TO OUR VALUED EMPLOYEES

Welcome to the City of Renton Employee Dental and Vision Health Care Plan!

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

All Plan expenses are directly paid by the City of Renton Employee Dental and Vision Health Care Plan. The major portion of the Plan cost is provided by City of Renton and is supplemented by the contributions you make to participate. This means that through careful use of the Plan, you, as a consumer of health care, can have a direct impact on the cost of our Plan which will benefit both you and the City by allowing us to continue to provide this high quality level of benefits.

Please read this booklet carefully and particularly the IMPORTANT INFORMATION section.

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

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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, 2024 hereby **amends and restates** City of Renton Employee Dental and Vision 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: Erika Eddins

Name: Erika Eddins

Date: April 25, 2024

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 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 Employee Dental and Vision 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 Dental and Vision
TYPE OF PLAN ADMINISTRATION	Contract Administration
BUNDLED OR UNBUNDLED	Dental coverage is bundled with vision coverage.
ORIGINAL PLAN EFFECTIVE DATE	January 1, 1985
LAST AMENDED DATE	January 1, 2024
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	4034
CONTRIBUTION REQUIRED	Employee Coverage - Varies based upon minimum hours worked Dependent Coverage - Varied based upon minimum hours worked
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.

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 and yourself. 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 Employee Dental and Vision 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.

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.

HOW TO FILE A CLAIM

All providers should send bills to the address listed on your Plan 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.

CONTINUATION OF COVERAGE PROVISIONS (COBRA)

Both you and your dependents should take the time to read the Continuation of Coverage Provisions. Under certain circumstances, you may be eligible for a temporary extension of health coverage, at group rates, where coverage under the Plan would otherwise end. The information in this section is intended to inform you, in a summary fashion, of your rights and obligations under the Continuation of Coverage provisions. To find out more about your Continuation of Coverage rights refer to the COBRA Section of this Summary Plan Description.

COORDINATION OF BENEFITS

This Plan is designed to help you 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 dental 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.

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

VISION SCHEDULE OF BENEFITS

The level of benefits received is based upon the Participant's decision at the time treatment is needed to access care through either preferred or non-contracted vision providers. Benefits are payable at the preferred level by accessing your care through a Preferred Provider or a Participating Provider. Covered services received from Non-contracted providers will be paid at the out-of-network level of benefits. Your Vision Preferred Provider Organization is:

HMA Preferred
800/869-7096
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.**

VISION BENEFITS

	Participating & Preferred Network	Out-of-Network
EXAMINATION, HARDWARE & LASER SURGERY		
Examination Limited to one exam per calendar year.	100%	$30 Copay then 100% of maximum allowable
Hardware* Limited to $650 every two calendar years.	100%	100% of maximum allowable
Laser Surgery Limited to a lifetime maximum of $1,000 per eye. In addition, the above hardware benefit may also be used for laser surgery.	100%	100% of maximum allowable

The vision benefit is a separate benefit from the medical benefit. The vision copayment applies to the medical out-of-pocket maximum.

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.

The vision hardware benefits is limited to $650 every two calendar years. The benefit works as follows: The benefit of $650 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 $650 in 2016/2017, one benefit of $650 in 2018/2019, and so on. Any benefits not used during the

applicable benefit period is forfeited. The vision exam does not apply towards the $650 annual maximum. Laser eye surgery is limited to a $1,000 lifetime maximum per eye. In addition, the above $650 hardware benefit may also be used for laser surgery.

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

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.	$2,000	$2,000

Applicable to Type II and III services.

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, X-rays, Fluoride, Night Guards, and Sealants.	100%	80% of maximum allowable
Preventive oral examinations, limited to two treatments per calendar year.		
Fluoride treatments are limited to 2 treatments per calendar year for individuals under the age of 19.		
Sealants are limited to children under the age of 19, for permanent teeth only.		
TYPE II - BASIC AND RESTORATIVE Fillings, Oral Surgery, Crowns, Endodontic Treatment, Periodontal Services, Pathology, Anesthesia, and Injectables.	100%	80% of maximum allowable
TYPE III - MAJOR AND PROSTHETICS Bridgework, Dentures, Relines, Rebases, Repairs, Adjustments, Tissue Conditioning, Addition of Teeth, and Implants.	80%	50% of maximum allowable
TYPE IV* - ORTHODONTIA		
Orthodontia Lifetime maximum $2,000.	50%	50% of maximum allowable
Temporomandibular Joint Disorder (TMJ) Not covered under dental benefit - see Medical benefit.	Not Applicable	Not Applicable

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

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

ELIGIBILITY AND ENROLLMENT PROVISIONS

ELIGIBILITY

Employee Eligibility

Council Members

If you work a minimum of 90 hours per month then you are eligible for coverage under the plan.

All Other Employees

You are defined as an active regular employee if you are an individual who is: (1) directly involved in the regular business of and compensated for services by the City of Renton; (2) regularly scheduled to work at least 20 hours, as indicated below, or (3) you are an individual listed below who is eligible for coverage.

You are eligible for coverage under this Plan:

If you are an active full-time employee, scheduled to work 35 hours or more a week, you and your dependents are eligible for full coverage.

If you are an active regular employee scheduled for at least 20 hours per week, you and your dependents are eligible for full coverage. The premium cost share for employee coverage is the same regardless of full-time or part-time status. The premium cost share for dependents is prorated for part-time employee's based on scheduled hours as noted below:

- 25% for 30 > 35 hours a week
- 37.5% for 25 > 30 hours a week
- 50% for 20 > 25 hours a week

You are ineligible if you are a supplemental employee or a regular part-time employee scheduled to work less than 20 hours per week.

Dependent Eligibility

The following dependents are eligible for coverage under this Plan:

- Your legally married spouse as defined in the definition section. Coverage may continue during a legal separation only if ordered by a court decree.
- Your State-Registered Domestic Partner, who has filed a Declaration of State Registered Domestic Partnership form with the State of WA, paid any requisite fees, and had the application approved by the State.

  Your State-Registered Domestic Partner is eligible for enrollment during the following times:

  - When you enroll as a new employee;
  - When your State-Registered Domestic Partner loses coverage under his/her group health plan; and
  - During open enrollment.

If enrollment of your State-Registered Domestic Partner is due to a loss of his/her own group health coverage, enrollment in the City's Plan must be completed within 31 days from the date his/her coverage terminated.

Coverage is available to the children of your Domestic Partner provided that the child meets the eligibility requirements for dependent children provided herein.

Please contact the City's Human Resources and Risk Management Department for more information on how to qualify for coverage under this provision.

- Your married or unmarried child, under the age of 26, regardless of whether or not your child is eligible for employer sponsored coverage through your child's own employer, whether or not a full-time student, whether or not claimed as a dependent on your federal income taxes, and whether or not dependent upon you for support.
- Your unmarried dependent child(ren) incapable of self-support because of intellectual disability, mental health condition or physical disability or developmental disability that began prior to the date on which your child's eligibility would have terminated due to age. Proof of incapacity must be received within 120 days after the date on which the maximum age is attained. Subsequent evidence of disability or dependency may be required as often as is reasonably necessary to verify continued eligibility for benefits.
- Your unmarried dependent child(ren) whose coverage is required pursuant to a valid court, administrative order or Qualified Medical Child Support Order (QMCSO).
- Your adopted children are eligible under the same terms and conditions that apply to your dependent, natural children covered under this Plan.
- If you are covered as an employee, you can also be covered as a dependent. Dependents can be covered as a dependent of more than one employee.

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

A dependent is defined as an individual who is: (1) listed on your application as your dependent; (2) eligible for dependent coverage (based upon the criteria above); (3) whose application has been accepted by the Plan Administrator; and (4) for whom the applicable rate of coverage has been paid.

ENROLLMENT

Regular Enrollment

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

When you acquire a new dependent (birth, marriage, adoption, etc.), your new dependent must be enrolled within the enrollment eligibility periods specified below.

Your domestic partner who is not enrolled when you are first eligible, will be eligible for Special Enrollment to the same extent as a spouse.

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

Newborn: Your newborn child may be covered from birth provided your child is enrolled within 60 days of the date of birth.

Adopted Child: Your child placed for adoption may be covered from the date of placement provided your child is enrolled within 60 days of the date of placement.

MID-YEAR ENROLLMENT CHANGES

You are given the opportunity to pay required contributions for participation in this group health plan through a Premium Only Plan sponsored by City of Renton, in accordance with the Internal Revenue Code, Section 125. The Premium Only Plan allows for your contributions to be made on a pre-tax basis. Since this plan is provided pursuant to Section 125, certain rules apply regarding changes in enrollment under the Premium Only Plan and therefore impact enrollment under the medical plan. IRS rules state that your enrollment decisions for the Premium Only Plan are irrevocable for the duration of the plan year, unless you experience an IRS qualifying status change.

Qualifying status changes are IRS-approved events to change your pre-tax benefit elections during the plan year. If you experience a qualifying status change, you may change your benefit election to adapt to that change.

IRS qualifying status change reasons include the following:

- Change in your legal marital status.
- Change in your number of dependents.
- Change in the employment status of you, your spouse or your child (includes termination or commencement of employment, strike or lockout; commencement of or return from an unpaid leave of absence; change in worksite; or other change in employment status that may affect eligibility).
- You, your spouse, or your child becomes eligible for COBRA continuation coverage.
- Change as required under a judgment, decree, or court order, including a Qualified Medical Child Support Order, resulting from your divorce, legal separation, annulment or change in legal custody of a child or foster child who is your dependent.
- You, your spouse, or your child's entitlement to Medicare or Medicaid or the loss of coverage under Medicare or Medicaid.
- Significant cost changes for a benefit package (increase or decrease).
- Significant curtailment of a benefit package with or without a loss of coverage.
- Addition or improvement of a benefit package option.
- Change in coverage under another employer plan (same employer or another employer).
- Loss of group health coverage sponsored by a governmental or educational institution, by you, your spouse, or your child.
- Changes due to you taking leave under the Family and Medical Leave Act.

To make a mid-year enrollment change, you must submit a written request to the Plan Administrator within 31 days after the status change occurs (within 31 days for a newly eligible dependent acquired through marriage, and within 60 days for newly eligible dependent acquired through birth, adoption, or placement for adoption.) Your request must describe the desired change and the status change reason. The requested change must be consistent with the status change event; otherwise, the request will be declined.

If you want to make a plan change, but one of the above events does not apply, you will need to wait until the Plan's next open enrollment period. For more information regarding mid-year plan changes, please contact your Human Resources Department.

Special Enrollment for Loss of Other Coverage

If you are a current employee, a special enrollment period is available for you and your dependents who lose coverage under another group health plan or had other health insurance coverage if the following conditions are met:

- You or your dependent is eligible for coverage under the terms of the Plan, but not enrolled.
- Enrollment in the Plan was previously offered to you.
- You declined coverage under the Plan because, at the time, you and/or your dependents were covered by another group health plan or other health insurance coverage.
- You have declared in writing that the reason for your declination was the other coverage.

You or your dependent may request the special enrollment within 31 days of the loss of your other health coverage under the following circumstances:

- If your other group coverage is not COBRA continuation coverage, special enrollment can only be requested after losing eligibility for the other coverage due to a COBRA qualifying event or after cessation of employer contributions for the other coverage. Loss of eligibility of other coverage does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause. You do not have to elect COBRA continuation in order to preserve the right to a special enrollment.
- If your other group coverage is COBRA continuation coverage, the special enrollment can only be requested after exhausting COBRA continuation coverage.
- If you no longer reside, live, or work in the service area and therefore your other individual or group coverage no longer provides benefits to you and in the case of group coverage, no other benefit packages are available.
- If your other plan no longer offers any benefits to your class of similarly situated individuals.

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

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

If you are a current employee, a special enrollment period is available for you and your dependents who are otherwise eligible for coverage under the Plan, if one of the following events occurs:

- You or your dependent's State Child Health Plan coverage or Medicaid coverage is terminated due to a loss of eligibility.
- You or your dependent become eligible for State Child Health Plan or Medicaid premium assistance.

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

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

Special Enrollment for New Dependents

If you are a current employee, a special enrollment period is available for you if you acquire a new dependent by birth, marriage, domestic partnership, legal guardianship, adoption, or placement for adoption. This special enrollment applies to the following events:

- When you become married, a special enrollment period is available for you and your newly acquired dependents. As long as the proper enrollment material is received by the Plan Administrator within the 31-day enrollment period, the effective date of coverage will be your date of marriage/date of domestic partnership agreement.
- When you or your spouse acquires a child through birth, adoption, or placement for adoption, a special enrollment period is available for you, your spouse and the dependent. As long as the proper enrollment material is received by the Plan within the 60-day enrollment period, the effective date of coverage will be the date of the birth, adoption, or placement of adoption.
- For a legal guardianship, on the date on which such child is placed in your home pursuant to a court order appointing you as the legal guardian for the child.

When you acquire a new dependent as outlined above, any pre-existing dependent(s) who meets the eligibility requirements of the Plan but not previously enrolled, will be eligible to enroll for coverage during the special enrollment period.

Special Enrollment for New Dependents through Qualified Medical Child Support Order

This Plan will honor the terms of a Qualified Medical Child Support Order (QMCSO). The order must be issued as a part of a judgment, order of decree or a divorce settlement agreement related to child support, alimony, or the division of marital property, issued pursuant to state law. Agreements made by you, but not formally approved by a court are not acceptable. If the child is enrolled within 60 days of the court or state agency order, the waiting period does not apply.

Late Enrollment

If you or your dependent is not enrolled during the regular enrollment periods specified above, you may apply for late enrollment.

The effective date of coverage will be the first of the month following the date your completed enrollment material is received by the Plan Administrator.

Open Enrollment

An open enrollment period is held once every 12 months to allow you to change your participation. The open enrollment period will be the month of November for an effective date of January 1st.

EFFECTIVE DATE OF COVERAGE

Employee Effective Date

Your effective date of coverage is the first of the month following your date of hire, or the first of the month following the date you become eligible.

Dependent Effective Date

If you elect coverage for your dependents during the first 31 days of eligibility, your dependents' effective date will be the same as your effective date.

If you get married, you must add your newly acquired dependents within 31 days of your date of marriage and the effective date of coverage is your date of marriage/date of domestic partnership agreement.

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

TERMINATION OF COVERAGE

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

Employee

- The date the City terminates the Plan and offers no other group health plan.
- The date you cease to meet the eligibility requirements of the Plan.
- The last day of the month in which your employment ends.
- The date you begin active duty military service in the armed forces of any country (coverage may continue in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994).
- The date you fail to make any required contribution when coverage is contributory.
- The first day you fail to return to work following an approved leave of absence.
- The last day of the month in which you retire.

Dependent(s)

- The date the City terminates the Plan and offers no other group health plan.
- The date your coverage terminates.
- The last day of the month in which such individual ceases to meet the eligibility requirements of the Plan.
- The last day of the month in which you (the employee) die.
- The date your dependent becomes eligible as an employee.
- The last day of the month in which contributions have been made on your dependent's behalf.
- The date your dependent begins active duty military service in the armed forces of any country (coverage may continue in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994).
- The date the Plan discontinues dependent coverage.

Your employer has the right to rescind your or your dependents 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 and/or your covered Dependents 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 and/or your dependent's paid contributions.

If you or your dependent commits fraud, makes 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 and your covered dependents 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.

APPROVED FAMILY AND MEDICAL LEAVE

If you are absent from work because of an approved leave of absence under the provisions of the Family and Medical Leave Act of 1993, coverage under the Plan shall be continued for you and your covered dependents for up to twelve weeks during any twelve month period, provided you make any required contributions. If you fail to return from Family and Medical Leave the City may require that you repay any health plan premiums paid on your behalf during that leave. If your leave extends more than 12 work-weeks, you will be eligible to continue coverage under the (COBRA) Continuation of Coverage provision to the plan.

You must continue to pay the same contributions toward the cost of coverage as y would when not on leave.

Please contact the City of Renton’s Human Resources and Risk Management Department for information on how to qualify for a Family/Medical Leave of Absence.

APPROVED LEAVE OF ABSENCE (OTHER THAN FEDERAL FAMILY AND MEDICAL LEAVE OF ABSENCE)

If you are granted an approved leave of absence (other than medical/family leave of absence) you, and your covered dependents, will be eligible to continue coverage for up to 30 days. You will be responsible for paying all of the premiums during the 30 days. If your leave extends more than 30 days you, and your covered dependents, will be eligible to continue coverage under the (COBRA) Continuation of Coverage Provisions of the Plan.

You and your dependents who are being reinstated to an active status after an approved leave of absence do not have to satisfy the initial waiting period again if it was satisfied prior to going out on the approved leave of absence. There will be no lapse in coverage for you and your dependents that have continued coverage while on the approved leave of absence. If you did not continue coverage while on the leave of absence, then coverage will be reinstated on the first day your return to active status.

You, and your dependents, who are reinstated after an approved leave of absence, which extends beyond 30 days, will be treated as a new enrollee.

Please contact your Human Resources and Risk Management Department for information on how to qualify for an Approved Leave of Absence.

MILITARY LEAVE OF ABSENCE

If you are going into or returning from military service, you may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights apply only to you and your dependents covered under the Plan before leaving for military service.

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

a. If your election is made on or after December 10, 2004, the 24-month period beginning on the date that your Uniformed Service leave commences; or

b. The period beginning on the date that your Uniformed Service leave commences and ending on the day after the date on which you were required to apply for or return to a position of employment and you fail to do so.

If you elect to continue Plan coverage you may be required to pay up to 102% of the full contribution under the Plan, except if you are on active duty for 30 days or less, you cannot be required to pay more than your employee share, if any, for the coverage.

Plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in or aggravated during your military service. If, while on active service, you obtain coverage through TRICARE, that coverage will be primary for any injury or illness that was caused by your active military service.

Your effective date of coverage after an active duty military service deployment has ended will be the date you return to work.

Please contact your Human Resources and Risk Management Department for information concerning your eligibility for USERRA and any requirements of the Plan.

REINSTATEMENT OF COVERAGE

If you or your dependent, who was covered under this Plan terminates employment or loses eligibility for coverage and is rehired or again becomes eligible for coverage within 3 months of the date of termination, the waiting period will be waived. If you are not reinstated on the Plan within 3 months, you must re-satisfy the waiting period before re-enrolling in the Plan; however, the deductibles, out-of-pocket maximums and benefit limitations previously applied/credited, will continue to apply once reinstated.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

City of Renton Employee Dental and Vision Health Care Plan (the Plan)

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

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your covered spouse and dependent children, upon loss of coverage under this Plan. **The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

In general, COBRA requires that a "qualified beneficiary" covered under this group health plan who experiences a "qualifying event" be allowed to elect to continue that health coverage for a period of time. **You and your dependents will be considered qualified beneficiaries if you were covered by the Plan on the day before the qualifying event occurred. Your domestic partner is not considered a qualified beneficiary and does not have independent rights under COBRA, however, your domestic partner will be entitled to COBRA continuation coverage as a dependent of a qualified beneficiary.** Coverage is elected on the election form provided by the Plan Administrator. Both you and your dependents should take the time to read the Continuation of Coverage Rights provisions.

The Plan has multiple group health components and you may be enrolled in one or more of these components. COBRA (and the description of COBRA coverage contained in this SPD) applies only to the group health plan benefits offered under the Plan and not to any other benefits offered under the Plan or by City of Renton (such as life insurance, disability, or accidental death or dismemberment benefits). The Plan provides no greater COBRA rights than what COBRA requires. Nothing in this SPD is intended to expand your rights beyond COBRAs requirements.

The Plan Administrator is:

City of Renton
1055 S. Grady Way
Renton, WA 98057
425/430-7650 (phone)
425/430-7665 (fax)

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

Mailing Address:

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

Street Address:

HMA, Inc.
10700 Northup Way, Suite 100
Bellevue, WA 98004
Attn: COBRA Unit
800/869-7093 (phone)
425/285-3662 (fax)
COBRARequest@accesstpa.com

WHAT IS COBRA COVERAGE?

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

After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage must be offered to you and your dependents losing Plan coverage who are "qualified beneficiaries." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

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

COBRA coverage is the same coverage that the Plan gives to other Participants or beneficiaries under the Plan who are not receiving COBRA coverage. If you elect COBRA, you will have the same rights under the Plan as other Participants or beneficiaries covered under the component or components of the Plan, including open enrollment and special enrollment rights. Under the Plan, if you elect COBRA you must pay for COBRA coverage.

Additional information about the components of the Plan is available in other portions of this SPD.

COBRA COVERAGE UNDER THE HEALTH FSA COMPONENT

COBRA coverage under the Health FSA will be offered to you if you have underspent accounts. You have an underspent account if the annual limit you elected, reduced by reimbursements up to the time of your qualifying event, is equal to or more than the amount of your premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year.

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

Unless otherwise elected, you and your dependents who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. However, each of you have separate election rights, and each could alternatively elect separate COBRA coverage, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact the Plan Administrator for more information.

You may not enroll in the Health FSA at open enrollment.

WHO IS ENTITLED TO ELECT COBRA?

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

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

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

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than gross misconduct;
- Your spouse becomes entitled to Medicare benefits (Part A, Part B, or both, only in limited circumstances as this entitlement should not cause a loss of coverage); or
- You become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

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

- Your parent-employee dies;
- Your parent-employee's hours of employment are reduced;
- Your parent-employee's employment ends for any reason other than gross misconduct;
- Your parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both, only in limited circumstances as this entitlement should not cause a loss of coverage);
- Your parents become divorced or legally separated; or
- You stop being eligible for coverage under the Plan as a "dependent child."

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

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

Special COBRA rights apply to you if you are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). If applicable, you are entitled to a second opportunity to elect COBRA for yourself and certain family members (that have not already elected COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which you become eligible for TAA or ATAA, but only if the election is made within the six months immediately after your group health plan coverage ended. If you qualify or may qualify for TAA or ATAA, contact the Plan Administrator using the Plan contact information provided below. **Contact the Plan Administrator promptly after qualifying for TAA or ATAA or you will lose the right to elect COBRA during a special second election period.**

WHEN IS COBRA COVERAGE AVAILABLE?

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

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

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

ELECTING COBRA COVERAGE

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

Under federal law, you must have 60 days from the date of the COBRA election notice provided to you at the time of your qualifying event to decide whether you want to elect COBRA under the Plan. Mail, fax, or e-mail the completed Election Form to:

Mailing Address:

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

Street Address:

HMA, Inc.
10700 Northup Way, Suite 100
Bellevue, WA 98004
Attn: COBRA Unit
800/869-7093 (phone)
425/285-3662 (fax)
COBRARequest@accesstpa.com

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

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

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

You do not have to send any payment with your Election Form when you elect COBRA. Important additional information about payment for COBRA coverage is included below.

You and your covered dependents will have an independent right to elect COBRA. For example, your spouse may elect COBRA even if you do not. COBRA may be elected for only one, several, or for all of your dependent children who are qualified beneficiaries. You and your spouse (if your spouse is a qualified beneficiary) may elect COBRA on behalf of you and your children, and parents or legal guardians may elect COBRA on behalf of children. **If you, your spouse, or your children do not elect COBRA within the 60-day election period specified in the Plan's COBRA election notice you WILL LOSE THE RIGHT TO ELECT COBRA COVERAGE.**

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

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

You are entitled to elect COBRA even if you have other group health plan coverage or are entitled to Medicare benefits on or before the date on which you elect COBRA. However, as discussed in more detail below, your COBRA coverage will terminate automatically if, after electing COBRA, you become entitled to Medicare benefits or become covered under other group health plan coverage. See the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you receive COBRA coverage for the maximum time available to you. In addition, affordable coverage may be available for you and your family through the Health Insurance Marketplace. Health Insurance Marketplace coverage may cost less than COBRA continuation coverage. You should compare other coverage options with COBRA and choose the coverage that is best for you. Please be aware once you've made your choice, it can be difficult or impossible to switch to another coverage option.

LENGTH OF COBRA COVERAGE

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

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

When Plan coverage is lost due to the end of your employment or reduction of your hours of employment, and you become entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than yourself) who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. For example, if you become entitled to Medicare eight months before the date of employment termination, COBRA coverage under the Plan's components for your spouse and children who lost coverage as a result of your termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if you become entitled to Medicare within 18 months BEFORE the termination or reduction of hours. However, COBRA coverage under the Health FSA component can last only until the end of the year in which your qualifying event occurred--see the section above entitled "COBRA Coverage Under the Health FSA Component."

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

MAXIMUM COVERAGE PERIOD FOR HEALTH FSA COMPONENT

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

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

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

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

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

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

Notwithstanding the above 60 day notification of disability period, notice of disability from the Social Security Administration must be delivered to the Plan Administrator during the initial 18 month qualifying event period for consideration of disability as a second qualifying event.

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

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

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

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

In providing this notice, you must use the Plan's form entitled "Notice of Second Qualifying Event (Form & Notice Procedures)," and you must follow the procedures specified in the section below entitled "Notice Procedures for Notice of Second Qualifying Event." If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT. (You may obtain a copy of the Notice of Second Qualifying Event (Form & Notice Procedures) from the COBRA Administrator.)

ENROLLING IN MEDICARE INSTEAD OF COBRA CONTINUATION COVERAGE

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don’t enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, the Plan will not discontinue COBRA coverage on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you

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

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

- Any required premium is not paid in full and on time;
- You become covered, after electing COBRA, under another group health plan;
- You become entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- Your employer ceases to provide any group health plan for its employees; or
- During a disability extension period, you, as a disabled qualified beneficiary, are determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period (Not Applicable to Health FSA Component)."

COBRA coverage may also be terminated for any reason the Plan would terminate your coverage or for you not receiving COBRA coverage (such as fraud).

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

Your COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the COBRA Administrator of Medicare entitlement or other group health plan coverage.

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

If the Social Security Administration determines that you are no longer disabled during a disability extension period, COBRA coverage for you and your family will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that you are no longer disabled. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the COBRA Administrator that you are no longer disabled. (For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period (Not Applicable to Health FSA Component).")

COST OF COBRA COVERAGE

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

PAYMENT FOR COBRA COVERAGE

All COBRA premiums must be paid by check.

Your first payment and all monthly payments for COBRA coverage must be mailed to:

Mailing Address:

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

Street Address:

HMA, Inc.
10700 Northup Way, Suite 100
Bellevue, WA 98004
Attn: COBRA Unit
800/869-7093 (phone)
425/285-3662 (fax)
COBRARequest@accesstpa.com

If mailed, your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed.) See the section above entitled "Electing COBRA Coverage."

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, if your employment is terminated on September 30, and you lose coverage on September 30. If you then elect COBRA on November 15, your initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of your COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator using the contact information provided below to confirm the correct amount of your first payment.

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

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

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

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the

month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

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

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

A child born to, adopted by, or placed for adoption with you during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if you are a qualified beneficiary, you have elected COBRA coverage for yourself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it may last for the duration of the maximum COBRA coverage period based upon the initial qualifying event and any second qualifying events (as applicable). To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age). Other pre-existing eligible dependents who were not previously enrolled, may enroll at the same time however, they are not considered qualified beneficiaries for purposes of COBRA continuation coverage.

A child of yours who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Plan Administrator during your period of employment with City of Renton is entitled to the same rights to elect COBRA as an eligible dependent child of yours.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/agencies/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

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

City of Renton
1055 S. Grady Way
Renton, WA 98057
425/430-7650 (phone)
425/430-7665 (fax)

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

NOTICE PROCEDURES

City of Renton Employee Dental and Vision Health Care Plan (the Plan)

Notice Procedures for Notice of Qualifying Event

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

You must mail, fax, or e-mail this notice to:

City of Renton
1055 S. Grady Way
Renton, WA 98057
425/430-7650 (phone)
425/430-7665 (fax)

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

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

Your notice must contain the following information:

- The name of the Plan (City of Renton Employee Dental and Vision Health Care Plan);
- The name and address of the employee or former employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the qualifying event (divorce, legal separation, or child's loss of dependent status);
- The qualifying event (divorce, legal separation, or child's loss of dependent status);
- The date that the divorce, legal separation, or child's loss of dependent status happened; and
- The signature, name, and contact information of the individual sending the notice.

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

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

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

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

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

You, as the covered employee, a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

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

Notice Procedures for Notice of Disability

The deadline for providing this notice is 60 days after the latest of (1) the date of the Social Security Administration's disability determination; (2) the date of your termination of employment or reduction of hours; and (3) the date on which you or your family member would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours. Notwithstanding the above 60 day notification of disability period, notice of disability from the Social Security Administration must be delivered to the Plan Administrator during the initial 18 month qualifying event period for consideration of disability as a second qualifying event.

You must mail, fax, or e-mail this notice to:

City of Renton
1055 S. Grady Way
Renton, WA 98057
425/430-7650 (phone)
425/430-7665 (fax)

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

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

Your notice must contain the following information:

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

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

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

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

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

You, as the covered employee, a qualified beneficiary who lost coverage due to your termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the disability reported in the notice.

Notice Procedures for Notice of Second Qualifying Event

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

You must mail, fax, or e-mail this notice to the COBRA Administrator at:

Mailing Address:

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

Street Address:

HMA, Inc.
10700 Northup Way, Suite 100
Bellevue, WA 98004
Attn: COBRA Unit
800/869-7093 (phone)
425/285-3662 (fax)
COBRARequest@accesstpa.com

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

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

Your notice must contain the following information:

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

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

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

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

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

You, as the covered employee, a qualified beneficiary who lost coverage due to your termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the second qualifying event reported in the notice.

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

If your notice was regarding the death of the covered employee, you must, if the COBRA Administrator requests it, provide documentation of the date of death that is satisfactory to the COBRA Administrator (for example, a death certificate or published obituary). This will allow the COBRA Administrator to determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the COBRA Administrator that the date of death was the date specified in your Notice of Second Qualifying Event, the COBRA coverage of all qualified beneficiaries receiving an extension of COBRA coverage as a result of the covered employee's death may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to the covered employee's death. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability

If you are providing a Notice of Other Coverage (a notice that you, your spouse, or your child has become covered, after electing COBRA, under other group health plan coverage), the deadline for this notice is 30 days after the other coverage becomes effective.

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

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

You must mail, fax, or e-mail this notice to the COBRA Administrator at:

Mailing Address:

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

Street Address:

HMA, Inc.
10700 Northup Way, Suite 100
Bellevue, WA 98004
Attn: COBRA Unit
800/869-7093 (phone)
425/285-3662 (fax)
COBRARequest@accesstpa.com

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

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

Your notice should contain the following information:

- The name of the Plan (City of Renton Employee Dental and Vision Health Care Plan);
- The name and address of the employee or former employee who is or was covered under the Plan;
- The name(s) and address(es) of all qualified beneficiary(ies);
- The qualifying event that started your COBRA coverage;
- The date that the qualifying event happened; and
- The signature, name, and contact information of the individual sending the notice.

If you are providing a Notice of Other Coverage, your notice should include the name and address of the qualified beneficiary who obtained other coverage, the date that the other coverage became effective, and evidence of the effective date of the other coverage (such as a copy of the insurance card or application for coverage).

If you are providing a Notice of Medicare Entitlement, your notice should include the name and address of the qualified beneficiary who became entitled to Medicare, the date that Medicare entitlement occurred, and a copy of the Medicare card showing the date of Medicare entitlement.

If you are providing a Notice of Cessation of Disability, your notice must include the name and address of the disabled qualified beneficiary, the date of the Social Security Administration's determination that the qualified beneficiary is no longer disabled, and a copy of the Social Security Administration's determination.

You, as the covered employee, a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the other coverage, Medicare entitlement, or cessation of disability reported in the notice.

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

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

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

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.

OPTIONAL PREDETERMINATION OF BENEFITS

Before beginning a course of treatment for which your dentist's charges are expected to be $300 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 applicable 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:

Visits and X-Rays

- Preventive oral examinations, limited to two treatments every calendar year.
- Prophylaxis (preventive teeth cleaning) limited to two treatments every calendar year.
- Night guards, limited to once every 36 months.
- Emergency examinations.
- Topical application of fluoride limited to two treatments every calendar year to age 19.
- Dental x-rays:
    - Full mouth series limited to once every 36 months.
    - Charges for bitewing x-rays are covered twice every calendar year.
- Sealants for permanent teeth to prevent crevice decay to age 19.
- Palliative (alleviation of pain) emergency treatment.
- 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) and appliances.
- Crowns and crown build up – Prosthesis Replacement Rule applies.
- Post and core.
- Inlays and onlays.
- Consultations.
- Alveoloplasty.
- Frenectomy.
- Bonded fillings and laminates.
- Veneers.
- 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 present 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 present 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.
- 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 crown, denture, bridgework, inlay, onlay, 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 crown, denture, bridgework, inlay, onlay, or implant was installed, and while you were covered.
- The existing crown, denture, bridgework, inlay, onlay, or implant cannot be made serviceable and was installed at least five years prior to its replacement.

- The existing crown, denture, bridgework, inlay, onlay, or implant is an immediate temporary, and replacement by a permanent crown, denture, bridgework, inlay, onlay, 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.

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.

Night Guards - Charges for night guards, or other habit breaking appliances, except as provided under the preventive benefit.

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 or your dependent(s).

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.

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 employees and dependents. Vision benefits include routine eye examination, including contact lens fitting, and vision hardware. Vision hardware benefits are payable at 100% up to a maximum of $650 every two calendar years and can also be applied towards the laser surgery benefit. Laser surgery is limited to a lifetime maximum of $1,000, per eye. The vision exam is limited to once every calendar year and does not apply to the hardware limit. The office visit co-pays will apply to the routine eye examination. This benefit is not subject to the deductible.

The hardware benefit works as follows: The benefit of $650 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 $650 in 2016/2017, one benefit of $650 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 vision, 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 employee's or covered dependent's coverage under the benefit will be considered to be covered vision care expenses, but only if a complete eye examination, including refraction, was performed during the 30 day period immediately preceding the termination of coverage and while coverage was in force and 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.

Please see the definition of Maximum Allowable Charge for additional information.

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.

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

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.

CONTRIBUTORY - You are required to pay a portion of the cost to be eligible to participate in the Plan.

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, your spouse, your domestic partner, your child, or a participating COBRA beneficiary meeting the eligibility requirements for coverage as specified in the Plan, and properly enrolled in the Plan.

DENTAL IMPLANTS - A graft or insert set firmly onto or deeply into the alveolar area prepared for its insertion. It may support a crown or crowns, a bridge abutment, a partial denture, or a complete denture.

DEPENDENT - Any individual who is or may be eligible for coverage according to Plan terms due to a relationship to you.

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:

- Employee - Your inability to engage, as a result of accident or illness, in your normal occupation with the City on a full time basis.
- Dependent - Your inability to perform the usual and customary duties or activities of someone in good health and of the same age.

DOMESTIC PARTNER - A State-Registered Domestic Partner, who has filed a Declaration of State Registered Domestic Partnership form with the State of WA, paid any requisite fees, and had the application approved by the State.

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.

ENDODONTICS - The branch of dentistry which deals with the diagnosis and treatment of diseases of the dental pulp and tissues around the root end.

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.

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 clinical trials as defined by the National Institute of Health, National Cancer Institute or the FDA, see https://clinicaltrials.gov; 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.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA) AS AMENDED - A leave of absence granted to you by the Employer in accordance with Public Law 103-3 for the birth or adoption of your child; placement in your care of a foster child; the serious health condition of your spouse, child or parent; your own disabling serious health condition; your spouse, son, daughter, or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation and this results in a qualifying exigency (as determined by the Secretary of Labor); or you are the spouse, son, daughter, parent, or next of kin of a member of the Armed Forces who suffered a serious injury or illness in the line of duty while on active-duty.

FLUORIDE - A substance when topically applied or applied to drinking water is effective in resisting tooth decay.

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

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.

INJURY - See Accident/Accidental Injury.

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

LEAVE OF ABSENCE - Shall mean a period of time during which you, the employee must be away from your primary job with your employer, while maintaining the status of employee during said time away from work, generally requested by you and having been approved by your employer, and as provided for in your employer's rules, policies, procedures and practices where applicable.

LEGAL SEPARATION AND/OR LEGALLY SEPARATED - Shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

LIFETIME - While covered under this Plan or any other City plan. Wherever this word appears in this document in reference to benefit maximums and limitations. Under no circumstances does lifetime mean during the lifetime of the covered person.

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 no Medicare reimbursement rate is available for a given item of service or supply, Medicare reimbursement rates will be calculated based on a percentage (as outlined in the Schedule of Benefits) of one of the following:

- Visium Medicare Equivalency tables (prices established by CMS utilizing standard Medicare payment methods and/or based upon supplemental Medicare or Medicaid pricing data for items Medicare doesn't cover based on data from CMS);
- Visium Approximation tool (prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care); or
- Visium Care Crosswalk (prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings).

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.

Please see the definition of Allowable Expenses for additional information.

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 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.

OCCLUSAL ADJUSTMENT - The modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the temporomandibular joints and the structure supporting the teeth.

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.

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.

PARTICIPANT - You, when you are an employee or a former employee 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.

PERIODONTICS - That branch of dentistry which deals with the prevention and treatment of disease of the bone and soft tissues surrounding the teeth.

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

PROPHYLAXIS - The control of dental and oral diseases by preventive measures, especially the mechanical cleansing of the teeth.

PROSTHODONTICS - That branch of dentistry which deals with the replacement of missing teeth or oral tissues by artificial means, such as crowns, bridges, and dentures.

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.

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

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration (FDA); and (c) the Centers for Medicare and Medicaid Services (CMS). A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not reasonable.

To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are reasonable based upon information presented to the Plan Administrator.

Reasonableness may be based upon coding and billing standards which include but are not limited to those defined by the American Medical Association CPT (Current Procedural Terminology) and the Centers for Medicare and Medicaid Services National Correct Coding Initiative, Optum Coding resource manuals, Regence reimbursement guidelines and policies, as well as the UB04 Billing Manual coding guidelines and definitions and the National Uniform Billing Committee guidelines as applicable. Claims are subject to additional review upon submission prior to final payment.

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

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.

RESTORATIVE - A process used to replace a lost tooth or part, or the diseased portion of one, by artificial means as with a filling, crown, bridge, or denture designed to restore proper dental function.

ROOT PLANING - A procedure done to smooth roughened root surfaces.

SEALANTS - A resinous material designed for application to the surfaces of posterior teeth in order to seal the surface irregularities and prevent tooth decay.

SPOUSE - Your lawfully wed, same or opposite gender spouse, which is legally recognized in the state in which you were married, not including a common-law marriage.

SUBSCRIBER - An employee of the Group who is enrolled in 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.

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

WAITING PERIOD - The period that must pass before coverage for you or your dependents that are otherwise eligible to enroll under the terms of the Plan can become effective. Periods of employment in an ineligible classification are not part of a waiting period.

GENERAL PROVISIONS

ADMINISTRATION OF THE GROUP DENTAL AND VISION 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 and your dependents 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, calendar year or lifetime 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 or your dependent discovers 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, you and your dependents coverage shall cease automatically without notice. You and your dependents shall not be entitled to further coverage or benefits, whether or not any medical condition was covered by the Plan prior to termination or cancellation.

The Plan may be 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, or other similarly expeditious method.
- 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 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 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 60 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 60 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 or your dependent shall present the Plan identification card to the provider of service upon admission to a medical facility or upon receiving service from a physician/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 and all your dependents agree that in order to receive benefits, any physician, nurse, medical facility or other provider of service, having rendered service or being in possession of information or records relating 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 UR Coordinator 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 and any of your enrolled dependents.
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.
6. When your dependent child is covered under more than one plan, the following rules apply. Unless there is a court decree stating otherwise, plans covering your dependent child shall determine the order of benefits as follows:
   (a) For your dependent child whose parents are married or are living together, who have or have not ever been married:
      (i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

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

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

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

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

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

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

I. The plan covering the custodial parent;

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

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

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

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

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

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

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

Coordination of Benefits with Medicaid

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

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. You and your dependents 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 and deductibles.

EFFECT OF TERMINATION OF THE PLAN

Upon complete or partial termination of the Plan, the Plan Administrator may, after the payment or provision for payment of all benefits to 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 and your dependents 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 or your dependent 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 or your dependents covered 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 Employer (Plan Sponsor) unless the Employer (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 Employer (Plan Sponsor) only to permit the Employer (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 Employer (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 Employer (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 Employer (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 Employer (Plan Sponsor) for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (Plan Sponsor).

Employer (Plan Sponsor) Obligations Regarding Protecting Health Information

The Employer (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 employee benefit plan of the Employer (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 Employer'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 Employer (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 Employer (Plan Sponsor) and the Plan

The following classes of employees or other workforce members under the control of the Employer (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 Employer (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 Employer (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 Employer (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.

Employer (Plan Sponsor) Obligations Regarding Electronic Protecting Health Information

Employer (Plan Sponsor) will:

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

INADVERTENT ERROR

Inadvertent error by the Plan Administrator in the keeping of records or in the transmission of your application shall not deprive you or your dependents 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 or dependent 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, 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:

Active Employees - If you are an active employee and/or non-working spouse of an active employee age 65 or over: This Plan will be primary and Medicare will be secondary.

Disabled Employees with Medicare (Except those with End-Stage Renal Disease) - If you are eligible for Medicare by reason of Disability the order of determination will be as shown below:

If employed by a company with 100 or more employees: This Plan will be primary and Medicare will be secondary. The Employer will remain the primary payor of medical benefits until the earliest of the following events occurs: (1) the group coverage ends for all employees; (2) your group coverage as an active individual ends.

If employed by a company with less than 100 employees: This Plan will be secondary and Medicare will be primary.

The Omnibus Budget Reconciliation Act of 1986 defines a large group health plan as one that covers employees of at least one employer that normally employed at least 100 employees on a typical business

day during the previous calendar year. A typical business day is defined as 50 percent or more of the employer's regular business days during the previous calendar year.

Disabled Employees 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.

Coordination - The regular Coordination of Benefits of this Plan 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 paid by Medicare. In no event will not 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.

PRIVILEGES AS TO DEPENDENTS

You shall have the privilege of adding or withdrawing the name or names of any of your dependent(s) to or from this coverage, as permitted by the Plan, by submitting to the Plan Administrator an application for reclassification on the enrollment form furnished by the Plan Supervisor. Each dependent added to the coverage shall be subject to all conditions and limitations contained in this 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 or your dependent on whose behalf such payment was made.

You, your dependent, 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 employee or dependent expressly authorizes any provider to fully inform the City of Renton as to any information of knowledge pertaining to the employee or dependent'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 or your eligible dependents have, or may have, any claim for damages or entitlement to recover from another party or parties arising from the acts or omissions of such third party (for example, an auto accident). In the event that another party fails or refuses to make prompt payment for the medical expenses incurred by you or your eligible dependents which expenses arise from an accident, injury, or sickness, subject to the terms of the Plan, the Plan may conditionally advance the payment of the eligible medical benefits and reserve all rights related to recovery of such benefits advanced.

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 you, and/or your dependents, 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").

You, your 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, you agree 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 you are entitled, regardless of how classified or characterized, at the Plan's discretion, if you fail to so pursue said rights and/or action.

You further agree that as a condition to participating in and receiving benefits under this Plan, you have a duty to cooperate. The duty to cooperate extends to the Plan's right of subrogation and requires you 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 you.

If you receive or become entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which you 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. You are 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. You are 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 your name, 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 you fail to file a claim or pursue damages against any of the following, you authorize the Plan to pursue, sue, compromise and/or settle any such claims in your 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.

You agree and assign 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 you are fully compensated by your 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 your recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by you is deemed held in constructive trust and should not be dissipated or disbursed until such time as your obligation to reimburse the Plan has been satisfied in accordance with these provisions. You are 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 your part, 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 you.

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

If you receive benefits, you are subject to the terms of this section and are hereby deemed a recipient and holder of Plan assets and are 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, you understand that you are 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 your attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where you are not represented by an attorney, instruct the insurance company or any third party from whom you obtain 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 you dispute this obligation to the Plan under this section, you or any of your agents or representatives are 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.

Neither you, your beneficiary, or your 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 you, and funds held in trust over which the Plan has an equitable lien exist separately from your property and estate, such that your death, or your filing of bankruptcy, 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 you die as a result of your 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 you and all others that benefit from such payment.

Obligations

It is your 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 you may have against any responsible party or coverage.
8. To instruct your attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
9. In circumstances where you are not represented by an attorney, instruct the insurance company or any third party from whom you obtain 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 you and the Plan over settlement funds is resolved.

If you and/or your 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, you will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from you.

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

Offset

If timely repayment is not made, or you and/or your 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 you are a minor as that term is defined by applicable law, your parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind you and your estate insofar as these subrogation and reimbursement provisions are concerned.

If your 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 you. Any court costs or legal fees associated with obtaining such approval shall be paid by your 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 Plan's 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 EMPLOYEES IN THE PLAN

As a Participant in the City of Renton Employee Dental and Vision 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, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA 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.

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, 2024

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