City of Puyallup Health Care Plan 1

Summary Plan Description (SPD)

Effective January 1, 2006

Plan Restated and Amended January 1, 2015

Claims Processed by:
Healthcare Management Administrators, Inc.
P. O. Box 85008
Bellevue, WA 98015-5008

TO OUR VALUED EMPLOYEES

Welcome to the City of Puyallup Health Care Plan 1!

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

The City of Puyallup became self-insured (with stop loss) for healthcare on January 1, 2006. As a result, the City assumes risk for routine claims and large, unexpected claims are covered by secondary insurance (stop loss). Thus, through careful use of the Plan, you (as a consumer of health care) have a direct impact on the cost of your plan. The City believes this is in the best long-term interest of you and your family.

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 800/700-7153.

We wish you the best of health.

City of Puyallup Health Care Plan 1

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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 the Plan participants 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.

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

INTRODUCTION AND PURPOSE

The Plan Sponsor has established the Plan for the benefit of eligible Employees, 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 Participants and/or the Plan Sponsor, or may be funded solely from the general assets of the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits.

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

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

GENERAL PLAN INFORMATION

NAME OF PLAN	City of Puyallup Health Care Plan 1
NAME & ADDRESS OF EMPLOYER/ PARTICIPATING GROUP	City of Puyallup 333 S. Meridian Puyallup, WA 98371 253/841-5541
EMPLOYER IDENTIFICATION NUMBER	91-6001274
TYPE OF PLAN	Employee Health Care Plan providing Medical and Prescription benefits
TYPE OF PLAN ADMINISTRATION	Contract Administration
ORIGINAL PLAN EFFECTIVE DATE	January 1, 2006
LAST AMENDED DATE	January 1, 2015
PLAN YEAR	January 1st through December 31st
PLAN ADMINISTRATOR/SPONSOR & NAMED FIDUCIARY & DESIGNATED LEGAL AGENT	City of Puyallup 333 S. Meridian Puyallup, WA 98371

EMPLOYEES	Eligible Employees of City of Puyallup, when they meet the eligibility requirements described herein.
GROUP NUMBER	020254
CONTRIBUTION REQUIRED	Employee Coverage for regular status employees who are working 20 – 39 hours and are PPA, PPA-SS, PPMA, or Non-Represented – Yes All Other Groups – No Dependent Coverage – Yes, per above
ELIGIBILITY	See Eligibility and Enrollment Provisions
PLAN SUPERVISOR	Healthcare Management Administrators, Inc. PO Box 85008 Bellevue, Washington 98015-5008 425/462-1000 Seattle Area 800/700-7153 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 the City of Puyallup and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the City of Puyallup or to interfere with the right of the City of Puyallup to discharge any employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the City of Puyallup with the bargaining representatives of any employees.

MENTAL HEALTH PARITY

Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

APPLICABLE LAW

This Plan is a governmental (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a federal law regulating employee welfare and pension plans. Your rights as a participant in the Plan are governed by the plan documents and applicable state law and regulations. 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 regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participants' 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 its activities to carrying out ministerial acts of notifying Plan Participants and making benefit payments as required by the Plan. Any matters for which discretion is required shall be referred by Plan Supervisor to the Plan Administrator, and Plan Supervisor shall take direction from Plan Administrator in all such matters. The Plan Supervisor shall not be responsible for advising the City of Puyallup or Plan Administrator with respect to their 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 of Puyallup, 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 Puyallup, of Puyallup, Washington hereby establishes this Plan for the payment of certain expenses for the benefit of its eligible employees to be known as the City of Puyallup Health Care Plan 1.

City of Puyallup assures its covered employees that during the continuance of the Plan, all benefits herein described shall be paid to or on behalf of the employees in the event they become eligible for benefits.

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

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

Important Information - Please Read

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

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

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

PRE-AUTHORIZATION OF INPATIENT MEDICAL FACILITY ADMISSIONS AND OUTPATIENT SURGERIES

This plan recommends pre-authorization of all inpatient medical facility admissions and all outpatient surgeries to potentially lower your cost, but is not required. Pre-authorization is recommended **five days prior** to an outpatient surgery or an admission into a medical facility.

At the time that your doctor recommends surgery or an inpatient admission for you, you or your doctor should contact the HMA Health Services Department to request the pre-authorization. All inpatient and outpatient non-emergency surgeries and all non-emergency admissions (excluding normal vaginal deliveries where the length of stay is 48 hours or less and cesarean section deliveries where the length of stay is 96 hours or less) should be pre-authorized in advance. You should call no later than five days prior to the medical facility admission or surgery. Surgeries performed in the doctor's own office do not need to be pre-authorized.

Preauthorization is not required for services provided in an emergency room of a hospital. It is recommended that all emergency medical facility admissions and emergency surgeries be authorized within 48 hours after the medical facility admission or surgery, or by the next business day, if later.

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

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

HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
425/462-1000 - SEATTLE
800/700-7153 - OTHER AREAS NATIONWIDE

CERTIFICATION OF ADDITIONAL DAYS

If your physician is considering lengthening a stay, you, your physician, the hospital, or the medical facility should call HMA's Health Services Department to request certification for additional days to reduce the high cost of medical care. Call no later than the last day previously certified. If medically necessary, additional days of confinement may be certified at that time.

STEPS TO TAKE

When an inpatient admission or surgery is recommended, the patient, the physician or a family member should call HMA's Health Services Department at least five days prior to the admission or surgery to obtain authorization, however it is not required. If an emergency admission or emergency surgery occurs, the patient or a family member should ask the attending physician or the medical facility to contact HMA's Health Services Department within 48 hours of admission or surgery, or by the next business day, if later. Please be prepared to give HMA's Health Services Department the following information when you make the call for authorization:

- Name and age of patient.
- Subscriber Identification Number on the front of your HMA ID Card.
- Group Number (020254).
- Medical Facility name and address.
- Name and phone number of admitting physician.
- Admission date.
- Diagnosis.
- Procedure being performed.

The Health Services Department will send written confirmation of the approved admission to the patient once authorized.

CASE MANAGEMENT/ALTERNATE TREATMENT

In cases where the covered participant's condition is expected to be or is of a serious nature, case management services from a professional qualified to perform such services may be recommended. The HMA Health Services nurse case manager will work with you, the Plan Administrator, your physician and other health care providers to help assure that the care you receive is provided in the most appropriate and cost effective manner. The case managers are your advocates to help improve the quality of your health care and to lower the cost of health care to you and the Plan.

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

HOW TO FILE A CLAIM

- All providers should send bills to the address listed on the back of your HMA medical identification card.

- You must provide the provider of service with the information listed on your HMA medical identification card. The provider must attach itemized bills to a claim form. An itemized bill is one that contains the provider's name, address, Federal Tax ID Number, and the nature of the accident or illness being treated.

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

CONTINUATION OF COVERAGE PROVISIONS (COBRA)

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

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 Service Department is available to answer questions about claims and how your benefits work. You may contact HMA's Customer Service Department at:

HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
P.O. Box 85008, Bellevue, WA 98015-5008
425/462-1000 - Seattle
800/700-7153 - Other Areas Nationwide

This plan does not require the designation of a primary care provider or to obtain a referral for services received from a specialist. Participants shall have free choice to obtain services from any licensed physician or surgeon, acting within the scope of their license (see the definition of physician/provider in the General Definitions section for a listing of covered physicians). The level of benefits received is based upon the participant's decision at the time treatment is needed to access care through either preferred or non-preferred providers. Benefits are payable at the preferred level by accessing your care through a Preferred Provider, Preferred Medical Facility or from a Preferred Hospital. Out-of-network charges will be paid at the out-of-network level of benefits. Your Preferred Provider Organizations are:

Idaho/Oregon/Utah/Washington Participants:
HMA Preferred
800/700-7153
OR
www.accesshma.com

Participants in all other States or when traveling:
PHCS Network
800/700-7153
OR
www.accesshma.com

Eligible expenses will be paid at the preferred level when:

- The services are billed by a preferred provider, hospital, or medical facility.
- The services are for a non-preferred assistant surgeon or anesthesiologist, where the medical facility and the primary surgeon are both preferred providers.
- You live outside the area serviced by the preferred provider organization.
- You receive emergency services inside or outside the network area.

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

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

MEDICAL BENEFITS

	Preferred Network	Participating Network	Out Of Network
INDIVIDUAL DEDUCTIBLE Per calendar year.	$100	$100	$100
FAMILY DEDUCTIBLE Per calendar year.	$300	$300	$300
INDIVIDUAL OUT-OF-POCKET MAXIMUM Per calendar year.	$375	$375	$1,000
FAMILY OUT-OF-POCKET MAXIMUM Per calendar year.	$1,125	$1,125	$3,000

The deductibles accumulate as a single amount. This means that there is one deductible amount for Preferred, Participating, and Out-of-Network services combined.

The amounts credited towards the Preferred and Participating Network out-of-pocket maximums will also count towards satisfying the Out-of-Network out-of-pocket maximums. However, services received from an Out-of-Network provider, which are credited towards satisfying the Out-of-Network out-of-pocket maximums, are not counted towards satisfying the Preferred or Participating Network out-of-pocket maximums.

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

Once the out-of-pocket maximum is reached, eligible expenses are paid at 100% of allowable charges for the remainder of the calendar year. There are some benefits that are not payable at the 100% coinsurance rate. The following expenses do not apply to the out-of-pocket maximum 1) Penalties; and 2) Ineligible charges. Where a copay is applicable, only one copay is to be taken per day for related outpatient services rendered.

PRE-AUTHORIZATION FOR MEDICAL FACILITY ADMISSIONS AND OUTPATIENT SURGERIES is recommended but is not required.

	Preferred Network	Participating Network	Out Of Network
ALLERGY INJECTIONS/TESTING	100%	80%	80%
ALTERNATIVE SERVICES Limited to $500 per calendar year. Includes acupuncture, massage therapy, and naturopathy.	100%	80%	80%
AMBULANCE (AIR AND GROUND)	100%	80%	80%
ANESTHESIOLOGIST	100%	80%	80%
ASSISTANT SURGEON Limited to 20% of surgeon's fee.	100%	80%	80%
BLOOD BANK	100%	80%	80%
CHEMOTHERAPY/RADIATION	100%	80%	80%
CHIROPRACTIC/OSTEOPATHIC SERVICES AND X-RAYS			
Examinations Limited to 1 exam per calendar year.	100%	80%	80%
Manipulations Limited to 20 visits per calendar year. Includes osteopathic manipulations.	100%	80%	80%
Physical Therapy Limited to $300 per calendar year.	100%	80%	80%
X-Rays Limited to $60 per calendar year.	100%	80%	80%
COMPOUND MEDICATIONS Limited to prescription drugs purchased at Beal's Pharmacy and Clarke's Pharmacy.	100% deductible waived	80% deductible waived	80% deductible waived
CONTRACEPTIVE SERVICES			
Fitting and Removal	100% deductible waived	100% deductible waived	$15 Copay then 80%
Supplies, Devices and Implants	100% deductible waived	100% deductible waived	80%
DIAGNOSTIC X-RAY AND LABORATORY	100%	80%	80%
DIETARY EDUCATION	100% deductible waived	100% deductible waived	80% deductible waived
DURABLE MEDICAL EQUIPMENT/SUPPLIES	100%	80%	80%

	Preferred Network	Participating Network	Out Of Network
EMERGENCY ROOM & SERVICES Copay waived if treatment is for an accidental injury or if admitted as an inpatient.	$75 Copay then 100%	$75 Copay then 100%	$75 Copay then 100%
FLU SHOTS	100% deductible waived	100% deductible waived	100% deductible waived
GROWTH HORMONE BENEFIT Limited to $25,000 per calendar year.	100%	80%	80%
HEARING BENEFIT			
Exams	100%	80%	80%
Hearing Aids Limited to $500 per hearing aid, maximum of 2 hearing aids every 5 calendar years.	100%	80%	80%
HOME HEALTH CARE Limited to 120 visits per calendar year.	100%	80%	80%
HOME PHOTOTHERAPY Limited to children only.	100%	80%	80%
HOSPICE CARE Lifetime maximum 120 days.	100%	80%	80%
IMMUNIZATIONS	100% deductible waived	100% deductible waived	80% deductible waived
INFUSION THERAPY	100%	80%	80%
INPATIENT PHYSICIAN VISIT	100%	80%	80%
MATERNITY (MEMBER AND SPOUSE) Inpatient/outpatient medical facility, surgical, and medical benefit.	paid the same as any other med condition	paid the same as any other med condition	paid the same as any other med condition
MEDICAL FACILITY SERVICES			
Inpatient	100%	80%	80%
Outpatient			
Outpatient Surgical Facility	100%	80%	80%
Miscellaneous Services	100%	80%	80%
MENTAL HEALTH SERVICES			
Inpatient	100%	80%	80%
Outpatient	100%	80%	80%

	Preferred Network	Participating Network	Out Of Network
NEURODEVELOPMENTAL THERAPY Limited to dependent children to age six and under.	100%	80%	80%
OFFICE VISIT	$15 Copay then 100%	$15 Copay then 80%	$15 Copay then 80%
ORTHOTICS All orthotics are covered, however, shoe orthotics are only covered if prescribed for diabetes management.	100%	80%	80%
PHENYLKETONURIA FORMULA	100%	80%	80%
PHYSICIANS ASSISTANT	paid the same as any other med condition	paid the same as any other med condition	paid the same as any other med condition
PRE-ADMISSION TESTING	100%	80%	80%
PREVENTIVE CARE	100% deductible waived	100% deductible waived	80% deductible waived
PREVENTIVE COLONOSCOPY Limited to once per calendar year.	100% deductible waived	100% deductible waived	80% deductible waived
PREVENTIVE GYNECOLOGICAL SERVICES Limited to one exam and one pap smear lab test per calendar year.	100% deductible waived	100% deductible waived	80% deductible waived
PREVENTIVE MAMMOGRAPHY Limited to once per calendar year.	100% deductible waived	100% deductible waived	80% deductible waived
PREVENTIVE PROSTATE EXAM Limited to one exam per calendar year.	100% deductible waived	100% deductible waived	80% deductible waived
PREVENTIVE X-RAY AND LABORATORY	100% deductible waived	100% deductible waived	80% deductible waived
PROSTHETICS	100%	80%	80%

	Preferred Network	Participating Network	Out Of Network
REHABILITATION SERVICES			
Inpatient Limited to 30 days per condition.	100%	80%	80%
Outpatient Limited to 24 visits per calendar year. Prescription or authorization is required.	100%	80%	80%
SECOND SURGICAL OPINION	100%	80%	80%
SKILLED NURSING FACILITY CARE Lifetime maximum 120 days.	100%	80%	80%
SMOKING CESSATION	100% deductible waived	100% deductible waived	80% deductible waived
STERILIZATION (ELECTIVE)	100% deductible waived	100% deductible waived	80%
SUBSTANCE USE DISORDER SERVICES			
Inpatient	100% deductible waived	80% deductible waived	80% deductible waived
Outpatient	100% deductible waived	80% deductible waived	80% deductible waived
SUPPLIES	100%	80%	80%
SURGEON	100%	80%	80%
TRANSPLANTS			
Transplants Limited to $200,000 per transplant.	100%	80%	80%
Donor Benefits Limited to $50,000 per transplant.	100%	80%	80%
Transportation Expenses (Travel, Meals, Lodging) Limited to $2,500 per transplant.	100%	100%	100%
URGENT CARE	$15 Copay then 100%	$15 Copay then 80%	$15 Copay then 80%
OTHER MISCELLANEOUS ELIGIBLE CHARGES **(Unless listed in the General Exclusions or Limitations Section of this Summary Plan Description)**	100%	80%	80%

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

Anything billed as an Office Visit will have a $15 Copay.

CALENDAR YEAR MAXIMUM BENEFITS

Alternative Services (acupuncture, massage therapy, and naturopathy)	$500
Chiropractic Services	
Examinations	1 exam
Manipulations	20 visits
Physical Therapy	$300
X-Rays	$60
Growth Hormone	$25,000
Hearing Aids (every 5 years)	$500 per hearing aid
Home Health Care	120 visits
Preventive Colonoscopy	1 screening
Preventive Gynecological Services	1 exam/1 lab
Preventive Mammography	1 screening
Preventive Prostate Exam	1 exam
Rehabilitation Services - Outpatient	24 visits

LIFETIME MAXIMUM BENEFITS

Hospice Care	120 days
Skilled Nursing Facility	120 days
Major Medical/Prescription Drug	Unlimited

PRESCRIPTION BENEFITS

Pharmacy benefits are subject to an Out of Pocket Maximum that is not combined with any other benefit. The Out of Pocket amounts are compliant with ACA requirements.

CVS/Caremark - Retail Pharmacies

Generic Drugs	$7 Copay
Brand Name Drugs	
On Performance Drug List	$20 Copay
Not On Performance Drug List	$35 Copay

Dispensing limit 34 days or 100 units.

CVS/Caremark Mail Service - Mail Order Prescriptions

Generic Drugs	$14 Copay
Brand Name Drugs	
On Performance Drug List	$40 Copay
Not On Performance Drug List	$70 Copay

Dispensing limit 90 days.

This plan allows the participant to receive the brand over the generic without a cost penalty to the participant. See Generic Substitution section for more information.

ELIGIBILITY AND ENROLLMENT PROVISIONS

ELIGIBILITY

Employee Eligibility

Regular-status City of Puyallup employees who are members of the following groups:

1. Local Union Number 1516, Washington State Council of County and City Employees, AFSCME who are regularly scheduled to work a minimum of 30 hours per week.
2. Local Union Number 313, International Brotherhood of Teamsters Chauffeurs, Warehousemen and Helpers of America representing Custodians or Public Works and Parks, who are regularly scheduled to work a minimum of 30 hours per week.
3. Non-Represented Employees who are regularly scheduled to work 40 hours or more per week are eligible for participation with all contributions paid by the City. Employees regularly scheduled to work between 20 – 39 hours per week are eligible but must pay pro-rated employee contributions.
4. Elected Officials.
5. Puyallup Police Association (PPA) who are regularly scheduled to work 40 hours or more per week are eligible for participation with all contributions paid by the City. Employees regularly scheduled to work between 20 – 39 hours per week are eligible but must pay pro-rated employee contributions.
6. Puyallup Police Association (PPA)-Support Services who are regularly scheduled to work 40 hours or more per week are eligible for participation with all contributions paid by the City. Employees regularly scheduled to work between 20 – 39 hours per week are eligible but must pay pro-rated employee contributions.
7. Puyallup Police Management Association (PPMA) who are regularly scheduled to work 40 hours or more per week are eligible for participation with all contributions paid by the City. Employees regularly scheduled to work between 20 – 39 hours per week are eligible but must pay pro-rated employee contributions.

Retiree Eligibility

This plan serves as the retiree plan for all City of Puyallup employees except LEOFF 1 employees. If the employee is a member of one of the following covered groups:

1. Local Union Number 1516, Washington State Council of County and City Employees (AFSCME)
2. Non-Represented Employees
3. Puyallup Police Association (PPA)
4. Puyallup Police Association (PPA)-Support Services
5. Puyallup Police Management Association (PPMA)
6. Local Union Number 313, International Brotherhood of Teamsters Chauffeurs, Warehousemen and Helpers of America representing Custodians or Public Works and Parks

The following criteria must be met:

1. The member must have five years of continuous medical coverage under a City sponsored medical plan,
2. The member must have coverage at the time of retirement, **and**
3. The member must meet the retirement criteria (age and years of service requirements) on the pension program contributed to by the employer at the time of retirement. See Pension Eligibility Requirements. The following is a brief overview of the current pension eligibility requirements.

Pension Eligibility Requirements

An Elected Official must meet the following criteria of age and years of service:

- Any age with 30 or more years of municipal service in an elected capacity or a combination of elected and appointed capacity, in Washington State, or
- At least age 55 with at least 25 years of municipal service in an elected capacity or a combination of elected and appointed capacity, in Washington State, or
- At least age 60 with at least 5 years of municipal service in an elected capacity or a combination of elected and appointed capacity, in Washington State.

City Manager must meet the following criteria of age and years of service:

- Any age with 30 or more years of documented municipal service in Washington State, or
- At least age 55 with at least 25 years of documented municipal service in Washington State, or
- At least age 60 with at least 5 years of documented municipal service in Washington State.

PERS 1

From active service:

- Any age with 30 or more service credit years, or
- At least age 55 with at least 25 service credit years, or
- At least age 60 with at least 5 service credit years.

From inactive status:

- At least age 65 with 5 years of accrued service credit, or
- At least age 60, with an actuarially reduced benefit, with 5 years of accrued service credit.

PERS 2

- At least age 65 or older with at least 5 service credit years, or
- At least age 55 with at least 20 service credit years.

PERS 3

- At least age 65 with at least 10 service credit years, or
- At least age 65 with 5 service credit years, including 12 service credit months that were earned after age 54, or
- At least age 65 with 5 service credit years that were earned under PERS 2 Plan, and transferred to Plan 3 before June 1, 2003.
- At least age 55 with at least 10 years of service credit, or
- At least age 55 and have at least 30 or more service credit years

LEOFF 2

- At least age 53 with at least 5 service credit years, or at least age 50, with at least 20 service credit years.

PSERS

- Full retirement at age 65 with at least 5 years of service credit, or
- Full retirement at age 60 with 10 years of PSERS service credit; or
- Early retirement at age 53 with at least 20 years of service credit (a benefit reduction of three percent per year from age 60 will apply).

If a retiree or dependent of a retiree terminates the Plan, no re-enrollment will be allowed. If a retiree terminates the Plan for any reason other than death, the dependents cannot continue coverage.

Dependent Eligibility

Dependents eligible for coverage under this plan are:

- An employee's legally married spouse as defined in the definition section. Coverage may continue during a legal separation only if ordered by a court decree.
- A domestic partner. Domestic Partners are defined as two adults, engaged in a spouse-like relationship, who are state registered domestic partners in the state in which they reside. In order for an employee's domestic partner to qualify for coverage under the Plan, the employee must provide the City with a copy of their Certificate of Registered Domestic Partnership ("Domestic Partnership").

  Coverage is available to the children of one or both Domestic Partners provided that the child meets the eligibility requirements for dependent children provided herein.

  Upon termination of a domestic partner relationship, an employee must notify the Plan Administrator within 30 days, acknowledging that the relationship has ended. Coverage for domestic partners and their children will cease on the last day of the month in which the domestic partnership ends.

  Please contact the group's Human Resources Department for more information on how to qualify for coverage under this provision.
- Dependents, who meet the eligibility criteria listed below, of LEOFF I employees and retirees (law enforcement officers or firefighters hired prior to October 1, 1977, and who are members of the LEOFF system as defined in Sections (3) and (4) CH 131, Law of 1972 1st Ex. Session).
- An employee's married or unmarried child, under the age of 26, regardless of whether or not the child is eligible for employer sponsored coverage through their own employer, whether or not a full-time student, whether or not claimed as a dependent on the employee's federal income taxes, and whether or not dependent upon the employee for support.
- An employee's unmarried dependent child(ren) who is incapable of self-support because of mental retardation, mental illness or physical incapacity that began prior to the date on which the child's eligibility would have terminated due to age. 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.

- An employee's unmarried dependent child(ren) whose coverage is required pursuant to a valid court, administrative order or Qualified Medical Child Support Order (QMCSO).

- Adopted children are eligible under the same terms and conditions that apply to dependent, natural children of parents covered under this Plan.

- Any individual who is covered as an employee can also be covered as a dependent. Dependents can be covered as a dependent of more than one employee.
- Covered spouses and eligible dependents are allowed to enroll on the Plan after the employee dies. Covered and eligible dependents are allowed to stay on the Plan after the retiree dies.

- If a retiree or dependent of the retiree terminates the Plan, no re-enrollment will be allowed. If a retiree terminates the Plan for any reason other than death, the dependents cannot continue coverage.

- Retiree coverage must be chosen immediately after active coverage/COBRA coverage terminates, no break in coverage is allowed.

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

A dependent is defined as an individual who is: (1) listed on the employee's application as a dependent of the employee; (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, the employee must complete and submit an enrollment form within 31 days of the date the individual first becomes eligible for coverage. The completed enrollment form should list all eligible dependents to be covered. Individuals not enrolled during the enrollment eligibility period will be required to wait until the next open enrollment period unless they become eligible to enroll as a result of a special enrollment period.

When the employee acquires a new dependent (birth, marriage, adoption, etc.), the dependents must be enrolled within the enrollment eligibility periods specified below. Domestic partners who are not enrolled when the employee is first eligible, will be eligible for special enrollment to the same extent as a spouse.

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

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

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

Special Enrollment for Loss of Other Coverage

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

- The employee or dependent is eligible for coverage under the terms of the Plan, but not enrolled.
- Enrollment in the Plan was previously offered to the employee.
- The employee declines the coverage under the Plan because, at the time, the employee and/or dependent was covered by another group health plan or other health insurance coverage.
- The employee has declared in writing that the reason for the declination was the other coverage.

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

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

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

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

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

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

- The employee or dependent becomes eligible for State Child Health Plan or Medicaid premium assistance.

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

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

Special Enrollment for New Dependents

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

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

- When an employee or spouse acquire a child through birth, adoption, or placement for adoption, a special enrollment period is available for the employee, the 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.

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 the parties, but not formally approved by a court are not acceptable. If the child is enrolled within 60 days of the court or state agency order, the waiting period does not apply.

Open Enrollment

An open enrollment period is held once every 12 months to allow eligible employees to change their participation. The open enrollment period will be the month of December for an effective date of January 1.

CERTIFICATE OF CREDITABLE COVERAGE

Under the Health Insurance Portability and Accountability Act of 1996, former Plan participants and their eligible dependents have the right to request and receive a Certificate of Creditable Coverage for any coverage, including COBRA coverage that was in effect June 1, 1996 or after. The right to receive this certificate continues for 24 months following the date of termination of coverage under this Plan.

If a participant loses coverage under this Plan they will be sent a Certificate of Creditable Coverage. Please contact the Plan Supervisor if you need assistance. This is an important document and should be kept in a safe place. The Certificate of Creditable Coverage will be important proof of coverage under the plan that may be needed to reduce any subsequent health plan's pre-existing condition limitation period which might otherwise apply to plan participants and/or their dependents.

Certificates of creditable coverage will be provided through December 31, 2014. After this date, they will no longer be necessary.

Plan participants and their dependents have the right to request a certificate from a prior plan or issuer, if necessary. The Plan Administrator will assist Plan participants and eligible dependents in obtaining a certificate from any prior plan or issuer, if necessary.

EFFECTIVE DATE OF COVERAGE

Employee Effective Date

The effective date of coverage for eligible employees is the first of the month following the date of hire, except if hired on the first working day of the month. If an employee is hired on the first working day of the month, the employee will be eligible for coverage on the first day of the month in which the employee was hired. (Example: The first working day in January is January 3; the employee is hired January 3 and is effective for coverage January 1.)

Retiree Effective Date

For eligible retirees, coverage begins on the date of retirement.

Dependent Effective Date

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

If the covered employee marries, the employee must add the newly acquired dependents within 31 days of the date of marriage and the effective date of coverage is the first of the month following the date of marriage.

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

TERMINATION OF COVERAGE

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

- The date the Employer terminates the Plan.

Employee

- The date the employee ceases to meet the eligibility requirements of the Plan.
- The last day of the month in which the employee's employment ends.
- The date the employee begins active service in the armed forces.
- The first day an employee fails to return to work following an approved leave of absence.
- The last day of the month in which the employee retires.

Dependent(s)

- The date the employee's coverage terminates.
- The last day of the month in which such individual ceases to meet the eligibility requirements of the Plan.
- The date the dependent becomes an active, full-time member of the armed forces of any country.
- The date dependent coverage is discontinued under the Plan.

Coverage will not be terminated retroactively except in the case of an employee’s failure to remit premiums or contributions in a timely manner or in the case of fraud or intentional misrepresentation. The Plan Administrator will provide 30 days advance written notice to covered employees and dependents that will lose coverage retroactively due to an act, practice, or omission that constitutes fraud or the employee or dependent makes an intentional misrepresentation of material fact.

APPROVED FAMILY AND MEDICAL LEAVE

The Plan will at all times comply with the Family and Medical Leave Act (FMLA) or similar state law that applies to coverage under this group health plan. During any leave taken under FMLA (or applicable state law), you may maintain coverage under this Plan on the same conditions as if you had been continuously employed during the entire leave period.

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

THREE MONTH LEAVE OF ABSENCE

You and your dependents may continue coverage for a period of not more than three months during a temporary employer-approved leave of absence. A leave of absence will begin when you are no longer receiving a full salary, but no later than 90 day calendar days from the date you are no longer actively at work. Dependent coverage cannot be extended if the employee is not covered.

MILITARY LEAVE OF ABSENCE

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights apply only to eligible employees and eligible 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. For elections made before December 10, 2004, the 18 month period beginning on the date that Uniformed Service leave commences; or

b. For elections made on or after December 10, 2004, the 24 month period beginning on the date that Uniformed Service leave commences;

c. The period beginning on the date that Uniformed Service leave commences and ending on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

A person who elects to continue Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the employee's share, if any, for the coverage.

Plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during military service.

Please contact the City's Human Resources Department for information concerning your eligibility for USERRA and any requirements of the Plan.

REINSTATEMENT OF COVERAGE

If an employee or dependent who was covered under this Plan terminates employment or loses eligibility for coverage and is rehired or again becomes eligible for coverage, all waiting periods, deductibles and out-of-pockets must be re-satisfied.

SELF-PAYMENT IN THE EVENT OF A LABOR DISPUTE

If a covered employee's compensation is suspended as a result of a strike, lockout, or other labor dispute, the employee may continue coverage for himself or herself and any covered dependents for up to six months. The covered employee must pay the full cost of coverage directly to the City of Puyallup. If the covered employee is not back at work at the end of the six-month extension period, coverage may be continued as described in "Termination of Coverage - COBRA." The six-month labor dispute period counts towards the maximum COBRA continuation period.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

City of Puyallup Health Care Plan 1 (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 spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. **The following paragraphs generally explain COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

In general, COBRA requires that a "qualified beneficiary" covered under the Employer's group health plan who experiences a "qualifying event" be allowed to elect to continue that health coverage for a period of time. ***Qualified beneficiaries are employees and dependents who were covered by the Plan on the day before the qualifying event occurred. Domestic partners are not considered qualified beneficiaries and do not have independent rights under COBRA, however, they 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 employees and 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 Puyallup (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:

The City of Puyallup
333 S. Meridian
Puyallup, WA 98371
253/841-5541

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

Mailing Address:

HMA, Inc.
P.O. Box 53168
Bellevue, WA 98015
Attn: COBRA Unit
800/869-7093

Street Address:

HMA, Inc.
220 120th Ave NE
Bellevue, WA 98005
Attn: COBRA Unit
800/869-7093

WHAT IS COBRA COVERAGE?

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

After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under 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. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the component or components of the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

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

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 his or her gross misconduct; or
- you become divorced or legally separated from your spouse. Also, if your spouse (the employee) reduces or eliminates your group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation.

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

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

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

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

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

In providing this notice, 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 COBRA Administrator (An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from the Plan Administrator.)

Under federal law, you must have 60 days 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 or hand deliver the completed Election Form to:

Mailing Address:

HMA, Inc.
P.O. Box 53168
Bellevue, WA 98015
Attn: COBRA Unit
800/869-7093

Street Address:

HMA, Inc.
220 120th Ave NE
Bellevue, WA 98005
Attn: COBRA Unit
800/869-7093

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

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

If you reject COBRA 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.

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

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

Qualified beneficiaries may be enrolled in one or more group health components of the Plan at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as

the result of a qualifying event, he or she may elect COBRA under any or all of the group health components of the Plan under which he or she was covered on the day before the qualifying event.

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

SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you will lose the guaranteed right to purchase individual health insurance policies if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you 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 the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months.

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan's components for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the covered employee

becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

EXTENSION OF MAXIMUM COVERAGE PERIOD

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the COBRA Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage.

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 61st day after the later of the covered employee's 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 one of them qualifies.

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

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

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 the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE. (You may obtain a copy of the Notice of Disability (Form & Notice Procedures) from the COBRA Administrator.)

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

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

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

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

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

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

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

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

You must notify the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). You must use the Plan's form entitled "Notice of Other Coverage,

Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures)," and you must follow the procedures specified below in the section entitled "Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability." (You may obtain a copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures) from the COBRA Administrator.)

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

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

If the Social Security Administration determines that the qualified beneficiary is no longer disabled during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the COBRA Administrator that the disabled qualified beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period.")

COST OF COBRA COVERAGE

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

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

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 or hand-delivered to:

Mailing Address:

HMA, Inc.
P.O. Box 53168
Bellevue, WA 98015
Attn: COBRA Unit
800/869-7093

Street Address:

HMA, Inc.
220 120th Ave NE
Bellevue, WA 98005
Attn: COBRA Unit
800/869-7093

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

If you elect COBRA, 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, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) See the section 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, Sue's employment terminates on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her COBRA election.) You are responsible for making sure that the amount of your first payment is correct. You may contact the COBRA Administrator using the contact information provided 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 a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan and COBRA 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:

The City of Puyallup
333 S. Meridian
Puyallup, WA 98371
253/841-5541

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 Puyallup Health Care Plan 1 (the Plan)

Notice Procedures for Notice of Qualifying Event

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

You must mail or hand deliver this notice to:

The City of Puyallup
333 S. Meridian
Puyallup, WA 98371
253/841-5541

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

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

Your notice must contain the following information:

- the name of the Plan (City of Puyallup Health Care Plan 1);
- 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 or hand-delivered to the individual and address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan;
- from the written notice provided, the Plan Administrator is able to identify the covered employee and 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.

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

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

(retroactively if applicable) as of the date that COBRA coverage would have started. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

Notice Procedures for Notice of Disability

The deadline for providing this notice is 60 days after the latest of (1) the date of the Social Security Administration's disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; and (3) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours. 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 or hand deliver this notice to:

The City of Puyallup
333 S. Meridian
Puyallup, WA 98371
253/841-5541

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

You must use the Plan's form entitled "Notice of Disability (Form & Notice Procedures)" to notify the 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 Puyallup Health Care Plan 1);
- 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 or hand-delivered to the individual and address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan and a qualified beneficiary's disability;
- from the written notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies) and the date on which the covered employee's termination of employment or reduction of hours occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Disability) within 15 business days after a written or oral request from the 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.

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

Notice Procedures for Notice of Second Qualifying Event

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

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

Mailing Address:

HMA, Inc.
P.O. Box 53168
Bellevue, WA 98015
Attn: COBRA Unit
800/869-7093

Street Address:

HMA, Inc.
220 120th Ave NE
Bellevue, WA 98005
Attn: COBRA Unit
800/869-7093

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

You must use the Plan's form entitled "Notice of 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 Puyallup Health Care Plan 1);
- the name and address of the employee or former employee who is or was covered under the Plan;
- the initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction of hours);
- the date that the covered employee's termination of employment or reduction of hours happened;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;
- the second qualifying event (a divorce or legal separation, the covered employee's death, or a child's loss of dependent status);
- the date that the divorce or legal separation, the covered employee's death, or a child's loss of dependent status happened; and
- the signature, name, and contact information of the individual sending the notice.

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

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

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

If any of these conditions 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.

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

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

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

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

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

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

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

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

Mailing Address:

HMA, Inc.
P.O. Box 53168
Bellevue, WA 98015
Attn: COBRA Unit
800/869-7093

Street Address:

HMA, Inc.
220 120th Ave NE
Bellevue, WA 98005
Attn: COBRA Unit
800/869-7093

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 Puyallup Health Care Plan 1);
- the name and address of the employee or former employee who is or was covered under the Plan;
- the name(s) and address(es) of all qualified beneficiary(ies);
- the qualifying event that started your COBRA coverage;
- the date that the qualifying event happened; and
- the signature, name, and contact information of the individual sending the notice.

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

evidence of the effective date of the other coverage (such as a copy of the insurance card or application for coverage).

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

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

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

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

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

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

DEDUCTIBLES

Individual

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

Family

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

Family Accident

If two or more family members are injured in the same accident, only one deductible will be required during that calendar year as a result of the accident. This deductible waiver applies only to medical bills incurred as a result of the accident; for services not related to the accident, the regular deductible amount would apply.

DEDUCTIBLE CARRYOVER

Although a new medical deductible will apply each calendar year, expenses incurred during October, November and December which are applied against that year's deductible will also be applied toward the deductible for the next year and thus reduce or eliminate the next year's deductible. Any amounts that satisfy an individual deductible will count toward satisfying the family deductible. Expenses carried over to satisfy the next year's deductible will not be applied to the next year's out-of-pocket maximum.

AMOUNTS NOT CREDITED TOWARD THE DEDUCTIBLE

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

- Expenses for services or supplies not covered by this Plan.
- Charges in excess of the usual, customary, and reasonable (UCR) charges.
- Copays.

COINSURANCE PERCENTAGE

The coinsurance is the percentage of the usual, customary, and reasonable (UCR) charge that the Plan will pay for non-participating providers, or the percentage of the negotiated rate for preferred providers and participating providers. Once the deductible is satisfied, the Plan shall pay benefits for covered expenses incurred during the remainder of the calendar year at the applicable coinsurance as specified in the Schedule of Benefits. The participant is responsible for paying the remaining percentage. The participant's portion of the coinsurance represents their out-of-pocket expense.

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

COPAY

A copay is the amount paid by you each time treatment is received. Only one copay is to be taken per day for related outpatient services rendered. Copays will be waived for services related to an accident.

OUT-OF-POCKET MAXIMUM

The amount of the coinsurance which is your responsibility is applied toward your out-of-pocket maximum. When you or your family's out-of-pocket total reaches the out-of-pocket maximum as shown in the Schedule of Benefits during one calendar year, the Plan will pay 100% of allowable charges of the participant’s incurred eligible medical expenses for the remainder of that calendar year.

Some benefits will remain at a constant coinsurance level, not applying toward the out-of-pocket maximum, and not payable at 100% when the out-of-pocket maximum is reached. These benefits are identified in the Schedule of Benefits.

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

- Expenses not covered under this Plan.

ELIGIBLE EXPENSES

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

ALLERGY INJECTIONS/TESTING

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

ALTERNATIVE SERVICES

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

AMBULANCE (AIR AND GROUND)

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

BLOOD BANK

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

CHIROPRACTIC CARE

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

COMPOUND MEDICATIONS

Compound medications will be covered in full at Beal's Pharmacy in Puyallup and Clarke's in Bellevue. The participant will need to submit the claims to HMA at the address shown on the back of your HMA identification card.

CONTRACEPTIVE SERVICES

Benefits will be provided for consultations, counseling, all contraceptive methods which require a prescription and have been approved by the United States Food and Drug Administration, and patient education. Benefits are also provided for insertion and removal of intrauterine devices and implants.

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

DENTAL SERVICES

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

- Treatment for accidental injuries to natural teeth provided that the injury occurred while covered under this Plan. Treatment for up to 12 months from the date of the accident for accidental injuries is provided under this Plan. Injuries caused by biting or chewing are not covered under the medical plan.

- Benefits for hospitalization and anesthesia for dental services are covered the same as relevant services listed on your Schedule of Benefits. Services should be prior authorized by the Plan and are only provided for members with complicating medical conditions and if medically necessary to safeguard the individuals health. Examples of these conditions include, but are not limited to:
  - mental handicaps.
  - physical disabilities.
  - a combination of medical conditions or disabilities that cannot be managed safely and efficiently in a dental office.
  - emotionally unstable, uncooperative, combative patients where treatment is extensive and impossible to accomplish in the office.

All other dental services are excluded under this medical plan.

DIAGNOSTIC X-RAY AND LABORATORY

Benefits will be provided for medical services, administration, and interpretation of diagnostic X-ray, pathology, and laboratory tests. Dental x-rays are excluded.

Screening for gestational diabetes, Human Papillomavirus (HPV) DNA testing, and Human Immune-deficiency Virus (HIV) for women will be covered under the Preventive Care benefits of the Plan.

DIETARY EDUCATION

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

DURABLE MEDICAL EQUIPMENT

Benefits are provided for rental or purchase (if more economical in the judgment of the Plan Supervisor's Health Services Department) of medically necessary durable medical equipment. Durable medical equipment is equipment able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally used in the absence of illness or injury. The durable medical equipment must be prescribed by a physician for therapeutic use, and include the length of time needed, the cost of rental and cost of purchase prior to any benefits being paid. Examples of durable medical equipment include: crutches; wheelchairs; kidney dialysis equipment; hospital beds; traction equipment; and equipment for administration of oxygen. Repairs or replacement of eligible equipment shall be covered when necessary to meet the medical needs of the covered patient.

Benefits are **not** provided for certain equipment including, but not limited to, air conditioners, humidifiers, over-the-counter arch supports, corrective shoes, hearing aids, keyboard communication devices, adjustable beds, orthopedic chairs, personal hygiene items, purifiers, heating pads, enuresis (bed-wetting) training equipment, exercise equipment, whirlpool baths, weights, or hot tubs. The fact that an item may serve a useful medical purpose will not ensure that benefits will be provided.

Services for breastfeeding equipment or supplies will be covered under the Preventive Care benefits of the Plan.

Purchase or rental of durable medical equipment that is over $1,000 should be reviewed by Plan Supervisor's Health Services Department.

EMERGENCY ROOM & SERVICES

Benefits will be provided for emergency room treatment of an accidental injury or a medical emergency. Benefits are paid at the level shown in the Schedule of Benefits. If you are traveling or receive emergency services inside or outside the network area, eligible emergency room and services will be reimbursed at the preferred network benefit level. All eligible services provided in an emergency room (physician/provider services and facility fees) will be covered at the level shown in the Schedule of Benefits. Use of an Emergency room in a non-emergent situation is not covered. Benefits are covered as outlined in the Schedule of Benefits. If services are received from an Out-of-Network provider, the plan will use a reasonable method of calculating reimbursement so payment is in line with reimbursement of services if received from an In-Network provider. Please see the definition of Reasonable Reimbursement Method for Out-of-Network Emergency Services in the General Definitions section.

GROWTH HORMONE BENEFIT

Services and supplies will be provided for growth hormone when performed and billed by an approved infusion therapy provider for growth hormone deficiency in children, Turner's syndrome, growth failure in children secondary to chronic renal insufficiency prior to renal transplant, or for the promotion of wound healing in enrollees with severe, acute burns. Benefits will be provided as shown in the Schedule of Benefits. Growth hormone treatment of these listed conditions should be prior authorized by Plan Supervisor's Health Services Department.

HEARING BENEFIT

A hearing examination as provided by a licensed physician, as defined under the definition of physician, will be covered as shown in the Schedule of Benefits. Examination must be obtained before a hearing aid is received.

Services will be provided for:

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

HOME HEALTH CARE

Services for Home Health Care must be ordered by a physician, include a treatment plan, and should be pre-authorized by the Health Services Department prior to services being rendered.

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

The following services will be considered eligible expenses:

- Part-time or intermittent nursing care by a registered nurse, a licensed vocational nurse or by a licensed practical nurse.
- Physical therapy by a licensed, registered, or certified physical therapist.
- Speech therapy services by a licensed, registered, or certified speech therapist.
- Occupational therapy services by a registered, certified, or licensed occupational therapist.
- Nutritional guidance by a registered dietitian.
- Nutritional supplements such as diet substitutes administered intravenously or by enteral feeding.
- Respiratory therapy services by a certified inhalation therapist.
- Home health aide services by an aide who is providing intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, completing appropriate records.
- Medical supplies, drugs and medicines prescribed by a physician, and laboratory services normally used by a patient in a skilled nursing facility, medical facility or hospital, but only to the extent that they would have been covered under this Plan if the participant had remained in the hospital or medical facility.
- Assessment by a Masters of Social Work (M.S.W.).

Exclusions to Home Health Care

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

HOME PHOTOTHERAPY

Services and supplies provided for newborn hyper-billi-rubinemia (newborn jaundice) are eligible for payment under this Plan for covered children.

HOSPICE CARE

Services for Hospice Care must be ordered by a physician, include a treatment plan, and should be pre-authorized by the Plan Supervisor's Health Services Department prior to services being rendered.

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

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

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

- A description of the medically necessary care to be provided to a terminally ill patient for palliative care or medically necessary treatment of an illness or injury but not for curative care.
- A provision that care will be reviewed and approved by the physician at least every 60 days.
- A prognosis of six months or less to live.

If the covered participant requires end of life care beyond 120 days, the Plan will approve additional hospice care benefits on receipt of a plan of care documenting the continued need for the services.

Exclusions to Hospice Care

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

IMMUNIZATIONS

Immunizations for routine use in children, adolescents, and adults that are recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) and listed on the Immunization Schedules of the CDC for children and adults are covered as shown in the Schedule of Benefits. Covered services do not include immunizations for the sole purpose of travel, occupation, or residence in a foreign country.

INFUSION THERAPY BENEFIT

Inpatient and outpatient services and supplies for infusion therapy are provided at the coinsurance level shown in the Schedule of Benefits. The attending physician must submit, and periodically review, a written treatment plan that specifically describes the infusion therapy services and supplies to be provided. The treatment plan should be pre-authorized in advance by the Plan Supervisor’s Health Services Department. Drugs and supplies used in conjunction with infusion therapy will be provided only under this benefit.

MATERNITY SERVICES

Benefits for maternity care and services are available to a covered employee or spouse. Pregnancy and complications of pregnancy will be covered as any other medical condition. Medical facility, surgical and medical benefits are available on an inpatient or outpatient basis for the following maternity services:

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

Breastfeeding support and services will be covered under the Preventive Care benefits of the Plan.

Preventive services will be covered for an employee, spouse, or child under the Plan's Preventive Care benefit as required by the Patient Protection and Affordable Care Act. All other services related to maternity care for a child are not covered.

Newborns' and Mothers' Health Protection Act

The Plan will at all times comply with the terms of the Newborns' and Mothers' Health Protection Act of 1996. The Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or to less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay for the mother or newborn child not in excess of the above periods.

MEDICAL FACILITY SERVICES

Inpatient Care

The following benefits will be provided for inpatient care in an accredited hospital or medical facility when the patient is under the care of a physician:

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

Outpatient Care

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

Miscellaneous

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

MEDICAL SUPPLIES

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

Diabetes management/maintenance (syringes, needles, test strips, meters, etc.) is covered with a copay under the pharmacy benefit. These items for diabetes management are not covered under the medical plan, unless in conjunction with treatment at a hospital/facility.

MENTAL HEALTH SERVICES

Benefits will be provided for Mental Health Services, including neurobiological disorders as defined in General Definitions, and treatment of eating disorders (such as anorexia nervosa, bulimia, or any similar condition) for medically necessary services received on an inpatient or intermediate care basis in a hospital or an alternate facility, and those received on an outpatient basis in a provider's office or at an alternate facility.

Mental health shall mean any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of the International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual ("DSM") of Mental Disorders, published by the American Psychiatric Association or other relevant State Guidelines or applicable sources. The fact that a condition is listed in the current DSM of the American Psychiatric Association does not mean that treatment for the condition is covered (see exclusions under the Plan).

Covered benefits for Mental Health Services include:

- Mental health evaluations and assessments;
- Diagnosis;
- Treatment planning;
- Referral services;
- Medication management;
  NOTE: Prescription drugs prescribed by and administered while IN an approved treatment facility are covered.
- Inpatient treatment;
- Partial hospitalization/day treatment;
- Intensive outpatient treatment;
- Services at a residential treatment facility;
- Individual, family and group therapeutic services; and
- Crisis intervention.

When inpatient or intermediate (excluding partial hospitalization/day treatment or intensive outpatient treatment) Mental Health Services, including neurobiological disorders, are recommended, the patient or their provider may first contact the Plan Supervisor's Health Services Department to pre-authorize the requested services.

Neurobiological Disorders - Autism Spectrum Disorder Services

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

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

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

NEURODEVELOPMENTAL THERAPY SERVICES

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

Such therapy includes occupational therapy, physical therapy, and speech therapy. The services of a physician, physical therapist, speech therapist, or occupational therapist will be provided in the provider’s office, medical facility, or hospital outpatient department. Inpatient hospital, medical facility, or skilled nursing facility expenses will be eligible when care cannot be safely provided on an outpatient basis.

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

NEWBORN NURSERY CARE BENEFIT

Medical facility charges incurred by a well newborn during the initial period of confinement will be covered as charges of the baby. In addition, a circumcision performed in an outpatient setting within 31 days of the birth of the baby will be covered under this benefit.

- Medical facility nursery expenses for a healthy newborn, including circumcision.

- Routine pediatric care for a healthy newborn child while confined in a hospital or medical facility immediately following birth.

- Phenylketonuria (PKU) testing.

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

Charges for preventive care (routine immunizations and examinations) will be considered eligible expenses only to the extent specifically shown in the Schedule of Benefits.

ORTHOTICS

Benefits are payable, at the coinsurance level indicated in the Schedule of Benefits. Expenses for orthotic appliances include, but are not limited to, foot supports, supplies, devices, and corrective shoes. Shoe orthotics are only covered if prescribed for diabetes management.

OUTPATIENT SURGICAL FACILITY

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

PHENYLKETONURIA (PKU) DIETARY FORMULA

Dietary formula which is medically necessary for the treatment of phenylketonuria is covered.

PHYSICIAN SERVICES

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

Services for well-women visits, sexually transmitted infection counseling for women, Human-Immune-deficiency virus (HIV) counseling for women, and screening and counseling for interpersonal and domestic violence for women will be covered under the Preventive Care benefits of the Plan.

PRE-ADMISSION TESTING

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

PRESCRIPTION DRUGS

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

See the Compound Medications benefit for additional details. All other outpatient prescription drugs are covered through your CVS/Caremark prescription drug plan.

PREVENTIVE CARE

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

be available and effective under this benefit. Services are payable as shown in the Schedule of Benefits.

PREVENTIVE COLONOSCOPY

Preventive colonoscopies are covered and are paid as shown in the Schedule of Benefits. Colonoscopies, other than routine screening, are covered when medically necessary if prescribed by your physician and payable at the Diagnostic, X-Ray and Laboratory Benefit as shown in the Schedule of Benefits.

PREVENTIVE GYNECOLOGICAL EXAM AND LAB

Preventive cervical examinations and PAP smears are covered for all female plan participants and are paid as shown in the Schedule of Benefits.

PREVENTIVE MAMMOGRAPHY BENEFIT

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

PREVENTIVE PROSTATE EXAM

A routine annual prostate examination, including prostate antigen screening, is covered and paid as shown in the Schedule of Benefits.

PROSTHETIC APPLIANCES

Benefits are provided for artificial devices which are medically necessary to replace a missing or defective body part, including (but not limited to) artificial limbs, eyes, breasts, and artificial hip. Benefits will also be payable for an external and permanent internal breast prosthesis following a mastectomy and as required by the Women's Health and Cancer Rights Act. Benefits are available for a testicular prosthesis if ordered related to orchiectomy for testicular cancer. External breast prostheses are limited to one replacement every three calendar years. A prosthesis ordered before your effective date of coverage will not be covered. A prosthesis ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be covered. Repair or replacement of prostheses due to normal use or growth of a child will be covered. Benefits are not provided for cosmetic prostheses except as stated in the Women's Health and Cancer Rights Act.

RADIATION THERAPY AND CHEMOTHERAPY

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

REHABILITATION BENEFIT

The Plan covers charges for you on an inpatient or outpatient basis in a rehabilitation center. Services for inpatient rehabilitation must be ordered by a physician, include a treatment plan and should be pre-authorized by the Plan Supervisor's Health Services Department. Outpatient rehabilitation treatment must be prescribed or pre-authorized All services specified below will be provided if continued measurable progress is demonstrated at regular intervals.

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

Occupational, physical, respiratory, speech therapy, pulmonary rehabilitation, and cardiac rehabilitation in the office, medical facility, or hospital will be paid under the rehabilitation benefit as shown in the Schedule of Benefits.

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

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

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

Physical therapy prescribed for the prevention of falls for individuals 65 years of age and older will be covered under the Preventive Care benefits of the Plan. Services are not applied towards the Rehabilitation Services per calendar year benefit limits.

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

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

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

Inpatient Treatment

The eligible expenses for inpatient rehabilitation are payable as shown in the Schedule of Benefits for the following services and supplies furnished while the patient requires 24-hour care and is under continuous care of the attending physician:

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

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

- custodial care;
- maintenance, non-medical self-help, recreational, educational, or vocational therapy;
- psychiatric care;
- learning disabilities or developmental delay;
- chemical dependency rehabilitative treatment;
- gym therapy;
- aquatic or swim therapy.

SECOND SURGICAL OPINION

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

Please note that all non-emergency surgery other than surgery done in the doctor's own office should be pre-authorized by the Plan Supervisor's Health Services Department. When requested, the Plan will pay the usual, customary, and reasonably accepted fee for a second surgical opinion, and for a third and final opinion in case of conflict between the first two opinions.

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

SKILLED NURSING FACILITY CARE

Services for Skilled Nursing Facility Care must be ordered by a physician, include a treatment plan, and should be pre-authorized by the Health Services Department prior to services being rendered.

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

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

SMOKING CESSATION

The services of a provider listed under the definition of physician, operating within the scope of their license, will be covered for a completed smoking cessation program. Medications to aid nicotine withdrawal will also be covered under this benefit. Benefits are payable as shown in the Schedule of Benefits.

Eligible expenses under this Plan shall not include, acupuncture, vitamins, and other food supplements, books, or tapes.

STERILIZATION - ELECTIVE

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

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

SUBSTANCE USE DISORDER SERVICES

Substance Use Disorder Services include those received on an inpatient or intermediate care basis in a hospital or an alternate facility, and those received on an outpatient basis in a provider's office or at an alternate facility.

Benefits for Substance Use Disorder Services include:

- Substance Use Disorder and chemical dependency evaluations and assessment;
- Diagnosis;
- Treatment planning;
- Detoxification (sub-acute/non-medical);
- Inpatient Treatment;
- Partial Hospitalization/Day Treatment;
- Intensive Outpatient Treatment;
- Services at a Residential Treatment Facility;
- Referral services;
- Medication management;
  NOTE: Prescription drugs prescribed by and administered while in an approved treatment facility are covered.

- Individual, family and group therapeutic services; and
- Crisis intervention.

Benefits under this section include chemical dependency and substance use disorder services provided on an outpatient, inpatient or intermediate care basis. Benefits include detoxification, which is the medical treatment of withdrawal from alcohol, drug or other substance addiction. Benefits are provided for treatment of alcohol, drug or other substance abuse withdrawal when medical complications occur or are highly probable. Detoxification is considered an emergency when rendered in a licensed hospital.

When inpatient or intermediate treatment (excluding partial hospitalization/day treatment and intensive outpatient treatment) is recommended, the participant or their provider may first contact the Plan Supervisor's Health Services Department to pre-authorize the requested services.

Benefit specific Exclusions and Limitations

No coverage is provided for the following services:

- Educational or correctional services or sheltered living provided by a school or halfway house; however, a participant may receive covered outpatient services while living temporarily in a sheltered living situation;
- A court-required screening interview or treatment program unless determined to be medically necessary;
- Support groups, including Alcoholics Anonymous or similar programs;
- Personal items;
- Custodial care or long-term care;
- Wilderness or outdoor treatment programs; or
- Tobacco cessation programs.

In-home services are limited to persons who are homebound under the care of a physician.

SURGERY AND RELATED SERVICES

Benefits are provided for the following inpatient or outpatient services:

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

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

TRANSPLANTS

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

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

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

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

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

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

No benefits will be provided for the following:

- Any procedure that has not been proven effective, is experimental or investigative, or is not standard of care for the community. (***See definition of Experimental and Investigative.)***
- When donor benefits are available through other group coverage.

- When government funding of any kind is available.
- When the recipient is not covered under this Plan.
- Private nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).

GENERAL EXCLUSIONS TO THE MEDICAL PLAN

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

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

Abortion -- Voluntary termination of pregnancy for dependent children.

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

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

Alcohol - Services, supplies, care or treatment to a covered participant for an injury or sickness which occurred as a result of that covered participant's illegal use of alcohol. Expenses will be covered for injured covered participants other than the person illegally using alcohol and expenses will be covered for substance abuse treatment as specified in this Plan. This exclusion does not apply if the injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

Alternative Medicine -- Services for acupressure, rolfing, faith healing services, or reflexology.

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

Biofeedback -- Charges for biofeedback treatment.

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

Bone Anchored Hearing Aids (BAHA) and Cochlear Implants – Charges or supplies with regard to bone anchored hearing aids (BAHA) and cochlear implants.

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

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

diagnosis. However, routine medical expenses associated with an approved clinical trial (phase I, II, III, or IV) will be covered under the plan if medically necessary.

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

1. When related to an illness or injury.

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

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

    - Reconstruction of the breast on which the mastectomy has been performed
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance
    - Prostheses
    - Treatment of physical complications of all stages of mastectomy, including lymphedemas

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

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

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

Dental -- Dental services including treatment of the mouth, gums, teeth, mouth tissues, jawbones or attached muscle, upper or lower jaw augmentation reduction procedures, orthodontic appliances, dentures and any service generally recognized as dental work. Hospital and Physician services rendered in connection with dental procedures are only covered if adequate treatment cannot be rendered without the use of hospital facilities, and if you have a medical condition besides the one requiring dental care that makes hospital care medically necessary. The only exceptions to this exclusion are the services and supplies covered under the Dental Services for Accidental Injuries Benefit

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

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

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

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

Family Counseling – Services for marital or family counseling except as provided under the Substance Use Disorder Services benefit.

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

Fertility and Infertility -- Charges in association with infertility, and procedures to restore fertility or to induce pregnancy, including but not limited to: corrective or reconstructive surgery; hormone injections; in-vitro fertilization; embryo transfer; artificial insemination, gamma intra-fallopian transfer (G.I.F.T.); fertility drugs (including but not limited to as Clomid, Pergonal or Serophene); or any other artificial means of conception, except as determined to be medically necessary, and as provided under the Prescription Drug Card Program.

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

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

Habilitative, Education, or Training Services -- Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor, or social skills, including evaluations therefore, except as provided herein under the Neurodevelopmental Therapy and Mental Health benefits.

Hospice Bereavement -- Charges for hospice bereavement treatment.

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

Impotency -- Charges associated with impotency and erectile dysfunction, and procedures to restore potency, including but not limited to: corrective or reconstructive surgery; hormone injections; penile implants; or impotency drugs whether or not they are the consequence of illness or injury except as determined to be medically necessary, and as provided under the Prescription Drug Card Program.

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

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

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

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

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

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

Mental Health -

1. Services performed in connection with conditions not classified in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association or the list below when listed as the primary diagnosis:
    - Dyspareunia which is not due to a general medical condition.
    - Exhibitionism.
    - Female Orgasmic Disorder.
    - Fetishism.
    - Frotteurism.
    - Gender Identity Disorder in children.
    - Gender Identity Disorder NOS.
    - Hypoactive Sexual Desire Disorder.
    - Male Erectile Disorder.
    - Male Orgasmic Disorder.
    - Paraphilia NOS.
    - Pedophilia.
    - Premature Ejaculation.
    - Sexual Aversion Disorder.
    - Sexual Disorder NOS.
    - Sexual Dysfunction NOS.
    - Sexual Masochism.
    - Sexual Sadism.
    - Transvestic Fetishism.
    - Voyeurism.
    - Sexual counseling.

2. Mental Health Services as treatments for V-code conditions as listed within the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association. These V-code conditions are:
    - Noncompliance with Treatment.
    - Partner Relational Problem.
    - Physical/Sexual Abuse of an Adult.

- Sibling Relational Problem.
- Relational Problem Related to a Mental Disorder or General Medical Condition.
- Occupational Problem.
- Academic Problem.
- Relational Problems.
- Borderline Intellectual Functioning.
- Phase of Life Problem.
- Religious or Spiritual Problem.
- Malingering.
- Adult Antisocial Behavior.
- Child or Adolescent Antisocial Behavior.
- No Diagnosis or Condition on Axis I.
- No Diagnosis on Axis II.
- Family counseling.
- Marital counseling.

3. Tuition for or services that are school-based for children and adolescents under the individuals with Disabilities Education Act.
4. Learning, motor skills, and primary communication disorders as defined in the current edition of the Diagnostic and Statistical Manual of the American Psychiatric Association.
5. Treatment provided in connection with or to comply with involuntary commitments, police detentions and other similar arrangements, unless authorized by the Plan.

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

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

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

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

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

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

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

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

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

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

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

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

Physical and Psychiatric Examinations – Physical and psychiatric examinations or psychological testing for the purpose of obtaining or continuing employment, licensure, legal proceedings, insurance, school admission or sports activities, or which are conducted for purposes of medical research.

Pregnancy (Dependent Children) -- Services for pregnancy or complications of pregnancy for dependent children.

Private Duty Nursing – Services for private duty nursing and hourly nursing, except as provided under the Medical Facility Services, Home Health Care, and Hospice Care benefits.

Professional (and Semi-Professional) Athletics (Injury/Illness) -- Charges in connection with any injury or illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

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

Relatives -- Charges incurred for treatment or care by any provider if he or she is a relative, or treatment or care provided by any individual who ordinarily resides with the participant.

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

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

Routine Foot Care -- Services for routine or palliative foot care, including hygienic care; impression casting for prosthetics or appliances and prescriptions thereof; fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, and toenails (except for ingrown toenail surgery), and other asymptomatic complaints of the foot. This includes foot-support supplies, devices, and shoes, except as stated under the "Medical Supplies," or “Orthotics,” or “Prosthetic Appliances" benefits of the Plan. This exclusion does not apply to medically necessary services for patients with diabetes.

Routine Services – Services or supplies that are not directly related to an illness, injury, or distinct physical symptoms. Examples of routine services include, but not limited to, routine physical exams, diagnostic surgery, premarital exams, insurance exams, routine pap

smears, and diagnostic screening. These exclusions do not apply to services and supplies specified under the Preventive Care Benefits, or to routine mammograms.

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

Temporomandibular Joint Disorder and Myofacial Pain Dysfunction -- Medical treatment of Myofascial Pain Dysfunction, Temporomandibular Joint Dysfunction (TMJ) and other jaw disorders and services and/or appliances directly attributable to the TMJ dysfunction will not be 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 or insurance when such contract or insurance is issued to, or makes benefits available to, the covered participant, whether or not application is made for such benefits. This also includes treatment of illness or injury for which the third party is liable. Any benefits provided by or advanced by the City contrary to this exclusion are provided solely to assist the participant. By paying such benefits, the City is not acting as a volunteer and is not waiving any right to reimbursement or subrogation. When no-fault insurance is available and benefit payments have not been exhausted or denied for reasons other than medical treatment being: (a) not reasonable; (b) not necessary; (c) not related to the accident; or (d) not incurred within three years of the accident, it will be the member’s responsibility to pursue their coverage through the no-fault carrier to obtain the available limits of the no-fault coverage.

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

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

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

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

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

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

Vision Care -- Eyeglasses, contact lenses, eye refractions or examinations for prescriptions or fitting of eyeglasses, contact lenses or charges for radial keratotomy**.** Charges for vision analysis, therapy, or training relating to muscular imbalance of the eye, and orthoptics are not covered under the Plan.

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

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

PRESCRIPTION DRUG CARD PROGRAMS

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

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

GENERIC SUBSTITUTION

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

BRAND NAME PERFORMANCE DRUGS

An important element of your CVS/Caremark Prescription Drug Card Program is the opportunity to select drugs from the Performance Drug List. The Performance Drug List is a guide to the best values within select therapeutic categories which helps the provider identify products that will provide optimal clinical results at a lower cost. The Performance Drug List undergoes a thorough review and/or revision annually by outside Pharmacy and Therapeutics Committee comprised of physicians, nurses, and physicians. Interim changes could occur to reflect changes in the market. These changes could include; entry of new products, entry of a generic option to a brand drug, or other events that alter the clinical or economic value of the products on the Performance Drug List. Please see your Group's Human Resources Department for a copy of the Performance Drug List, or visit the CVS/Caremark website address www.caremark.com.

Other brand name drugs are any brand name drugs covered through the CVS/Caremark Plan, but not listed on the Performance Drug List.

PAYMENT SCHEDULE

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

This plan allows the participant to receive the brand over the generic without a cost penalty to the participant.

DRUGS COVERED

- Legend drugs. Exceptions: See Drugs Excluded and Limited below.
- Anti-obesity drugs and anorectics (any drug used for the purpose of weight loss, e.g., Didrex®, Meridia® , Xenical®).
- Anti-wrinkle agents (e.g. Renova®, Avage®).
- Alcohol swabs.
- Disposable insulin needles/syringes.
- Disposable blood/urine glucose/acetone testing agents (e.g. Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes-Tape.)
- Insulin and insulin pens.
- Lancets, lancet devices, and blood glucose monitors.
- Injectables.
- Injectables and Oral anabolic steroids.
- Emergency allergic kits (e.g., Epi-pen and Glucagon).
- Tretinoin, all dosage forms (e.g. Retin-A).
- Compounded medication of which at least one ingredient is a legend drug.
- Legend contraceptives, all dosage forms, whether medication, device, implant or other (copay does not apply).
- Legend prenatal vitamins.
- State controlled medications.
- Dietary supplements and health and beauty aids.
- Drugs used for cosmetic purposes (e.g., Botox®, Myobloc, Renova®, Eldoquin, Solage, Vaniqua®).
- Drugs used for the treatment of impotency (e.g., Viagra®, Caverject®, Muse®, Levitra®, Yocon®, Edex®).
- Drugs used for the treatment of hair loss (e.g., Propecia®, Rogaine®).
- Drug Efficacy Study Implementation (DESI) drugs.
- Drugs used for the treatment of ADHD and Narcolepsy (e.g., Dexadrine, Ritalin, Cylert, Adderall).
- Fluoride preparations (copay does not apply)
- Folic Acid and Iron supplements when prescribed by a physician (copay does not

apply).

- Growth Hormones.
- Hematinics.
- Fertility medications, all dosage forms (e.g., Clomid®, Pergonal®, Metrodin®).
- Smoking deterrent medications containing nicotine or any other smoking cessation aids, all dosage forms (e.g. Nicorette, Nicoderm, etc.).
- Depo-Provera.
- Drugs used for the treatment of sleep disorders (e.g., Ambien, Restoril, Sonata).
- Drugs used for the treatment of migraines (e.g., Imitrex, Migranal, Maxalt, Zomig).
- Pigmenting and depigmenting agents.
- Nutrients and nutritional agents.
- Vitamin D supplements when prescribed for fall prevention (copay does not apply.)
- Preventive medications as required by the Patient Protection and Affordable Care Act.
- Any other drug which under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

DRUGS EXCLUDED AND LIMITED

- Acthar H.P.
- Non-legend drugs other than insulin.
- Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, except those listed above.
- Prescriptions which an eligible individual is entitled to receive without charge from any Worker's Compensation Laws.
- Drugs labeled Caution-limited by federal law to investigational use or experimental drugs, even though a charge is made to the individual.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed medical facility, rest home, sanitarium, extended care facility, convalescent medical facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises or a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number specified by the provider, or any refill dispensed after one year from the provider's original order.
- Prescription drugs which may be obtained without charge under local, state, or

federal programs.

- Drugs purchased outside the U.S. that are not legal inside the U.S.

SPECIALTY PHARMACY

CVS/Caremark® Specialty Pharmacy Services include treatment of patients with narrow-niche, high-cost, chronic conditions such as multiple sclerosis, hepatitis C, rheumatoid arthritis, hemophilia, growth hormone deficiency, alpha 1-antitrypsin disorder, and other special medical conditions. Products provided are typically injectable drugs but may also include infusion drug products. The plan has established a specialty pharmacy program whereby certain pharmaceutical products that are generally biotechnological in nature and given by injection or otherwise require special handling (specialty medications), are provided by a network of preferred providers. CVS/Caremark's specialty pharmacies ("CVS/Caremark® Specialty Pharmacy Services") is a preferred provider within this network of specialty medications under the plan.

CVS/Caremark® Specialty Pharmacy Services provides individualized patient care for specialty medications which includes mail delivery of medications with all necessary supplies for administration of the medication.

In the event that you are prescribed a specialty medication, please call or have your healthcare provider contact CVS/CaremarkConnect® at 800/237-2767 to inquire about or begin services with CVS/Caremark® Specialty Pharmacy Services. Additional information may be obtained via the CVS/Caremark website: http://www.caremark.com.

If you would like to know more information about the drug coverage policies under this program, or if you have a question or concern about your pharmacy benefit, please contact CVS/Caremark at 866/885-4944.

Note: Compound medications will be covered in full at Beall's Pharmacy in Puyallup and Clarke's Pharmacy in Bellevue. The participant will need to submit the claims to HMA at the address shown on the back of your HMA identification card.

RETAIL PRESCRIPTION DRUG PROGRAM

CVS/Caremark

Dispensing Limitations

The amount normally prescribed by a physician or other lawful prescriber, but not to exceed a 34 day supply or 100 units.

Benefit Limitations When Not Using the Drug Card

If the prescription card is not used by the participant at the time of the prescription purchase or the prescription is purchased at a non-participating pharmacy, you must file a claim directly with the drug card service agency using their claim form.

Benefits For Employees And Dependents Prior to Receiving A Card

Prescription drugs that are eligible for reimbursement by the prescription drug card program can be submitted to CVS/Caremark prior to the enrollee's receipt of the card. To claim this benefit, a receipt for the paid prescription with a CVS/Caremark claim form must be submitted to CVS/Caremark.

CVS/Caremark will reimburse eligible claims as if the card had been used (100% reimbursement following the applicable copay).

MAIL ORDER PRESCRIPTION DRUG PROGRAM

CVS/Caremark Mail Service

When to Use Your Mail Order Prescription Drug Card Program

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

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

Dispensing Limitations

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

Ordering Information

Have your physician write a prescription for a 90 day supply and send the prescriptions along with a completed CVS/Caremark mail order form to CVS/Caremark.

Order forms can be obtained from HMA, your Group’s Human Resources Department or at: http://www.caremark.com. The physician can also phone in prescriptions to save time. Prescriptions can be reordered over the telephone with a credit card by calling 800/966-5772 or via the CVS/Caremark website at www.caremark.com. You may also reorder by using a mail service order form and pay by check or credit card.

CVS/Caremark Mail Service maintains a quick turnaround time. Orders which do not require a conversation with the participant or the physician, prior to dispensing, will be received within 7 to 10 days. Prescriptions that require communication with either the participant or the physician will not be filled until all questions have been answered. For this reason, please be sure to allow at least 14 days for your prescription request, to avoid running out of medication.

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

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

B) Federally funded trials – The study or investigation is approved or funded by one or more of the following:

   i. The National Institutes of Health.
   ii. The Centers for Disease Control and Prevention.
   iii. The Agency for Health Care Research and Quality.
   iv. The Centers for Medicare & Medicaid Services.
   v. Cooperative group or center of any of the entities listed above (i.-iv.) or the Department of Defense or the Department of Veteran Affairs.
   vi. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
   vii. The Department of Veteran Affairs, The Department of Defense, or the Department of Energy if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

C) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

D) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

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

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

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

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

CHEMICAL DEPENDENCY - An illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by a frequent or intense pattern of pathological use to the extent the covered participant exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use of the controlled substance or alcoholic beverage is reduced or discontinued; and the covered participant's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted.

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

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

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

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

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

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

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

- Employee - their inability to engage, as a result of accident or illness, in their normal occupation with the City of Puyallup on a full time basis;

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

DOMESTIC PARTNER – Two adults, engaged in a spouse-like relationship and who are state registered domestic partners with the state in which they reside.

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

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

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

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

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

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. For a person who is a late enrollee or who enrolls on a special enrollment date, the “enrollment date” will be the first date of actual coverage. If an individual receiving benefits under a group health plan changes benefit packages, or if the Plan changes group health insurance issuers, the individual’s enrollment date does not change.

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; or
2. The treatment is the subject of ongoing Phase I, II or III clinical trials as defined by the National Institute of Health, National Cancer Institute or the FDA; or
3. There is documentation in published U.S. peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine the safety, toxicity, or efficacy of the treatment.

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

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

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

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

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

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 - The term "illness" means an illness causing loss to the participant whose illness is the basis of the claim. For the purposes of this Plan only, "illness" shall also be deemed to include disability caused or contributed to by pregnancy of the covered employee or spouse, including miscarriage, childbirth, and recovery therefrom. It shall only mean illness or disease which requires treatment by a physician.

INCURRED CHARGE - The charge for a service or supply is considered to be incurred on the date it is furnished or delivered. In the absence of 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 - A person physically occupying a room and being charged for room and board in a facility (hospital, skilled nursing facility, etc.) which is covered by the Plan and to which the person has been assigned on a 24-hour per day basis.

INPATIENT STAY - An uninterrupted confinement that follows formal admission to a hospital, skilled nursing facility or inpatient rehabilitation facility.

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

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

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

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

LIFETIME - While covered under this Plan or any other City of Puyallup 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 AMOUNT AND/OR MAXIMUM ALLOWABLE CHARGE - Shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of:

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

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

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

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

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

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

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

- Continuous 24 hours a day nursing services by registered nurses.

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

The term ‘Hospital’ or ‘Medical Facility’ will **not** include an institution which is primarily: a place for rest or retirement; a residential treatment facility (except as provided under the Substance Use Disorder Services and Mental Health Services benefit), a health resort; a place for the aged; a convalescent home; juvenile boot camps (e.g., Outward Bound, wilderness survival programs); or a nursing home.

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

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

- Appropriate with regard to standards of good medical practice.

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

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

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

MENTAL ILLNESS - Those mental health or psychiatric diagnostic categories that are listed in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services Diagnostic and Statistical Manual of the American Psychiatric Association, unless those services are specifically excluded under the Plan.

NON-EMERGENCY MEDICAL FACILITY ADMISSIONS - A medical facility admission (including normal childbirth) which may be scheduled at the convenience of a participant without endangering such participant's life or without causing serious impairment to that participant's bodily functions.

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

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

    A. Drug Compendia: One of the following drug compendia indicates that the drug is recognized as effective for the indication:
        - The American Hospital Formulary Service Drug Information;
        - Drug Facts and Comparison;
        - The U.S. Pharmacopoeia Dispensing Information;
        - American Medical Association Drug Evaluation;
        - National Cancer Care Network;
        - National Cancer Institute; or
        - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services.

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

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

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

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

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

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

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

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

PARTICIPANT – Any employee or former employee who 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.

PHYSICIAN/PROVIDER - Individuals who are legally qualified and appropriately licensed, and providing service within their lawful scope of practice under the laws of the state in which they perform such services, are considered physicians and/or providers when acting within the scope of their license for services covered by this Plan.

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 in the Plan Specifications.

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.

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.

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

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

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

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

REASONABLE REIMBURSEMENT METHOD FOR OUT-OF-NETWORK EMERGENCY SERVICES – Reimbursement amounts for out-of-network emergency services will be reasonable if reimbursement is equal to the greatest of the following:

- The amount negotiated with in-network providers for the same emergency service provided (excluding any in-network copayment or coinsurance amount applied). If multiple rates with in-network providers are negotiated, the amount used will be the median of all negotiated rates;

- The amount for the emergency service calculated using the normal method used for calculating other out of network reimbursements (such as the usual, customary, and reasonable amount) excluding any in-network copayment or coinsurance imposed;

- The amount that would be paid under Medicare for the emergency service, excluding any in-network copayment or coinsurance imposed.

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

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

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

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

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

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

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

SIGNIFICANT BREAK IN COVERAGE - Any period of 63 days or more without Creditable Coverage. Periods of no coverage during an HMO affiliation period, a waiting period, or for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period, shall not be taken into account for purposes of determining whether a Significant Break in Coverage has occurred.

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

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

- Its services are provided for compensation from its patients and patients are under the full-time supervision of a physician or Registered Graduate Nurse (R.N.).

- It provides 24 hours per day nursing services by a licensed nurse, under the direction of a full-time Registered Graduate Nurse (R.N.).

- It maintains a complete medical record on each patient.

- It has an effective utilization review plan.

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

SPOUSE - The employee's lawfully wed, same or opposite gender spouse, which is legally recognized in the state in which the employee was married, not including a common-law marriage.

SUBSCRIBER – An employee of the Group who is enrolled in the Plan.

SUBSTANCE USE DISORDER SERVICES – Eligible covered services for the diagnosis and treatment of alcoholism and substance use disorders that are listed in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services Diagnostic unless those services are specifically excluded. The fact that a disorder is listed in the current edition of International Classification of Diseases does not mean that treatment of the disorder is covered under this Plan. Substance Dependence: Substance use history which includes the following: (1) substance abuse; (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

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. The Plan Document is maintained by the City of Puyallup's Human Resources Department.

SURGICAL PROCEDURE - A surgical procedure is defined as:

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

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

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

- Sober living arrangements such as drug-free housing, or alcohol/drug halfway houses. These are transitional, supervised living arrangements that provide stable and safe housing, an alcohol/drug free environment and support for recovery. A sober living arrangement may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the covered participant with recovery.

- Supervised living arrangements which are residences such as transitional living facilities, group homes and supervised apartments that provide members with stable and safe housing and the opportunity to learn how to manage their activities of daily living. Supervised living arrangements may be utilized as an adjunct to ambulatory treatment when treatment doesn't offer the intensity and structure needed to assist the covered participant with recovery.

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

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

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

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

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

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

USUAL, CUSTOMARY, AND REASONABLE (UCR) -- Please refer to the definitions for Reasonable and/or Reasonableness, and Usual & Customary (U&C).

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

ADMINISTRATION OF THE GROUP MEDICAL PLAN

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

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

AMENDMENT OF PLAN DOCUMENT

The Plan Administrator may terminate, modify, or amend the Plan in its sole discretion without prior notice. The Plan Administrator must notify the Plan Supervisor in writing requesting an amendment to the Plan. The Plan Supervisor will prepare an amendment to be signed by the Plan Administrator. Once the Plan Administrator has signed the amendment, such termination, amendment or modification which affects covered employees and their dependents will be communicated to the employees 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, an eligible employee must complete and deliver to the Plan Administrator an application on the enrollment form supplied by the Plan Supervisor.

Acceptance of this application will be evidenced by the delivery of an identification card showing the employee's name, by the Plan Supervisor to the participant.

ASSIGNMENT OF PAYMENT

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

AUDIT AND REVIEW FEES

Reasonable charges made by an audit and/or independent or peer review organization firm when the services are requested by the Plan Supervisor and approved by the Plan Administrator shall be payable.

CANCELLATION

An employee may cancel their 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, all employees' and dependents' coverage shall cease automatically without notice. Employees and dependents shall not be entitled to further coverage or benefits, whether or not any medical condition was covered by the Plan prior to termination or cancellation.

The Plan may be canceled or terminated at any time 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. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the participant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Plan Supervisor; provided, however, that the Plan Supervisor is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

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

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

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

A participant has the right to request a review of an adverse benefit determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a final adverse benefit determination. If the Participant receives notice of a final adverse benefit determination, or if the Plan does not follow the claims procedures properly, the Participant then has the right to request an independent external review. The external review procedures are described below.

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

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

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

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

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

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

- Concurrent Claims. A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

  - The Plan Administrator determines that the course of treatment should be reduced or terminated; or

  - The participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

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

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

When Health Claims Must Be Filed

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

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

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

Timing of Claim Decisions

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

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

- If the participant has not provided all of the information needed to process the claim, then the participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the participant (if additional information was requested during the extension period).

- Concurrent Claims:

  - Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The participant will be notified sufficiently in advance of the reduction or termination to allow the participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

  - Request by Participant Involving Urgent Care. If the Plan Administrator receives a request from a participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

  - Request by Participant Involving Non-urgent Care. If the Plan Administrator receives a request from the participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

  - Request by Participant Involving Rescission. With respect to rescissions, the following timetable applies:

    - Notification to Participant - 30 days

    - Notification of adverse benefit determination on appeal - 30 days

- Post-service Claims:

  - If the participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

  - If the participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the participant will be notified of the determination by a date agreed to by the Plan Administrator and the participant.

- Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.

- Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

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

Notification of an Adverse Benefit Determination

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

- Information sufficient to allow the participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

- A description of any additional information necessary for the participant to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the participant's right to bring a civil action following an adverse benefit determination on final review;

- A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the participant's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the participant, free of charge, upon request; and

- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes.

- In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determination

Full and Fair Review of All Claims

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

- Participants 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 180 days to appeal a second adverse benefit determination.

- Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- For a review that takes into account all comments, documents, records, and other information submitted by the participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;

- For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

- That a participant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits in possession of the Plan Administrator or the Plan Supervisor; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances; and

- In an urgent care claim, for an expedited review process pursuant to which:

  - A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the participant; and

  - All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the participant by telephone, facsimile or other available similarly expeditious method.

Requirements for First Appeal

The participant must file the first appeal in writing using a Request for Review of Benefit Denial form (although oral appeals are permitted for pre-service urgent care claims) within 180 days following receipt of the notice of an adverse benefit determination. If the participant would like to authorize another individual to act on their behalf in regards to the appeal, an Appointment of Authorized Representative form must be submitted with the appeal. A Request for Review of Benefit Denial form and an Appointment of Authorized Representative form can be obtained by calling HMA's Customer Service Department at 800/700-7153 or at www.accesshma.com.

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

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

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

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

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

- A completed Request for Review of Benefit Denial form;

- The name of the employee/participant;

- The employee/participant's member ID number;

- The group name or identification number;

- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the participant will lose the right to raise factual arguments and theories which support this claim if the participant fails to include them in the appeal**;

- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

- Any material or information that the participant has which indicates that the participant is entitled to benefits under the Plan.

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

Timing of Notification of Benefit Determination on First Review

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

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

- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.

- Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

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

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

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

- Information sufficient to allow the participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

- A reference to the specific portion(s) of the plan provisions upon which a denial is based;

- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

- A description of any additional information necessary for the participant to perfect the claim and an explanation of why such information is necessary;

- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the participant's right to bring a civil action following an adverse benefit determination on final review;

- A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits;

- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);

- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the participant, free of charge, upon request; and

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

Requirements for Second Appeal

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

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

Timing of Notification of Benefit Determination on Second Review

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

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

- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.

- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.

- Post-service Claims: Within a reasonable period of time, but not later than 30 days after receipt of the appeal.

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

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

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

- A description of any additional information necessary for the covered person to perfect the claim and an explanation of why such information is needed; and

- A description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination

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

Decision on Review

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

External Review Process

A. Standard external review

Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request for external review must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

   The participant must request the external review in writing using a Request for Review of Benefit Denial form. If the participant would like to authorize another individual to act on their behalf, an Appointment of Authorized Representative form must be submitted with the external review request. A Request for Review of Benefit Denial form and an Appointment of Authorized Representative form can be obtained by calling HMA's Customer Service Department at 800/700-7153 or at www.accesshma.com.

   The participant must submit the request for external review in writing, and it must be addressed and mailed or faxed as follows:

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

2. Preliminary review. Within five (5) business days following the date of receipt of the Request for Review of Benefit Denial form requesting external review, the Plan will complete a preliminary review of the request to determine whether:

   (a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

   (b) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);

   (c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and

(d) The claimant has provided all the information and forms required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Plan Supervisor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

B. Expedited external review

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:

   (a) An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

   (b) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

   The participant may request an expedited external review orally or in writing. Written requests must include a Request for Review of Benefit Denial form. If the participant would like to authorize another individual to act on their behalf, an Appointment of Authorized Representative form must be submitted with the expedited external review request. A Request for Review of Benefit Denial form and an Appointment of Authorized Representative form can be obtained by calling HMA's Customer Service Department at 800/700-7153 or at www.accesshma.com.

Oral requests for expedited external review can be made by telephone at:

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

A written request for an expedited external review may be addressed and mailed or faxed as follows:

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

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.

3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. Notice of final external review decision. The Plan's (or Plan Supervisor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

CONDITIONS PRECEDENT TO THE PAYMENT OF BENEFITS

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

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

an itemized statement with a diagnosis, the employee's name and Social Security Number and the name of the Plan Administrator or the Participating Group.

The employee and all 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 Health Services Department as needed to determine the medical necessity of the treatment being rendered.

COORDINATION OF BENEFITS

Definitions

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

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

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

Application

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

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

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

3. The plan covering the person as a retiree will be secondary.

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

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

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

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

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

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

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

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

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

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

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

I. The plan covering the custodial parent;

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

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

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

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

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

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

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

Coordination of Benefits with Medicaid

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

CREDIT FOR PRIOR GROUP COVERAGE

This Plan amends and replaces the prior Plan. Employees and dependents who were covered under the prior Plan sponsored by the Employer immediately prior to the time this Plan became effective shall not lose their eligibility or benefits due to the change in Plans. 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 each employee who has 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.

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 the covered person and are therefore equitably entitled thereto. In the event of the death of the covered person prior to such time as all benefit payments due him/her have been made, the Plan Supervisor may, at its sole discretion and option, honor benefit assignments, if any, prior to the death of such covered person.

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 their duties with respect to the Plan solely in the interest of the employees and beneficiaries and: (1) for the exclusive purposes of providing benefits to employees and their 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

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

Nothing contained herein shall confer upon an employee or 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 he/she receives care, for the acts of any physician from whom he/she receives service under this Plan, or for the acts of the Health Services Department in performing their duties under this Plan.

FUNDING

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 **effective April 14, 2003**, the Plan Sponsor must establish the permitted and required uses of Protected Health Information (PHI).

Plan Sponsor's Certification of Compliance

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Enrollees' 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.

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 Plan Enrollees' 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 Plan Enrollees' 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 Plan Enrollees' Protected Health Information to the Employer (Plan Sponsor) unless the disclosures are explained in the Notice of Privacy Practices distributed to the Plan Enrollees.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Enrollees' 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 Plan Enrollees' 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 Plan Enrollees' Protected Health Information, agrees to the restrictions and conditions of the Plan Documents, including this Article, with respect to Plan Enrollees' Protected Health Information.

- Not use or disclose Plan Enrollees' 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 Plan Enrollees' Protected Health Information that is inconsistent with the uses and disclosures allowed under this Article promptly upon learning of such inconsistent use or disclosure.

- Make Protected Health Information available to the Plan Enrollee who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524.

- Make Plan Enrollees' Protected Health Information available for amendment, and will on notice amend Plan Enrollees' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526.

- Track disclosures it may make of Plan Enrollees' 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 Plan Enrollees' 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 Plan Enrollee 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 any Enrollee who is the subject of the Protected Health Information, when the Plan Enrollees' 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 Plan Enrollee Protected Health Information, the Employer (Plan Sponsor) will limit the use or disclosure of any Plan Enrollee 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 Plan Enrollees' Protected Health Information received from the Plan or a health insurance issuer or business associate servicing the Plan:

- ***Accountant;***
- ***Coordinator;***
- ***Financial Analyst***
- ***Finance Director;*** *and*
- ***Human Resources Director***

This list includes every class of employees or other workforce members under the control of the Employer (Plan Sponsor) who may receive Plan Enrollees' 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 Plan Enrollees' 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 Plan Enrollees' 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 on any Enrollee, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

Employer (Plan Sponsor) Obligations Regarding Electronic Protecting Health Information

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

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

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

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

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

INADVERTENT ERROR

Inadvertent error by the Plan Administrator in the keeping of records or in the transmission of employee's applications shall not deprive any employee or dependent 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.

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

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

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

Total benefits of this Plan shall be determined as follows:

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

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

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) the group coverage as an active individual ends.

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

Retirees with Medicare

For covered persons who are not active employees age 65 or over, and that are eligible for Medicare by reason of age alone, this Plan will be secondary and Medicare will be primary. This Plan will be secondary not only to Medicare, but to any other Plan, individual or group, that the retiree may be enrolled in. The following formula shall be used in determining the total amount payable under this Plan as secondary payor during each claim submission.

Coordination - The regular Coordination of Benefits of this Plan when Medicare is the primary payor and this Plan is the secondary payor 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 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 which 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 may not be paid in full by this Plan or Medicare.

MISREPRESENTATION

Any material misrepresentation on the part of the Plan Administrator or the employee in making application for coverage, or any application for reclassification thereof, or 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 an employee, when addressed to the employee at their address as it appears on the records of the Plan Supervisor on the employee's enrollment form and any corrections made to it.

PHOTOCOPIES

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

PLAN ADMINISTRATION

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

PRIVILEGES AS TO DEPENDENTS

The employee shall have the privilege of adding or withdrawing the name or names of any 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

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

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT – THE PLANS 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.

Benefits Conditional Upon Cooperation

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

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

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

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

You and your eligible dependents are also required to:

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

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

- Provide the Plan Administrator all information requested by the Plan Administrator regarding an action against another party, including an insurance carrier; this includes responding to letters from the Plan Supervisor (and other parties designated by Plan Administrator acting on behalf of the Plan) on a timely basis;

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

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

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

Right of Full Restitution

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

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

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

    - Uninsured motorist coverage;

    - Under-insured motorist coverage;

    - Other medical coverage;

    - No fault coverage;

    - Workers' compensation coverage;

    - Personal injury coverage;

    - Homeowner's coverage; or

    - Any other insurance coverage available.

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

Payment Recovery to be Held in Trust

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

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

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

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 Puyallup Health Care Plan 1, you are entitled to certain rights and protections under Plan. All plan participants 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 copies of the latest annual report 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for up to 12 months, (and up to 18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, 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 is frivolous.

Assistance With Your Questions

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

Plan Effective January 1, 2006

Plan Restated and Amended January 1, 2015

Plan Arranged By:

Wells Fargo Insurance Services
Louise Brueske
Two Union Square
601 Union Street, Ste 1300
Seattle, WA 98101

800/876-0505

Claim Administration By:

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

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