LEOFF 1 PLAN

Medical and Prescription Benefits

Effective January 1, 2017

Administered by:

HEALTHCARE MANAGEMENT ADMINISTRATORS

TO OUR VALUED EMPLOYEES

Welcome to the Whatcom County Employee Health Care Plan!

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

With the exception of very large medical claims from which the Plan is protected by insurance, all Plan expenses are directly paid by the Whatcom County Employee Health Care Plan. The major portion of the Plan cost is provided by Whatcom County and is supplemented by the contributions you make to participate. This means that through careful use of the Plan, you, as a consumer of health care, can have a direct impact on the cost of our Plan which will benefit both you and the County by allowing us to continue to provide this high quality level of benefits.

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

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

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

We wish you the best of health.

Whatcom County Employee Health Care Plan

TABLE OF CONTENTS

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

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

This Plan Document and Summary Plan Description, made by Whatcom County (the "County" or the "Plan Sponsor") as of January 1, 2017 hereby **amends and restates** Whatcom County Employee Health Care Plan (the "Plan"), which was originally adopted by the County, effective January 1, 2004.

Effective Date

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

Adoption of the Plan Document

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

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

Whatcom County

By: _____

Name: _____

Date: _____ Title: _____

INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

INTRODUCTION AND PURPOSE

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

The Plan Sponsor's purpose in establishing the Plan is to help offset, for yourself, the economic effects arising from 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 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 drug charges. The Plan Document is maintained by Whatcom County and may be inspected by you at any time during normal working hours.

GENERAL PLAN INFORMATION

NAME OF PLAN	Whatcom County Employee Health Care Plan
NAME & ADDRESS OF EMPLOYER	Whatcom County 311 Grand Avenue, Suite 107 Bellingham, WA 98225 360/676-6802
EMPLOYER IDENTIFICATION NUMBER	91-6001283
TYPE OF PLAN	Employee Health Care Benefits Plan providing Medical and Prescription
TYPE OF PLAN ADMINISTRATION	Contract Administration
ORIGINAL PLAN EFFECTIVE DATE	January 1, 2004
LAST AMENDED DATE	January 1, 2017
PLAN YEAR	January 1 - December 31
PLAN ADMINISTRATOR **PLAN SPONSOR** **NAMED FIDUCIARY** **DESIGNATED LEGAL AGENT**	Whatcom County 311 Grand Avenue, Suite 107 Bellingham, WA 98225 360/676-6802
EMPLOYEES	You will be considered an eligible employee of Whatcom County, when you meet the eligibility requirements described herein.

GROUP NUMBER	020211
CONTRIBUTION REQUIRED	Employee Coverage - Yes
PLAN SUPERVISOR	Healthcare Management Administrators, Inc. PO Box 85008 Bellevue, Washington 98015-5008 425/462-1000 Seattle Area 800/869-7093 All Other Areas
FUNDING MEDIUM	Benefits are paid through general assets.

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

LEGAL ENTITY; SERVICE OF PROCESS

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

NOT A CONTRACT

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

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. The Plan is funded with contributions made by your employer and yourself. This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations.

Whatcom County of Bellingham, WA hereby establishes this Plan for the payment of certain expenses for your benefit to be known as Whatcom County Employee Health Care Plan.

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

The Plan is subject to all the terms, provisions and conditions recited on the 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

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status to non-grandfathered health plan status can be directed to the Plan Administrator at 360/676-6802.

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

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

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

PRE-AUTHORIZATION OF INPATIENT MEDICAL FACILITY ADMISSIONS AND OUTPATIENT SURGERIES

At the time that your doctor recommends surgery or an inpatient admission for you, you or your doctor should contact the HMA Care Management Department to request 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) may be pre-authorized in advance. You may call no later than 5 days prior to the medical facility admission or surgery. Surgeries performed in the doctor's own office do not need to be pre-authorized. Emergency medical facility admissions and emergency surgeries may 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 may be pre-authorized at the time your provider recommends the extended stay.

Additional Services Requiring Pre-Authorization

There are additional services which require pre-authorization in advance by HMA's Care Management Department. The following expenses require pre-authorization:

- Durable Medical Equipment over $2,000.
- Growth Hormone Therapy.

- Home Health Care.
- Hospice Care.
- Infusion Therapy.
- Prosthetics over $2,000.
- Inpatient Rehabilitation Services.
- Kidney Dialysis.
- Skilled Nursing Facility.

Failure to obtain pre-authorization from the HMA Care Management Department prior to the receipt of the above services may result in the denial of your claim and the expenses will not apply towards the out-of-pocket maximum.

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

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

CERTIFICATION OF ADDITIONAL DAYS

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

STEPS TO TAKE

When an inpatient admission or surgery is recommended, you, the physician/provider or a member of your family may call HMA's Care Management Department at least 5 days prior to the admission or surgery to obtain authorization. If an emergency admission or emergency surgery occurs, you or a member of your family should ask the attending physician/provider or the medical facility to contact HMA's Care Management Department within 48 hours of admission or surgery, or by the next business day, if later. Please be prepared to give HMA's Care Management Department the following information when you make the call for authorization:

- Your name and your age.
- Your subscriber identification number.
- Your group number (020211).
- Your medical facility name and address.
- The name and phone number of your admitting physician/provider.
- Your admission date.
- Your diagnosis.
- The procedure being performed.

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

CARE MANAGEMENT/ALTERNATE TREATMENT

In cases where your condition is expected to be or is of a serious nature, care management services from a professional qualified to perform such services may be recommended. The Care Management nurse will

work with you, the Plan Administrator, your physician/provider and other health care providers to help assure that the care you receive is provided in the most appropriate and cost effective manner. The care managers are Registered Nurses who act as 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 you or any other covered Participant.

HOW TO FILE A CLAIM

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

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

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

CONTACT FOR QUESTIONS ABOUT THE PLAN BENEFITS

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

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

SCHEDULE OF BENEFITS

This Plan does not require the designation of a primary care provider or to obtain a referral for services received from a specialist. You shall have the free choice to obtain services from any licensed physician/provider or surgeon, acting within the license's scope.

The level of benefits received is based upon 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. Participating Network charges will be paid at the Participating Network level of benefits. **Charges from providers who are neither Preferred Providers nor Participating Providers are not considered eligible for reimbursement under the Plan.** However, eligible charges for the following benefits will be considered for payment when incurred by Non-Preferred or Non-Participating providers: Ambulance; Blood Bank, Diagnostic X-Ray & Laboratory, Emergency Room Visits, Immunizations, MRI's, or if otherwise eligible services are provided by a non-preferred or non-participating dentist or oral surgeon. Your Preferred Provider Organization is:

If you live in Idaho/Oregon/Utah/Washington:
HMA Preferred Provider Network
800/869-7093
OR
Log in to the myHMA member portal at www.accesshma.com

If you live in any other State or when traveling:
PHCS Network
800/869-7093
OR
Log in to the myHMA member portal at www.accesshma.com

Eligible expenses will be paid at the preferred level when:

- The services are billed by a preferred 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 are traveling and receive emergency services (includes Ambulance, Emergency Room Services, and Urgent Care) inside or outside the network area.
- The services are for Durable Medical Equipment (DME) distributed by a preferred provider but the DME company is non-preferred.
- The services are for non-preferred diagnostic lab, MRI, and x-ray services, where the physician/provider who ordered the services is a preferred provider.

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

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

MEDICAL BENEFITS

	Preferred Network	Participating Network
INDIVIDUAL DEDUCTIBLE Per calendar year.	None	None
INDIVIDUAL OUT-OF-POCKET MAXIMUM Per calendar year.	Not Applicable	Not Applicable

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

	Preferred Network	Participating Network
ALLERGY INJECTIONS/TESTING	100%	100%
AMBULANCE (AIR AND GROUND)	100%	100%
ANESTHESIOLOGIST	100%	100%
ASSISTANT SURGEON Limited to 20% of surgeon's fee.	100%	100%
BLOOD BANK	100%	100%
BREAST PUMPS	100%	100%
CHIROPRACTIC SERVICES AND X-RAYS	100%	100%
DENTAL ACCIDENT	100%	100%
DIAGNOSTIC X-RAY, IMAGING AND LABORATORY	100%	100%
DIETARY EDUCATION	100%	100%
DURABLE MEDICAL EQUIPMENT	100%	100%
EMERGENCY ROOM & SERVICES	100%	100%
GROWTH HORMONE	100%	100%
HEARING BENEFIT Limited to one exam and one pair of hearing aids every 36 months.	100%	100%
HOME HEALTH CARE Limited to 130 visits per calendar year.	100%	100%
HOME PHOTOTHERAPY	100%	100%
HOSPICE CARE Lifetime maximum 6 months. Inpatient care is limited to 14 days. Skilled care limited to 120 hours per three month-period (combined). Respite care (without skilled care) limited to 120 hours per three month-period (combined).	100%	100%
IMMUNIZATIONS	100%	100%
INFUSION THERAPY	100%	100%
INJECTIONS	100%	100%
KIDNEY DIALYSIS (OUTPATIENT SERVICES) **Basic Coverage - Initial Benefit Period**	100%	100%
Supplemental Coverage	100%	100%

	Preferred Network	Participating Network
MEDICAL FACILITY SERVICES **Inpatient**	100%	100%
Outpatient Surgical Facility	100%	100%
Miscellaneous Services	100%	100%
MEDICAL SUPPLIES	100%	100%
MENTAL HEALTH SERVICES **Inpatient**	100%	100%
Outpatient	100%	100%
Applied Behavioral Analysis	100%	100%
NATUROPATHIC SERVICES	Paid the same as any other condition	Paid the same as any other condition
ORTHOTICS	100%	100%
PHENYLKETONURIA (PKU) DIETARY FORMULA	100%	100%
PHYSICIAN SERVICES		
Inpatient Services	100%	100%
Office Visits	100%	100%
PRE-ADMISSION TESTING	100%	100%
PREVENTIVE CARE	100%	100%
PREVENTIVE GYNECOLOGICAL SERVICES	100%	100%
PREVENTIVE MAMMOGRAPHY	100%	100%
PRIVATE DUTY NURSING	100%	80%
PROSTHETICS	100%	100%
RADIATION AND CHEMOTHERAPY	100%	100%
REHABILITATION SERVICES **Inpatient**	100%	100%
Outpatient	100%	100%
SECOND SURGICAL OPINION	100%	100%
SKILLED NURSING FACILITY CARE (Professional, Facility, and Ancillary)	100%	100%
SUBSTANCE USE DISORDER SERVICES **Inpatient**	100%	100%
Outpatient	100%	100%
SURGEON FEES	100%	100%
TEMPOROMANDIBULAR JOINT DISORDER	100%	100%

	Preferred Network	Participating Network
TOBACCO CESSATION Limited to 8 visits per calendar year.	100%	100%
TRANSPLANTS **Transplants**	Paid the same as any other condition	Paid the same as any other condition
Transportation Expenses (Travel, Meals, Lodging) Available only when required to travel more than 30 miles. Limited to $5,000 per transplant.	100%	100%
URGENT CARE FACILITY	100%	100%
WIGS	100%	100%
OTHER MISCELLANEOUS ELIGIBLE CHARGES	100%	100%

Benefit maximums described herein are combined for the Preferred Network and Participating Network.

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

PRESCRIPTION BENEFITS

Express-Scripts - Retail Pharmacies

Generic Drugs	$0 Copay
Brand Name Drugs	
On Formulary Drug List	$0 Copay
Dispensing limit	90 days

Express-Scripts - Mail Order Prescriptions

Generic Drugs	$0 Copay
Brand Name Drugs	
On Formulary Drug List	$0 Copay
Dispensing limit	90 days

This Plan allows you to receive the brand over the generic without a cost penalty.

ELIGIBILITY AND ENROLLMENT PROVISIONS

ELIGIBILITY

Employee Eligibility

You are eligible for coverage under this Plan if:

All Law Enforcement Officers and Fire Fighters hired prior to October 1, 1977 (LEOFF 1) are eligible for coverage under this plan.

Dependent Eligibility

Dependents are ***not*** eligible for coverage under this Plan. Dependents are, however, eligible for coverage under an available alternate Whatcom County Plan.

ENROLLMENT

Regular Enrollment

To apply for coverage under this plan, you must complete and submit an enrollment form within 31 days of the date you first become eligible for coverage. If you do not enroll during the enrollment eligibility period, you will not be eligible to enroll, unless you become eligible for a special enrollment period.

When you acquire an eligible dependent (birth, marriage, adoption etc.), the dependents must be enrolled within 60 days of the date they first become eligible for coverage.

Special Enrollment for Loss of Other Coverage

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

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

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

- If your other group coverage is not COBRA continuation coverage, special enrollment can only be requested after losing eligibility for the other coverage due to a COBRA qualifying event or after cessation of employer contributions for the other coverage. Loss of eligibility of other coverage does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause. You do not have to elect COBRA continuation in order to preserve the right to a special enrollment.
- If your other group coverage is COBRA continuation coverage, the special enrollment can only be requested after exhausting COBRA continuation coverage.

- If you no longer reside, live, or work in the service area and therefore your other individual or group coverage no longer provides benefits to you and in the case of group coverage, no other benefit packages are available.
- If your other plan no longer offers any benefits to your class of similarly situated individuals.

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

Special Enrollment for New Dependents

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

- When you marry, 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 60 day enrollment period, the effective date of coverage will be 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 you, but not formally approved by a court are not acceptable. If the child is enrolled within 60 days of the court or state agency order, the waiting period does not apply.

EFFECTIVE DATE OF COVERAGE

Employee Effective Date

Your effective date of coverage is the first of the month following the waiting period. The waiting period is the period that must pass before coverage for you or your 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 your waiting period.

Coverage Waiting Period: The waiting period is determined by your Collective Bargaining Agreement or Unrepresented Resolution. Please refer to these documents for description of your waiting period. Coverage begins for eligible employees on the earlier of: (1) the first of the month coinciding with the end of the waiting period; or (2) the first of the month following the end of the waiting period.

Dependent Effective Date

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

If you get married, you must add your newly acquired dependents within 60 days of your date of marriage and the effective date of coverage is your date of marriage.

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

In either of the aforementioned instances, the dependents must be enrolled in an applicable Whatcom County plan.

TERMINATION OF COVERAGE

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

Employee

- The date your Employer terminates the Plan and offers no other group health plan.
- The date you cease to meet the eligibility requirements of the Plan.
- The date you fail to make any required contribution when coverage is contributory.
- The first day you fail to return to work following an approved leave of absence.

Dependent(s)

- The date the Employer terminates the Plan and offers no other group health plan.
- 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 last day of the month in which contributions have been made on their behalf.
- The date dependent coverage is discontinued under the Plan.

Coverage will not be terminated retroactively except in the case of your failure to remit premiums or contribution in a timely manner or in the case of fraud or intentional misrepresentation.

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 your Human Resources Department for information on how to qualify for a Family/Medical Leave of Absence.

MILITARY LEAVE OF ABSENCE

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

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

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

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

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

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

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

REINSTATEMENT OF COVERAGE

If you or your dependent, who was covered under this Plan terminates employment or loses eligibility for coverage and is rehired or again becomes eligible for coverage, the eligibility waiting period must be re-satisfied; however, deductibles, out-of-pocket maximums and benefit limitations previously applied/credited, will continue to apply once reinstated.

CHARGES INCURRED BY NON-PREFERRED PROVIDERS

Charges from providers who are neither Preferred Providers nor Participating Providers are not considered eligible for re-imbursement under the Plan, except as described herein.

COMPREHENSIVE MAJOR MEDICAL BENEFITS

ELIGIBLE EXPENSES

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

ALLERGY INJECTIONS/TESTING

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

AMBULANCE (AIR AND GROUND)

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

BLOOD BANK

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

CHIROPRACTIC CARE

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

DENTAL SERVICES

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

- Treatment for accidental injuries to natural teeth 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. Treatment must commence within 30 days from the date of the injury. Injuries caused by biting or chewing are not covered under the medical plan.
- Treatment performed by an oral surgeon to excise and/or biopsy suspected lesions, excised confirmed tumors or malignancies of the oral cavity, tongue, or jaw; whether done in a dental office or hospital.
- Benefits for anesthesia for dental services are covered the same as relevant services listed on your Schedule of Benefits. Services may be prior authorized by the Plan and are only provided for Participants with complicating medical conditions. Examples of these conditions include, but are not limited to:
    - Mental handicaps.

- Physical disabilities.
- A combination of medical conditions or disabilities that cannot be managed safely and efficiently in a dental office.
- Emotionally unstable, uncooperative, combative Participants where treatment is extensive and impossible to accomplish in the office.

All other dental services are excluded.

DIAGNOSTIC X-RAY AND LABORATORY

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

DIETARY EDUCATION

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

DURABLE MEDICAL EQUIPMENT

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

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

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

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

EMERGENCY ROOM & SERVICES

Benefits will be provided for emergency room treatment of an accidental injury or a medical emergency. Benefits are paid at the level shown in the Schedule of Benefits. All eligible services provided in an emergency room (physician/provider services and facility fees) will be covered at the level shown in the Schedule of Benefits. Use of an Emergency room in a non-emergent situation is not covered.

GENDER REASSIGNMENT SERVICES

Medically necessary medical and surgical services for gender reassignment, including related mental health services and prescription drugs, are covered by the Plan. Surgical services may include initial mastectomy/breast reduction, hysterectomy, salpingo-oophorectomy, colpectomy, metoidioplasty, vaginoplasty, colovaginoplasty, orchiectomy, penectomy, clitoroplasty and labiaplasty. Services must be pre-authorized by the Plan Supervisor's Care Management Department. Other than gender reassignment surgeries listed herein, surgery and/or additional treatments to change specific appearance characteristics are considered not medically necessary as treatments of gender dysphoria.

The Plan does not cover any related services which are not medically necessary nor does it cover travel expenses.

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

HEARING BENEFIT - EMPLOYEES ONLY

The Plan will pay as outlined in the Schedule of Benefits for an exam and a hearing aid device. ***This benefit is available to employees only.***

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

Services will be provided for:

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

HOME HEALTH CARE

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

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

The following services will be considered eligible expenses:

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

Exclusions to Home Health Care

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

HOME PHOTOTHERAPY

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

HOSPICE CARE

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

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

- Confinement in a hospice facility or at home.
- Ancillary charges furnished by the hospice while you are confined.
- Medical supplies and drugs prescribed by your attending physician/provider, but only to the extent such items are necessary for pain control and management of the terminal condition.
- Physician/provider services and/or nursing care by a registered nurse, licensed practical nurse, master in social work, or a licensed vocational nurse.
- Home health aide services and home health care.
- Nutritional advice by a registered dietitian, nutritional supplements, such as diet substitutes, administered intravenously or through hyperalimentation.
- Physical therapy, speech therapy, occupational therapy, respiratory therapy.

Limitations to Hospice Care

- Respite care of four or more hours per day in which no skilled care is required will be limited to a combined total of 120 hours per three-month period. Respite care is continuous care of the patient to provide temporary relief to family members or friends from the duties of caring for the patient.
- Visits of four or more hours in which skilled care is required by a registered nurse, licensed practical nurse, or home health aide will be limited to a combined total of 120 hours.
- Any expenses for hospice care that qualify both under this benefit and under any other benefit of this Plan will be covered only under the benefit the Plan Supervisor determines to be the most appropriate.
- If the participant exhausts the above benefit limits, the participant may apply to the Plan Supervisor for an extension of benefits. Limited extensions will be granted by the Plan Supervisor if it determines the treatment to be Medically Necessary.
- When the participant is confined as an inpatient in an approved hospice that is not a Hospital or skilled nursing facility, the same benefits that are available in the participant's home will be available to the participant as an inpatient. In addition, a semi-private room allowance will be provided. This inpatient hospice benefit will be limited to a maximum of 14 (fourteen) days during the six-month benefit period. For services in a Hospital or skilled nursing facility, see the sections that describe those benefits.

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

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

If you require end of life care beyond six months, 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 your family or household.
- Services not included in your approved treatment plan.
- Supportive environmental materials such as handrails, ramps, telephones, air conditioners or similar appliances or devices.
- Hospice bereavement services.

IMMUNIZATIONS

Immunizations for routine use in children, adolescents, and adults if ordered by your physician/provider and are medically necessary or are recommended by the Federal Drug Administration (FDA) or Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) and listed on the Immunization Schedules of the CDC for adults are covered as shown in the Schedule of Benefits. Covered services 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. Your attending physician/provider must submit, and periodically review, a written treatment plan that specifically describes the infusion therapy services and supplies to be provided. The treatment plan must be approved in advance by the Plan Supervisor's Care Management Department. Failure to pre-authorize services may result in the denial of the claim. Drugs and supplies used in conjunction with infusion therapy will be provided only under this benefit.

KIDNEY DIALYSIS (OUTPATIENT SERVICES)

Basic Coverage – Initial Benefit Period

Charges for professional treatment, supplies, medications, labs, and facility fees related to outpatient kidney dialysis are covered services under the Plan for up to the first 42 treatments following the initial dialysis treatment date, upon the completion of which your Basic Coverage (Initial Benefit Period) benefits under this Plan have been exhausted, for the remainder of the current treatment period. A treatment period is defined as the beginning and end of the prescribed dialysis treatment. When kidney dialysis is recommended, you must first contact the Plan Supervisor's Care Management Department to pre-authorize the treatment. Failure to pre-authorize services may result in the denial of the claim. Eligible services during the first 42 treatments received following the initial dialysis treatment will be covered as shown in the Schedule of Benefits (Basic Coverage) and will be paid in accordance with the applicable provider network agreements.

Eligible services include, but are not limited to, hemodialysis, peritoneal dialysis, and hemofiltration. Eligible expenses include the first 42 treatments received, starting from your initial kidney dialysis treatment. Benefits are payable as shown in the Schedule of Benefits.

The Basic Coverage is subject to your annual deductible and coinsurance up to the Out-of-Pocket Maximum amount offered under the Plan for Preferred Network or Participating Network coverage. You may elect to enroll in Medicare coverage as a secondary insurance and the Plan will coordinate benefits as primary payer during the applicable Medicare coordination period, and you will be eligible to have your Medicare Part B premiums reimbursed by the Plan under the Supplemental Coverage benefit outlined below.

The Plan Supervisor's assigned Care Manager will work with you to understand how the benefit works, and assist in setting up Part B premium reimbursements.

At the conclusion of your Initial Benefit Period, you will be covered under the Supplemental Coverage benefit offered as outlined in the Schedule of Benefits.

Supplemental Coverage

For any subsequent kidney dialysis treatment (beyond the Basic Coverage period), the Plan will provide additional supplemental coverage for kidney dialysis treatment and related services for you under the Supplemental Coverage benefit. Charges for professional treatment, supplies, medications, labs, and facility fees related to outpatient kidney dialysis are covered services under this benefit. Eligible services include, but are not limited to, hemodialysis, peritoneal dialysis, and hemofiltration. The Plan's pre-authorization requirements apply.

This Supplemental Coverage benefit for a covered service under this plan provision will be paid in accordance with the applicable provider network agreement for a contracted provider, subject to the annual deductible and coinsurance, up to the Out-of-Pocket Maximum amount offered under this Plan for Preferred Network or Participating Network coverage.

Standard coordination of benefit provisions will apply. In addition, if you have ESRD, you will be eligible to have your Medicare Part B premiums reimbursed by the Plan as an eligible plan expense for the duration of your ESRD treatment as long as you continue to be covered under the Part B coverage and you continue to be eligible for coverage under this Plan (proof of payment of the Part B premium will be required prior to reimbursement). Please contact the Plan Supervisor's Customer Care Department for additional information regarding reimbursement of Medicare premiums.

MATERNITY SERVICES

Benefits for maternity care and services are available to you. 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.

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 you or your 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 your provider obtain authorization from the Plan for prescribing a length of stay for you or your 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 you are under the care of a physician/provider:

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

Outpatient Care

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

Miscellaneous

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

MEDICAL SUPPLIES

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

MENTAL HEALTH 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 you receive on an inpatient or intermediate care basis in a hospital or an alternate facility, and those you receive on an outpatient basis in your provider's office or at an alternate facility. Applied Behavioral Analysis is covered as outlined in the Schedule of Benefits.

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 you are 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 treatment (excluding partial hospitalization/day treatment or intensive outpatient treatment) for Mental Health Services, including neurobiological disorders, are recommended, you or your provider may first contact the Plan Supervisor's Care Management Department to pre-authorize the requested services.

Neurobiological Disorders - Autism Spectrum Disorder Services

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

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

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

ORTHOTICS

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

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

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

OUTPATIENT SURGICAL FACILITY

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

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.

PRE-ADMISSION TESTING

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

PRESCRIPTION DRUGS

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

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

PREVENTIVE CARE

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

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/provider and payable at the Diagnostic, X-Ray and Laboratory Benefit as shown in the Schedule of Benefits.

PROSTHETIC APPLIANCES

Benefits are provided for artificial devices which are medically necessary to replace a missing or defective body part, including (but not limited to) artificial limbs, eyes, breasts, cochlear implant, BAHA, 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 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 your child will be covered. Benefits are not provided for cosmetic prostheses except as stated in the Women's Health and Cancer Rights Act.

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

RADIATION THERAPY AND CHEMOTHERAPY

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

REHABILITATION BENEFIT

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

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

Occupational, physical, respiratory, speech therapy, pulmonary rehabilitation, 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.

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

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

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

Inpatient Treatment

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

- 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/substance use rehabilitative treatment.
- Gym therapy.
- Aquatic or swim therapy.

SECOND SURGICAL OPINION

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

Please note that all non-emergency surgery other than surgery done in your doctor's own office may be pre-authorized by the Plan Supervisor's Care Management 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 your physician/provider, include a treatment plan, and must be pre-authorized by the Care Management Department prior to services being rendered. Failure to pre-authorize services may result in the denial of the claim.

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

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

SUBSTANCE USE DISORDER SERVICES

Substance Use Disorder Services include those received by you on an inpatient or intermediate care basis in a hospital or an alternate facility, and those received on an outpatient basis in your provider's office 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 you are 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 to you 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 or intensive outpatient treatment) is recommended, you or your provider may first contact the Plan Supervisor's Care Management 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, you 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.

TEMPOROMANDIBULAR JOINT DISORDER (TMJ)

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

TOBACCO CESSATION

The services of a provider listed under the definition of physician/provider, operating within the scope of their license, will be covered for a completed tobacco cessation program. Acupuncture for tobacco cessation will be covered under this benefit. Benefits are payable as shown in the Schedule of Benefits.

For medications to aid with nicotine withdrawal, please contact your Pharmacy Benefit Manager for further information.

TRANSPLANTS

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

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

Also remember that pre-authorization is 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.
- Private nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).
- The rental of wheelchairs, hospital-type beds, and mechanical equipment required to treat respiratory impairment.
- Local ambulance services, medications, x-rays and other diagnostic services, laboratory tests, and oxygen.
- Rehabilitative therapy consisting of: speech therapy (not for voice training or lisp), audio therapy, visual therapy, occupational therapy, and physiotherapy. Any of these must be in direct respect to rehabilitation from the covered transplant procedure.
- Surgical dressing and supplies.
- Transportation, lodging, and meals.
- Other services approved by the Plan Supervisor's Care Management Department.

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

No benefits will be provided for the following:

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

GENERAL EXCLUSIONS TO THE MEDICAL PLAN

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

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

Abortion -- Voluntary termination of pregnancy for your dependent children.

Abuse of Substances, Drugs, or Other Medications -- Services, supplies, care or medical treatment for injury or sickness resulting from taking of or being under the influence of any substance, drug, hallucinogen or narcotic not administered on the advice of your physician/provider, except as provided under the Substance Use Disorder Benefit. Expenses will be covered for injured covered Participants, such as yourself, except the person who took or was under the influence of substances, and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the injury resulted from 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.

Acupuncture -- Charges for acupuncture treatment, except as provided under the Tobacco Cessation benefit.

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

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

Alternative Medicine -- Services for acupuncture, acupressure, massage therapy, Rolfing, faith healing services, or reflexology.

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

Biofeedback -- Charges for biofeedback treatment.

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

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

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) (see definition of Approved Clinical Trials) 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, except as excluded herein.
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. If you are receiving benefits for a medically necessary mastectomy and elect breast reconstruction after the mastectomy, you will also receive coverage for:
    - Reconstruction of the breast on which the mastectomy has been performed
    - Surgery and reconstruction of the other breast to produce a symmetrical appearance
    - Prostheses
    - Treatment of physical complications of all stages of mastectomy, including lymphedemas
    - Areola tattooing if performed in your surgeon's office and billed by your surgeon

This coverage will be provided in consultation with your attending physician/provider and yourself, 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 Tobacco Cessation benefits. This includes vocational assistance and outreach; job training such as work hardening programs; tobacco cessation programs; family, marital, sexual, social, lifestyle, nutritional, and fitness counseling; and other services or supplies that are primarily educational in nature other than as defined herein.

Court Ordered -- Services and supplies that are court-ordered or are related to deferred prosecution, deferred or suspended sentencing, or driving rights, if those services are not deemed medically necessary under the Plan.

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

Dental -- Dental services including treatment of the mouth, gums, teeth, mouth tissues, jawbones or attached muscle, orthodontic appliances, dentures and any service generally recognized as dental work. Hospital and physician services rendered in connection with dental procedures are only covered if adequate treatment cannot be rendered without the use of hospital facilities, and if you have a medical condition besides the one requiring dental care that makes hospital care medically necessary. The only exceptions to this exclusion are the services and supplies covered under the Dental Accident Benefit and TMJ Benefit or if treatment is necessary due to a malignant tumor.

Dependents -- Charges for any treatment provided to the dependents of a covered LEOFF I Participant.

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

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

Excess -- Charges 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.

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

Fertility and Infertility -- Charges in association with infertility, and procedures to restore fertility or to induce pregnancy, including but not limited to: corrective or reconstructive surgery; hormone injections; in-vitro fertilization; embryo transfer; artificial insemination, gamma intra-fallopian transfer (G.I.F.T.); fertility drugs (including but not limited to Clomid, Pergonal or Serophene); or any other artificial means of conception. Expenses related to fertility preservation are not covered.

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

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

Hearing Exams and Hearing Aids -- Charges or supplies with regard to routine hearing exams and hearing aids except as provided herein for employees covered under the Plan.

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; medications specific for treatment of sexual dysfunction; penile implants; or impotency drugs whether or not a consequence of illness or injury. This exclusion does not apply to medically necessary hormones.

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

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

Massage Therapy -- Charges for massage therapy treatment.

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

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

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

Mental Health -

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.
    - 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.
    - Voyeurism.
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 you are 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).

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

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

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

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

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

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

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

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

Routine Services -- Services or supplies that are not directly 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. This exclusion does not apply to services and supplies specified under the Preventive Care Benefit, or to routine mammograms.

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

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

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

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

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

Travel Expenses -- Travel, whether or not recommended by your physician/provider, except as provided herein under the Ambulance 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, except as may be provided within the Transplant benefit.
4. Respite care. This exclusion does not apply to respite care that is part of an integrated hospice care program for services provided to a terminally ill person by a licensed hospice care agency for which Benefits are provided as described under Hospice Care Benefits within this Summary Plan Description.

5. Rest cures.
6. Services of personal care attendants.
7. Work hardening (individualized treatment programs designed to return a person to work or to prepare a person for specific work).

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

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

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

Worker's Compensation -- Services covered by or for which you are entitled to benefits under any Worker's Compensation or similar law.

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

PRESCRIPTION DRUG CARD PROGRAMS

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

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

GENERIC SUBSTITUTION

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

BRAND NAME FORMULARY DRUGS

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

Other brand name drugs are any brand name drugs covered through the Express-Scripts Plan, but not listed on the Formulary Drug List.

PAYMENT SCHEDULE

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

This Plan allows you to receive the brand over the generic without a cost penalty.

DRUGS COVERED

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

- Legend Drugs. Exceptions: See Exclusions below.
- Insulin.
- Preventive medications as required by the Patient Protection and Affordable Care Act.
- Any other drug which under the applicable state or federal law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

Note: FDA approval of a drug does not guarantee inclusion as a covered medication under this Prescription Drug Card Program. In addition, coverage for some prescriptions may vary depending

upon the medication's therapeutic classification As a result, some medications may be subject to quantity limits or may require pre-authorization.

If you would like to know more information about the drug coverage policies under this program, or if you have a question or concern about your pharmacy benefit, please contact Express-Scripts at 800/282-2881.

DRUGS EXCLUDED AND LIMITED

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

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

If you would like to know more information about the drug coverage policies under this program, or if you have a question or concern about your pharmacy benefit, please contact Express-Scripts at 800/282-2881.

PRESCRIPTION DRUG PREAUTHORIZATION

There may be certain prescription drugs that need to be pre-authorized prior to dispensing for reasons of treating one or more health conditions (some of these conditions may not be covered by the medical plan such as cosmetic procedures for wrinkles) and to determine if the medication is medically necessary. You can obtain a listing of drugs that require pre-authorization by contacting Express-Scripts at: 800/282-2881 or via the website at: www.expressscripts.com.

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

SPECIALTY PHARMACY

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

injection or otherwise require special handling (specialty medications), are provided by Express-Scripts specialty pharmacies.

To inquire about or begin specialty pharmacy services, please call or have your healthcare provider call Express-Scripts at 800/282-2881. Additional information may be obtained via: www.expressscripts.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 Express-Scripts at 800/282-2881.

RETAIL PRESCRIPTION DRUG PROGRAM

Express-Scripts

Dispensing Limitations

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

Benefit Limitations When Not Using the Drug Card

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

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

Benefits For Employees And Dependents Without A Card

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

Express-Scripts will reimburse eligible claims as if the card had been used (100% reimbursement following the applicable copay).

MAIL ORDER PRESCRIPTION DRUG PROGRAM

Express-Scripts Mail Order Service

When to Use Your Mail Order Prescription Drug Card Program

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

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

Dispensing Limitations

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

Ordering Information

For an existing prescription, provide Express-Scripts Mail Service Pharmacy with the information requested on the initial order form and an Express-Scripts Mail Service Pharmacist will transfer your existing prescription to the Express-Scripts Mail Service Pharmacy.

Have your physician/provider write a prescription for a 90 day supply and send the prescriptions along with a completed Express-Scripts Mail Service form with the information requested on the initial order form and an Express-Scripts Mail Service Pharmacist will transfer your existing prescription to the Express-Scripts mail service program.

Order forms can be obtained from HMA, your Human Resources Department or at the mail order website. Your physician can also phone in prescriptions to save time. Prescriptions can be reordered over the telephone with a credit card by calling 800/282-2881. You may also reorder by using a mail service order form and pay by check or credit card.

Express-Scripts mail order program maintains a quick turnaround time. Orders which do not require a conversation with you or the physician/provider, prior to dispensing, will be received within 7 to 10 days. Prescriptions that require communication with either you or your physician/provider 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.

GENERAL DEFINITIONS

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

ALLOWABLE EXPENSES - Shall mean the 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:

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

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

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

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

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

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

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

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

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

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 you exhibit 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 your health is substantially impaired or endangered or your social or economic function is substantially disrupted.

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

COVERED INDIVIDUAL OR PARTICIPANT - You, when you are an employee who is eligible for benefits under this Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

1. The treatment is governed by the United States Food and Drug Administration ("FDA") or another United States governmental agency and the FDA or the other United States governmental agency has **not** approved the treatment for the particular condition at the time the treatment is provided;
2. The treatment is the subject of ongoing 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 you by the Employer in accordance with Public Law 103-3 for the birth or adoption of your child; placement in your care of a foster child; the serious health condition of your spouse, child or parent; your own disabling serious health condition; your spouse, son, daughter, or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation and this results in a qualifying exigency (as determined by the Secretary of Labor); or you are the spouse, son, daughter, parent, or next of kin of a member of the Armed Forces who suffered a serious injury or illness in the line of duty while on active-duty.

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

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

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

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

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

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

INJURY - See Accident/Accidental Injury.

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

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

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

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

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

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

LIFETIME - While covered under this Plan or any other County 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 yourself.

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

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

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

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

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

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

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

MENTAL 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 your convenience without endangering your life or without causing serious impairment to your bodily functions.

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

1. Medically necessary off-label drug use will be accepted if the drug is otherwise covered by the Plan and if one of the following criteria are met:
    A. Drug Compendia: One of the following drug compendia indicates that the drug is recognized as effective for the indication:
        - The American Hospital Formulary Service Drug Information;
        - Drug Facts and Comparison;
        - The U.S. Pharmacopoeia Dispensing Information;
        - American Medical Association Drug Evaluation;
        - National Cancer Care Network;
        - National Cancer Institute; or
        - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services.

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

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

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

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

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

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

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

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

PARTICIPANT – You, when you are an employee or a former employee and is or may become eligible to receive a benefit under the Plan.

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

PHYSICIAN/PROVIDER - Individuals who are legally qualified and appropriately licensed, and providing service within the lawful scope of practice under the laws of the state in which such services are performed, 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 under the General Plan Information.

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

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

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

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

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 related to similar scenarios; and the cause of injury or illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. 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 have serious consequences 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 resulting 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.

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 you, or any other person related to you through blood, marriage, domestic partnership or adoption.

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

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

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

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

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

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

- It is licensed to provide and is engaged in providing, on an inpatient basis, for you if you are convalescing from injury or disease, professional nursing services rendered by a Registered Graduate Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Graduate Nurse, physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
- Its services are provided for compensation from its patients and patients are under the full-time supervision of a physician/provider or Registered Graduate Nurse (R.N.).
- It provides 24 hours per day nursing services by a licensed nurse, under the direction of a full-time Registered Graduate Nurse (R.N.).
- It maintains a complete medical record on each patient.
- It has an effective utilization review plan.
- It is not, other than incidentally, a place for rest for the aged, drug addicts, alcoholics, the mentally handicapped, custodial, or educational care, or care of mental disorders.

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.

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

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

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 you 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 you or your dependents that are otherwise eligible to enroll under the terms of the Plan can become effective. Periods of employment in an ineligible classification are not part of a waiting period.

GENERAL PROVISIONS

ADMINISTRATION OF THE GROUP MEDICAL PLAN

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

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

AMENDMENT OF PLAN DOCUMENT

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

APPLICATION AND IDENTIFICATION CARD

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

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

ASSIGNMENT OF PAYMENT

The Plan will pay any benefits accruing under this Plan to you unless you 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 you 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

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

In the event of the cancellation of this Plan, or the cancellation of the Participating Group's participation in the Plan, you and your dependents coverage shall cease automatically without notice. You and your

dependents shall not be entitled to further coverage or benefits, whether or not any medical condition was covered by the Plan prior to termination or cancellation.

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

Upon termination of this Plan, or the cancellation of the Participating Group's participation in the Plan, all claims incurred prior to termination, but not submitted to the Plan Supervisor within 75 days of the effective date of termination of this Plan, will be excluded from any benefit consideration.

CLAIMS FOR BENEFITS AND APPEALING A CLAIM

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

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

A call from a provider who wants to know if you are covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a clean claim (a claim which includes all the information necessary to make a decision) must be filed with the Plan (which will be considered a "Post-Service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

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

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

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

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

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

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

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

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

  If the Plan does not require you to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. You simply follow the Plan's procedures with respect to any notice which may be required after receipt of treatment, and file the claim as a post-service claim.
- Post-service Claims. A "post-service claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

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

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

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

Timing of Claim Decisions

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

- Pre-service Urgent Care Claims:
  - If you have provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
  - If you have not provided all of the information needed to process the claim, then you will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
  - You will be notified of a determination of benefits as soon as possible, but not later than 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 you to provide the information.
  - If there is an adverse benefit determination, a request for an expedited appeal may be submitted orally or in writing by you. All necessary information, including the Plan's benefit determination

on review, may be transmitted between you and the Plan by telephone, facsimile, or other similarly expeditious method. Alternatively, you may request an expedited review under the external review process.

- Pre-service Non-urgent Care Claims:
  - If you have provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
  - If you have not provided all of the information needed to process the claim, then you will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. You will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and yourself (if additional information was requested during the extension period).
- Concurrent Claims:
  - Plan Notice of Reduction or Termination. If the Plan Administrator is notifying you of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments, you will be notified sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
  - Request by You Involving Urgent Care. If the Plan Administrator receives a request from you to extend the course of treatment beyond the period of time or number of treatments and the claim is involving urgent care, the claim will be decided as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
  - Request by You Involving Non-urgent Care. If the Plan Administrator receives a request from you to extend the course of treatment beyond the period of time or number of treatments and the claim is not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).
  - Request by You Involving Rescission. With respect to rescissions, the following timetable applies:
    - Notification to You - 30 days
    - Notification of adverse benefit determination on appeal - 30 days
- Post-service Claims:
  - If you have provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then the claim will be decided prior to the end of the 15-day extension period.
  - If you have not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then you will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then you will be notified of the determination by a date agreed to by the Plan Administrator and yourself.
- Extensions - Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.

- Extensions - Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
- Extensions - Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies you, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
- Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

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

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

Appeal of Adverse Benefit Determination

Full and Fair Review of All Claims

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

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

Requirements for First Appeal

You must file the first appeal in writing using an Appeals Submission Form (although oral appeals are permitted for pre-service urgent care claims) within 180 days following receipt of the notice of an adverse benefit determination. If you would like to authorize another individual to act on your behalf in regards to the appeal, an Appointment of Authorized Representative form must be submitted with the appeal. An Appeals Submission Form and an Appointment of Authorized Representative form can be obtained by calling HMA's Customer Care Department at 800/869-7093, or at www.accesshma.com.

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

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

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

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

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

- A completed Appeals Submission Form;
- Your name;
- Your ID number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any facts or theories in the appeal will result in the facts and theories being deemed waived. In other words, you will lose the right to raise factual arguments and theories which support this claim if you fail to include the facts and theories in the appeal;**
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that you have which indicates that you are entitled to benefits under the Plan.

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

Timing of Notification of Benefit Determination on First Review

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

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

- Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim - pre-service urgent, pre-service non-urgent or post-service.
- Post-service Claims: Within a reasonable period of time, but not later than 30 days 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 you 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 you to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- A reference to the specific portion(s) of the plan provisions upon which a denial is based;
- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- A description of any additional information necessary for you to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of your right to bring a civil action following an adverse benefit determination on final review;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon the expert's advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to you, free of charge, upon request;
- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to you, free of charge, upon request; and
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Requirements for Second Appeal

Upon receipt of notice of the Plan's adverse benefit determination regarding the first appeal, you must submit a second appeal in writing using an Appeals Submission Form (although oral appeals are permitted for pre-service urgent care claims) within 180 days. If you would like to authorize another individual to act on your behalf in regards to the second appeal, an Appointment of Authorized Representative form must be submitted with the appeal. An Appeals Submission Form and an Appointment of Authorized Representative form can be obtained by calling HMA's Customer Care Department at 800/869-7093, or at www.accesshma.com.

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

Timing of Notification of Benefit Determination on Second Review

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

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

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

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

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

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

Furnishing Documents in the Event of an Adverse Determination

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

Decision on Review

If, for any reason, you do not receive a written response to the appeal within the appropriate time period set forth above, you may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be

afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted (first level and second level review) before any legal action is brought.**

The decision of the Plan on Second Review is the final level of appeal available to you under the Plan. No further appeal rights are available. You have the right to bring civil action under state law.

CONDITIONS PRECEDENT TO THE PAYMENT OF BENEFITS

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

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

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

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

COORDINATION OF BENEFITS

Definitions

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

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

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

Application

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

1. The plan which does not include a Coordination of Benefits provision will be primary.
2. The plan covering you as a retiree will be secondary for you and any of your enrolled dependents.
3. The plan covering you as the employee (or insured, member, Participant, or subscriber) of the policy will be primary.
4. This Plan will pay secondary to any individual policy.
5. If this Plan is covering you as a COBRA Participant or a Participant of continuation coverage pursuant to state law, this Plan is secondary to your other plan.

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

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

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

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

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

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

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

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

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

         I. The plan covering the custodial parent;

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

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

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

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

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

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

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

Coordination of Benefits with Medicaid

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

CREDIT FOR PRIOR GROUP COVERAGE

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

EFFECT OF TERMINATION OF THE PLAN

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

EVIDENCE BASED MEDICINE

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

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

FACILITY OF PAYMENT

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

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

FIDUCIARY OPERATION

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

FREE CHOICE OF PHYSICIAN

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

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

FUNDING

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

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

All funds received by the Trust and all earnings of the Trust shall be applied toward the payment of claims and reasonable expenses of administration of the Plan except to the extent otherwise provided by the Plan Documents. The Plan Administrator may appoint an investment manager or managers to manage (including the power to acquire and dispose of) any assets of the Plan.

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

HIPAA PRIVACY AND SECURITY

Use and Disclosure of Protected Health Information

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

Plan Sponsor's Certification of Compliance

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

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

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

Protecting Health Information and **Adequate Separation Between the Employer (Plan Sponsor) and the Plan** of this Article.

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

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

Employer (Plan Sponsor) Obligations Regarding Protecting Health Information

The Employer (Plan Sponsor) will:

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

Adequate Separation Between the Employer (Plan Sponsor) and the Plan

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

- A.S. Human Resources Manager.

- A.S. Human Resources Representative.
- A.S. Human Resources Office Coordinator.
- Administrative Services Director.
- Civil Deputy Prosecutor.

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

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

Employer (Plan Sponsor) Obligations Regarding Electronic Protecting Health Information

Employer (Plan Sponsor) will:

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

INADVERTENT ERROR

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

MEDICARE

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

Person - As used in this section means you, if you are eligible for benefits as an employee in an eligible class of this Plan and if you are 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, if you are a retiree or a Participants with End Stage Renal Disease (ESRD), and 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 - If you are an active employee and/or non-working spouse of an active employee age 65 or over: This Plan will be primary and Medicare will be secondary.

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

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

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

The Omnibus Budget Reconciliation Act of 1986 defines a large group health plan as one that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year. A typical business day is defined as 50 percent or more of the employer's regular business days during the previous calendar year.

Disabled Employees with End-Stage Renal Disease (ESRD)

This Plan shall be primary for you if you are an ESRD Medicare beneficiary during the initial 30 months of 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 if you take a course in self-dialysis training during the three month waiting period.

MISREPRESENTATION

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

NOTICE

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

PHOTOCOPIES

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

PLAN ADMINISTRATION

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

PRIVILEGES AS TO DEPENDENTS

You shall have the privilege of adding or withdrawing the name or names of any of your dependent(s) to or from this coverage, as permitted by the Plan, by submitting to the Plan Administrator an application for reclassification on the enrollment form furnished by the Plan Supervisor. Each dependent added to the coverage shall be subject to all conditions and limitations contained in this Plan. Eligible dependents must be enrolled in an applicable Whatcom County 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 PLAN'S RIGHT TO RESTITUTION

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

Benefits Conditional Upon Cooperation

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

- The cooperation of you and your 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 County, 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 800/869-7093 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.

Surrogacy Arrangement or Agreement

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

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

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

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

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

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 Whatcom County Employee Health Care Plan you are entitled to certain rights and protections under Plan. You shall be entitled to:

Receive Information About Your Plan and Benefits

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

Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, and 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.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Assistance With Your Questions

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

Plan Effective January 1, 2004

Plan Restated and Amended January 1, 2017

Plan Arranged By:

Whatcom County
311 Grand Avenue, Suite 107
Bellingham, WA 98225
360/676-6802

Claim Administration By:

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

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