TO OUR VALUED EMPLOYEES

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

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

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

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

If you have any questions regarding either your Plan's benefits or the procedures necessary to receive these benefits, please call the Plan Supervisor - Healthcare Management Administrators, Inc. (HMA) at 425/462-1000. When calling from outside of Seattle, you may call HMA toll free at 800/700-7153.

We wish you the best of health.

City of Renton Employee Health Care Plan

TABLE OF CONTENTS

This booklet is the Summary Plan Description. This booklet and any amendments constitute the plan document for this benefit plan. This Plan is maintained for the exclusive benefit of the employees and each covered individual's rights under this Plan are legally enforceable.

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

Important Information - Please Read

CONTACT FOR QUESTIONS ABOUT THE PLAN BENEFITS

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

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

CLAIMS AND BENEFIT INFORMATION

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

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

When the Utilization Review (UR) Coordinator 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 of the treatment or 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 UR Coordinator whether by telephone or in writing.

HOW TO FILE A CLAIM

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

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

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

CONTINUATION OF COVERAGE PROVISIONS (COBRA)

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

COORDINATION OF BENEFITS

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

DENTAL SCHEDULE OF BENEFITS

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

HMA National Dental Network
800/700-7153 (HMA)
OR
www.accesshma.com

Eligible expenses will be paid at the preferred level when:

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

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

DENTAL BENEFITS

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

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

	Participating & Preferred Network	Out Of Network
TYPE I - PREVENTIVE Oral Exam, Cleaning, X-rays, Fluoride, Sealants. Fluoride treatments are limited to 2 treatments per calendar year for individuals under the age of 19. Sealants are limited to children under the age of 19, for permanent teeth only.	100%	100%

TYPE II - BASIC AND RESTORATIVE Fillings, Oral Surgery, Crowns, Endodontic Treatment, Periodontal Services, Pathology, Anesthesia, Injectables.	100%	100%
TYPE III - MAJOR AND PROSTHETICS Bridgework, Dentures, and their repairs, Relines and Rebases.	50%	50%
TYPE IV* - ORTHODONTIA & TMJ **Orthodontia** Lifetime maximum $1,250.	50%	50%
Temporomandibular Joint Disorder (TMJ) Not covered under dental benefit – see Medical benefit.	**N/A**	

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

VISION SCHEDULE OF BENEFITS

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

HMA Preferred
800/700-7153 (HMA)
OR
www.accesshma.com

Eligible expenses will be paid at the preferred level when:

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

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

VISION BENEFITS

	Participating & Preferred Network	Out Of Network
EXAMINATION, HARDWARE & LASER SURGERY*		
Examination	$25 Copay then 100%	$25 Copay then 100%
Hardware & Laser Surgery	100%	100%

The vision benefit is a separate benefit from the medical benefit, however the copayment does apply to the medical copay maximum.

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

All combined vision benefits are limited to $550 every two calendar years.

ELIGIBILITY AND ENROLLMENT PROVISIONS

ELIGIBILITY

Employee Eligibility

An employee is defined as an individual who is: (1) directly involved in the regular business of and compensated for services by the City of Renton; (2) regularly scheduled to work at least the minimum number of hours, as indicated below, on an active, full-time basis; or (3) other individuals listed below who are eligible for coverage.

Employees eligible for coverage under this plan are:

All active full-time and part-time employees of City of Renton who are regularly scheduled to work 20 hours or more per week are eligible for coverage under this Plan.

Active regular employees are entitled to coverage on a pro-rated basis depending on their scheduled weekly hours of work in accordance with the following accrual rate ratio:

- 20 but less than 25 hours - 50%;
- 25 but less than 30 hours - 62.5%;
- 30 but less than 35 hours - 75%;
- 35 hours or more - 100%

Regular full-time employees and their dependents are eligible for full coverage. Regular part-time employees covered by the City of Renton Employee Health Care Plan as of 12/31/92 are eligible to receive either full medical or dental benefits for themselves only.

Effective 1/1/93, regular part-time employees scheduled to work 20 hours or more per week are entitled to purchase medical/dental benefits for themselves by paying a pro-rated percent of the premium based on the above accrual rate ratio, per City policy.

Ineligible classes of employees are: (1) regular part-time employees normally scheduled to work less than 20 hours per week; and (2) temporary/non-regular employees, per City policy.

Dependent Eligibility

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

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

Dependents eligible for coverage under this plan are:

- An employee's legally married spouse. Coverage may continue during a legal separation only if ordered by a court decree.

- An employee's married or unmarried child, under the age of 26, regardless of whether or not the child is eligible for employer sponsored coverage through their own employer, whether or not a full-time student, whether or not claimed as a dependent on the employee's federal income taxes, and whether or not dependent upon the employee for support.

  A special enrollment period will be held from November 1, 2010 through November 30, 2010 to allow dependent children whose coverage previously ended or were not previously eligible for coverage due to the attainment of age, to now enroll for coverage under the Plan. The dependent (and covered employee) will be eligible to enroll in any benefit package available to other similarly situated individuals. Coverage for eligible dependents that are enrolled during this special enrollment period, will become effective January 1, 2011.

- An employee's unmarried dependent child(ren) who is incapable of self-support because of mental retardation, mental illness, or physical incapacity that began prior to the date on which the child's eligibility would have terminated due to age. Proof of incapacity must be received within 120 days after the date on which the maximum age is attained. Subsequent evidence of disability or dependency may be required as often as is reasonably needed to verify continued eligibility for benefits.

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

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

- Any individual who is covered as an employee cannot also be covered as a dependent. No dependent can be covered as a dependent of more than one employee.

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

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

  1) When you enroll as a new employee;

  2) When the State-Registered Domestic Partner loses coverage under his/her group health plan; and

  3) During open enrollment.

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

  Coverage is available to the children of a State-Registered Domestic Partner provided that the child meets the eligibility requirements for dependent children provided herein.

Coverage for your State-Registered Domestic Partner shall terminate upon a change in circumstances/qualifications as outlined above. You must provide written notice to the City's Human Resources & Risk Management Department if there is any change of circumstances which does not meet the eligibility requirements as outlined above, within 30 days of the change by filing a "Statement of Termination of Domestic Partnership".

After such termination, an application to add a new State-Registered Domestic Partner cannot be filed earlier than six months from the filing of a "Statement of Termination of Domestic Partnership" form with the Human Resources & Risk Management Department.

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

ENROLLMENT

Regular Enrollment

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

When the employee acquires an eligible dependent (birth, marriage, adoption etc.), the dependents must be enrolled within the enrollment eligibility periods specified below:

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

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

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

Late Enrollment

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

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

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

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

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

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

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

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

Special Enrollment for Loss of Other Coverage

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

- The employee or dependent is eligible for coverage under the terms of the Plan, but not enrolled.

- Enrollment in the Plan was previously offered to the employee.

- The employee declines the coverage under the Plan because, at the time, the employee and/or dependent was covered by another group health plan or other health insurance coverage.

- The employee has declared in writing that the reason for the declination was the other coverage.

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

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

- If the other group coverage is COBRA continuation coverage, the special enrollment can only be requested after exhausting COBRA continuation coverage.

- If the other individual or group coverage does not provide benefits to individuals who no longer reside, live, or work in a service area, and in the case of group coverage, no other benefit packages are available.

- If the other plan no longer offers any benefits to the class of similarly situated individuals.

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

Special Enrollment for New Dependents

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

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

Section 609(a) of ERISA requires medical benefit plans to honor the terms of a Qualified Medical Child Support Order (QMCSO). The order must be issued as a part of a judgment, order of decree or a divorce settlement agreement related to child support, alimony, or the division of marital property, issued pursuant to state law. Agreements made by the parties, but not formally approved by a court are not acceptable. If the child is enrolled within 60 days of the court or state agency order, the waiting period does not apply.

Open Enrollment

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

EFFECTIVE DATE OF COVERAGE

Employee Effective Date

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

Dependent Effective Date

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

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

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

TERMINATION OF COVERAGE

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

Termination of Coverage

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

Employee

- The date the City terminates the Plan and offers no other group health plan.
- The date the employee ceases to meet the eligibility requirements of the Plan.
- The last day of the month in which the employee's employment ends.
- The date the employee begins active service in the armed forces.
- The date the employee fails to make any required contribution when coverage is contributory.
- The first day an employee fails to return to work following an approved leave of absence.
- The last day of the month in which the employee retires.

Dependent(s)

- The date the City 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 date the dependent becomes eligible as an employee.
- The last day of the month in which contributions have been made on their behalf.
- The date the dependent becomes an active, full-time member of the armed forces of any country.
- The date the Plan discontinues dependent coverage.

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

APPROVED FAMILY AND MEDICAL LEAVE

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

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

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

If you are granted an approved leave of absence (other than medical/ family leave of absence) you and your covered dependents will be eligible to continue coverage for up to 30 days from the last day of the month in which the employees' employment ends. If your leave extends more than 30 days you will be eligible to continue coverage under the Continuation of Coverage (COBRA) Provisions of the Plan.

There will be no lapse in coverage for employees and dependents that have continued coverage while on the approved leave of absence. If the employee or dependents did not continue coverage while on the leave of absence, then coverage will be reinstated on the day they return to active status.

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

MILITARY LEAVE OF ABSENCE

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

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

a. For elections made before December 10, 2004, the 18 month period beginning on the date that Uniformed Service leave commences; or

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

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

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

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

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

REINSTATEMENT OF COVERAGE

If an employee or dependent who was covered under this Plan terminates employment or loses eligibility for coverage and is rehired or again becomes eligible for coverage within three months of the date of termination, the waiting period will be waived. Credit will be given towards the deductible and out-of-pocket maximum if reinstated within three months. An employee will be eligible for reinstatement of coverage on the date he/she returns to work. A dependent will be eligible for reinstatement of coverage the first of the month from the date the application was received. Individuals not reinstated on the Plan within three months and not continuously covered under the COBRA Continuation of Coverage of this Plan will be treated as a new hire.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

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

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

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

In general, COBRA requires that a "qualified beneficiary" covered under the Employer's group health plan who experiences a "qualifying event" be allowed to elect to continue that health coverage for a period of time. ***Qualified beneficiaries are employees and dependents who were covered by the Plan on the day before the qualifying event occurred.*** Coverage is elected on the election form provided by the Plan Administrator. Both employees and dependents should take the time to read the Continuation of Coverage Rights provisions.

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

The Plan Administrator is:

The City of Renton
1055 South Grady Way
Renton, Washington 98057
425.430.7659

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

HMA, Inc.
Attn: COBRA Unit
P.O. Box 85016
Bellevue, Washington 98015-5016
800.869.7093

HMA, Inc.
Attn: COBRA Unit
220 120th Avenue NE, Building D
Bellevue, Washington 98005
800.869.7093

WHAT IS COBRA COVERAGE?

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

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

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

COBRA coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the component or components of the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect
COBRA must pay for COBRA coverage.

Additional information about the Medical, Prescription, Dental, Vision, and Health FSA components of the Plan is available in other portions of this SPD.

COBRA COVERAGE UNDER THE HEALTH FSA COMPONENT

COBRA coverage under the Health FSA will be offered only to qualified beneficiaries losing coverage who have underspent accounts. A qualified beneficiary has an underspent account if the annual limit elected by the covered employee, reduced by reimbursements up to the time of the qualifying event, is equal to or more than the amount of the premiums for Health FSA COBRA coverage that will be charged for the remainder of the plan year.

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

Unless otherwise elected, all qualified beneficiaries who were covered under the Health FSA will be covered together for Health FSA COBRA coverage. However, each beneficiary has separate election rights, and each could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate Health FSA annual limit and a separate premium. If you are interested in this alternative, contact the Plan Administrator for more information.

Qualified beneficiaries may not enroll in the Health FSA at open enrollment.

WHO IS ENTITLED TO ELECT COBRA?

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

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

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

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

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

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

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

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

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

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

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

ELECTING COBRA COVERAGE

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

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

HMA, Inc.
Attn: COBRA Unit
P.O. Box 85016
Bellevue, Washington 98015-5016
800.869.7093

HMA, Inc.
Attn: COBRA Unit
220 120th Avenue NE, Building D
Bellevue, Washington 98005
800.869.7093

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

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

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

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

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

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

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

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

SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

LENGTH OF COBRA COVERAGE

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

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

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

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

MAXIMUM COVERAGE PERIOD FOR HEALTH FSA COMPONENT

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

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

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

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

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

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

You must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

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

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

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

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

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

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

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

- any required premium is not paid in full on time;
- a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied);
- a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA;
- the employer ceases to provide any group health plan for its employees; or

- during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period (Not Applicable to Health FSA Component)."

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

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

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

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

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

COST OF COBRA COVERAGE

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

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

PAYMENT FOR COBRA COVERAGE

All COBRA premiums must be paid by check.

Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to:

HMA, Inc.
Attn: COBRA Unit
P.O. Box 85016
Bellevue, Washington 98015-5016
800.869.7093

HMA, Inc.
Attn: COBRA Unit
220 120th Avenue NE, Building D
Bellevue, Washington 98005
800.869.7093

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

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) See the section above entitled “Electing COBRA Coverage.”

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

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

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

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

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if you pay a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

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

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

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

The City of Renton
1055 South Grady Way
Renton, Washington 98057
425.430.7659

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

NOTICE PROCEDURES

City of Renton Employee Health Care Plan (the Plan)

NOTICE PROCEDURES FOR NOTICE OF QUALIFYING EVENT

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

You must mail or hand deliver this notice to:

The City of Renton
1055 South Grady Way
Renton, Washington 98057
425.430.7659

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

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

Your notice must contain the following information:

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

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

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

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

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

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

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

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

NOTICE PROCEDURES FOR NOTICE OF DISABILITY

The deadline for providing this notice is 60 days after the latest of (1) the date of the Social Security Administration's disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; and (3) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours. Your Notice of Disability must also be provided within 18 months after the covered employee's termination of employment or reduction of hours.
You must mail or hand deliver this notice to:

The City of Renton
1055 South Grady Way
Renton, Washington 98057
425.430.7659

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

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

Your notice must contain the following information:

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

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

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

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

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

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

NOTICE PROCEDURES FOR NOTICE OF SECOND QUALIFYING EVENT

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

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

HMA, Inc.
Attn: COBRA Unit
P.O. Box 85016
Bellevue, Washington 98015-5016
800.869.7093

HMA, Inc.
Attn: COBRA Unit
220 120th Avenue NE, Building D
Bellevue, Washington 98005
800.869.7093

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

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

Your notice must contain the following information:

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

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

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

- the notice is mailed or hand-delivered to the individual and address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, the COBRA Administrator is able to determine that the notice relates to the Plan;
- from the written notice provided, the COBRA Administrator is able to identify the covered employee and qualified beneficiary(ies), the first qualifying event (the covered employee's termination of employment or reduction of hours), the date on which the first qualifying event occurred, the second qualifying event, and the date on which the second qualifying event occurred; and

- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Second Qualifying Event) within 15 business days after a written or oral request from the COBRA Administrator for more information (or, if later, by the deadline for this Notice of Second Qualifying Event described above).

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

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

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

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

NOTICE PROCEDURES FOR NOTICE OF OTHER COVERAGE, MEDICARE ENTITLEMENT, OR CESSATION OF DISABILITY

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

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

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

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

HMA, Inc.
Attn: COBRA Unit
P.O. Box 85016
Bellevue, Washington 98015-5016
800.869.7093

HMA, Inc.
Attn: COBRA Unit
220 120th Avenue NE, Building D
Bellevue, Washington 98005
800.869.7093

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

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

Your notice should contain the following information:

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

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

If you are providing a Notice of Medicare Entitlement, your notice should include the name and address of the qualified beneficiary who became entitled to Medicare, the date that Medicare entitlement occurred, and a copy of the Medicare card showing the date of Medicare entitlement. If you are providing a Notice of Cessation of Disability, your notice must include the name and address of the disabled qualified beneficiary, the date of the Social Security Administration's determination that he or she is no longer disabled, and a copy of the Social Security Administration's determination.

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

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

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

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

DENTAL BENEFITS

For participants covered under this section, the Plan will pay the dental benefits listed herein. Benefits are subject to the limitations shown in the Schedule of Benefits in addition to limitations shown in this section.

OPTIONAL PREDETERMINATION OF BENEFITS

Before beginning a course of treatment for which dentist's charges are expected to be $300 or more, you are encouraged to send a description of the proposed course of treatment and charges to the Plan Supervisor. This information may be transmitted on a standard dental claim form available from the dentist. The Plan Supervisor will then determine the estimated benefits payable for the proposed treatment and advise the participant and the dentist before treatment begins.

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

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

DESCRIPTION OF BENEFITS

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

CALENDAR YEAR MAXIMUM

Dental benefits are payable at the level indicated in the Schedule of Benefits. Dental benefits are payable at the amount indicated in the Schedule of Benefits up to a maximum of $1,600 per covered individual per calendar year. Orthodontia has a separate lifetime maximum benefit of $1,250 per covered individual. TMJ is covered under the Medical Benefit.

COVERED DENTAL EXPENSES

The Plan pays for Type I, II, and III covered charges at the rate stated in the Schedule of Benefits up to the calendar year maximum. All charges must be incurred while the covered individual is insured. Type IV charges are paid at the rate stated in the Schedule of Benefits with Orthodontia up to the lifetime maximum benefit of $1,250. TMJ is covered under the Medical Benefit.

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

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

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

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

ALTERNATE TREATMENT

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

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

TYPE I - PREVENTIVE

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

Visits and X-Rays

- Preventive oral examinations during regular business hours limited to two treatments per calendar year.

- Prophylaxis (preventive teeth cleaning) limited to two treatments per calendar year.
- Topical application of fluoride limited to two treatments per calendar year to age 19.
- Night guards limited once every three calendar years.
- Dental x-rays:
  - Full mouth series limited to once in any 36 consecutive month period.
  - Charges for bitewing x-rays are covered twice per calendar year.
- Sealants will be covered for children under age 19, on permanent teeth to prevent crevice decay.
- Space maintainers limited to initial appliance only. Allowance includes all adjustments in the first six months after installation: fixed, unilateral, band or stainless steel crown type or removal bilateral type.
- Palliative (alleviation of pain) emergency treatment.

TYPE II - BASIC AND RESTORATIVE

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

- Fillings of silver amalgam, silicate, and plastic restoration; including plastic or stainless steel crowns.
- Extractions (removal of teeth).
- Endodontics (treatment of disease of the tooth pulp) including pulpotomy, pulp capping and root canal treatment.
- Oral surgery, including surgical extractions and general anesthetic (when necessary).
- Apicoectomy (including retrograde filling).
- Periodontic services (treatment of the supporting tooth structures) and appliances.
- Crowns and crown build up.
- Post and core.
- Inlays and onlays.
- Occlusal adjustments.

TYPE III - MAJOR AND PROSTHETICS

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

- Bridges, fixed and removable.
- Dentures, full and partial.
- Denture tissue conditioning.
- Relining of present dentures, but only if they were installed more than six (6) months earlier and if they have not been relined during the past twelve (12) months.
- Rebasing of present dentures, but only if they were installed more than six (6) months earlier and if they have not been rebased during the past thirty-six (36) months.
- Charges for denture adjustment - once per twelve (12) consecutive months - only if done more than six (6) months after the initial insertion of the denture.
- Implants (not to exceed the amount that would have been allowed) for fixed bridgework or dentures to restore the missing teeth.

PROSTHESIS REPLACEMENT RULE

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

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

TYPE IV – ORTHODONTIA

Orthodontia

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

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

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

Covered expenses include the following:

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

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

EXCLUSIONS AND LIMITATIONS TO THE DENTAL PLAN

This section of your booklet explains circumstances in which all the dental benefits of this Plan are limited or in which no benefits are provided. Benefits may also be affected by your eligibility and expenses are subject to all Plan conditions, exclusions, and limitations, including medical necessity. In addition, some benefits have their own limitations.
In addition to the specific limitations stated elsewhere in this booklet, the Plan will not provide benefits for:

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

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

Congenital Malformation -- Charges for congenital malformation.

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

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

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

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

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

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

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

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

Nitrous oxide -- Charges for Nitrous oxide.

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

Oral Hygiene Instruction – Charges related to oral hygiene instruction.

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

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

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

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

Provisional Splinting – Charges for provisional splinting.

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

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

1. An appliance, or modification of an appliance, for which an impression was made before such person became covered.

2. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered.

3. Root canal therapy, for which the pulp chamber was opened before such person became covered.

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

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

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

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

VISION BENEFITS

Vision benefits are available to all covered employees and dependents. Vision benefits include routine eye examination and vision hardware. Vision benefits, after applicable co-pays, are payable at 100% up to a maximum of $550 every two calendar years for exam and vision hardware. The office visit co-pays will apply to the routine eye examination. This benefit is not subject to the deductible.

The benefit works as follows: The benefit is based upon a 24-month period within a calendar year beginning in January and ending in December regardless of the month enrollee is hired. Benefits are determined based upon the year an employee is eligible for benefits. For example, if the employee is hired in or before 1994, their benefit years would be 1994/1995, 1996/1997, and so on. If the employee was hired in 1995, their benefit years would be 1995 and 1996, 1997/1998, and so on. If they did not use the benefit in the two calendar year period, they would lose it and would start over again with a new $550 benefit in their next benefit period.

As the example above shows, the calculation of the two calendar year benefit is determined by the year you and/or your eligible dependents first entered the vision insurance plan. A full or partial benefit year will be considered as the first calendar year in the two calendar year period.

COVERED SERVICES

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

An eye examination must be completed by an optometrist or ophthalmologist.

Covered vision hardware includes:

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

VISION BENEFITS AFTER TERMINATION OF COVERAGE

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

EXCLUSIONS TO THE VISION PLAN

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

Charges for special procedures, such as orthoptics or vision training, or for special supplies, such as non prescription sunglasses and subnormal vision aids.

Drugs or medications of any kind.

Charges for services or supplies which are received while the participant is not covered.

Charges for any vision care services or supplies which are included as covered expenses under any other benefit section included in this Plan, or under any other medical or vision care expense benefit plan carried or sponsored by the City, whether benefits are payable as to all or only part of the charges.

Charges for vision care services or supplies for which benefits are provided under any worker's compensation law or any other law of similar purpose, whether benefits are payable as to all or only part of the charges.

Charges for any eye examination required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement, or which is required by any law or government.

GENERAL DEFINITIONS

ACCIDENT/ACCIDENTAL INJURY - Shall mean a personal bodily injury to the employee or dependent effected solely through external violent and unintentional means. All injuries sustained in connection with one accident will be considered one Accidental Injury. Accidental Injury does not include ptomaine poisoning, disease, or infection (except pyogenic infection occurring through an accidental cut or wound).

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

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

CITY OF RENTON - The Plan Administrator.

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

CONTRIBUTORY - The employee is required to pay a portion of the cost to be eligible to participate in the Plan.

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

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

DENTAL HYGIENIST - A person who is licensed to practice dental hygiene and who is practicing within the scope of their license.

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

DENTIST - A doctor of dentistry and/or doctor of dental surgery practicing within licensed authority, or a legally qualified Physician authorized by license to perform the particular dental service rendered.

DENTURIST - A person who is licensed to make, fit and repair dentures and who is practicing within the scope of their license.

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

DISABILITY - See Total Disability.

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

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

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

ENROLLMENT DATE - The enrollment date is the first day of coverage or, if there is a waiting period for coverage to begin under the Plan, the first day of the waiting period. The term “waiting period” refers to the period after employment starts and the first day of coverage under the Plan. For a person who is a late enrollee or who enrolls on a special enrollment date, the “enrollment date” will be the first date of actual coverage. If an individual receiving benefits under a group health plan changes benefit packages, or if the Plan changes group health insurance issuers, the individual’s enrollment date does not change.

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

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

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

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

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

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

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

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

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

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

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

INJURY - The term injury shall mean only bodily injury caused by an accident while the Plan is in force as to the participant whose injury is the basis of the claim. Injury shall mean only those injuries which require treatment by a physician.

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

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

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

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

- Consistent with the symptoms or diagnosis and treatment of the participant's condition.
- Appropriate with regard to standards of good medical practice.
- Not solely for the convenience of the participant, family members or a provider of services or supplies.

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

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

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

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

PARTICIPANT – Any employee or former employee who is or may become eligible to receive a benefit under the Plan.

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

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

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

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

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

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

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

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.

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

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

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

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

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

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

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

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

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

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

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

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

TREATMENT - Any service or supply used to evaluate, diagnose, or remedy a condition of a participant or their covered dependents.

UTILIZATION REVIEW COORDINATOR - 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.

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

ADMINISTRATION OF THE GROUP DENTAL AND VISION PLAN

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

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

AMENDMENT OF PLAN DOCUMENT

The Plan Administrator may terminate, modify, or amend the Plan in its sole discretion without prior notice. The Plan Administrator must notify the Plan Supervisor in writing requesting an amendment to the Plan. The Plan Supervisor will prepare an amendment to be signed by the Plan Administrator. Once the Plan Administrator has signed the amendment, such termination, amendment or modification which affects covered employees and their dependents will be communicated to the employees in the manner of a new Plan document or City of Renton 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 either a Plan year, calendar year or lifetime basis.

APPLICABLE LAW

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

APPLICATION AND IDENTIFICATION CARD

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

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

ASSIGNMENT OF PAYMENT

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

AUDIT AND CASE MANAGEMENT FEES

Reasonable charges made by an audit and/or case management firm when the services are requested by the Plan Supervisor and approved by the Plan Administrator shall be payable.

AUDIT INCENTIVES

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

CANCELLATION

An employee may cancel their coverage by giving written notice to the Plan Administrator who will notify the Plan Supervisor.

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

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

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

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

CLAIMS FOR BENEFITS AND APPEALING A CLAIM

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

When Health Claims Must Be Filed

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

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

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

Timing of Claim Decisions

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

- Pre-service Urgent Care Claims:

  - If the participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.

- If the participant has not provided all of the information needed to process the claim, then the participant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.

- The participant will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:

  - The Plan's receipt of the specified information; or

  - The end of the period afforded the participant to provide the information.

- If there is an adverse benefit determination, a request for an expedited appeal may be submitted orally or in writing by the participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the participant may request an expedited review under the external review process.

- Pre-service Non-urgent Care Claims:

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

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

- Concurrent Claims:

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

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

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

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

  - Notification to Participant - 30 days

  - Notification of adverse benefit determination on appeal - 30 days

- Post-service Claims:

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

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

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

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

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

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

Notification of an Adverse Benefit Determination

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

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

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

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

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

- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the participant's right to bring a civil action under State laws or section 502(a) of ERISA, as applicable, following an adverse benefit determination on final review;

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

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

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

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

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

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

Appeal of Adverse Benefit Determination

Full and Fair Review of All Claims

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

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

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

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

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

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

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

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

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

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

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

Requirements for First Appeal

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

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

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

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

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

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

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

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

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

Timing of Notification of Benefit Determination on First Review

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

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

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

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

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

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

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

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

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

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

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

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

- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the participant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final review;

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

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

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

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

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

Requirements for Second Appeal

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

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

Timing of Notification of Benefit Determination on Second Review

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

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

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

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

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

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

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

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

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

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

Furnishing Documents in the Event of an Adverse Determination

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

Decision on Review

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

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

CONDITIONS PRECEDENT TO THE PAYMENT OF BENEFITS

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

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

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

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

COORDINATION OF BENEFITS

Definitions

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

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

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

Application

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

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

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

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

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

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

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

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

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

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

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

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

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

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

I. The plan covering the custodial parent;

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

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

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

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

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

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

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

Coordination of Benefits with Medicaid

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

EFFECT OF TERMINATION OF THE PLAN

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

FACILITY OF PAYMENT

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

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

FIDUCIARY OPERATION

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

FREE CHOICE OF DENTIST

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

Nothing contained herein shall confer upon an employee or dependent any claim, right, or cause of action, either at law or in equity, against the Plan for the acts of any medical facility in which he/she receives care, for the acts of any dentist from whom he/she receives service under this Plan, or for the acts of the Utilization Review Coordinator in performing their duties under this Plan.

FUNDING

If contributions are required of employees or 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 Groups 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 (Effective April 14, 2004)

Use and Disclosure of Protected Health Information

Under the HIPAA privacy rules **effective April 14, 2004**, the Plan Sponsor must establish the permitted and required uses of Protected Health Information (PHI).

Plan Sponsor's Certification of Compliance

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

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

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

Obligations Regarding Protecting Health Information and **Adequate Separation Between the City of Renton (Plan Sponsor) and the Plan** of this Article.

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

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

Employer (Plan Sponsor) Obligations Regarding Protecting Health Information

The City of Renton (Plan Sponsor) will:

- Neither use nor further disclose Plan Enrollees' Protected Health Information, except as permitted or required by the Plan Documents, as amended, or required by law.

- Ensure that any agent, including any subcontractor, to whom it provides Plan Enrollees' Protected Health Information, agrees to the restrictions and conditions of the Plan Documents, including this Article, with respect to Plan Enrollees' Protected Health Information.

- Not use or disclose Plan Enrollees' Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the City of Renton (Plan Sponsor).

- Report to the Plan any use or disclosure of Plan Enrollees' Protected Health Information that is inconsistent with the uses and disclosures allowed under this Article promptly upon learning of such inconsistent use or disclosure.

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

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

- Track disclosures it may make of Plan Enrollees' Protected Health Information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.

- Make available its internal practices, books, and records, relating to its use and disclosure of Plan Enrollees' Protected Health Information, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.

- If feasible, return or destroy all Plan Enrollee Protected Health Information, in whatever form or medium (including in any electronic medium under the City's (Plan Sponsor's) custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Enrollee who is the subject of the Protected Health Information, when the Plan Enrollees' Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan Enrollee Protected Health Information, the City of Renton (Plan Sponsor) will limit the use or disclosure of any Plan Enrollee Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

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

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

- ***Human Resources and Risk Management Administrator****;*
- ***The City of Renton Employees' Health Plan Board of Trustees;***
- ***Manager, Supervisor and Benefit Specialists of Human Resources and Risk Management****; and*
- ***Financial Officer.***

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

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

Employer (Plan Sponsor) Obligations Regarding Electronic Protecting Health Information

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

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

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

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

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

INADVERTENT ERROR

Inadvertent error by the Plan Administrator in the keeping of records or in the transmission of employee's applications shall not deprive any employee or dependent of benefits otherwise due, provided that such inadvertent error be corrected by the Plan Administrator within ninety (90) days after it was made.

MEDICARE

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

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

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

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

Total benefits of this Plan shall be determined as follows:

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

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

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

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

Coordination - The regular Coordination of Benefits of this Plan when Medicare is the primary payer and this Plan is the secondary payer as described under the Coordination of Benefits section. This Plan's benefits are determined by calculating the amount, which would have been paid by this Plan in the absence of Medicare, then, reducing that by the amount paid by Medicare. In no event will not more than 100% of the total allowable expenses be paid between this Plan and Medicare, nor will the total payment by this Plan exceed the amount that this Plan would have paid as the Primary Plan. The difference between the amount this Plan would have paid as primary and the amount this Plan actually paid as secondary will accrue as a credit reserve for the remainder of the calendar year. The credit reserve is available, in an amount not to exceed that, which would have been paid by this Plan as primary, to pay for expenses subsequently incurred which this Plan or Medicare may not pay in full.

MISREPRESENTATION

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

NOTICE

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

PHOTOCOPIES

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

PLAN ADMINISTRATION

The Plan Administrator shall be responsible for all compliance with applicable State and Federal Laws.

PLAN IS NOT A CONTRACT OF EMPLOYMENT

The Plan shall not be deemed to constitute a contract of employment between the Plan Administrator or Participating Company and any employee or to be a consideration for, or an inducement to or condition of the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Plan Administrator or Participating Company or to interfere with the right of the Plan Administrator or Participating Company to discharge any employee at any time; provided however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the Plan Administrator or Participating Company with the bargaining representative of any employees.

PLAN SUPERVISOR NOT A FIDUCIARY

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

PRIVILEGES AS TO DEPENDENTS

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

RIGHT OF RECOVERY

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

It is the employee’s responsibility to notify the Plan Administrator or the Plan Supervisor of any payments received or changes in the actual amount of the services rendered.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT – THE PLANS RIGHT TO RESTITUTION

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

Benefits Conditional Upon Cooperation

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

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

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

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

You and your eligible Dependents are also required to:

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

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

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

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

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

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

Right of Full Restitution

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

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

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

    - Uninsured motorist coverage;

    - Under-insured motorist coverage;

    - Other medical coverage;

    - No fault coverage;

    - Workers' compensation coverage;

    - Personal injury coverage;

    - Homeowner's coverage; or

    - Any other insurance coverage available.

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

Payment Recovery to be Held in Trust

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

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

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

SUMMARY PLAN DESCRIPTION

This document is the Summary Plan Description.

SPECIAL DISCLOSURE INFORMATION
PARTICIPANTS RIGHTS

The Plan Administrator requires that you be provided with the statement below and with the following list of information:

Statement of Rights Under the Plan

1. As an employee in this Plan, you are entitled to certain rights and protections under the Plan. The Plan provides that all plan employees shall be entitled to:

   A. Examine, without charge, at the Plan Administrator's office and at other locations (work sites and union halls), plan documents, including insurance contracts; collective bargaining agreements and copies of Plan documents, such as annual reports and plan descriptions.

   B. Obtain copies of all plan documents and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

   C. Continue Group Health Plan Coverage:
      i. 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 federal continuation coverage rights.

      ii. reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect federal continuation coverage, when your federal continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for up to 12 months (and up to 18 months for late enrollees) after your enrollment date in your coverage.

   D. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each employee with a copy of this summary financial report.

2. In addition to creating rights for plan employees, the Plan imposes obligations upon the persons who are responsible for the operation of the benefit plan.

3. These persons are referred to as fiduciaries of the Plan. Fiduciaries must act solely in the interest of the plan employees and they must exercise prudence in the performance of their plan duties.

4. Your employer may not fire you or discriminate against you to prevent you from obtaining a benefit or exercising your Plan rights.

5. If you are improperly denied a welfare benefit in full or in part, you have a right to file suit in a federal or state court.

6. If you have any questions about this statement of your rights under this Plan, you should contact the Plan Administrator.

PLAN SPECIFICATIONS

PARTICIPATING GROUP	City of Renton
PLAN ADMINISTRATOR	City of Renton 1055 S. Grady Way Renton, WA 98057
TELEPHONE NUMBER OF PLAN ADMINISTRATOR	425/430-7659
EMPLOYER ID NUMBER	91-6001271
NAME OF PLAN	City of Renton Employee Health Care Plan
EMPLOYEES	Eligible Employees of City of Renton
PARTICIPANTS	Eligible Employees and Dependents of the City of Renton
ORIGINAL PLAN EFFECTIVE DATE	January 1, 1985
AMENDED DATE	January 1, 2014
GROUP NUMBER	4034
TYPE/PLAN NUMBER	Health Care Plan / 501
CONTRIBUTION REQUIRED	Employee Coverage - varies on minimum hours worked Dependent Coverage - varies on minimum hours worked
PLAN SUPERVISOR	Healthcare Management Administrators, Inc. PO Box 85008 Bellevue, Washington 98015-5008 425/462-1000 Seattle Area 800/700-7153 All Other Areas

City of Renton, of Renton, Washington hereby establishes this Plan for the payment of certain expenses for the benefit of its eligible employees to be known as the City of Renton Employee Health Care Plan.

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

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

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

Plan Effective January 1, 1985

Plan Amended and Restated Effective January 1, 2014

Plan Arranged By:

R. L. Evans
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425/455-0501

Claim Administration By:

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

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800/700-7153 All Other Areas