treatment of injury or disease, and performed by an appropriate provider.

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

Personal Items - Services for the convenience of you, your family, or your physician/provider. 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.

Prior to Coverage - Charges arising from care, supplies, treatment, and/or services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

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 your relative, or treatment or care provided by any individual who ordinarily resides with you.

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. This exclusion does not apply to medically necessary services for you if you have diabetes.

Routine Services - Services or supplies that are not directly ordered by a physician or 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 (including 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 (not including COVID-19);
- To attend a camp, 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, to routine mammograms, or COVID-19 related testing for employment purposes, return to school requirements, travel screenings, or any other reason.

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

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

Tobacco Cessation - Treatment or classes for tobacco cessation.

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 your physician/provider, except as provided herein under the Ambulance benefits.

Types of Care - The following types of care are excluded from coverage under the Plan:

1. Custodial Care or maintenance care.
2. Domiciliary care.
3. Private Duty Nursing, except as may be provided within the Transplant benefit.
4. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program for services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care Benefits within this Summary Plan Description.
5. Rest cures.
6. Services of personal care attendants.
7. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

Unreasonable - Charges arising from care, supplies, treatment, and/or services that are not "Reasonable" and are required to treat illness or injuries arising from and due to a provider's error, wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating provider whose error caused the loss(es).

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 you are 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.

PRESCRIPTION DRUG CARD PROGRAMS

Benefits will be provided as described below and as shown in the Schedule of Benefits for state and federal approved legend drugs requiring a prescription and for other items as specifically provided, when such drug or other items are furnished by an approved pharmacy or an approved mail order supplier. Benefits will be subject to any waiting periods, limitations and exclusions, except that prescription drug benefits will not be subject to Coordination of Benefits provisions or to any deductible.

Legend Drugs are those drugs which cannot be purchased without a prescription written by a physician or other lawful prescriber.

GENERIC SUBSTITUTION

Over 400 commonly prescribed drug products are now available in a generic form at an average cost of 50% less than the brand name products. This Plan encourages the use of generic prescription drugs. By law, generic and brand name drugs must meet the same standards of safety, purity, strength, and effectiveness. At the same time, brand name drugs are often 2 to 3 times more expensive than generic drugs. Use of generics with this benefit will save you money and we encourage you to ask your provider to prescribe generics whenever possible.

BRAND NAME FORMULARY DRUGS

An important element of your Costco Health Solutions Prescription Drug Card Program is the opportunity to select drugs from the Formulary Drug List. The Formulary Drug List is a guide to the best values within select therapeutic categories which helps the provider identify products that will provide optimal clinical results at a lower cost. The Formulary Drug List undergoes a thorough review and/or revision annually. Interim changes could occur to reflect changes in the market. These changes could include: entry of new products, entry of a generic option to a brand drug, or other events that alter the clinical or economic value of the products on the Formulary Drug List. Please see your Human Resources Department for a copy of the Formulary Drug List or visit www.costcohealthsolutions.com.

Other brand name drugs are any brand name drugs covered through the Costco Health Solutions Plan, but not listed on the Formulary Drug List.

PAYMENT SCHEDULE

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

This Plan requires your pharmacist to fill the prescription with a generic product whenever it is available, unless the prescription is written as "Dispense as Written." If the prescription is not specified as "Dispense as Written" and the prescription is filled with a name brand prescription at your request, then the copay **plus** the difference between the ingredient cost of the generic drug and the brand name drug will be charged.

DRUGS COVERED

Medications covered under this Prescription Drug Card Program include but are not limited to:

- Legend Drugs. Exceptions: See Exclusions below.
- Insulin; Syringes and needles; and all other diabetic supplies will be covered at 100%
- Prilosec OTC and Omeprazole will be covered at the generic copay level when prescribed by a physician. All other proton pump inhibitors will be covered at the "not on Formulary Drug list" copay as shown in the Schedule of Benefits.

- Legend oral contraceptives, devices, implants, injectables, and patches.
- Any other drug which under the applicable state or federal law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

Note: FDA approval of a drug does not guarantee inclusion as a covered medication under this Prescription Drug Card Program. In addition, coverage for some prescriptions may vary depending upon the medication's therapeutic classification. As a result, some medications may be subject to quantity limits, step therapy or may require pre-authorization.

If you would like to know more information about the drug coverage policies under this program, or if you have a question or concern about your pharmacy benefit, please contact Costco Health Solutions at 877/908-6024.

DRUGS EXCLUDED AND LIMITED

In addition to exclusions listed elsewhere in this document, the following drugs are excluded from coverage under this Prescription Drug Card Program (this is **not** an all-inclusive list):

- Biological sera, blood, or blood plasma.
- Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use.
- Charges for the administration or injection of any drug.
- Prescriptions which an eligible individual is entitled to receive without charge from any Worker's Compensation Laws.
- Drugs labeled Caution-limited by federal law to investigational use or experimental drugs, even though a charge is made to the individual.
- Medication which is to be taken by you or administered to you, in whole or in part, while you are a patient in a licensed medical facility, rest home, sanitarium, extended care facility, convalescent medical facility, nursing home or similar institution which operates on its premises or allows to be operated on its premises, or a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number specified by your provider, or any refill dispensed after one year from your provider's original order.
- Prescription drugs which may be obtained without charge under local, state, or federal programs.
- Drugs purchased outside the U.S. that are not legal inside the U.S.

If you would like to know more information about the drug coverage policies under this program, or if you have a question or concern about your pharmacy benefit, please contact Costco Health Solutions at 877/908-6024.

PRESCRIPTION DRUG PREAUTHORIZATION

There may be certain prescription drugs that need to be pre-authorized prior to dispensing for reasons of treating one or more health conditions (some of these conditions may not be covered by the medical plan such as cosmetic procedures for wrinkles) and to determine if the medication is medically necessary. You can obtain a listing of drugs that require pre-authorization by contacting Costco Health Solutions at: 877/908-6024 or via the website at: www.costcohealthsolutions.com.

Pharmacies are generally notified if a prescription requires pre-authorization. Your prescribing provider must provide the information required to determine medical necessity for the medication.

SPECIALTY PHARMACY

Specialty pharmacy services include treatment of Participants with narrow-niche, high-cost, chronic conditions such as multiple sclerosis, hepatitis C, rheumatoid arthritis, hemophilia, growth hormone deficiency, alpha 1-antitrypsin disorder, and other special medical conditions. Products provided are typically injectable drugs but may also include infusion drug products. The Plan has established a specialty pharmacy program whereby certain pharmaceutical products that are generally biotechnological in nature and given by injection or otherwise require special handling (specialty medications), are provided by Costco Health Solutions specialty pharmacies.

In the event that you are prescribed a specialty medication, regardless of your diagnosis, you must participate in the Plan's specialty program for the medication to be covered under the Plan and therefore, the specialty medication must be dispensed by a Costco Health Solutions specialty pharmacy. To inquire about or begin specialty pharmacy services, please call or have your healthcare provider call Costco Health Solutions at 866/443-0060. Additional information may be obtained via: www.costcohealthsolutions.com.

If you would like to know more information about the drug coverage policies under this program, or if you have a question or concern about your pharmacy benefit, please contact Costco Health Solutions at 877/908-6024.

PRESCRIPTION REFILLS

The prescription drug plan will cover prescription refills when you have taken 75% of the previous prescription (please note: Schedule II or III controlled substance medications may be refilled only after you have taken 85% of the previous prescription), if your prescribing physician has allowed refills of the prescribed medication. Refills obtained through the mail order pharmacy are allowed after you have taken all but 20 days of the previous prescription order. If you choose to refill your prescription sooner, you will be responsible for the full costs of the medication and these costs will not count toward your deductible (if applicable) or any Out-of-Pocket Maximum. If you feel you need a refill sooner than allowed, a refill exception may be considered at Costco Health Solutions' discretion on a case-by-case basis. You may request an exception by calling Costco Health Solutions at 877/908-6024.

RETAIL PRESCRIPTION DRUG PROGRAM

Costco Health Solutions

Dispensing Limitations

The amount normally prescribed by a physician or other lawful prescriber, but not to exceed a 90-day supply.

Benefit Limitations When Not Using the Drug Card

If you do not use the prescription card at the time of the prescription purchase or the prescription is purchased at a non-participating pharmacy, you must file a claim directly with the drug card service agency using the agency's claim form.

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

Benefits For Retirees Without A Card

Prescription drugs that are eligible for reimbursement by the prescription drug card program can be submitted to Costco Health Solutions prior to your receipt of the card. To claim this benefit, a receipt for the paid prescription with a Costco Health Solutions claim form must be submitted to Costco Health Solutions.

Costco Health Solutions will reimburse eligible claims as if the card had been used (100% reimbursement following the applicable copay).

MAIL ORDER PRESCRIPTION DRUG PROGRAM

Costco Health Solutions Mail Order Service

When to Use Your Mail Order Prescription Drug Card Program

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

Using the mail order program when purchasing prescriptions and paying the applicable copay, the Plan pays 100% of the eligible balance due direct to the pharmacy.

Dispensing Limitations

The amount normally prescribed by a physician or other lawful prescriber, but not to exceed a 90-day supply.

Ordering Information

The Costco Mail Order Pharmacy is an extension of your current prescription drug benefit. Mail Order service allows you to take advantage of the convenience of having your maintenance medications delivered to your home. You do not need to be a member of Costco to utilize the Costco Mail Order Pharmacy. Costco Mail Order Pharmacy offers two great ordering services: Traditional Mail Order and Online Ordering.

Traditional Mail Order Service – where all orders are placed through the mail or by phone. You would complete and mail in the mail order patient profile form along with your 90 day handwritten prescriptions to Costco Mail Order Pharmacy. If using the mail order form, you must fill out the patient profile section. Also include your prescription written for 90-days and your first form of payment (either a check or supply your credit card information on the patient profile form). Please ensure all new prescriptions include legible spelling of your first and last name, telephone number, date of birth, and address. If you do not have your prescription(s) your physician/provider may fax the prescription(s) to Costco Mail Order at 800/633-0334 or call in the prescription at 800/607-6861.

Online order service – where orders can be placed online at www.pharmacy.costco.com. Each family member will be required to have a separate email address. Payments are made by credit/debit card only. When using the online service, all orders for new prescriptions must be initiate online prior to mailing in the prescription or having your physician/provider Escribe, phone or fax.

Your co-pays are shown in the Schedule of Benefits and can also be obtained by calling Costco Health Solutions at 877/908-6024.

To assist Costco with proper identification, please identify yourself and include your City of Renton Prescription ID and group number.

Please remember all prescription profiles and prescriptions need to be mailed to Costco Mail Order Pharmacy at 802 134th St SW, Suite 140 Everett, WA 98204. Your physician/provider may also call your prescription in to the pharmacy at 800/607-6861 or fax to 800/633-0334. If you have questions on how to get started using the Costco Mail Order/Online Pharmacy please contact the pharmacy at 800/607-6861.

Costco Mail Order Services maintains a quick turnaround time. It may take up to two weeks to process; therefore you are encouraged to contact your physician/provider as soon as possible to ensure adequate time for your new prescription(s) to process. Prescriptions that require communication with either you or the physician/provider will not be filled until all questions have been answered.

DENTAL BENEFITS

If you are covered under this section, the Plan will pay the dental benefits listed herein. Benefits are subject to the limitations shown in the Schedule of Benefits in addition to limitations shown in this section. Charges in excess of the maximum allowable charge are not eligible under this Plan.

OPTIONAL PREDETERMINATION OF BENEFITS

Before beginning a course of treatment for which your dentist's charges are expected to be \$250 or more, you are encouraged to send a description of the proposed course of treatment and charges to the Plan Supervisor. This information may be transmitted on a standard dental claim form available from your dentist. The Plan Supervisor will then determine the estimated benefits payable for the proposed treatment and advise you and your dentist before treatment begins.

The estimate will allow both you and your dentist to know in advance what benefits will be payable by the Plan. If desired, the estimate will also allow you to discuss the proposed treatment with another dentist and obtain a competitive opinion of needed treatment and the price for the treatment.

Please note that the estimate from the Plan Supervisor will be based on the coverage available at the time the estimate is given and will always be subject to the annual dental maximum benefit shown in the Schedule of Benefits.

DESCRIPTION OF BENEFITS

The Plan pays for covered dental expenses that are incurred during a calendar year on your behalf 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 maximum allowable charge that the Plan will pay for non-participating providers, or the percentage of the negotiated rate for preferred providers and participating providers.

CALENDAR YEAR MAXIMUM

Dental benefits are payable at the level indicated in the Schedule of Benefits. Dental benefits are payable at the amount indicated in the Schedule of Benefits up to a maximum of \$2,000 per covered individual per calendar year. Orthodontia has a separate lifetime maximum benefit of \$2,000 per covered individual. TMJ is covered under the Medical Benefit.

COVERED DENTAL EXPENSES

The Plan pays for Type I, II, and III covered charges at the rate stated in the Schedule of Benefits up to the calendar year maximum. All charges must be incurred while the covered individual is insured. Type IV charges are paid at the rate stated in the Schedule of Benefits with Orthodontia up to the lifetime maximum benefit of \$2,000. TMJ is covered under the Medical Benefit.

Covered dental expenses include your dentist's charges for the services and supplies listed below which meet all of the following tests:

- They are necessary and customarily employed nationwide for the treatment of the dental condition.
- They are appropriate and meet professionally recognized national standards of quality.
- They are the least costly dental care that will provide adequate treatment based upon national standards of the dental profession.

Benefits are determined by American Dental Association (ADA) codes submitted on the itemized bills. The correct ADA code must be used to ensure the benefit is paid at the correct coinsurance level.

The Plan pays only for covered charges incurred by you while you are insured. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is seated. A covered charge for any other prosthetic device is incurred on the date the prosthetic device is placed. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. A covered charge for orthodontic treatment is incurred on the date the active appliance is first placed. All other covered charges are incurred on the date the services are rendered.

ALTERNATE TREATMENT

If more than one type of service can be used to treat a dental condition, the plan has the right to consider charges for the least expensive one, which meets the accepted standards of dental practice.

If alternate services or supplies are used to treat a dental condition, covered dental expenses will be limited to the services and supplies which are customarily employed nationwide to treat the dental condition and which are recognized by the profession to be appropriate methods of treatment in accordance with broadly accepted national standards of dental practice, taking into account your total current oral condition.

TYPE I - PREVENTIVE

The following services and supplies are payable at the coinsurance amount as shown in the Schedule of Benefits:

- Preventive oral examinations limited to two treatments per calendar year.
- Prophylaxis (preventive teeth cleaning) limited to two treatments per calendar year.
- Dental x-rays:
 - Full mouth series limited to once every 36 months.
 - Charges for bitewing x-rays are covered twice per calendar.
- Emergency oral examinations.
- Palliative (alleviation of pain) emergency treatment.
- Night guards limited to once every 36 months.
- Space maintainers limited to initial appliance only. Allowance includes all adjustments in the first six months after installation: fixed, unilateral, band or stainless steel crown type or removal bilateral type.

TYPE II - BASIC AND RESTORATIVE

The following services and supplies are payable at the coinsurance amount shown in the Schedule of Benefits.

- Fillings of silver amalgam, silicate, and plastic restoration; including plastic or stainless steel crowns.
- Extractions (removal of teeth).
- Endodontics (treatment of disease of the tooth pulp) including pulpotomy, pulp capping and root canal treatment.
- Oral surgery, including surgical extractions and general anesthetic (when necessary).

- Apicoectomy (including retrograde filling).
- Periodontic services (treatment of the supporting tooth structures).
- Consultations.
- Alveoloplasty.
- Frenectomy.
- Bonded fillings and laminates.
- Veneers.
- Crowns and crown build up – Prosthesis Replacement Rule applies.
- Post and core.
- Inlays and onlays.
- Occlusal adjustments.

TYPE III - MAJOR AND PROSTHETICS

The following services and supplies are payable at the coinsurance amount shown in the Schedule of Benefits:

- Bridges, fixed and removable.
- Dentures, full and partial.
- Rebasing of dentures, but only if they were installed more than six (6) months earlier and if they have not been rebased during the past thirty-six (36) months.
- Relining of dentures, but only if they were installed more than six (6) months earlier and if they have not been relined during the past twelve (12) months.
- Denture adjustments. Limited to once every twelve (12) consecutive months - only if done more than six (6) months after the initial insertion of the denture.
- Addition of teeth to partial denture or bridgework to replace extracted natural teeth.
- Denture tissue conditioning.
- Repairs of dentures and bridges; including recementing of crowns, inlays, onlays, and bridgework.
- Implants (not to exceed the amount that would have been allowed) for fixed bridgework or dentures to restore the missing teeth.

PROSTHESIS REPLACEMENT RULE

The Prosthesis Replacement Rule states that replacements or additions to existing restorations provided under Type III Major and Prosthetics of the Plan, (including but not limited to denture, bridgework, or implant), will be covered only if one of the following applies:

- The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture, bridgework, or implant was installed, and while you were covered.
- The existing denture, bridgework, or implant cannot be made serviceable and was installed at least five years prior to its replacement.
- The existing denture, bridgework, or implant is an immediate temporary, and replacement by a permanent denture, bridgework, or implant is required within 12 months from the date of initial installation of the immediate temporary restoration.

TYPE IV - ORTHODONTIA

The following services and supplies are payable as shown in the Schedule of Benefits:

Charges shall only be eligible if submitted as part of an orthodontic treatment plan to Healthcare Management Administrators, Inc. (HMA) prior to the procedures being performed. HMA will advise your dentist of the estimated benefit for services listed in the treatment plan. If additional services are determined to be needed after submission of the original orthodontic treatment plan, you should contact HMA to see if a supplemental treatment plan must be submitted for those services to be covered. An orthodontic treatment plan is a dentist report, on a form satisfactory to HMA or, which includes the following:

- Provides a classification of the malocclusion or malposition.
- Recommends and describes necessary treatment by orthodontic procedures.
- Estimates the duration over which treatment will be complete.
- Estimates the total charges for such treatment.
- Is accompanied by cephalometric X-rays, study models, and other such supporting evidence as HMA may reasonably require.

Covered expenses include the following:

- X-rays.
- Extractions.
- Space maintainers.
- Appliances for tooth guidance.
- Appliances to control harmful habits.
- Retention appliances.
- Diagnostic procedures.
- Study models.
- Banding.
- Post treatment.

The initial benefit payment is made when the active appliance is first placed. Subsequent payments are made at the end of each subsequent month. Total covered dental charges for the entire course of treatment will be divided into monthly payments, after the initial payment for installation of the appliance. No portion will be deemed to be incurred on any date unless you are covered under this benefit on that date.

EXCLUSIONS AND LIMITATIONS TO THE DENTAL PLAN

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:

After the Termination Date - Charges arising from care, supplies, treatment, and/or services that are Incurred Charges by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Appointments (Missed, Cancelled, Telephonic and Electronic) - Missed or cancelled appointments or for telephone and electronic consultations.

Broken Appointments - Charges arising from care, supplies, treatment, and/or services that are charged solely due to the Participant's having failed to honor an appointment.

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.

Excess - Charges arising from care, supplies, treatment, and/or services that exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

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.

Fluoride - Charges for fluoride.

Incurred by Other Persons - Charges arising from care, supplies, treatment, and/or services that are expenses actually incurred charges by other persons.

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 your becoming covered under the Plan, unless the denture or fixed bridgework also includes replacement of a natural tooth which:

1. Is extracted while you are 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.

Myofascial Pain Dysfunction (MPD) or Temporomandibular Joint Disorder (TMJ) - Charges for the treatment of Myofascial Pain Dysfunction (MPD) or Temporomandibular Joint Disorder (TMJ).

Negligence - Charges arising from care, supplies, treatment, and/or services that are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, institution, or provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

Nitrous Oxide - Charges for nitrous oxide.

No Coverage - Charges arising from care, supplies, treatment, and/or services that are incurred charges at a time when no coverage is in force for you.

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.

Prior to Coverage - Charges arising from care, supplies, treatment, and/or services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

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

Prohibited by Law - Charges arising from care, supplies, treatment, and/or services that are to the extent that payment under this Plan is prohibited by law.

Provider Error - Charges arising from care, supplies, treatment, and/or services that are required as a result of unreasonable provider error.

Providers Other Than Dentists - Charges for treatment by someone 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 who is your relative, or treatment or care provided by any individual who ordinarily resides with you.

Sealants - Charges for sealants.

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 you became covered.

2. A crown, bridge or gold restoration, for which a tooth was prepared before you became covered.
3. Root canal therapy, for which the pulp chamber was opened before you 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 you. This also includes treatment of an illness or injury for which the third party is liable.

Unreasonable - Charges arising from care, supplies, treatment, and/or services that are not "Reasonable" and are required to treat illness or injuries arising from and due to a provider's error, wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating provider whose error caused the loss(es).

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 you are entitled to benefits under any Worker's Compensation or similar law.

VISION BENEFITS

Vision benefits are available to all covered retirees. Vision benefits include routine eye examination, including contact lens fitting, and vision hardware. Vision benefits are payable at 100% up to a maximum of \$450 every two calendar years for vision hardware. This benefit is not subject to the deductible. One vision exam every calendar year is available and does not apply to the hardware limit.

The benefit works as follows: The benefit of \$450 is based upon a 24-month period beginning the first of January of even years and ending the end of December of odd years. For example, employees are eligible for one benefit amount of \$450 in 2016/2017, one benefit of \$450 in 2018/2019, and so on. Any benefits not used during the applicable benefit period is forfeited.

COVERED SERVICES

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

An eye examination must be completed by a licensed optometrist or ophthalmologist.

Covered vision hardware includes:

- Single, bifocal and trifocal lenses
- Frames
- Contact lenses
- Laser eye surgery, radial keratotomy or Lasik surgery

VISION BENEFITS AFTER TERMINATION OF COVERAGE

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

EXCLUSIONS TO THE VISION PLAN

To assure coverage at a reasonable cost, and to prevent unnecessary use of services, the following exclusions have been incorporated:

1. Charges for special procedures, such as orthoptics or vision training, or for special supplies, such as non-prescription sunglasses and subnormal vision aids.
2. Drugs or medications of any kind.
3. Charges for services or supplies which are received while you are not covered.
4. Charges for any vision care services or supplies which are included as covered expenses under any other benefit section included in this Plan, or under any other medical or vision care expense benefit plan carried or sponsored by the City, whether benefits are payable as to all or only part of the charges.

5. Charges for vision care services or supplies for which benefits are provided under any worker's compensation law or any other law of similar purpose, whether benefits are payable as to all or only part of the charges.
6. Charges for any eye examination required by your employer as a condition of employment, or which your employer is required to provide under a labor agreement, or which is required by any law or government.

GENERAL DEFINITIONS

ACCIDENT/ACCIDENTAL INJURY - Shall mean an accidental bodily injury which is the direct result of a sudden, unexpected, and unintended element, such as a blow or fall, which requires treatment by a physician/provider. It must be independent of sickness/illness or any other cause, including, but not limited to, complications from medical care.

ALLOWABLE EXPENSES - Shall mean the maximum allowable charge for any medically necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some other plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's allowable expenses shall in no event exceed the other plan's allowable expenses.

When some other plan provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any other plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

ALTERNATIVE SITES OF CARE - The Plan will consider alternate sites of care specifically set up by local, state, or federal authorities for the testing and treatment of COVID-19, the same as any other licensed facility for the purposes of payment of services by this Plan.

APPROVED CLINICAL TRIAL - An approved clinical trial means a phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following:

- A) Federally funded trials - The study or investigation is approved or funded by one or more of the following:
- i. The National Institutes of Health.
 - ii. The Centers for Disease Control and Prevention.
 - iii. The Agency for Health Care Research and Quality.
 - iv. The Centers for Medicare & Medicaid Services.
 - v. Cooperative group or center of any of the entities listed above (i.-iv.) or the Department of Defense or the Department of Veteran Affairs.
 - vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
 - vii. The Department of Veteran Affairs, The Department of Defense, or the Department of Energy if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.
- B) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.
- C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

APPROVED TREATMENT PLAN - A written outline of proposed treatment that is submitted by the attending physician/provider to the Plan Supervisor for review and approval.

ASSIGNMENT OF BENEFITS - An arrangement whereby you, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less deductibles, copayments and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan Document, to your provider. If your provider accepts said arrangement, your providers' rights to receive Plan benefits are equal to yours and are limited by the terms of this Plan Document. If your provider accepts this arrangement and indicates acceptance of an "Assignment of Benefits" and deductibles, copayments and the coinsurance percentage are your responsibility, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an assignment of benefits previously issued to your provider at its discretion and continue to treat you as the sole beneficiary.

AUTISM SPECTRUM DISORDERS - A group of neurobiological disorders that may include, but are not limited to Autistic Disorder, Rhett's Syndrome, Asperger's Disorder, Childhood Disintegrated Disorder, and Pervasive Development Disorders Not Otherwise Specified (PDDNOS).

BIOFEEDBACK THERAPY - Biofeedback therapy is an electronic method which allows you to monitor the functioning of the body's autonomic systems (e.g., body temperature, heart rate) that were previously thought to be involuntary.

BIRTHING CENTERS - An outpatient facility licensed in the jurisdiction where it is located to provide comprehensive birth services to individuals considered normal, low risk patients.

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

CARE MANAGEMENT - The individual or organization designated by the Plan Administrator to authorize medical facility admissions and surgeries and to determine the medical necessity of treatment for which Plan benefits are claimed.

CERTIFIED IDR ENTITY - Shall mean an entity responsible for conducting determinations under the No Surprises Act and that has been properly certified by the Department of Health and Human Services, the Department of Labor, and the Department of the Treasury.

CHEMICAL DEPENDENCY - See Substance Use Disorder Service definition.

CITY OF RENTON - The Plan Administrator.

CO-INSURANCE - A cost-sharing requirement under this program that requires the enrollee to pay a portion of the cost of specified covered services, through a copayment, deductible, or percentage of cost-share.

COSMETIC - Services or supplies that are applied to normal structures of the body primarily to improve or change appearance.

COUNSELING - Brief treatment that is focused most upon behavior. It targets a particular symptom or problematic situation and offers suggestions and advice for management.

COVERED EXPENSE(S) - A service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the maximum allowable charge for an eligible medically necessary service, treatment or supply, meant to improve a condition or your health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the covered expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Schedule of Benefits and as set forth elsewhere in this document.

COVERED INDIVIDUAL OR PARTICIPANT - You, a retiree meeting the eligibility requirements for coverage as specified in the Plan, and properly enrolled in the Plan.

CUSTODIAL CARE - Care or service which is not medically necessary and is designed essentially to assist you in the activities of daily living. Such care includes, but is not limited to: bathing, feeding, preparation of special diets, assistance in walking, dressing, getting into or out of bed and supervision over taking of medication which can normally be self-administered.

DEDUCTIBLE - The deductible is the amount of eligible expenses each calendar year that you must incur before any benefits are payable by the Plan. The individual deductible amount is listed in the Schedule of Benefits.

DIAGNOSIS - The act or process of identifying or determining the nature and cause of a disease or injury through evaluation of your history, examination, and review of laboratory data.

DISABILITY, TOTAL DISABILITY AND DISABLED - The terms total disability and disabled mean for the:

- Retiree – Your inability to engage, as a result of accident or illness, in your normal occupation with the City on a full time basis.

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

DURABLE MEDICAL EQUIPMENT - Equipment prescribed by the attending physician/provider which meets all of the following requirements:

- Is medically necessary;
- Is designed for prolonged and repeated use;
- Is for a specific purpose in the treatment of an illness or injury and not solely your convenience;
- Would have been covered if provided in a medical facility;
- Is necessary for activities of daily living; and
- Is appropriate for use in the home.

EFFECTIVE DATE - The effective date shall mean the first day this Plan was in effect as shown under the General Plan Information. Your effective date is the first day the benefits under this Plan would be in effect, after satisfaction of the waiting period (if applicable) and any other provisions or limitations contained herein.

ELECTIVE SURGICAL PROCEDURE - A surgical procedure that need not be performed on an emergency basis because reasonable delay will not cause life endangering complications.

EMERGENCY SERVICES - Services rendered due to an accident or illness, which requires immediate medical attention, without which death or serious impairment to an individual's bodily functions could occur.

EMERGENCY SERVICES - Shall mean, with respect to a medical emergency, the following:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition.
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, as required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) or as would be required under such section if such section applied to an independent freestanding emergency department, to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

When furnished with respect to an emergency medical condition, emergency services shall also include an item or service provided by an Out-of-Network provider or Out-of-Network health care facility (regardless of the department of the hospital in which items or services are furnished) after the participant is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the emergency services are furnished, until such time as the provider determines that the participant is able to travel using non-medical transportation or non-emergency medical transportation, and the participant is in a condition to, and in fact does, give informed consent to the provider to be treated as an Out-of-Network provider.

ENROLLMENT DATE - The enrollment date is the first day of coverage or, if there is a waiting period for coverage to begin under the Plan, the first day of the waiting period. The term "waiting period" refers to the period after employment starts and the first day of coverage under the Plan. If you are a late enrollee or you enroll on a special enrollment date, the "enrollment date" will be the first date of actual coverage. If you are receiving benefits under a group health plan and you change benefit packages, or if the Plan changes group health insurance issuers, your enrollment date does not change.

ESSENTIAL HEALTH BENEFITS - Shall mean, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

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

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

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

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

HIPAA - Health Insurance Portability and Accountability Act. This Plan is subject to and complies with HIPAA rules and regulations.

HMA - Healthcare Management Administrators, Inc., the Plan Supervisor.

HOMEBOUND - You are homebound when leaving the home could be harmful, involves a considerable and taxing effort, and you are unable to use transportation without the assistance of another.

HOME HEALTHCARE VISIT - Each visit by a representative of a home healthcare agency shall be considered one visit. Each four hours of home services by a representative shall be considered as one home healthcare visit.

ILLNESS - A pathological condition of the body that presents a group of clinical signs and symptoms and laboratory findings peculiar to it and that sets the condition apart as an abnormal state differing from other normal body states; typically indicates a disease, physical sickness or Mental Disorder. For purposes of the administration of this Plan, Illness also includes Pregnancy, childbirth, miscarriage or complications thereof.

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

INDEPENDENT FREESTANDING EMERGENCY DEPARTMENT - Means a health care facility that is geographically separate and distinct, and licensed separately, from a hospital under applicable state law, and which provides any emergency services.

INJURY - See Accident/Accidental Injury.

INPATIENT - A person physically occupying a room and being charged for room and board in a facility (Hospital, Skilled Nursing Facility, etc.) which is covered by the Plan and to which the person has been assigned on a 24- hour-day basis.

INPATIENT STAY - An uninterrupted confinement that follows formal admission to a Hospital, Skilled Nursing Facility or Inpatient Rehabilitation Facility.

INTENSIVE OUTPATIENT TREATMENT - A structured outpatient Mental Health or Substance Use Disorder treatment program that may be free-standing or Hospital-based and provides services for at least three hours per day, two or more days per week.

INTERMEDIATE LEVEL OF CARE - Mental Health or Substance Use Disorder treatment that encompasses the following:

- Care at a residential treatment facility.
- Care at a partial hospitalization/day treatment program.
- Care through an intensive outpatient treatment program.

LEOFF I - Retirees covered under the Department of Retirement System LEOFF I Plan.

LIFE ENDANGERING CONDITION - An injury or illness which requires immediate medical attention, without which death or serious impairment to your bodily functions could occur.

MAXIMUM ALLOWABLE CHARGE - Shall mean the benefit payable for a specific coverage item or benefit under this Plan. The maximum allowable charge will be a negotiated rate, including a case/claims negotiation agreement, if one exists. In the event that the negotiated rate per the terms of an applicable provider contract is higher than billed, the Plan may reimburse at the higher allowance in order to comply with terms of the provider contract.

For claims subject to the No Surprises Act (see "No Surprises Act within the section "Important Information") if no negotiated rate exists, the maximum allowable charge will be:

- An amount determined by an applicable all-payer model agreement; or
- If no such amount exists, an amount determined by applicable state law; or
- If neither such amount exists, an amount deemed payable by a Certified IDR Entity or a court of competent jurisdiction, if applicable.

If none of the above factors are applicable, the maximum allowable charge will be at the discretion of the Plan Administrator and will be determined to be a percentage, as outlined in the Schedule of Benefits,

multiplied by the Medicare reimbursement rates presently utilized by the Centers for Medicare and Medicaid Services ("CMS"), a percentage of billed charges, or multiplied by a percentage that the particular provider and/or others in the area customarily accept from all payers.

If and only if none of the factors above are applicable, the Plan Administrator will exercise its discretion to determine the maximum allowable charge based on any of the following: Medicare cost data, amounts actually collected by providers in the area for similar services, or average wholesale price (AWP) or manufacturer's retail pricing (MRP). These ancillary factors will take into account generally-accepted billing standards and practices.

When more than one treatment option is available, and one option is no more effective than another, the least costly option that is no less effective than any other option will be considered within the maximum allowable charge. The maximum allowable charge will be limited to an amount which, in the Plan Administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of provider negligence or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

MEDICAL EMERGENCY - An illness or injury which is life threatening or one that must be treated promptly to avoid serious adverse health consequences to yourself.

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

- Diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and ill Participants, such as yourself.
- Services performed by or under the supervision of a staff of physicians/providers who are duly licensed to practice medicine.
- Continuous 24 hours a day nursing services by registered nurses.

For the services covered under this Plan and for no other purpose, inpatient treatment of mental illness or substance use, provided by any psychiatric medical facility licensed by the State Board of Health or the Department of Mental Health, will be considered services rendered in a medical facility as defined subject to the limitations shown in this booklet.

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 Substance Use Disorder Treatment or Mental Health Services 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.

A facility designated by the United States government (local, state, or federal agency) for the purposes of testing and treatment of COVID-19 will be considered a Medical Facility under this Plan.

MEDICAL RECORD REVIEW - The process by which the Plan, based upon a medical record review and audit, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the maximum allowable charge according to the medical record review and audit results.

MEDICALLY NECESSARY - Medical services and/or supplies which are absolutely needed and essential to diagnose or treat an illness or injury of yours while covered by this Plan. The following criteria must be met. The treatment must be:

- Consistent with the symptoms or diagnosis and treatment of your condition.
- Appropriate with regard to standards of good medical practice.

- Not solely for the convenience of you, your family members or your provider of services or supplies.
- The least costly of the alternative supplies or levels of service which can be safely provided to you. When specifically applied to a medical facility inpatient, it further means that the service or supplies cannot be safely provided in other than a medical facility inpatient setting without adversely affecting your condition or the quality of medical care rendered.

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

MENTAL OR NERVOUS DISORDER - Any disease or condition, regardless of whether the cause is organic, that is classified as a mental or nervous disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant state guideline or applicable sources. The fact that a disorder is listed in any of these sources does not mean that treatment of the disorder is covered by the Plan.

NON-EMERGENCY MEDICAL FACILITY ADMISSIONS - A medical facility admission (including normal childbirth) which may be scheduled at your convenience without endangering your life or without causing serious impairment to your bodily functions.

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

1. Medically necessary off-label drug use will be accepted if the drug is otherwise covered by the Plan and if one of the following criteria are met:
 - A. Drug Compendia: One of the following drug compendia indicates that the drug is recognized as effective for the indication:
 - The American Hospital Formulary Service Drug Information;
 - Drug Facts and Comparison;
 - The U.S. Pharmacopoeia Dispensing Information;
 - American Medical Association Drug Evaluation;
 - National Cancer Care Network;
 - National Cancer Institute; or
 - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services.
 - B. Scientific Evidence/Substantially Accepted Peer-Reviewed Medical Literature: The majority of the scientific evidence indicates that the drug is effective for the off-label indication. The evidence must:
 1. Consist of an adequate number of well-designed studies with sufficient numbers of patients in relation to the incidence of the disease;
 2. Be published in peer reviewed journals. The studies must be printed in journals or other publications that publish original manuscripts only after the manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy, validity, and reliability;
 3. There must be enough information in the peer-reviewed literature to allow judgment of the safety and efficacy;
 4. Demonstrate consistent results throughout all studies; and

5. Document positive health outcomes and demonstrate:
 - i. That the drug is as effective as or more effective than established alternatives; and
 - ii. Improvements that are attainable outside the investigational setting.
- C. Recognized as effective for treatment of such indication by the Federal Secretary of Health and Human Services.

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

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

OTHER PLAN - Shall include, but is not limited to:

1. Any primary payer besides the Plan.
2. Any other group health plan.
3. Any other coverage or policy covering you.
4. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
5. Any policy of insurance from any insurance company or guarantor of a responsible party.
6. Any policy of insurance from any insurance company or guarantor of a third party.
7. Workers' compensation or other liability insurance company.
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

OUT-OF-NETWORK - Health care providers not included in the Preferred Provider Network of providers.

OUTPATIENT CARE AND/OR SERVICES - Treatment including services, supplies and medicines provided and used at a hospital under the direction of a physician/provider when you are not admitted as a registered inpatient; services rendered in a physician's/provider's office, laboratory or X-ray facility, an ambulatory surgical center, or your home.

OUTPATIENT SURGICAL FACILITY - A licensed surgical facility, surgical suite or medical facility surgical center in which a surgery is performed and you are not admitted for an overnight stay.

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.

PARTIAL HOSPITALIZATION/DAY TREATMENT - A structured ambulatory program that may be a free-standing or Hospital-based program and that provides services for at least 20 hours per week.

PARTICIPANT - You, when you are a retiree and is or may become eligible to receive a benefit under the Plan.

PARTICIPATING (PAR) PROVIDER - A provider who is part of a network of providers who has entered into a current participating agreement with the Plan Supervisor, or a contractor for the Plan Supervisor.

PLAN - Shall mean the Benefits described in the Plan Document. The Plan is the Covered Entity as defined in HIPAA (§160.103).

PLAN ADMINISTRATOR/PLAN SPONSOR - The individual, group or organization responsible for the day-to-day functions and management of the Plan. The Plan Administrator/Plan Sponsor may employ individuals or firms to process claims and perform other Plan connected services. The Plan Administrator/Plan Sponsor is as shown under the General Plan Information.

PLAN DOCUMENT - The term Plan Document whenever used herein shall, without qualification, mean the document containing the complete details of the benefits provided by this Plan. The Plan Document is kept on file at the office of the Plan Administrator.

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

PLAN YEAR - The term Plan Year means an annual period beginning on the effective date of this Plan and ending twelve (12) calendar months thereafter or upon termination of the Plan, whichever occurs earliest.

PREFERRED NETWORK HEALTH CARE FACILITY - Shall mean a hospital or hospital outpatient department, critical access hospital, outpatient surgical center, or other provider as required by law, which has a direct or indirect contractual relationship with the Plan with respect to the furnishing of a healthcare item or service. A single direct contract or case agreement between a health care facility and a plan constitutes a contractual relationship for purposes of this definition with respect to the parties to the agreement and particular individual(s) involved.

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

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

PROVIDER - An entity whose primary responsibility is related to the supply of medical care. Each provider must be licensed, registered, or certified by the appropriate state agency where the medical care is performed, as required by that state's law where applicable. Where there is no applicable state agency, licensure, or regulation, the provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a provider as defined herein if that entity is not deemed to be a provider by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

QUALIFYING PAYMENT AMOUNT - Means the median of the contracted rates recognized by the Plan, or recognized by all plans serviced by the Plan Supervisor (if calculated by the Plan Supervisor), for the same or a similar item or service provided by a provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a qualifying payment amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law.

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

RECOGNIZED AMOUNT - Means, except for Non-Network air ambulance services, an amount determined under an applicable all-payer model agreement, or if unavailable, an amount determined by applicable state law. If no such amounts are available or applicable and for Out-of-Network air ambulance services generally,

the recognized amount shall mean the lesser of your provider's billed charge or the qualifying payment amount.

RECONSTRUCTIVE - Services, procedures or surgery performed on abnormal structures of the body, caused by congenital anomalies, developmental abnormalities, trauma, infection, tumors or disease. It is performed to restore function, but, in the case of significant malformation, is also done to approximate a normal appearance.

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

RESIDENTIAL TREATMENT FACILITY - A facility which provides a program of effective Mental Health Services or Substance Use Disorder Services treatment and which meets all of the following requirements:

- It is established and operated in accordance with applicable state law for residential treatment programs.
- It provides a program of treatment under the active participation and direction of a physician/provider and approved by the Mental Health/Substance Use Disorder Designee.
- It has or maintains a written, specific and detailed treatment program requiring full-time residence and full-time participation by the patient.
- It provides at least the following basic services in a 24-hour per day, structured milieu:
 - Room and board.
 - Evaluation and diagnosis.
 - Counseling.
 - Referral and orientation to specialized community resources.

A residential treatment facility that qualifies as a hospital is considered a hospital.

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

SEMI-PRIVATE RATE - The daily room and board charge which an institution applies to the greatest number of beds in its semi-private rooms containing 2 or more beds. If the institution has no semi-private rooms, the semi-private rate will be the daily room and board rate most commonly charged for semi-private rooms with two or more beds by similar institutions in the area. The term "area" means a city, a county, or any greater area necessary to obtain a representative cross section of similar institutions.

SERIOUS AND COMPLEX CONDITION - In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm. In the case of a chronic illness or condition, a condition that is, a) life-threatening, degenerative, potentially disabling, or congenital; and b) requires specialized medical care over a prolonged period of time.

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

- It is licensed to provide and is engaged in providing, on an inpatient basis, for you if you are convalescing from injury or disease, professional nursing services rendered by a Registered Graduate Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Graduate Nurse, physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.

- Its services are provided for compensation from its patients and patients are under the full-time supervision of a physician/provider or Registered Graduate Nurse (R.N.).
- It provides 24 hours per day nursing services by a licensed nurse, under the direction of a full-time Registered Graduate Nurse (R.N.).
- It maintains a complete medical record on each patient.
- It has an effective utilization review plan.
- It is not, other than incidentally, a place for rest for the aged, drug addicts, alcoholics, the mentally handicapped, custodial, or educational care, or care of mental disorders.

SUBSTANCE ABUSE AND/OR SUBSTANCE USE DISORDER - Any disease or condition that is classified as a substance use disorder as listed in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, as listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, or other relevant state guideline or applicable sources. The fact that a disorder is listed in any of the above publications does not mean that treatment of the disorder is covered by the Plan.

SUMMARY PLAN DESCRIPTION - This document contains a summary of the benefits provided under the Plan. In the event of a discrepancy between the summary and the Plan Document, the provisions stated in the Plan Document will supersede.

SURGICAL PROCEDURE - A surgical procedure is defined as:

- A cutting operation.
- Treatment of a fracture.
- Reduction of a dislocation.
- Radiotherapy if used in lieu of a cutting operation for removal of a tumor.
- Electrocauterization.
- Injection treatment of hemorrhoids and varicose veins.

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

THERAPY - Includes cognitive behavioral therapy, interpersonal therapy, dialectical behavior therapy, psychoanalysis, psychotherapy, family therapy, individual therapy, marriage therapy, or marital therapy.

TRANSITIONAL CARE - Mental Health Services and Substance Use Disorder Services that are provided through transitional living facilities, group homes and supervised apartments that provide 24-hour supervision that are either:

- Sober living arrangements such as drug-free housing, alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist you with recovery.
- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide you with stable and safe housing and the opportunity to learn how to manage your activities of daily living. Supervised living arrangements may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist you with recovery.

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

WAITING PERIOD - The period of time you, as a potential retiree must be actively at work prior to becoming eligible for coverage under the terms of the Plan.

GENERAL PROVISIONS

ADMINISTRATION OF THE GROUP MEDICAL PLAN

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

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

AMENDMENT OF PLAN DOCUMENT

The Plan Administrator may terminate, modify, or amend the Plan in its sole discretion without prior notice. The Plan Administrator must notify the Plan Supervisor in writing requesting an amendment to the Plan. The Plan Supervisor will prepare an amendment to be signed by the Plan Administrator. Once the Plan Administrator has signed the amendment, such termination, amendment or modification which affects you will be communicated to you in the manner of a new Plan document or employer communication. The amended Plan Benefits shall be the basis for determining all Plan payments for all expenses incurred on or after the effective date of such amendment. Plan payments made under the Plan prior to amendment shall continue to be included as Plan payments in determining the total benefits remaining toward satisfaction of any benefit maximums calculated on a Plan year or calendar year basis.

APPLICATION AND IDENTIFICATION CARD

To obtain coverage, you must complete and deliver to the Plan Administrator an application on the enrollment form supplied by the Plan Supervisor.

Acceptance of this application will be evidenced by the delivery of an identification card showing your name, by the Plan Supervisor to the Plan Administrator.

ASSIGNMENT OF BENEFITS

Assignment by you to your provider of your right to submit claims for payment to the Plan, and receive payment from the Plan, may be achieved via an assignment of benefits, if and only if your provider accepts said assignment of benefits as consideration in full for services rendered. If benefits are paid, however, directly to you, the claimant – despite there being an assignment of benefits – the Plan shall be deemed to have fulfilled its obligations with respect to such payment, and it shall be your responsibility to compensate the applicable provider(s). The Plan will not be responsible for determining whether an assignment of benefits is valid; and you shall retain final authority to revoke such assignment of benefits if a provider subsequently demonstrates an intent not to accept it as payment in full for services rendered. As such, payment of benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by you, the Claimant, has been received.

You shall not, at any time, either during the time in which you are a Claimant in the Plan, or following your termination as a claimant, in any manner, have any right to assign your right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which you may have against the Plan or its fiduciaries. This prohibition applies to providers as well.

A provider which accepts an assignment of benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

Benefits due to any Preferred Provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any

assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, agrees to be bound by the terms of this Plan and agrees to submit claims for reimbursement in strict accordance with applicable law, ICD, and/or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer.

AUDIT AND REVIEW FEES

In addition to the Plan's medical record review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not maximum allowable and/or medically necessary and reasonable, if any, and may include your medical billing records review and/or audit of your medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the maximum allowable amounts or other applicable provisions, as outlined in this Plan Document. Cost containment fees may be charged as a percent of savings under the Plan due to the application of cost containment provisions and are considered covered expenses under the Plan.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a maximum allowable charge, in accord with the terms of this Plan Document.

AUDIT INCENTIVES

If you discover an error in the provider's medical billing which is subsequently recovered or if the benefits payable are reduced due to the identification of the error, the medical plan will reimburse you 50% of the recovered or reduced amount. Provider errors eligible for the audit incentive must be greater than \$50.00; incentive payments to enrollees are limited to \$500 per incident. No benefit is payable for any errors made by the Plan Supervisor in processing the claim.

BALANCE BILLING

In the event that a claim submitted by a Preferred or Non-Preferred Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that you should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many jurisdictions, and the Plan has no control over Out-of-Network Providers that engage in balance billing practices.

In addition, with respect to services rendered by a Preferred or Participating Provider being paid in accordance with a discounted rate, it is the Plan's position that you should not be responsible for the difference between the amount charged by the Preferred or Participating Provider and the amount determined to be payable by the Plan Administrator, and should not be balance billed for such difference. Again, the Plan has no control over any Preferred or Participating Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Preferred or Participating Provider.

You are responsible for any applicable payment of coinsurances, deductibles, and out-of-pocket maximums and may be billed for any or all of these.

CANCELLATION

You may cancel your coverage by giving written notice to the Plan Administrator who will notify the Plan Supervisor.

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

In the event of the cancellation of this Plan, or the cancellation of the Participating Group's participation in the Plan, your coverage shall cease automatically without notice. You shall not be entitled to further coverage or benefits, whether or not any medical condition was covered by the Plan prior to termination or cancellation.

The Plan may be cancelled or terminated at any time without advance notice by the Participating Group or Groups. Any Participating Group may cancel its participation at any time without notice and without effect on any remaining Participating Group.

Upon termination of this Plan, or the cancellation of the Participating Group's participation in the Plan, all claims incurred prior to termination, 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.

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. All claims must be received within the Plan's timely filing limits and will be processed based upon available benefits and the terms and conditions of the Plan once the claim and all necessary supporting documentation is received by the Plan Supervisor. The Plan has no control over when claims are submitted, nor when all required records and other requested documentation (i.e., itemizations, medical records, etc.) to process the claim, will actually be received. Therefore, due to the multitude of factors that impact the timing of claim processing, claims cannot and will not be considered in the same order the services were actually received by you. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that you are entitled to the benefits. 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.

If you are claiming benefits under the Plan you 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 you have not incurred a covered expense or that the benefit is not covered under the Plan, or if you should 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 you are 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.

You have 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 you receive notice of a final adverse benefit determination, then you have 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 you, 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 your life or health or your ability to regain maximum function, or, in the opinion of a physician/provider with knowledge of your medical condition, would subject you 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 you to obtain approval of a specific medical service prior to getting treatment, then there is no pre-service claim. You simply follow the Plan's procedures with respect to any notice which may be required after receipt of treatment, and file 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
 - You request an extension of the course of treatment beyond that which the Plan Administrator has approved.

If the Plan does not require you 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. You simply follow the Plan's procedures with respect to any notice which may be required after receipt of treatment, and file 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.** If you can show that it was not reasonably possible to submit the claim within one year from the date of service or if you can provide proof that you had attempted to submit the claim within one year, we will waive the timely filing provision and process the claim in accordance with the terms of the Plan.

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 your receipt 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 you, 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 you have 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 you have not provided all of the information needed to process the claim, then you 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.
 - You will be notified of a determination of benefits as soon as possible, but not later than 48 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 you 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 you. All necessary information, including the Plan's benefit determination on review, may be transmitted between you and the Plan by telephone, facsimile, e-mail, or other similarly expeditious method. Alternatively, you may request an expedited review under the external review process.
- Pre-service Non-urgent Care Claims:
 - If you have 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 you have not provided all of the information needed to process the claim, then you 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. You 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 yourself (if additional information was requested during the extension period).
- Concurrent Claims:
 - **Plan Notice of Reduction or Termination.** If the Plan Administrator is notifying you 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, you will be notified sufficiently in advance of the reduction or termination to allow you 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 You Involving Urgent Care. If the Plan Administrator receives a request from you to extend the course of treatment beyond the period of time or number of treatments and the claim is involving urgent care, the claim will be decided as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
- Request by You Involving Non-urgent Care. If the Plan Administrator receives a request from you to extend the course of treatment beyond the period of time or number of treatments and the claim is 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 You Involving Rescission. With respect to rescissions, the following timetable applies:
 - Notification to You - 30 days
 - Notification of adverse benefit determination on appeal - 30 days
- Post-service Claims:
 - If you have 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 the claim will be decided prior to the end of the 15-day extension period.
 - If you have not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then you 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 you will be notified of the determination by a date agreed to by the Plan Administrator and yourself.
- 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 you, 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 you, 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 you with a notice, either in writing or electronically (or, in the case of pre-service urgent care claims, by telephone, facsimile, e-mail, 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 you. The notice will contain the following information:

- Information sufficient to allow you 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 you 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 your right to bring a civil action following an adverse benefit determination on final review;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your 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 the expert's 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 you, 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 your medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to you, free of charge, upon request;
- 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 you with the internal claims and appeals and external review processes; and
- In the case of 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 you believe the claim has been denied wrongly, you may appeal the denial and review pertinent documents. The claims procedures of this Plan provide you with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

- 180 days following your 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;
- The opportunity for you 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 you 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 the expert's advice;
- That you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your 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 your medical circumstances; and
- In the case of 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 you; and
 - All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and yourself by telephone, facsimile, e-mail, or other available similarly expeditious method.

Requirements for First Appeal

You must file the first appeal in writing using an Appeals Submission 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 you would like to authorize another individual to act on your behalf in regard to the appeal, an Appointment of Authorized Representative form must be submitted with the appeal (an Authorized Representative form is not required in the case of an urgent care claim). An Appeals Submission Form and an Appointment of Authorized Representative form can be obtained by calling HMA's Customer Care Department at 800/869-7093, or at www.accesshma.com.

For pre-service urgent care claims, if you choose to orally appeal, you may telephone:

Healthcare Management Administrators, Inc.
425/462-1000 Seattle Area
800/869-7093 All Other Areas

To file an appeal in writing, your appeal must include an Appeals Submission Form and be addressed and mailed, e-mailed, or faxed as follows:

Healthcare Management Administrators, Inc.
Attn: Appeals
P.O. Box 85016
Bellevue, Washington 98015-5016
425/462-1000 - Seattle Area
800/869-7093 - All Other Areas
855/462-8875 – Fax
appeals@accesshma.com – E-mail

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

- A completed Appeals Submission Form;
- Your name;
- Your ID number;

- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any facts or theories in the appeal will result in the facts and theories being deemed waived. In other words, you will lose the right to raise factual arguments and theories which support this claim if you fail to include the facts and theories 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 you have which indicates that you are entitled to benefits under the Plan.

If you provide 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 you 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 per internal 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 you with notification, with respect to pre-service urgent care claims, by telephone, facsimile, e-mail, 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 you 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 you 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 your right to bring a civil action following an adverse benefit determination on final review;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your 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 the expert's 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 you, 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 your medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to you, 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, you must submit a second appeal in writing using an Appeals Submission Form (although oral appeals are permitted for pre-service urgent care claims) within 180 days. If you would like to authorize another individual to act on your behalf in regard to the second appeal, an Appointment of Authorized Representative form must be submitted with the appeal (an Authorized Representative form is not required in the case of an urgent care claim). An Appeals Submission Form and an Appointment of Authorized Representative form can be obtained by calling HMA's Customer Care Department at 800/869-7093, or at www.accesshma.com.

As with the first appeal, your second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Two Levels of Appeal

This Plan requires two levels of appeal by you before the Plan's internal appeals are exhausted. For each level of appeal, you and the Plan are subject to the same procedures, rights, and responsibilities as stated within this Plan. Each level of appeal is subject to the same submission and response guidelines.

Once you receive an Adverse Benefit Determination in response to an initial claim for benefits, you may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If you receive an Adverse Benefit Determination in response to that initial appeal, you may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If you receive an Adverse Benefit Determination in response to your second appeal, such Adverse Benefit Determination will constitute the final Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

Timing of Notification of Benefit Determination on Second Review

The Plan Administrator shall notify you 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 you 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, you do not receive a written response to the appeal within the appropriate time period set forth above, you 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 you under the Plan. No further appeal rights are available. You have the right to bring civil action under state law.

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with applicable law, applies only to an adverse benefit determination that involves consideration of whether the Plan is complying with the surprise billing and cost-sharing protections set forth in the No Surprises Act.

CONDITIONS PRECEDENT TO THE PAYMENT OF BENEFITS

You shall present the Plan identification card to the provider of service upon admission to a medical facility or upon receiving service from a physician/provider.

Written proof of the nature and extent of service performed by a physician or other provider of service shall be furnished to the Plan Supervisor within one year after the service was rendered. Claim forms are available through the Plan Supervisor and are required along with an itemized statement with a diagnosis,

your name and subscriber identification number and the name of the Plan Administrator or the Participating Group.

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

The Plan Supervisor shall have the right to review these records with the Plan's Insurance Company and with any medical consultant or with the Care Manager as needed to determine the medical necessity of the treatment being rendered.

COORDINATION OF BENEFITS

Definitions

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

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.

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 you are 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 you as a retiree will be secondary for you.
3. The plan covering you as the employee (or insured, member, Participant, or subscriber) of the policy will be primary.
4. This Plan will pay secondary to any individual policy.
5. If this Plan is covering you as a COBRA Participant or a Participant of continuation coverage pursuant to state law, this Plan is secondary to your other plan.

Coordination of benefits with Medicare is governed by the Medicare Secondary Payer rules. This Plan's benefits are determined by calculating the amount, which would have been paid by this Plan in the absence of Medicare, then, reducing that by the amount Medicare would have paid if the covered person was enrolled in Medicare. If a covered person chooses to forgo coverage under Medicare, they may be subject to balance billing by their provider for care received. Please see the Medicare section within this document for additional details on how this Plan will coordinate coverage with Medicare, **whether enrolled or not**.

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.

Excess Insurance

If at the time of Injury, sickness, disease or disability there is available, or potentially available any other source of coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible, any of the following:

1. Any primary payer besides the Plan.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

CREDIT FOR PRIOR GROUP COVERAGE

This Plan amends and replaces the prior Plan. Retirees who were covered under the prior Plan sponsored by the Employer immediately prior to the time this Plan became effective shall not lose eligibility or benefits due to the change in Plans. All charges incurred on or after the effective date of this Plan will be subject to the benefits available under this Plan and not the prior Plan. Credit will be given for time enrolled under the prior Plan for payments towards coinsurance.

EFFECT OF TERMINATION OF THE PLAN

Upon complete or partial termination of the Plan, the Plan Administrator may, after the payment or provision for payment of all benefits to you if you have incurred covered expenses and charges properly payable, including all expenses incurred and to be incurred in the liquidation and distribution of the Trust Fund or separate account, direct the disposition of all assets held in the Trust Fund or separate account to the Participating Group or Groups, subject to any applicable requirement of an accompanying Trust Document or applicable law or regulation.

EVIDENCE BASED MEDICINE

In making a medical necessity determination, the discretion and standard of review is neither arbitrary nor capricious and is based upon the following provisions and approved citations:

- MCG, Milliman Care Guidelines.
- NCCN, National Cancer Care Network.

- Cambia Medical Policy including clinical practice guidelines, clinical position statements and referenced citations.
- Wolters Kluwer Facts and Comparisons.
- Other authoritative compendia (references) as identified from time to time by the Federal Secretary of Health and Human Services or other approved policy.

FACILITY OF PAYMENT

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

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

FIDUCIARY OPERATION

Each fiduciary shall discharge duties with respect to the Plan solely in the interest of you and your beneficiaries and: (1) for the exclusive purposes of providing benefits to you and your beneficiaries and defraying reasonable expenses of administering the Plan, (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a like character and with like aims, and (3) in accordance with the documents and instruments governing the Plan.

FREE CHOICE OF PHYSICIAN

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

Nothing contained herein shall confer upon you any claim, right, or cause of action, either at law or in equity, against the Plan for the acts of any medical facility in which you receive care, for the acts of any physician/provider from whom you receive service under this Plan, or for the acts of the Care Manager performing duties under this Plan.

FUNDING

If contributions are required of you under this Plan, the Plan Administrator will maintain a Trust or otherwise account for the receipt of money and property to fund the Plan, for the management and investment of such funds and for the payment of claims and expenses from such funds. The terms of the Trust (when applicable) are hereby incorporated by reference, as of the effective date of the Trust, as a part of this Plan.

The Participating Group(s) shall deliver from time to time to the Plan Administrator or the Trust such amounts of money and property as shall be necessary to provide the Trust with sufficient funds to pay all claims and reasonable expenses of administering the Plan as the same shall be due and payable. The Plan Administrator may provide for all or any part of such funding by insurance issued by a company duly qualified to issue insurance for such purpose in the state of situs and may pay the premiums therefore directly or by funds deposited in the Trust.

All funds received by the Trust and all earnings of the Trust shall be applied toward the payment of claims and reasonable expenses of administration of the Plan except to the extent otherwise provided by the Plan

Documents. The Plan Administrator may appoint an investment manager or managers to manage (including the power to acquire and dispose of) any assets of the Plan.

Any fiduciary, employee, agent, representative, or other individual performing services to or for the Plan or Trust shall be entitled to reasonable compensation for services rendered, unless such individual is the Plan Administrator, and for reimbursement of expenses properly and actually incurred.

HIPAA PRIVACY AND SECURITY

Use and Disclosure of Protected Health Information

Under the HIPAA privacy rules the Plan Sponsor must establish the permitted and required uses of Protected Health Information (PHI).

Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose summary health information to the Plan Sponsor, provided that the Plan Sponsor requests the summary health information for the purpose of obtaining premium bids, determining participant enrollment status, or for modification, amendment or termination of the Plan.

Plan Sponsor's Certification of Compliance

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose your Protected Health Information to the City of Renton (Plan Sponsor) unless the City of Renton (Plan Sponsor) certifies its compliance with 45 Code of Federal Regulations §164.504(f)(2) (collectively referred to as The Privacy Rule) as set forth in this Article and agrees to abide by any revisions to The Privacy Rules.

Notice of Privacy Practices

The Plan provides each participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of the Plan's Notice of Privacy Practices are available by calling your Human Resources Department.

Restrictions on Disclosure of Protected Health Information to Employer (Plan Sponsor)

The Plan and any health insurance issuer or business associate servicing the Plan will disclose your Protected Health Information to the City of Renton (Plan Sponsor) only to permit the City of Renton (Plan Sponsor) to carry out plan administration functions for the Plan consistent with the requirements of the Privacy Rule. Any disclosure to and use by the City of Renton (Plan Sponsor) of your Protected Health Information will be subject to and consistent with the provisions of paragraphs on **Employer (Plan Sponsor) Obligations Regarding Protecting Health Information** and **Adequate Separation Between the City of Renton (Plan Sponsor) and the Plan** of this Article.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose your Protected Health Information to the City of Renton (Plan Sponsor) unless the disclosures are explained in the Notice of Privacy Practices distributed to you.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose your Protected Health Information to the City of Renton (Plan Sponsor) for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the City of Renton (Plan Sponsor).

Employer (Plan Sponsor) Obligations Regarding Protecting Health Information

The City of Renton (Plan Sponsor) will:

- Neither use nor further disclose your Protected Health Information, except as permitted or required by the Plan Documents, as amended, or required by law.
- Ensure that any agent, including any subcontractor, to whom it provides your Protected Health Information, agrees to the restrictions and conditions of the Plan Documents, including this Article, with respect to your Protected Health Information.
- Not use or disclose your Protected Health Information for employment-related actions or decisions or in connection with any other benefit or retiree benefit plan of the City of Renton (Plan Sponsor).
- Report to the Plan any use or disclosure of your Protected Health Information that is inconsistent with the uses and disclosures allowed under this Article promptly upon learning of such inconsistent use or disclosure.
- If you are the subject of information, make Protected Health Information available to you in accordance with 45 Code of Federal Regulations § 164.524.
- Make your Protected Health Information available for amendment, and will on notice amend your Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526.
- Track disclosures it may make of your Protected Health Information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.
- Make available its internal practices, books, and records, relating to its use and disclosure of your Protected Health Information, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.
- If feasible, return or destroy all of your Protected Health Information, in whatever form or medium (including in any electronic medium under the City of Renton's (Plan Sponsor's) custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of you if you are the subject of the Protected Health Information, when your Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all of your Protected Health Information, the City of Renton (Plan Sponsor) will limit the use or disclosure of any of your Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Adequate Separation Between the City of Renton (Plan Sponsor) and the Plan

The following classes of employees or other workforce members under the control of the City of Renton (Plan Sponsor) may be given access to your Protected Health Information received from the Plan or a health insurance issuer or business associate servicing the Plan:

- Benefits: HR Benefits Manager; Human Resources Specialist; Sr. Benefits Analyst; Benefits Analyst..
- Human Resources: HR and Risk Management Administrator; HR Labor Manager.
- Finance: Finance Operations Manager; Fiscal Services Director; Finance Administrator; Payroll Technician 2 and 3.
- Trustees: City of Renton Employees' Health Plan Board of Trustees.

This list includes every class of employees or other workforce members under the control of the City of Renton (Plan Sponsor) who may receive your Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The identified classes of employees or other workforce members will have access to your Protected Health

Information only to perform the plan administration functions that the City of Renton (Plan Sponsor) provides for the Plan.

The identified classes of employees or other workforce members will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the City of Renton (Plan Sponsor), for any use or disclosure of your Protected Health Information in breach or violation of or noncompliance with the provisions of this Article to the Plan Documents. Employer (Plan Sponsor) will promptly report such breach, violation or noncompliance to the Plan, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance for you, if the privacy of your Protected Health Information may have been compromised by the breach, violation or noncompliance.

City of Renton (Plan Sponsor) Obligations Regarding Electronic Protecting Health Information

City of Renton (Plan Sponsor) will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
- Ensure that the adequate separation between the Plan and Plan Sponsor with respect to electronic PHI is supported by reasonable and appropriate security measures.
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect the electronic PHI.
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

INADVERTENT ERROR

Inadvertent error by the Plan Administrator in the keeping of records or in the transmission of your application shall not deprive you of benefits otherwise due, provided that such inadvertent error is corrected by the Plan Administrator within ninety (90) days after it was made.

MEDICARE

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

Eligible Expenses - As used in this section services, supplies and treatment shall mean the same benefits, limits, and exclusions as defined in this Plan Document. However, as allowed pursuant to Federal Medicare Secondary Payer regulations, if you are eligible for benefits as an employee of this Plan and you are entitled to be covered by Medicare Parts A and B, whether or not actually enrolled, then Eligible Expenses shall mean the lesser of the total amount of charges allowable by Medicare, which will be assumed at 20% coinsurance applied by Medicare on Part B claims, whether enrolled or not, and the total eligible expenses allowable under this Plan exclusive of coinsurance and deductible, but only if the provider accepts Medicare assignment as payment in full. Expenses in excess of the above Eligible Expenses may result in balanced billing, unless prohibited under Federal Medicare regulations.

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

Total benefits of this Plan shall be determined as follows:

Disabled Retirees with End-Stage Renal Disease (ESRD)

This Plan shall be primary for you if you are an ESRD Medicare beneficiary during the initial 30 months of entitlement to Medicare coverage, in addition to the usual three month waiting period, or a maximum of 33 months, referred to as the "Coordination Period". ESRD Medicare Entitlement usually begins on the fourth month of renal dialysis, but can start as early as the first month of dialysis if you take a course in self-dialysis training during the three month waiting period. Upon completion of the Coordination Period, this Plan shall be secondary to Medicare and shall coordinate benefits.

LEOFF I Retirees with Medicare

For covered retirees age 65 or over, and who are eligible for Medicare by reason of age alone, this Plan will be secondary and Medicare "A" and "B" will be primary. The City of Renton reimburses the Medicare Part B premium to LEOFF I retirees on a quarterly basis. This Plan shall use Medicare allowances, whether or not the covered person is enrolled on Medicare, to the fullest extent allowed by law to determine the total amount payable under this Plan as the secondary payer during each claim submission. If a covered person chooses to forgo coverage under Medicare, they may be subject to balance billing by their provider for care received.

Coordination - The regular Coordination of Benefits of this Plan applies when Medicare is the primary payer and this Plan is the secondary payer as described under the Coordination of Benefits section. This Plan's benefits are determined by calculating the amount, which would have been paid by this Plan in the absence of Medicare, then, reducing that by the amount Medicare would have paid if you were enrolled in Medicare. Please see the Eligible Expenses subsections within this Medicare section.

In no event will more than 100% of the total allowable expenses be paid between this Plan and Medicare, nor will the total payment by this Plan exceed the amount that this Plan would have paid as the Primary Plan. The difference between the amount this Plan would have paid as primary and the amount this Plan actually paid as secondary will accrue as a credit reserve for the remainder of the calendar year. The credit reserve is available, in an amount not to exceed that, which would have been paid by this Plan as primary, to pay for expenses subsequently incurred which this Plan or Medicare may not pay in full.

MISREPRESENTATION

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

NOTICE

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

PHOTOCOPIES

Reasonable charges made by a provider for photocopies of medical records when the copies are requested by the Plan Supervisor shall be payable. The Plan does not reimburse administrative fees charged related to records requests.

PLAN ADMINISTRATION

The Plan Administrator shall be responsible for compliance by the Plan.

RIGHT OF RECOVERY OF PAYMENTS

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan's terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the maximum allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment, from other payers, or from you, on whose behalf such payment was made.

You, your provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied. If the Plan must bring an action against you, your provider or other person or entity to enforce the provisions of this section, then you, your provider, or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

If the Plan seeks to recoup funds from your provider, due to a claim being made in error, a claim being fraudulent on the part of your provider, or the claim is the result of your provider's misstatement, the provider shall, as part of its assignment to benefits from the Plan, abstain from billing you for any outstanding amount(s).

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

The retiree expressly authorizes any provider to fully inform the City of Renton as to any information of knowledge pertaining to the retiree's condition acquired by such provider and further agrees that Healthcare Management Administrators, Inc. may examine or have examined any relevant medical or hospital records pertaining to his/her condition.

STATE AND FEDERAL EMERGENCY OR EXECUTIVE ORDER

This Plan intends to comply with and shall deem its Plan terms automatically amended to conform to any Plan coverage requirement deemed mandatory or otherwise necessary as a result of a declared public health emergency or other state or federal executive order(s) that is applicable to this Plan and/or any regulatory action or sub-regulatory guidance that applies directly to this Plan as a result of a declared emergency and its associated order(s). Upon the conclusion of such declared emergency and expiration of any such state or federal executive orders, the Plan's terms shall automatically revert to pre-emergency order coverage terms, unless express action is taken by the Plan Sponsor or Plan Administrator to modify this Plan's terms via an executed amendment or restated Summary Plan Description to extend such coverage beyond the timeframe of the emergency order.

STATUTE OF LIMITATIONS CLAUSE

Any and all claims or legal cause of action against this Plan and its designated fiduciaries must be brought and filed with the courts within the time periods specified under WA State Law not to exceed 3 years from the date the Plan Participant exhausts their internal appeal rights under this Plan.

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

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

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Participants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Participant(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant shall be a trustee over those Plan assets.

In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Participant(s) fails to so pursue said rights and/or action.

The Participant(s) further agree that as a condition to participating in and receiving benefits under this Plan, the Participant(s) have/has a duty to cooperate. The duty to cooperate extends to the Plan's right of subrogation and requires all Participant(s) to provide any such necessary information as requested by the Plan to determine and evaluate subrogation interests including but not limit to: demand letters, Complaints,

Independent Medical Examination(s), and other documents requesting any recovery on behalf of the Participant(s).

If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Participant(s) fails to file a claim or pursue damages against any of the following, the Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Participant's/Participants' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims:

1. The responsible party, its insurer, or any other source on behalf of that party; or
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage; or
3. Any policy of insurance from any insurance company or guarantor of a third party; or
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

The Participant(s) agree and assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above

Right of Reimbursement

The Plan shall be entitled to recover 100% of the benefits paid without deduction for attorneys' fees or costs, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant's/Participants' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which

attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Participant(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, Injury, disease or disability.

Participant is a Trustee Over Plan Assets

Any Participant who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Participant disputes this obligation to the Plan under this section, the Participant or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Participant, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

If at the time of Injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.

4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the Participant(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Wrongful Death

In the event that the Participant(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations

It is the Participant's/Participants' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the sickness, disease, disability, or Injury, including accident reports, Independent Medical Examination(s), settlement demands, settlement information, demand letters, and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
7. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.
8. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
9. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

If the Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Participant(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant's/Participants' cooperation or adherence to these terms.

Offset

If timely repayment is not made, or the Participant and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan. This provision applies even if the Participant has disbursed settlement funds.

Minor Status

In the event the Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Surrogacy Arrangement or Agreement

If you enter into a surrogacy arrangement or agreement and you receive compensation or reimbursement for medical expenses, you must reimburse the Plan for covered services you receive related to conception, pregnancy, or delivery in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the compensation you receive under the surrogacy arrangement or agreement. A surrogacy arrangement or agreement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Note: This "Surrogacy Arrangement or Agreement" section does not affect your obligation to pay your portion of the coinsurance for these services, but we will credit any such payments toward the amount you must reimburse the Plan under this provision.

By accepting Surrogacy Health Services, you automatically assign to the Plan, your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement or agreement, regardless of whether those payments are characterized as being for medical expenses. To secure the rights of the Plan, the Plan will also have a lien on those payments. Those payments shall first be applied to satisfy the lien. The assignment and our lien will not exceed the total amount of your obligation to the Plan under the preceding paragraph.

Within 30 days after entering into a surrogacy arrangement or agreement, you must provide written notice of the arrangement, including the names and addresses of the other parties to the arrangement, and a copy of any contracts or other documents, explaining the arrangement, to the Plan.

You must complete and provide to the Plan, all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this Surrogacy Arrangement or Agreement section and to satisfy those rights. You may not agree to waive, release, or reduce the Plans rights under this provision without prior written consent from the Plan.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement or agreement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to the Plans liens and other rights to the same extent as if you had asserted the claim against the third party. The Plan may assign its rights to enforce the Plans liens and other rights.

SUMMARY PLAN DESCRIPTION

This document is the Summary Plan Description.

TAXES

Charges for surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) and other state imposed surcharges (as applicable to the Plan), will be considered covered expenses by this Plan. Local, State and Federal taxes, associated with supplies or services covered under this Plan, will also be considered covered expenses by this Plan.

SPECIAL RIGHTS TO RETIREES IN THE PLAN

As a Participant in the City of Renton LEOFF I Retiree Health Care Plan you are entitled to certain rights and protections under Plan. You shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report.

Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and updated summary plan description. The administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage

Continue health care coverage for yourself if there is a loss of coverage under the Plan as a result of a qualifying event. You may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your federal continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for you, the Plan imposes duties on the people who are responsible for the operation of the employee benefit plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under the Plan.

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules, under the Plan's claims procedures.

Under the Plan, there are steps you can take to enforce the above rights. If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim if frivolous.

STATUTE OF LIMITATIONS CLAUSE

Any and all claims or legal cause of action against this Plan and its designated fiduciaries must be brought and filed with the courts within the time periods specified under WA State Law not to exceed 3 years from the date the Plan Participant exhausts their internal appeal rights under this Plan.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator.

Plan Effective January 1, 1985

Plan Restated and Amended January 1, 2023

Plan Arranged By:

**City of Renton
1055 S. Grady Way
Renton, WA 98057
425/430-7650**

Claim Administration By:

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

**425/462-1000 Seattle Area
800/869-7093 All Other Areas**