



City Council Meeting Agenda

Special Meeting

June 23, 2016-6:30 pm
City Council Chambers, City Hall, Bethel, AK

Rick Robb
Mayor
Term Expires 2017
543-1879
rrobb@cityofbethel.net

Byron Maczynski
Vice-Mayor
Term Expires 2016
545-0970
bmacynski@cityofbethel.net

Leif Albertson
Council Member
Term Expires 2017
543-2819
lalbertson@cityofbethel.net

Chuck Herman
Council Member
Term Expires 2016
545-5394
cherman@cityofbethel.net

Zach Fansler
Council Member
Term Expires 2016
545-3300
zfansler@cityofbethel.net

Nikki C. Hoffman
Council Member
Term Expires 2017
545-6653
nhoffman@cityofbethel.net

Alisha Welch
Council Member
Term Expires 2017
545-6026
arwelch@cityofbethel.net

Ann Capela
City Manager
543-2047
acapela@cityofbethel.net

Lori Strickler
City Clerk
543-1384
lstrickler@cityofbethel.net

Patty Burley
City Attorney

Mary Sattler
Lobbyist

- I. **CALL TO ORDER**
- II. **PLEDGE OF ALLEGIANCE**
- III. **ROLL CALL**
- IV. **PEOPLE TO BE HEARD** – Five minutes per person
- V. **APPROVAL OF AGENDA**
- VI. **NEW BUSINESS**
 - a) City of Bethel Employee Group Medical Health Plan Coverage (Council Member Fansler)
 - b) City of Bethel, Public Safety Classification Plan (Council Member Fansler)
- VII. **EXECUTIVE SESSION**
 - a) AS 44.62.310 (C) 1: Matters, The Immediate Knowledge Of Which Would Clearly Have An Adverse Effect Upon The Finances Of The Public Entity – Labor Negotiation Contract Between City of Bethel Employees Association, Local 6055, APEA/AFT And City of Bethel (Mayor Robb)
 - b) Executive Session: Subjects That Tend To Prejudice The Reputation And Character Of Any Person As Per Alaska Statutes 44.62.310: –City Manager Evaluation (Council Member Albertson)
- VIII. **ADJOURNMENT**

Agenda Posted June 17, 2016 at City Hall, AC Co., Swanson's, and the Post Office.

Lori Strickler, City Clerk's Office

The Council may, after 12:00am, and only by a unanimous consent vote, recess this meeting until the following day at 6:30 p.m.

**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION**

**CITY OF BETHEL
HEALTH CARE BENEFITS PLAN**

PLAN RESTATED EFFECTIVE:

APRIL 1, 2014

AS AMENDED:

APRIL 1, 2014
SEPTEMBER 1, 2014

TPSC GROUP #45330

TABLE OF CONTENTS

STATEMENT OF GRANDFATHERED STATUS..... 1

MEDICAL SUMMARY OF BENEFITS 2

MEDICAL SUMMARY OF BENEFITS (continued) 3

VISION SUMMARY OF BENEFITS FOR ADULTS AGES NINETEEN (19) & OLDER..... 4

VISION SUMMARY OF BENEFITS FOR DEPENDENT CHILDREN AGES EIGHTEEN (18) & YOUNGER 4

DENTAL SUMMARY OF BENEFITS 5

INTRODUCTION..... 6

 PURPOSE 6

 EFFECTIVE DATE 6

 PLAN SPONSOR 6

 NAMED FIDUCIARY AND PLAN ADMINISTRATOR 6

 CONTRIBUTIONS 6

 PROTECTION AGAINST CREDITORS 6

 PLAN IS NOT AN EMPLOYMENT CONTRACT..... 7

ELIGIBILITY 8

 WHO MAY RECEIVE BENEFITS 8

EFFECTIVE DATE OF COVERAGE 9

 HOW TO ENROLL..... 9

 CHANGES IN ENROLLMENT 9

 WHEN COVERAGE BEGINS 9

 REINSTATEMENT OF COVERAGE 9

 SPECIAL ENROLLMENT PROVISIONS 9

 OPEN ENROLLMENT PROVISION 11

TERMINATION OF COVERAGE 12

 PARTICIPANT TERMINATION..... 12

 DEPENDENT TERMINATION 12

 HIPAA CERTIFICATES OF CREDITABLE COVERAGE 12

 RESCISSION OF COVERAGE..... 13

FEDERAL LAWS AND REGULATIONS 14

 HIPAA PRIVACY 14

 HIPAA SECURITY STANDARDS 18

 CONTINUATION COVERAGE RIGHTS UNDER COBRA 19

 UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA) 27

 FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA) 27

 QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)..... 28

 GENETIC INFORMATION NONDISCRIMINATION ACT 28

 MENTAL HEALTH PARITY..... 28

MEDICAL PLAN 29

 ALLOCATION AND APPORTIONMENT OF BENEFITS..... 29

 COINSURANCE 29

 COPAY/COPAYMENT 29

 DEDUCTIBLE..... 29

 LOCATING A MEMBER PHARMACY 29

 LOCATING A PREFERRED PROVIDER 29

 MAXIMUM BENEFITS 29

 OUT-OF-POCKET MAXIMUM..... 29

BENEFITS PROVIDED BY YOUR MEDICAL PROGRAM 30

 I. PHYSICIAN SERVICES 30

II.	PREVENTIVE CARE SERVICES	30
III.	HOSPITAL SERVICES	30
IV.	DIAGNOSTIC SERVICES.....	31
V.	MATERNITY & NEWBORN CARE BENEFIT	31
VI.	CHEMICAL DEPENDENCY & MENTAL HEALTH TREATMENT	31
VII.	HOME HEALTH CARE	32
VIII.	TRANSPLANT BENEFIT	33
IX.	OTHER BENEFITS.....	34
X.	OUTPATIENT PRESCRIPTION DRUGS	36
	MEDICAL PLAN LIMITATIONS AND EXCLUSIONS	38
	PRE-CERTIFICATION OF INPATIENT ADMISSION.....	42
	PRE-CERTIFICATION OF INPATIENT ADMISSION.....	42
	EMERGENCY INPATIENT ADMISSION	42
	CONTINUED STAY REVIEW	42
	HEALTH MANAGEMENT PROGRAM.....	43
	CARELINE (NURSELINE) PROGRAM.....	43
	MEDICAL CASE MANAGEMENT	43
	VISION PLAN.....	44
	COVERED VISION SERVICES	44
	VISION PLAN LIMITATIONS	44
	VISION PLAN EXCLUSIONS.....	44
	DENTAL PLAN.....	45
	ALLOCATION AND APPORTIONMENT OF BENEFITS.....	45
	BENEFIT LIMITATIONS	45
	CALENDAR YEAR MAXIMUM.....	45
	COINSURANCE.....	45
	DEDUCTIBLE.....	45
	DENTAL PLAN EXPENSES INCURRED	45
	DENTAL PLAN LIMITATIONS	45
	BENEFITS PROVIDED BY YOUR DENTAL PROGRAM	45
	— CLASS I BENEFITS—.....	45
	— CLASS II BENEFITS—.....	46
	— CLASS III BENEFITS—.....	47
	— CLASS IV BENEFITS—.....	48
	— CLASS V BENEFITS—.....	49
	DENTAL PLAN LIMITATIONS AND EXCLUSIONS	50
	CLAIMS PROCEDURES.....	52
	HEALTH CLAIMS.....	52
	TYPES OF CLAIMS	52
	WHEN HEALTH CLAIMS MUST BE FILED	52
	HOW TO FILE A CLAIM	52
	EXTENSION OF TIME	54
	ADVERSE BENEFIT DETERMINATIONS.....	54
	INCOMPLETE CLAIMS.....	54
	NOTIFICATION OF BENEFIT DETERMINATION.....	55
	ADVERSE CLAIM DETERMINATION	55
	RIGHT TO APPEAL.....	55
	RECOVERY OF PAYMENTS	58
	CLAIMS AUDIT	59
	GENERAL PROVISIONS.....	60
	ALTERNATE BENEFITS	60
	AVAILABILITY OF BENEFITS	60

CONFORMITY WITH LAW	60
EXAMINATION.....	60
FREE CHOICE OF PROVIDER.....	60
MISCELLANEOUS.....	60
STATEMENTS	60
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT	60
TIME LIMITATION	63
WORKER'S COMPENSATION NOT AFFECTED.....	63
COORDINATION OF BENEFITS.....	64
EXCESS INSURANCE.....	64
FACILITY OF PAYMENT	64
RIGHT OF RECOVERY	64
RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION.....	64
VEHICLE LIMITATION.....	64
COORDINATION OF BENEFITS DEFINITIONS.....	65
COORDINATION ORDER OF BENEFIT DETERMINATION.....	65
COORDINATION WITH MEDICARE.....	66
EXCHANGE OF INFORMATION.....	66
SECONDARY COVERAGE	66
PLAN ADMINISTRATION	67
DEFINITIONS.....	68
PLAN INFORMATION.....	85

STATEMENT OF GRANDFATHERED STATUS

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the City of Bethel, 300 State Highway, Bethel, AK 99559, (907) 543-2087.

Covered Persons may also contact the Employee Benefits Security Administration, U. S. Department of Labor at 1-866-444-3272, or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered plans.

MEDICAL SUMMARY OF BENEFITS

BENEFIT PERIOD	Calendar Year	
BENEFIT LIMITATIONS	Services received from Non-Preferred Providers are limited to a Usual & Customary and/or Reasonable (UCR) allowance.	
PRE-CERTIFICATION	Pre-certification is required for certain Inpatient admissions. Refer to the section PRE-CERTIFICATION OF INPATIENT ADMISSIONS for details.	
LIFETIME MAXIMUM BENEFIT	Unlimited	
	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
DEDUCTIBLE— <i>Applies to all services, unless otherwise noted.</i>	\$100 per person per Calendar Year \$300 per Family per Calendar Year	
OUT-OF-POCKET MAXIMUM	100% payment when an individual's out-of-pocket expenses for allowable Deductibles and Coinsurance reach \$600 in a Calendar Year (\$1,800 per Family). Copays, non-covered charges, expenses over the maximum allowable amounts, expenses payable at 50% and Outpatient Prescription Drugs, do not apply to the Out-of-Pocket Maximum and do not increase to the 100% benefit level.	
PRIMARY BENEFITS		
I. PHYSICIAN SERVICES		
Inpatient	Hospital Visit Surgery	Paid at 80% Paid at 80%
Outpatient	Office Visit/Office Surgery X-ray and Lab Surgery	Paid at 80% Paid at 80% Paid at 80%
		Paid at 80%* Paid at 80%* Paid at 80%* Paid at 80%*
II. PREVENTIVE CARE SERVICES		
	Routine Physical Exam & Related Tests— <i>Limited to one (1) exam per Calendar Year.</i> Mammogram Screening Colonoscopy Well-Child Care & Immunizations— <i>To Age 7</i>	Paid at 80% Paid at 80% Paid at 80% Paid at 80%
		Paid at 80%* Paid at 80%* Paid at 80%* Paid at 80%*
III. HOSPITAL SERVICES		
Inpatient	Room & Board Intensive Care & Coronary Care Unit Prescription Drugs X-ray and Lab Hospital Miscellaneous Expenses	Deductible Waived, \$50 Copay (per admission), then Paid at 80% Deductible Waived, Paid at 80% Deductible Waived, Paid at 80% Deductible Waived, Paid at 80% Deductible Waived, Paid at 80%
Outpatient	Outpatient Department/Ambulatory Surgical Center/Birthing Center	Paid at 80%
Emergency Room	Services & Supplies X-ray and Lab	Paid at 80% Paid at 80%
		Deductible Waived, \$50 Copay (per admission), then Paid at 50%* Deductible Waived, Paid at 50%* Deductible Waived, Paid at 50%* Deductible Waived, Paid at 50%* Deductible Waived, Paid at 50%* Deductible Waived, Paid at 50%*
IV. OUTPATIENT DIAGNOSTIC SERVICES (Including interpretations)— Non-routine/non-preventive scans, imaging and labs; non-routine cancer screenings		
		Paid at 80%
		Paid at 50%*
V. MATERNITY		
		Paid same as any other condition; available to Employees and Spouses only.
<i>*Services received from Non-Preferred Providers are limited to a Usual & Customary and/or Reasonable (UCR) allowance.</i>		

REFER to the attachment for the 2016 updates.

MEDICAL SUMMARY OF BENEFITS (continued)

PRIMARY BENEFITS (continued)	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
VI. CHEMICAL DEPENDENCY & MENTAL HEALTH TREATMENT		
Inpatient Facility	Deductible Waived , \$50 Copay (per admission), then Paid at 80%	Deductible Waived , \$50 Copay (per admission), then Paid at 50%*
Inpatient Physician	Paid at 80%	Paid at 80%*
Outpatient Physician/Facility	Paid at 80%	Paid at 80%*
VII. HOME HEALTH CARE — <i>Limited to 130 visits per Calendar Year.</i>	Paid at 80%	Paid at 80%*
VIII. TRANSPLANT BENEFIT — <i>Twelve (12) Month Waiting Period.</i>	Paid at 80%	Paid at 50%*
IX. OTHER BENEFITS		
Allergy Testing & Injections— <i>Testing is limited to one (1) test per Calendar Year.</i>	Paid at 80%	Paid at 80%*
Ambulance	Paid at 80%	Paid at 80%*
Air Transportation— <i>Limited to two (2) round-trips per Calendar Year for diagnostic care and two (2) round-trips per Calendar Year for surgical care.</i>	Deductible Waived , then Paid at 100%	Deductible Waived , then Paid at 100%*
Cardiac Rehabilitation— <i>Limited to one (1) visit/assessment per Calendar Year.</i>	Paid at 80%	Paid at 80%*
Chiropractic Care, Manipulations & Massage Therapy— ALL Visits, Treatment & Procedures— <i>Limited to \$3,600 per Calendar Year.</i>	Paid at 80%	Paid at 80%*
Diabetes Care Training— <i>Limited to one (1) visit/assessment per Calendar Year.</i>	Paid at 80%	Paid at 80%*
Durable Medical Equipment, Supplies and Prosthetic and Orthopedic Appliances	Paid at 80%	Paid at 80%*
Home Infusion Therapy	Paid at 80%	Paid at 80%*
Neurodevelopmental Therapy—To age 7— <i>Limited to six (6) days/visits per Calendar Year</i>	Paid at 80%	Paid at 80%*
Physical, Occupational & Speech Therapy	Paid at 80%	Paid at 80%*
Pulmonary Rehabilitation— <i>Limited to one (1) visit/assessment per Calendar Year.</i>	Paid at 80%	Paid at 80%*
X. OUTPATIENT PRESCRIPTION DRUGS Deductible Waived	<u>Express Scripts Pharmacies</u>	<u>Non-Participating Pharmacies</u>
Retail— <i>Limited to a 34-day supply.</i>		
Generic Drugs	\$10 Copay	\$10 Copay
Brand Name Drugs	Paid at 80%	Paid at 80%
Mail Order— <i>Limited to a 90-day supply.</i>		
Generic Drugs	\$20 Copay	Not Covered
Brand Name Drugs	Paid at 80%	Not Covered
*Services received from Non-Preferred Providers are limited to a Usual & Customary and/or Reasonable (UCR) allowance.		

REFER to the attachment for the 2016 updates.

VISION SUMMARY OF BENEFITS FOR ADULTS AGES NINETEEN (19) & OLDER

SERVICE PROVIDED	ANY PROVIDER
VISION EXAM — <i>Limited to one (1) exam per Calendar Year</i>	Paid at 100%*
VISION HARDWARE — <i>Limited to \$400 combined per person per Calendar Year. Benefit is available for eyeglass lenses and frames OR contacts, not both.</i>	
Eyeglass Lenses, Fitting Fee, Frames & Special Features (<i>tinting, scratch resistant coating, etc.</i>)—	
Single vision lenses and frames	Paid at 100%
Bifocal lenses and frames	Paid at 100%
Trifocal lenses and frames	Paid at 100%
Lenticular lenses and frames	Paid at 100%
Contact Lenses & Fitting Fee (<i>covered in lieu of eyeglass lenses & frames</i>)—	Paid at 100%
Conventional	Paid at 100%
Disposable	Paid at 100%
* These services are limited to a Usual & Customary and/or Reasonable (UCR) allowance.	

REFER to the attachment for the 2016 updates.

VISION SUMMARY OF BENEFITS FOR DEPENDENT CHILDREN AGES EIGHTEEN (18) & YOUNGER

SERVICE PROVIDED	ANY PROVIDER
VISION EXAM — <i>Limited to one (1) exam per Calendar Year</i>	Paid at 100%*
VISION HARDWARE	
Eyeglass Lenses & Fitting Fee	Paid at 100%*, limited to two (2) lenses per Calendar Year
Frames	Paid at 100%*, limited to one (1) per Calendar Year
Contact Lenses & Fitting Fee (<i>covered in lieu of eyeglass lenses & frames</i>) and Special Features (<i>tinting, scratch resistant coating, etc.</i>)	Paid at 100%*, limited to \$400 per Calendar Year
*All services are limited to a Usual & Customary and/or Reasonable (UCR) allowance.	

DENTAL SUMMARY OF BENEFITS

Class I ¹	Class II ¹	Class III ^{1,2}	Class IV ²	Class IV ^{1,2}	Class V
Diagnostic & Preventive Services	Restorative Services	Major Services	Non-Medically Necessary Orthodontia	Medically Necessary Orthodontia	TMJ
No Deductible	\$50 Deductible per person per Calendar Year				No Deductible
Paid at 90%³	Paid at 90%³	Paid at 50%³	Paid at 70%³	Paid at 70%³	Paid at 80%³
Cleanings	Anesthesia	Bridge work	Banding	Banding	
Exams	Emergency Exam	Crowns	Necessary Extractions	Necessary Extractions	
Fluoride	Endodontics	Dentures	X-Rays	X-Rays	
Sealants	Fillings	Inlays & Onlays			
X-Rays	Oral Surgery				
	Pathology				
	Periodontics				
	Space Maintainers				
\$3,000 maximum per person per Calendar Year. ¹				Limited to one (1) comprehensive course of treatment per Lifetime; Available only to dependent Children ages eighteen (18) & younger.	\$1,000 Lifetime Maximum
¹ Dollar maximums do not apply to dependent Children ages eighteen (18) & younger for services in classes I, II, III and Medically Necessary Orthodontia.					
² Benefits for dental treatment, services and supplies for Class III (Major) and Class IV (Orthodontia) will not be provided until the Individual has been continuously enrolled in the Plan for six (6) consecutive months.					
³ All services are limited to a Usual & Customary and/or Reasonable (UCR) allowance.					

REFER to the attachment for the 2016 updates.

INTRODUCTION

City of Bethel, hereinafter referred to as the "City", as the Plan Sponsor, hereby establishes the benefits, rights and privileges which shall pertain to participating Employees, hereinafter referred to as "Participants" or "Covered Persons", and the eligible dependents of such Participants.

Masculine pronouns used in this Plan Document shall include masculine or feminine gender unless the context indicates otherwise. Wherever any words are used herein in the singular or plural, they shall be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan which provide for the payment or reimbursement of all or a portion of eligible Medical, Prescription Drug, Vision and Dental expenses. This Plan Document will also serve as the Employee booklet.

EFFECTIVE DATE

The effective date of the Plan was April 1, 1996. The Plan was restated on January 1, 2003, April 1, 2005, June 1, 2008, April 1, 2011 and April 1, 2014. The Plan was amended on April 1, 2014 and September 1, 2014.

PLAN SPONSOR

The Plan Sponsor is the City, whose address and telephone number is:

300 State Highway
Bethel, AK 99559
(907) 543-2087.

NAMED FIDUCIARY AND PLAN ADMINISTRATOR

The Named Fiduciary and Plan Administrator is the City, whose street address and telephone number is:

300 State Highway
Bethel, AK 99559
(907) 543-2087

CONTRIBUTIONS

Employees may be required to pay a portion of the cost of coverage for themselves and their eligible dependents.

The amount of contributions to the Plan is to be made on the following basis:

1. The Plan Sponsor shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Plan Sponsor (if any) and the amount to be contributed (if any) by each Participant. Any amounts paid by the Plan Sponsor shall be paid out of its general assets.
2. Notwithstanding any other provision of the Plan, the Plan Sponsor's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Plan Sponsor's obligation with respect to such payments.
3. In the event that the Plan Sponsor terminates the Plan, then as of the effective date of termination, the Plan Sponsor and Participants shall have no further obligation to make additional contributions to the Plan.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Participant, the Plan Administrator in its sole discretion may terminate the interest of such Participant or former Participant in such payment, and in

such case shall apply the amount of such payment to or for the benefit of such Participant, his spouse, adult child, guardian of a minor child, or other relative of a dependent of such covered Participant or former Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment.

PLAN IS NOT AN EMPLOYMENT CONTRACT

The Plan will not be deemed to constitute a contract of employment or give any Employee of the City the right to be retained in the service of the City or to interfere with the right of the City to discharge or otherwise terminate the employment of any Participant.

ELIGIBILITY

WHO MAY RECEIVE BENEFITS

Benefits are provided to eligible Employees of the City and their covered dependents. The following is a description of the qualifications needed to be eligible.

In order for a dependent to be covered under the Plan, the Employee must also be enrolled in the Plan (except in the case of COBRA continuation coverage) and the dependent must be enrolled in the same coverage options as the Employee.

Individuals who are working in violation of U.S. immigration laws or those individuals who have made false representations of any kind in order to obtain employment are excluded from eligibility for participation in the Plan. Any loss of coverage resulting from this situation will not be a qualifying event for Continuation Coverage Rights under COBRA.

Employees—Regular, full-time (scheduled to work thirty [30] or more hours per week), who have met the Waiting Period described in "When Coverage Begins".

Ineligible classes of Employees are part-time and temporary Employees.

Spouse—Spouse means the lawful opposite-gender spouse of an Employee, unless legally separated or divorced. Common law marriages are not recognized under this Plan. A Spouse shall be a "dependent" for purposes of this Plan.

Children—Children include any eligible child under age 26, regardless of financial dependency, residency with a parent, marital status, or student status. An eligible child shall include the following:

1. Natural or legally adopted children (including any child placed in the home during a probationary period prior to the adoption).
2. Stepchildren.
3. Foster children or any other child for whom the Employee is the court-appointed legal guardian.
4. Eligible children for whom the Employee is required to provide coverage under the terms of a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice (NMSN). (See additional information under the heading "Qualified Medical Child Support Order" in the section titled FEDERAL LAWS AND REGULATIONS.)
5. Continued eligibility for physically or mentally disabled children—Coverage may continue beyond the limiting age for children described above who are unable to support themselves because of a developmental or physical disability with no age limitation if the following has been met:
 - a) The child is unmarried; and
 - b) The child became disabled before reaching the limiting age; and
 - c) The child is incapable of self-sustaining employment by reason of developmental disability or physical handicap and is chiefly dependent upon the subscriber for support and maintenance; and
 - d) The Employee is covered under this Plan; and
 - e) The child's required contribution for coverage, if any, continue to be paid; and
 - f) Within 31 days of the child reaching the limiting age or the child's original effective date under this Plan, whichever is later, the Employee furnishes the Claims Administrator documentation of the disability form from the child's primary medical doctor. The Claims Administrator must approve the request for certification for coverage to continue; and
 - g) The Employee provides the Claims Administrator with proof of the child's disability and dependent status when we request it. Proof will not be required more often than once a year following the child's attainment of the limiting age; and
 - h) They are dependent on the Employee as defined by the IRS; and
 - i) They are not covered by another group plan.

A Child meeting the definition set forth above shall be a "dependent" under this Plan.

NOTE: If more than one parent is an Employee, children may be covered as dependents of either parent or both. If both parents elect to cover the children as dependents, benefits will be processed according to the Coordination of Benefits provision. Likewise, an Employee may be covered both as an Employee and a dependent.

EFFECTIVE DATE OF COVERAGE

HOW TO ENROLL

The Personnel Office has enrollment forms, which must be properly completed within thirty (30) days of eligibility in order to enroll in this Plan.

New dependents of Employees must be enrolled in this Plan within thirty (30) days of marriage or other eligibility described in the section titled "Eligibility" (in the case of birth or adoption, within sixty [60] days of birth or adoption). If an Employee or dependent declined coverage by signing a "Waiver of Coverage" form, he may only enroll as allowed under Special Enrollment Provision.

CHANGES IN ENROLLMENT

The Personnel Office must be notified immediately if any change which affects eligibility to participate in this Plan occurs.

WHEN COVERAGE BEGINS

Participant Coverage under the Plan shall become effective with respect to a Covered Person on the date of eligibility provided that written application for such coverage is made as provided in this Plan.

New Employees and their eligible dependents will be covered the first day of the month coinciding with or immediately following thirty (30) continuous days of employment.

Newborn Children and newly adopted Children will be covered on the date of birth or adoption or upon meeting the eligibility requirements described in the section titled "Eligibility" if enrollment forms have been properly completed. New Spouses or step-Children will be covered on the first of the month following the date of marriage or upon meeting the eligibility requirements described in the section titled "Eligibility" if enrollment forms have been properly completed.

All coverage will commence at 12:01 a.m. on the date such coverage is in effect.

REINSTATEMENT OF COVERAGE

Employees rehired or returning from an approved leave of absence will be required to re-qualify as a new Employee, regardless of length of absence or leave (except as otherwise required by law). New Deductibles, Plan Limitations and Waiting Periods will apply.

SPECIAL ENROLLMENT PROVISIONS

HIPAA requires a group health plan to offer a Special Enrollment opportunity upon the exhaustion of COBRA continuation coverage, the loss of eligibility for coverage that is not COBRA continuation coverage, or the termination of Employer contributions toward coverage that is not COBRA continuation coverage. This Special Enrollment right is available to eligible Employees, dependents of eligible Employees, and dependents of COBRA qualified beneficiaries. Also, HIPAA requires a group health plan to offer a Special Enrollment opportunity to certain newly acquired spouses and dependents of Participants, and to Employees who have previously declined coverage but who have since acquired a new spouse or dependent.

Opportunity #1—Individuals Who Lose Coverage: For this Special Enrollment right to apply:

1. The Employee or dependent of an Employee must be eligible, but not enrolled, for coverage under the terms of this Plan, and when coverage under this Plan was previously offered, the Employee or dependent had coverage under any group health plan (or through health insurance). (An individual who initially declined enrollment even though he did not have other coverage, but then acquires other coverage and is again offered the opportunity to enroll in this Plan would also be eligible for Special Enrollment.)
2. The Employee or dependent must lose coverage under a group health plan or health insurance (including coverage under a state health benefits risk pool, a public health plan, or Medicaid).
3. The Employee or dependent must have lost health insurance or other group health plan coverage because:
 - a) The coverage was provided under COBRA, and the COBRA coverage was exhausted. Exhaustion includes the following:
 - i. The entire 18-, 29-, or 36-month COBRA period must be completed;

- ii. The Employer or other responsible entity (*other than the COBRA individual*) failed to remit premiums on a timely basis;
 - iii. The individual no longer resides in the service area for an HMO (or similar program) and there is no other COBRA coverage available; or
 - iv. The individual incurs a claim that would meet or exceed a lifetime limit on all benefits and there is no other COBRA continuation coverage available to the individual.
- b) The coverage was non-COBRA coverage and (a) the coverage terminated due to loss of eligibility for coverage, or (b) Employer contributions for the coverage were terminated, or (c) there was voluntary cancellation by the Employee or dependent when the other plan is less beneficial. "Loss of eligibility" includes (but is not limited to):
- i. Legal separation, divorce, cessation of dependent status, death of an Employee, termination of employment, reduction in the number of hours of employment;
 - ii. Coverage offered through an HMO in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area;
 - iii. Coverage offered through an HMO in the group market that does not provide benefits to individuals who no longer reside, live, or work in a service area, and no other benefit package is available to the individual;
 - iv. A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits; and
 - v. A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.

Loss of eligibility **does not** include (a) a loss resulting from the failure of the individual to pay premiums on a timely basis; **or** (b) a termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan).

4. The Employee or dependent must request Special Enrollment in this Plan within thirty (30) days after a loss of coverage or the Employer's cessation of contributions for such coverage. If the loss of eligibility is due to a situation in which an Employee incurs a claim that would meet or exceed a lifetime maximum on all benefits, the Employee must request Special Enrollment within thirty (30) days after a claim is denied because of the operation of the lifetime limit. If all other eligibility requirements are met, coverage will be effective on the first day following the loss of other coverage so that there is no lapse in coverage.

Opportunity #2—Acquisition of a New Dependent

- 1. In the case of a new dependent as a result of marriage, an Employee may enroll himself and his dependents, provided that the Employee requests Special Enrollment within thirty (30) days after the date of marriage and all other eligibility requirements are met. Coverage will be effective the first day of the month following such marriage.
- 2. In the case of a new dependent as a result of birth, adoption, or placement for adoption, an Employee may enroll himself and his dependents, provided that the Employee requests Special Enrollment within sixty (60) days of birth, adoption, or placement for adoption. Coverage will be effective on the date of birth, adoption, or placement for adoption.
- 3. In the case of a dependent over the age of 18 whose coverage was previously terminated due to loss of dependent status, but who later fulfills the eligibility requirements under the section entitled "Who May Receive Benefits", you may enroll this dependent only, provided that you request Special Enrollment within thirty (30) days after the dependent regains dependent status as defined by this Plan. Coverage will be effective on the first day of the month following the change in the dependent's status.

Opportunity #3—Medicaid/CHIP Special Enrollment Periods:

- 1. The Employee's or dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within sixty (60) days after termination; or
- 2. The Employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within sixty (60) days after eligibility is determined.

NOTE: The Enrollment Date for anyone who enrolls under a Special Enrollment Provision is the first date of coverage. Thus, the time between the dates a special enrollee first becomes eligible for enrollment under this Plan and the first day of coverage is not treated as a Waiting Period.

OPEN ENROLLMENT PROVISION

You may also enroll or make coverage selection changes during the annual open enrollment period (provided all other eligibility requirements are met). The annual open enrollment is during the month of December for coverage to be effective January 1st.

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION

Participant Coverage shall automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation Coverage Rights under COBRA or Family Medical Leave Act (FMLA):

1. On the last day of the month immediately following the date of termination of the Participant's employment or layoff;
2. On the last day of the month immediately following the date the Participant ceases to meet the eligibility provisions of the Plan;
3. On the date the Participant fails to make any required contribution for coverage;
4. On the date the Plan is terminated;
5. On the date the Plan Sponsor terminates the Participant's coverage;
6. On the date the Participant dies; or
7. On the date the Participant enters the armed forces of any country as a full-time member if active duty is to exceed thirty (30) days, except as allowed under the Uniformed Services Employment and Reemployment Rights Act (USERRA).

Coverage under this Plan will not otherwise be extended if the Employee is temporarily absent from work due to Illness or Injury or by the use of unused sick leave, unused vacation time, and unused benefits under any disability benefit plan, even though contributions to the Plan are made for such time.

DEPENDENT TERMINATION

The Dependent Coverage of a Participant shall automatically terminate immediately upon the earliest of the following dates, except as provided in any Continuation Coverage Rights under COBRA:

1. On the last day of the month immediately following the date the dependent ceases to be an eligible dependent under the Plan;
2. On the last day of the month immediately following the date of termination of the Participant's coverage under the Plan;
3. On the last day of the month immediately following the date the Participant ceases to meet the eligibility provisions of the Plan;
4. On the date the Participant fails to make any required contributions for Dependent Coverage;
5. On the date the Plan is terminated;
6. On the date the Plan Sponsor terminates the dependent's coverage;
7. On the last day of the month in which the Participant dies; or
8. On the date the dependent enters the armed forces of any country as a full-time member if active duty is to exceed thirty (30) days.

HIPAA CERTIFICATES OF CREDITABLE COVERAGE

The Plan will provide a Certificate of Creditable Coverage to Participants and dependents covered under the Plan as required by HIPAA at the following times:

1. Automatically at the time an individual loses coverage under the Plan (or would lose coverage under the Plan in the absence of continuation coverage under COBRA).
2. Automatically at the time an individual's COBRA continuation coverage ceases (or after the expiration of any grace period for nonpayment of premiums).

3. Upon request, within twenty-four (24) months after the date coverage ceases, regardless of whether the individual has previously received an automatic Certificate. (The requested Certificate will be provided by the earliest date that the Plan, acting in a reasonable and prompt fashion, can provide the Certificate.)

RESCISSION OF COVERAGE

A “rescission” is defined as a cancellation or discontinuance of coverage that has retroactive effect. A cancellation or discontinuation of coverage under the Plan is not a rescission if:

1. The cancellation or discontinuance of coverage has only a prospective effect; or
2. The cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions toward the cost of coverage.

Two examples involving nonpayment of premiums where coverage may be canceled retroactively:

1. Retroactive terminations in the “normal course of business” are permissible.
2. Retroactive terminations for failure to notify the Plan when dependents covered by the Plan became ineligible.

The Plan is prohibited from rescinding coverage for individuals who are covered under the Plan, except in cases where the individual has engaged in fraud or made an intentional misrepresentation of material fact, as prohibited by the terms of the Plan and with advance notice.

The Plan is required to provide at least thirty (30) days advance written notice to each individual who would be affected before coverage may be rescinded. This thirty (30)-day period will provide individuals with an opportunity to explore their rights to contest the rescission or look for alternative coverage, as appropriate.

Coverage will be canceled prospectively to correct errors in coverage, such as mistakenly covering a part-time Employee, but not by retroactively rescinding coverage, unless there was some fraud or intentional misrepresentation by the individual.

The Plan reserves the right to recover from the Employee and his covered dependents any benefits paid as a result of the wrongful activity that is in excess of the contributions paid. In the event the Plan terminates or rescinds coverage for gross misconduct on the part of the Employee, as determined by the Employer, continuation coverage under COBRA may be denied to the Employee and his covered dependents.

FEDERAL LAWS AND REGULATIONS

HIPAA PRIVACY

**NOTE: This section does not constitute the triennial HIPAA Privacy Notice.
Contact the Plan Sponsor for a copy of the HIPAA Privacy Notice**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations restrict the Plan Sponsor's ability to use and disclose Protected Health Information (PHI). The following HIPAA definition of PHI applies to this Plan Document:

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Plan Participants. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take Reasonable steps to ensure the privacy of the Plan Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The Plan Participant's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Plan Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR Sections 160.103 and 164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for plan administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;
4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for Payment or Plan Health Care Operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;
7. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
8. Make available PHI in accordance with section 164.524 of the privacy standards (45 CFR 164.524);
9. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards (45 CFR 164.526);
10. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards (45 CFR 164.528);
11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);
12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
13. Train Employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
14. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - (a) The following Employees, or classes of Employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed: The Plan Sponsor shall allow the Privacy Officer and Executive Assistant access to PHI. No other persons shall have access to PHI. These specified employees (or classes of employees) shall only have access to and use PHI to the extent necessary to perform the Plan administration functions that the Plan Sponsor performs for the Plan.
 - (b) In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose Reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to section 164.504(f)(1)(iii) of the privacy standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor may hereby authorize and direct the Plan, through the Plan Administrator or the third party administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other

purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

Other Disclosures and Uses of PHI:

A. PRIMARY USES AND DISCLOSURES OF PHI

1. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Plan Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.
2. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant's information.
3. Other Covered Entities: The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

B. OTHER POSSIBLE USES AND DISCLOSURES OF PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.
2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
 - (a) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;
 - (b) report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
 - (c) locate and notify persons of recalls of products they may be using; and
 - (d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.
3. The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (5) above, when required or authorized by law, or with the Plan Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.
4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.
5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Plan Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Participant of the request or to obtain an order protecting such

information, and done in accordance with specified procedural safeguards.

6. **Law Enforcement:** The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Plan Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.
7. **Decedents:** The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.
8. **Research:** The Plan may use or disclose PHI for research, subject to certain limited conditions.
9. **To Avert a Serious Threat to Health or Safety:** The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.
10. **Workers' Compensation:** The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
11. **Military and National Security:** The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

C. REQUIRED DISCLOSURES OF PHI

1. **Disclosures to Plan Participants:** The Plan is required to disclose to a Plan Participant most of the PHI in a Designated Record Set when the Plan Participant requests access to this information. The Plan will disclose a Plan Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Plan Participant's personal representative if it has a Reasonable belief that the Plan Participant has been, or may be, subjected to domestic violence, abuse, or neglect by such person, it is not in the Plan Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Plan Participant.

2. **Disclosures to the Secretary of the U.S. Dept of Health and Human Services:** The Plan is required to disclose the Plan Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Rights to Individuals

The Plan Participant has the following rights regarding PHI about him/her:

1. **Request Restrictions:** The Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Participant may request the Plan restrict disclosures to Family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.
2. **Right to Receive Confidential Communication:** The Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Plan Participant would like to be contacted. The Plan will accommodate all Reasonable requests.
3. **Copy of This Notice:** The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Officer.
4. **Accounting of Disclosures:** The Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment,

health care operations, and certain other purposes. The Plan Participant is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Plan Participant of the basis of the disclosure, and certain other information. If the Plan Participant wishes to make a request, please contact the Privacy Officer.

5. Access: The Plan Participant has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Plan Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Officer. In very limited circumstances, the Plan may deny the Plan Participant's request. If the Plan denies the request, the Plan Participant may be entitled to a review of that denial.
6. Amendment: The Plan Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Officer. The Plan may deny the Plan Participant's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

Questions or Complaints

If the Plan Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Plan Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Plan Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Plan Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

Contact Information:

Privacy Officer Contact Information:

City of Bethel
300 State Highway
Bethel, AK 99559
Phone: (907) 543-2087

HIPAA SECURITY STANDARDS

The Plan Sponsor shall have access to Electronic Protected Health Information (Electronic PHI) from the Plan only as permitted under this Plan Document or as otherwise required or permitted by HIPAA. Notwithstanding the provisions of this Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose Electronic PHI in a manner inconsistent with 45 C.F.R. § 164.504(f).

This section is intended to bring the City of Bethel Health Care Benefits Plan (hereinafter the "Plan") into compliance with the requirements of 45 C.F.R § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing Plan Sponsor obligations with respect to the security of Electronic Protected Health Information.

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions: Standards for Security of Individually Identifiable Health Information ("Security Rule")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions:

"*Electronic Protected Health Information*" (ePHI) is defined in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

“*Security Incidents*” is defined within Section 164.304 of the Security Standards (45 C.F.R. 164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

“*Health Breach Notification Rule*” is defined in 16 CFR Part 318, as amended from time to time, and generally means as the acquisition of unsecured PHR identifiable health information of an individual in a personal health record without the authorization of the individual.

Plan Sponsor Obligations

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR §164.504(a)), the Plan Sponsor agrees to:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
2. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by Reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement Reasonable and appropriate report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications—in accordance with the Health Breach Notification Rule (16 CFR Part 318)—are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the individual who’s PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach.
2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.
3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each calendar year.
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

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.

The Plan has three (3) health components, Medical, Vision and Dental, and you must be enrolled in all of these components. COBRA (and the description of COBRA coverage contained in this Plan Document) applies only to the group health plan benefits offered under this Plan (that is, the Medical, Vision and Dental components) and not to any other benefits offered by the Plan or by City of Bethel (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 Plan Document is intended to expand your rights beyond COBRA’s requirements.

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?”

COBRA coverage may become available to “qualified beneficiaries”—After a qualifying event occurs and any required notice of that event is properly provided to City of Bethel, 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 the “Qualified Medical Child Support Orders” provisions may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

Who is entitled to elect COBRA?

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.

Qualifying events for the covered Employee—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:

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

Qualifying events for the covered Spouse—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:

1. Your Spouse dies;
2. Your Spouse’s hours of employment are reduced;
3. Your Spouse’s employment ends for any reason other than his or her gross misconduct; or
4. 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.

Qualifying events for dependent Children—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:

1. Your parent-Employee dies;
2. Your parent-Employee’s hours of employment are reduced;
3. Your parent-Employee’s employment ends for any reason other than his or her gross misconduct;
4. You stop being eligible for coverage under the Plan as a “dependent Child.”

Individuals who are working in violation of U.S. immigration laws or those Individuals who have made false representations of any kind in order to obtain employment are excluded from eligibility for participation in the Plan. Any loss of coverage resulting from this situation will not be a qualifying event for continuation of coverage rights under COBRA.

Electing COBRA after leave under the Family and Medical Leave Act (FMLA)—Under special rules that apply if an Employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Plan during the leave. Contact City of Bethel for more information about these special rules.

Special second election period for certain eligible Employees who did not elect COBRA—Certain Employees and former Employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA) 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 of 60 days or less (but only if the election is made within six months after Plan

coverage is lost). If you are an Employee or former Employee and you qualify for TAA or ATAA, **CONTACT CITY OF BETHEL PROMPTLY AFTER QUALIFYING FOR TAA OR ATAA OR YOU WILL LOSE ANY RIGHT THAT YOU MAY HAVE 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 City of Bethel of any of these three qualifying events.

*You must notify the Plan Administrator of certain qualifying events by this deadline—***For 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 only if you notify City of Bethel 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.**

*No COBRA election will be available unless you follow the Plan’s notice procedures and meet the notice deadline—***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 City of Bethel 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 City of Bethel).

Electing COBRA Coverage

*How to elect COBRA—***to elect COBRA, you must complete the Election Form that is part of the Plan’s COBRA election notice and mail, hand deliver or fax it to Trusteed Plans Service Corporation.** (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 Trusteed Plans Service Corporation or City of Bethel.)

*Deadline for COBRA election—***If mailed, your election must be postmarked (and if hand-delivered or faxed, your election must be received by the individual at the address specified on the Election Form) no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event (or, if later, 60 days after the date that Plan coverage is lost). IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

*Independent election rights—*Each qualified beneficiary will have an independent right to elect COBRA. **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.**

Special Considerations in Deciding Whether to Elect COBRA

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. You 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.”

*Death, divorce, legal separation, or child’s loss of dependent status—*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.

If the covered Employee becomes entitled to Medicare within 18 months before his or her termination of employment or reduction of hours—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, Vision 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.

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

Extension of Maximum Coverage Period

If the qualifying event that resulted in your COBRA election was the covered Employee’s termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Trusteed Plans Service Corporation 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. (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.)

Disability extension of COBRA coverage—If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify Trusteed Plans Service Corporation 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.

You must notify Trusteed Plans Service Corporation of a qualified beneficiary’s disability by this deadline—The disability extension is available only if you notify Trusteed Plans Service Corporation in writing of the Social Security Administration’s determination of disability within sixty (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 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 eighteen (18) months after the covered Employee’s termination of employment or reduction of hours in order to be entitled to a disability extension.

No disability extension will be available unless you follow the Plan’s notice procedures and meet the notice deadline—**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 Trusteed Plans Service Corporation 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 Trusteed Plans Service Corporation or City of Bethel.

Second qualifying event extension of COBRA coverage—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.)

You must notify Trusteed Plans Service Corporation of a second qualifying event by this deadline—This extension due to a second qualifying event is available only if you notify Trusteed Plans Service Corporation 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).

No extension will be available unless you follow the Plan's notice procedures and meet the notice deadline—**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 Trusteed Plans Service Corporation during the 60-day notice period, **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 Trusteed Plans Service Corporation or City of Bethel.)

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:

1. any required premium is not paid in full on time;
2. a qualified beneficiary becomes covered, after electing COBRA, under another group health plan;
3. a qualified beneficiary becomes entitled to Medicare benefits (under Part A, Part B and/or Part D) after electing COBRA;
4. the Employer ceases to provide any group health plan for its Employees; or
5. during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period."

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

You must notify Trusteed Plans Service Corporation if a qualified beneficiary becomes entitled to Medicare or obtains other group health plan coverage—You must notify Trusteed Plans Service Corporation in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B and/or Part D) or becomes covered under other group health plan coverage. You must use the Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures)," and you must follow the procedures specified below in the section entitled "Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability." (You may obtain a copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability [Form & Notice Procedures] from Trusteed Plans Service Corporation or City of Bethel.)

You must notify Trusteed Plans Service Corporation if a qualified beneficiary ceases to be disabled—If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify Trusteed Plans Service Corporation 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 Trusteed Plans Service Corporation or City of Bethel.)

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.

Payment for COBRA Coverage

How premium payments must be made—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 the individual at the address specified on the Election

Form that is part of the Plan's COBRA election notice.

When premium payments are considered to be made—If mailed, your payment is considered to have been made on the date 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 on the Election Form. 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.

First payment for COBRA coverage—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 Trusteed Plans Service Corporation using the contact information provided on the Election Form 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.

Monthly payments for COBRA coverage—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. Trusteed Plans Service Corporation will send monthly notices of payments due for these coverage periods (that is, Trusteed Plans Service Corporation will send a bill to you for your COBRA coverage—if you do not receive a notice of payment due for a coverage period (e.g., it is lost in the mail), it is your responsibility to pay your COBRA premiums on time).

Grace Periods for monthly COBRA premium payments—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

Children born to or placed for adoption with the covered Employee during a period of COBRA coverage—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).

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep City of Bethel and/or the COBRA Administrator informed of any changes in the addresses of family members. If a covered dependent resides at a separate address, it is your responsibility to provide this dependent with a copy of this notice or any other COBRA notice.

You should also keep a copy, for your records, of any notices you send to City of Bethel and/or the COBRA Administrator, along with proof of mailing.

Plan Contact Information

You may obtain information about the Plan and COBRA coverage on request from the COBRA Administrator, Trusteed Plans Service Corporation, P.O. Box 1894, Tacoma, WA 98401-1894 or 6901 6th Avenue, Tacoma, WA 98406, (253) 564-5850.

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 Plan Document (if you are not sure whether this is the Plan's most recent plan document, you may request the most recent one from City of Bethel).

NOTICE PROCEDURES City of Bethel (the Plan)

Notices Must Be Mailed, Faxed or Hand Delivered to:

**COBRA Administrator
Trusteed Plans Service Corporation
P.O. Box 1894 or 6901 – 6th Avenue
Tacoma, WA 98401-1894 or 98406
Facsimile: (253) 564-5881**

Notice Procedures for Notice of Qualifying Event

Deadline 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.

How to provide Notice of Qualifying Event—**You must mail, fax or hand deliver this notice to the individual at the address specified above. Your notice must be in writing (using the Plan's form described below) and must be mailed, faxed or hand delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If faxed or hand delivered, your notice must be received by the individual at the address specified above no later than the deadline described above.**

Required form and information for Notice of Qualifying Event—**You must use the Plan's form entitled "Notice of Qualifying Event (Form & Notice Procedures)" to notify City of Bethel 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 City of Bethel.)

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

Notice Procedures for Notice of Disability

Deadline 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.

How to provide Notice of Disability—**You must mail, fax or hand deliver this notice to the COBRA Administrator at the address specified above. Your notice must be in writing (using the Plan’s form described below) and must be mailed, faxed or hand delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If faxed or hand delivered, your notice must be received by the COBRA Administrator at the address specified above no later than the deadline described above.**

Required form and information for Notice of Disability—**You must use the Plan’s form entitled “Notice of Disability (Form & Notice Procedures)” to notify the COBRA 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 COBRA Administrator.)

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

Notice Procedures for Notice of Second Qualifying Event

Deadline 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).

How to provide Notice of Second Qualifying Event—**You must mail, fax or hand deliver this notice to the COBRA Administrator specified above. Your notice must be in writing (using the Plan’s form described below) and must be mailed, faxed or hand delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If faxed or hand delivered, your notice must be received by the COBRA Administrator at the address specified above no later than the deadline described above.**

Required form and information for Notice of Second Qualifying Event—**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).

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.

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

Deadline for Notice of Other Coverage—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.

Deadline for Notice of Medicare Entitlement—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 and/or Part D), the deadline for this notice is 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).

Deadline for Notice of Cessation of Disability—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.

How to provide notices—**You must provide these notices to the COBRA Administrator at the address specified above. Your notice must be provided no later than the deadline described above.**

Information and form required—**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.)

Additional information required for certain notices—If you are providing a Notice of Other Coverage, your notice should include 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 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 a copy of the Social Security Administration's determination.

UNIFORM SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

It is the intent of this Plan to comply with all provisions of the Uniform Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Employees going into or returning from military service may elect to continue Plan coverage as mandated by USERRA. 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:

1. The 24-month period beginning on the date that Uniformed Service leave commences; or
2. 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 Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

There are time limits for reporting back to work upon release from the military as well as notice requirements. For further details, please contact the Personnel Office.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA)

The Family and Medical Leave Act (FMLA) is a Federal law that provides for an unpaid leave of absence for up to twelve (12) weeks per year for:

1. the birth or adoption of a child or placement of a Foster Child in a Participant's home;
2. the care of a child, spouse, Domestic Partner or parent (not including parents-in-law), as defined by Federal law, who has a serious health condition;
3. a Participant's own serious health condition; or
4. a qualifying exigency leave related to the call to active military service of the Participant's spouse, child, or parents;

and up to 26 weeks per year for:

5. military care leave to care for a seriously injured or ill covered service member.

If a Participant takes an approved leave under the Family and Medical Leave Act (FMLA) coverage will continue while the Participant is on a leave of absence that qualifies under the FMLA or any similar state law. The Participant will be required to

make monthly contributions while on leave. Contributions will be the same as for active Employees, except that they will be made on an after-tax basis during any unpaid leave. For additional information about FMLA, contact the [Personnel Office](#).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

The Plan Administrator will comply with any Qualified Medical Child Support Order or National Medical Support Notice received by the Plan. This shall include any court order that: 1) provides for child support with respect to an Employee's child or directs the Employee to provide coverage under a health benefit plan under a state domestic relations law, or 2) enforces a law relating to medical child support described in the Social Security Act, Section 1908, with respect to a group health plan. A QMCSO or an NMSN also may be issued through an administrative process established under state law.

The Plan Administrator has sole discretion and authority to determine whether a medical child support order or NMSN is a qualified order. Any issues relating to this determination will be resolved in accordance with the procedures set forth in the Plan's written QMCSO Procedure. A Participant must notify the Plan Administrator if he is subject to a QMCSO or an NMSN.

GENETIC INFORMATION NONDISCRIMINATION ACT

In accordance with the Genetic Information Nondiscrimination Act ("GINA"), the Plan and the City will not discriminate against an Employee and/or his covered dependents on the basis of Genetic Information, will protect the confidentiality of Genetic Information it receives, and will not request Genetic Information except as permitted by law.

MENTAL HEALTH PARITY

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

MEDICAL PLAN

ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan Administrator reserves the right to allocate any applicable Deductible amount to any eligible charges and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

COINSURANCE

Coinsurance is the percentage share payable by you on claims for which the Plan provides benefits at less than 100% of the allowed amount.

COPAY/COPAYMENT

A Copay or Copayment is an amount a Covered Person pays at the time of service (these are listed in the MEDICAL SUMMARY OF BENEFITS). Copays are in addition to any Deductible.

DEDUCTIBLE

The Deductible is the dollar amount of Covered Expenses (as shown in the MEDICAL SUMMARY OF BENEFITS) which must be Incurred during the year before any other Covered Expenses can be considered for payment (unless otherwise noted).

LOCATING A MEMBER PHARMACY

To locate a member pharmacy, refer to your Plan ID card. You may contact the pharmacy benefit manager directly, or contact the Claims Administrator.

LOCATING A PREFERRED PROVIDER

To locate a Preferred Provider, refer to your Plan ID card. You may contact the Preferred Provider Network directly, or contact the Claims Administrator.

MAXIMUM BENEFITS

Lifetime Maximum Benefits for Essential Health Benefits (as defined) are "unlimited". Annual and/or Lifetime Maximum Benefits for services not defined as "Essential Health Benefits", if any, are as shown in the MEDICAL SUMMARY OF BENEFITS.

OUT-OF-POCKET MAXIMUM

The amount that you are required to pay for medical services and supplies received is subject to an annual Out-of-Pocket Maximum (as shown in the MEDICAL SUMMARY OF BENEFITS).

Deductibles and Coinsurance applied to all allowable medical services and supplies (except Outpatient Prescription Drugs and Covered Expenses payable at 50%) **do apply to the Out-of-Pocket Maximum and do increase to the 100% benefit level.**

Copays, Covered Expenses payable at 50%, Outpatient Prescription Drugs, non-covered services and amounts in excess of Plan maximums **do not apply to the Out-of-Pocket Maximum and do not increase to the 100% benefit level.**

BENEFITS PROVIDED BY YOUR MEDICAL PROGRAM

In order to be eligible for benefits under this provision, expenses actually Incurred by a Covered Person must meet all of the following requirements:

1. They are ordered by a Physician and administered by a Physician and/or Licensed Health Care Provider;
2. They are Medically Necessary for the diagnosis and treatment of an Illness or Injury unless otherwise specifically included as a Covered Expense; and
3. They are not excluded under any provision or section of this Plan.

Covered Expenses include the following and are payable—based on the Deductibles, Copayments, Coinsurance levels, and maximum amounts—as outlined in the MEDICAL SUMMARY OF BENEFITS:

I. PHYSICIAN SERVICES

- A. **Visits & Surgery Services.** Covered services of a legally qualified Physician for medical care and/or surgical treatments include but are not limited to: Inpatient and Outpatient visits/exams (including Urgent Care Center and walk-in clinic visits), office and home visits, clinic care, surgical care, Medically Necessary biofeedback and surgical opinion consultations. Also included are injectable contraceptives dispensed or administered by a Physician.
- B. **Contraceptive Management.** Charges for “contraceptive management services”, including visits for prescription of oral, injectable, emergency and implant contraceptives are included in this benefit. Also included are injectable contraceptives dispensed or administered by a Physician. This benefit does not include services related to contraceptive devices (diaphragms, IUDs, etc.). For sterilization procedures, refer to the benefit titled “Voluntary Sterilization” in “IX. OTHER SERVICES” below.

II. PREVENTIVE CARE SERVICES

- A. **Well-Child Care.** Routine physical exam, related X-ray and laboratory services and immunizations for Children through age six (6).
- B. **Preventive Care.** One (1) routine physical exam will be provided each Calendar Year. Charges for X-ray and lab associated with the routine exam are covered.
- C. **Mammograms.** Covered Expenses include charges for screening and diagnostic mammogram services.
- D. **Colonoscopies.** Screening colonoscopies, limited to the frequency generally recommended by the American Medical Association as a cancer-screening tool for those aged fifty (50) and over.

III. HOSPITAL SERVICES

Charges made by a Hospital, for:

- A. **Room & Board.** Daily Room and Board and general nursing services, or confinement in an Intensive Care Unit. Room and Board (other than in a Coronary Care Unit and Intensive Care Unit) is limited to the Hospital's average Semi-Private room rate. If the Hospital does not have Semi-Private rooms, benefits are limited to 90% of its lowest daily Room and Board charge.
- B. **Inpatient & Outpatient.** Medically Necessary services and supplies other than Room and Board furnished by the Hospital, including but not limited to: Inpatient Hospital Miscellaneous Expenses and supplies, Outpatient Hospital treatments, Physical Therapy treatments, hemodialysis, and linear therapy. Coverage is as shown in the MEDICAL SUMMARY OF BENEFITS.
- C. **Emergency.** Emergency room services, including related services and supplies, such as diagnostic imaging (including x-ray) and laboratory services, surgical dressings and drugs, furnished by and used in the Emergency room. Coverage is as shown in the MEDICAL SUMMARY OF BENEFITS.
- D. **ASC.** Charges made by an Ambulatory Surgical Center or Minor Emergency Medical Clinic. Coverage is as

shown in the MEDICAL SUMMARY OF BENEFITS.

IV. **DIAGNOSTIC SERVICES**

Charges are covered for diagnostic laboratory, pathology, imaging and scans (such as X-rays and EKGs), microscopic tests, and tests, including their administration and interpretation. This includes services billed as:

- A. **Physician Services.** Coverage is as shown in the MEDICAL SUMMARY OF BENEFITS.
- B. **Inpatient Services.** Coverage is as shown in the MEDICAL SUMMARY OF BENEFITS.
- C. **Other Outpatient Services.** Coverage is as shown in the MEDICAL SUMMARY OF BENEFITS.

V. **MATERNITY & NEWBORN CARE BENEFIT**

- A. **Maternity Care.** Routine obstetrical/maternity benefits, including termination of Pregnancy and Cesarean surgeries, will be provided for Employees and covered Spouses only. Included in this benefit are charges for a Birthing Center.

Under the Newborns' and Mothers' Protection Act of 1996, group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or Newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or Newborn's attending provider, after consulting with the mother, from discharging the mother or her Newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). In no event will an "attending provider" include a plan, Hospital, managed care organization or other issuer.

Dependent Children are not eligible for benefits under this provision, except for charges Incurred due to Complications of Pregnancy. Benefits are also not provided for pregnancies that are the result of, or for the purposes of, surrogate maternity.

- B. **Newborn Care.** Medical facility charges Incurred by a well Newborn during the initial period of confinement (as determined by the Plan Administrator) will be covered as charges of the baby. This benefit includes the medical facility nursery expenses for a healthy Newborn, routine pediatric care for a healthy Newborn child while confined in a Hospital or medical facility immediately following birth, and Phenylketonuria (PKU) testing.

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

Coverage is not automatic. In all cases the Newborn must be enrolled on the Plan within sixty (60) days from birth to be eligible for benefits.

VI. **CHEMICAL DEPENDENCY & MENTAL HEALTH TREATMENT**

Coverage is as shown in the MEDICAL SUMMARY OF BENEFITS and includes:

- A. **Inpatient.** This benefit covers Medically Necessary Inpatient Chemical Dependency Treatment and Mental Health Treatment provided to a Covered Person in an Alcoholism Treatment Center, Drug Addiction Treatment Facility or Residential Treatment Facility, Hospital or Psychiatric Health Facility. A Physician must order the Inpatient treatment in writing for the entire length of time the patient is confined. Coverage for treatment for the neuroses known as eating disorders is limited to anorexia nervosa and bulimia. This benefit includes:
 - 1. Inpatient Room and Board.
 - 2. Medical and psychiatric evaluations.
 - 3. Psychiatric Care including, but not limited to, psychotherapy (individual and group), counseling (individual and group), behavior therapy, family therapy (individual and group) for the Covered Person.

4. Prescription drugs prescribed by and administered while confined in an approved treatment facility.
5. Supplies prescribed by an approved treatment facility, except for personal items.

Detoxification is not considered Chemical Dependency Treatment or Mental Health Treatment (refer to the Hospital Services benefit above for coverage details).

B. Outpatient. This benefit covers Medically Necessary Outpatient Chemical Dependency Treatment and Mental Health Treatment provided to a Covered Person that is not confined as Inpatient in an Alcoholism Treatment Center, Drug Addiction Treatment Facility, Residential Treatment Facility, Hospital or Psychiatric Health Facility. Coverage for treatment for the neuroses known as eating disorders is limited to anorexia nervosa and bulimia. This benefit includes:

1. Medical and psychiatric evaluations.
2. Psychiatric Care including, but not limited to, psychotherapy (individual and group), counseling (individual and group), behavior therapy, family therapy (individual and group) for the Covered Person.
3. Partial Confinement Treatment may be considered a Covered Expense. Refer to the Partial Confinement Treatment benefit for coverage information.

Residential Crisis Treatment Centers and Residential Treatment Facilities designed to provide **only** a substance-free residential setting are not covered.

Treatment for chemical dependency and mental health does not include:

- A. Personal items.
- B. Items or treatment not Medically Necessary to the care or recovery of the patient.
- C. Long-term or Custodial Care and Recovery Houses.
- D. Education, training and educational materials.
- E. Smoking cessation.
- F. Alcoholics Anonymous and similar programs.

VII. **HOME HEALTH CARE**

Charges made by a Home Health Care Agency for care in accordance with the written Home Health Care Plan filed by the attending Physician with the Claims Administrator. Coverage is limited as shown in the MEDICAL SUMMARY OF BENEFITS, with visits limited to four (4) hours of care. These charges are only covered for care and treatment of an Injury or Illness when Hospital or skilled nursing confinement would otherwise be required.

This benefit includes:

- A. Part-time or intermittent nursing care by a Registered Nurse or by a Licensed Practical Nurse, a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse.
- B. Home health aide services by an aide who is providing intermittent care under the supervision of a Registered Nurse, physical therapist, occupational therapist or speech therapist. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in the patient's condition and needs and completing appropriate records.
- C. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under this Plan if the Covered Person had remained in the Hospital.
- D. Physical Therapy by a licensed, registered or certified physical therapist.
- E. Occupational Therapy services by a registered, certified or licensed occupational therapist.
- F. Nutritional guidance by a registered dietician.
- G. Nutritional supplements such as diet substitutes administered intravenously or by enteral feeding.
- H. Respiratory Therapy services by a certified inhalation therapist.

Specifically excluded from coverage under this benefit are the following:

- A. Non-medical or Custodial Care except as specifically included as a Covered Expense.

- B. Meals on Wheels or similar home-delivered food services.
- C. Services and supplies not included in the Home Health Care Plan.
- D. Services of a person who ordinarily resides in the home of the Covered Person, or is a Close Relative of the Covered Person.
- E. Services of any social worker.
- F. Transportation services.
- G. Supportive environmental materials such as handrails, ramps, telephones, air conditioners or similar appliances or devices.

VIII. **TRANSPLANT BENEFIT**

All transplants must be pre-authorized; that is, the Plan conditions receipt of transplant benefits on approval of the benefit in advance of obtaining medical care.

Organ Transplant Network. As a result of the pre-authorization review, the Covered Person may be asked to consider obtaining transplant services from a participating Center of Excellence facility arranged by the Plan Administrator. The purpose of designating Centers of Excellence networks is to perform necessary transplants in the most appropriate setting for the procedure, to improve the quality and probability of a successful outcome, and to reduce the average cost of the procedures. Using a participating Center of Excellence facility is not mandatory but may be considered to be in the best health interest of the Covered Person and provide a less-costly alternative.

Services and supplies in connection with transplant procedures are covered, subject to the following conditions:

- A. Only human tissue-to-tissue transplants will be considered as eligible for coverage under the Plan. The following transplant procedures will be considered as covered: heart, heart/lung combined, kidney, kidney/pancreas combined, liver and lungs (single and bilateral). All other transplant procedures, including Experimental and/or Investigational, non-human organ or artificial organ implant procedures, are specifically excluded. No benefits will be provided for selective islet cell transplants of the pancreas, transplant of a lung or other organ (except kidney) from a living donor unless such donor has been declared brain dead by the attending provider.
- B. Allogenic (related or unrelated) bone marrow transplants will be provided, limited to the following malignancies or conditions: acute leukemias (lymphocytic or non-lymphocytic), chronic myelogenous leukemia, aplastic anemia, lymphoma (Hodgkin and Non-Hodgkin), neuroblastoma stage III and IV in children over one year of age, or multiple myeloma.

Autologous (self-donor) bone marrow transplants or stem cell support will be provided, limited to the following malignancies or conditions: Lymphoma (Hodgkin or Non-Hodgkin), neuroblastoma, acute leukemias (lymphocytic or non-lymphocytic) or multiple myeloma. Bone marrow transplants and stem cell support for other conditions will not be covered.

Services and supplies related to removal and treatment of the bone marrow and the hospitalization from the day of bone marrow infusion until the patient is discharged will be applied toward the benefit maximum.

- C. In addition, a second opinion must be obtained and submitted to the Claims Administrator for pre-authorization prior to undergoing any transplant procedure. This mandatory second opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.
- D. If the donor is covered under this Plan but the recipient is not covered under this Plan, Covered Expenses Incurred by the donor will be eligible for benefits, up to \$20,000 per Lifetime.
- E. If the recipient is covered under this Plan, Covered Expenses Incurred by the recipient will be eligible for benefits. Expenses Incurred by the donor, who is not ordinarily covered under this Plan according to Participant eligibility requirements, will be considered Covered Expenses, to the extent that such expenses are not payable by the donor's plan.
- F. If both the donor and the recipient are covered under this Plan, Covered Expenses Incurred by each person

will be treated separately for each person.

- G. The Usual & Customary and/or Reasonable (UCR) cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ will be considered a Covered Expense.

In no event will a transplant be covered under this Plan until the Individual has been eligible for twelve (12) consecutive months, whether or not the condition is an Emergency

IX. **OTHER BENEFITS**

- A. **Air Transportation.** The Plan will pay charges for air transportation charges, as stated in the MEDICAL SUMMARY OF BENEFITS to the nearest facility where care can be given for the following:

1. Air transportation for medical diagnostic care to the nearest care facility, limited to two (2) round-trips per Calendar Year. For transportation of a dependent child under age twelve (12), an accompanying parent or legal guardian will also be covered. The attending Physician must certify, in writing, that such transportation is Medically Necessary and attach such certification to the claim.
2. Air transportation for medical surgical care to the nearest care facility, limited to two (2) round-trips per Calendar Year. For transportation of a dependent child under age twelve (12), an accompanying parent or legal guardian will also be covered. The attending Physician must certify, in writing, that such transportation is Medically Necessary and attach such certification to the claim.

There are no transportation benefits for treatment of dental, vision or chiropractic services. There is no benefit payable for taxi cabs, rental cars, telephone calls, meals, hotel rooms or any other type of housing facility, or other like expenses while waiting for treatment.

- B. **Allergy Services.** Charges for allergy testing and injections, including syringes and medication. Coverage for testing is limited as shown in the MEDICAL SUMMARY OF BENEFITS.
- C. **Ambulance.** Charges for professional ambulance service to the nearest facility equipped to treat the specific illness or injury. Coverage is as shown in the MEDICAL SUMMARY OF BENEFITS.
- D. **Anesthesia.** The cost and administration of an anesthetic.
- E. **Blood.** Charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if replaced.
- F. **Chemotherapy.** Chemotherapy and radiation therapy or treatment.
- G. **Chiropractic Care, Manipulations & Massage Therapy.** Coverage is limited as shown in the MEDICAL SUMMARY OF BENEFITS and includes:
 1. **Massage Therapy.** Charges for Medically Necessary massage therapy for a covered condition received from and billed by a Licensed Massage Therapist (LMP or LMT).
 2. **Chiropractic Care & Manipulations.** This includes **ALL** charges made by a chiropractor, including but not limited to office visits, manipulations, physical treatment and Medically Necessary X-rays.
- H. **Cornea Transplants.**
- I. **Diabetes Care Training.** Coverage is limited as shown in the MEDICAL SUMMARY OF BENEFITS.
- J. **Durable Medical Equipment (DME), Supplies and Prosthetic & Orthopedic Appliances.** Coverage is as shown in the MEDICAL SUMMARY OF BENEFITS and includes:
 1. **DME.** The lesser of: a) the rental (up to the purchase price, including sales tax) of wheelchairs, Hospital beds, respirators or other Durable Medical Equipment required for temporary therapeutic use, OR b) the purchase (including sales tax) of this equipment if economically justified.

NOTE: Items that may be useful to persons in the absence of Illness or Injury, such as air conditioners, purifiers, humidifiers, special furniture, bicycles, whirlpools, hot tubs, spas, dehumidifiers, exercise equipment, health club memberships, etc., are not included, whether or not they have been prescribed or recommended by a Physician.

2. **Medical Supplies.** Dressings, sutures, casts, splints, trusses, crutches, braces (except dental braces), Medically Necessary Foot Orthotics (foot inserts) or other necessary medical supplies, with the exception of corrective shoes.
3. **Prosthetic & Orthopedic Appliances.** Artificial limbs, eyes or larynx, Orthopedic Appliances, or other Prosthetic Appliances.

For repairs or replacements of the above Durable Medical Equipment and Prosthetic & Orthopedic Appliances, the Covered Person must have:

1. The attending Physician's prescription; and
2. A written explanation from the Physician as to why repair or replacement is necessary; and
3. An itemized repair or replacement cost statement.

For repairs, the Plan will pay up to the maximum that would be allowed for replacement of the equipment.

NOTE: No benefit is provided for cosmetic prostheses (except as provided for under the Mastectomy and Breast Reconstruction benefits of this Plan).

K. **Home Infusion Therapy.** Professional services, supplies, drugs, and solutions required for Home Infusion Therapy. Over-the-counter drugs, solutions and nutritional supplements are not covered. Coverage is as shown in the MEDICAL SUMMARY OF BENEFITS.

L. **Mastectomy and Breast Reconstruction Services.** As required by the Women's Health and Cancer Rights Act of 1998, benefits are provided for mastectomy that is Medically Necessary due to Illness or accidental Injury. For any Covered Person electing breast reconstruction in connection with a mastectomy, this benefit covers:

1. Reconstruction of the breast on which mastectomy has been performed.
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses.
4. Physical complications of all stages of a mastectomy, including lymphedemas.

Services are to be provided in a manner determined in consultation with the attending Physician and the patient.

M. **Neurodevelopmental Therapy.** Charges for neurodevelopmental therapy, for children age six (6) and under. This includes services and supplies for learning disabilities in cases where significant deterioration would result without such services or supplies. Coverage is limited as shown in the MEDICAL SUMMARY OF BENEFITS.

N. **NY Surcharge.** Charges for surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or any other similar state statutes requiring such surcharges will be considered Covered Expenses by this Plan. Local, state and federal taxes associated with supplies or services covered under this Plan will also be considered Covered Expenses by this Plan.

O. **Oxygen.** Oxygen and other gases and their administration.

P. **Partial Confinement Treatment.** Charges made by a Hospital, Psychiatric Health Facility or Residential Treatment Center for Medically Necessary Partial Confinement Treatment in accordance with the written Partial Confinement Treatment Plan filed by the attending Physician with the Claims Administrator. Services must be more than four (4) hours, but less than twenty-four (24) hours per day and provided for the intermediate short-term or medically-directed intensive treatment. These charges are only covered for care and treatment of an Injury or Illness when Inpatient confinement would otherwise be required.

Specifically excluded from the Partial Confinement Treatment benefit are the following:

1. Non-medical, long-term or Custodial Care.
2. Services performed by a member of the patient's Family or household.
3. Services not included in the written Partial Confinement Treatment Plan.
4. Charges for Recovery Houses.
5. Education, training and educational materials.
6. Items or treatment not Medically Necessary to the care or recovery of the patient.

Q. **PKU.** Charges for PKU (Phenylketonuria) dietary formula.

R. **Rehabilitation.** Covered Expenses include:

1. **Cardiac Rehabilitation.** Coverage is limited as shown in the MEDICAL SUMMARY OF BENEFITS.
2. **Inpatient Rehabilitation.** Charges for Inpatient rehabilitation therapy to restore or improve bodily function previously normal, but lost due to Illness or Injury. Benefits will also be provided for treatment of congenital anomalies for a Newborn child covered from birth, or an adopted child covered from date of placement under this Plan or a previous Plan sponsored by the City. Care must be received within twenty-four (24) months from the onset of the Injury or Illness or from the date of the surgery that made rehabilitation necessary.
3. **Outpatient Physical, Occupational & Speech Therapy.** Charges for treatment or services rendered by a licensed physical, occupational or speech therapist or other approved Physician and/or Licensed Health Care Provider acting within the scope of their license on an Outpatient basis. Outpatient rehabilitation therapy must be to restore or improve bodily function previously normal, but lost due to Illness or Injury. Benefits will also be provided for treatment of congenital anomalies for a Newborn child covered from birth, or an adopted child covered from date of placement under this Plan or a previous Plan sponsored by the City. Coverage for Outpatient Physical Therapy, Occupational Therapy and Speech Therapy is as shown in the MEDICAL SUMMARY OF BENEFITS. This benefit does not include services from a massage therapist or chiropractor. Refer to the "**Chiropractic Care, Manipulations & Massage Therapy**" benefit above for services performed by a licensed massage therapist (LMT or LMP) or chiropractor (DC).
4. **Pulmonary Rehabilitation.** Coverage is limited as shown in the MEDICAL SUMMARY OF BENEFITS.

S. **Specialty Medications.** If a patient is physically incapable because of his Illness of administering specialty medications (as defined below in section X. "Outpatient Prescription Drugs") to himself as prescribed, the Plan may provide coverage when administered by a Physician and/or Licensed Health Care Provider.

However, specialty medications (as defined below in section "X. OUTPATIENT PRESCRIPTION DRUGS") that a patient is physically capable of administering to himself are only covered under the "Outpatient Prescription Drugs" benefits of this Plan.

T. **Voluntary Sterilization.** Services for voluntary sterilization for Participants and dependent Spouses are covered the same as any other condition. In no event will a voluntary sterilization procedure be covered until the Individual has been eligible for twelve (12) consecutive months.

X. **OUTPATIENT PRESCRIPTION DRUGS**

Benefits for Outpatient prescription drugs are provided in three (3) ways:

1. Employees and their eligible dependents may purchase prescription drugs at Express Scripts member pharmacies by showing their ID card. Covered Persons will be required to pay the applicable Copay or Coinsurance (as stated in the MEDICAL SUMMARY OF BENEFITS) at the time of purchase for covered prescriptions, subject to the Limitations and Exclusions set forth below. Purchases are limited to a 34-day supply.

2. Employees and their eligible dependents who purchase prescription drugs from non-member pharmacies or who fail to use their ID card must pay the cost of the prescription in full and file a claim for reimbursement directly with Express Scripts (less the applicable Copay or Coinsurance stated in the MEDICAL SUMMARY OF BENEFITS). Reimbursement is limited to Express Scripts' allowance for the drug, and purchases are limited to a 34-day supply.
3. Employees and their eligible dependents may purchase prescription drugs through the Express Scripts mail order pharmacy, subject to the applicable Copay or Coinsurance (as stated in the MEDICAL SUMMARY OF BENEFITS) for covered prescriptions. Eligible prescriptions will be mailed directly to the Covered Person's home. Mail order prescriptions are limited to a 90-day supply.

The Outpatient prescription drug benefit includes, but is not limited to:

- A. Drugs requiring a prescription, subject to the Medical Plan Limitations and Exclusions.
- B. Diabetic supplies.
- C. **Specialty Medications.** The Outpatient Prescription Drugs benefit includes coverage for certain products that are referred to as specialty medications. Specialty medications are injectable drugs defined as having one or more of several key characteristics, including: a) requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes; b) need for intensive patient training and compliance assistance to facilitate therapeutic goals; c) limited or exclusive product availability and distribution; d) specialized product handling and/or administration requirements; and e) cost in excess of \$500 for a 30-day supply. These medications can be filled at Express Scripts retail member pharmacies or ordered through CuraScript, a subsidiary of Express Scripts. Specialty medications are limited to a 30-day supply. Express Scripts retail Copays apply, as shown in the MEDICAL SUMMARY OF BENEFITS.
- D. Oral, injectable, Emergency and implant contraceptives.
- E. Prenatal vitamins.
- F. Estrogen replacement medications.
- G. Erectile dysfunction medications.
- H. Compounds.
- I. Subject to prior approval by the Claims Administrator: Tazorac, Regranex, injectable growth hormones, Aranesp injections, Epogen/Procrit injections, Botox injections, Prolastin injections, Aralast injections, Myobloc injections, and Revatio.

Outpatient Prescription Drug Limitations and Exclusions

1. Benefits for Outpatient prescription drugs are provided at a constant benefit amount and do not increase to 100% and do not apply to the Deductible or Out-of-Pocket Maximum.
2. Benefits for Outpatient prescription drugs are subject to the COORDINATION OF BENEFITS provisions, found later in this Plan Document.
3. The following are excluded from the Outpatient prescription drug benefit:
 - a. Experimental and/or Investigational drugs, including compounded medications for non-FDA approved use.
 - b) Drugs intended for use in a Physician's office or another setting other than home use.
 - c) Therapeutic devices or appliances; support garments and other non-medical substances; hair growth agents; anorexients (weight loss medications); smoking cessation products; contraceptive devices (i.e. IUD and diaphragms); prescription vitamins (except as provided for prenatal vitamins); fertility medications; drugs with cosmetic indications; steroids for body building; over-the-counter and over-the-counter equivalent medications; replacement of lost or stolen prescriptions; and injectable allergens.

MEDICAL PLAN LIMITATIONS AND EXCLUSIONS

The following Exclusions and Limitations apply to expenses Incurred by all Covered Persons:

1. Charges Incurred prior to the effective date of coverage under the Plan, or after coverage is terminated;
2. Charges Incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country. An act of terrorism will not be considered an act of war, declared or undeclared;
3. An Illness, Injury or condition arising out of or in the course of employment or charges for which the Covered Person is entitled to benefits under any Worker's Compensation or Occupational Disease Law, or any such similar law (this Exclusion includes any occupational Injury or disease arising out of self-employment);
4. Charges Incurred for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage;
5. Any charge for care, supplies, treatment, and/or services for any Injury or Illness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a Reasonable doubt is not required to be deemed an illegal act. This Exclusion does not apply if the Injury: (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions);
6. Charges for vitamins and nutritional supplements or adult immunizations, unless specifically provided in a benefit section of this Plan;
7. Charges Incurred for services or supplies: a) which constitute personal comfort or beautification items, b) for television or telephone use, c) in connection with Custodial Care; d) for education or training expenses actually Incurred by other persons, or e) occupational therapy except as specifically provided in a benefit section of this Plan;
8. Charges Incurred in connection with the care or treatment of, or surgery performed for, a Cosmetic Procedure, unless Medically Necessary:
 - a) Due to an Injury while covered under this Plan or the prior City-sponsored plan (unless otherwise required by applicable law).
 - b) For correction of congenital deformity in a child covered either from birth or the date of placement for adoption. To be covered, the surgery must be done within six (6) years of the date of birth (unless otherwise required by applicable law). The Plan will also cover correction of congenital deformities for Covered Persons who were not born while covered by this Plan (or the prior City-sponsored plan), after a period of two (2) years on the Plan and within six (6) years of birth (unless otherwise required by applicable law).
 - c) For reconstructive surgery as necessary for the prompt treatment of a diseased condition while covered under this Plan or the prior City-sponsored plan (unless otherwise required by applicable law).
 - d) By reconstructive breast surgery that is in connection with a mastectomy as provided under the Mastectomy and Breast Reconstruction Services benefit of this Plan.
9. Charges Incurred in connection with services and supplies which are not Medically Necessary for treatment of the Injury or Illness or are in excess of Usual & Customary and/or Reasonable (UCR) charges as determined by the Plan Administrator or the Preferred Provider allowance, or are not recommended and approved by a Physician, unless specifically shown as a Covered Expense elsewhere in the Plan;
10. Charges for services, supplies or treatments not recognized by the American Medical Association as generally accepted and Medically Necessary for the diagnosis and/or treatment of an Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value, unless specified as a Covered Expense elsewhere in the Plan;
11. Charges for services rendered by a Physician, nurse, or licensed therapist if such Physician, nurse, or licensed therapist is a Close Relative of the Covered Person or resides in the same household as the Covered Person;
12. Charges Incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies;

13. Charges for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or occurring in an institution which is primarily a place for the treatment of chronic or long-term Injuries or Illnesses;
14. Charges for Physician-provided fees for any treatment which is not rendered by or in the physical presence of a Physician;
15. Charges Incurred in connection with the purchase or fitting of eyeglasses, contact lenses, hearing aids, or such similar aid devices, except as specifically provided under the Vision Benefits of this Plan. This Exclusion does not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery, nor to the initial purchase of a hearing aid if the loss of hearing is a result of a surgical procedure performed while coverage is in effect;
16. Services, supplies or charges: a) that is directly related to the care, filling, removal or replacement of teeth; and b) the treatment of disease of the teeth, gums or structures directly supporting or attached to the teeth. However, benefits will be payable for treatment required because of accidental bodily Injury to Sound Natural Teeth sustained while covered. Such expenses must be Incurred within six (6) months of the date of the accident, and are limited to a maximum of \$500. This exception shall not in any event be deemed to include charges for treatment for the repair or replacement of a denture;
17. Charges for treatment of impotency, infertility, and procedures to restore fertility or to induce Pregnancy, including but not limited to: corrective or reconstructive surgery; hormone injections; in-vitro fertilization; artificial insemination; gamma intra-fallopian transfer (G.I.F.T.) and penile implants;
18. Charges for professional services on an Outpatient basis that can be credited toward earning a degree or furtherance of the education or training of a Covered Person regardless of the diagnosis that are in connection with mental Illness, Alcoholism, drug addiction, functional nervous disorders, mental and nervous disorders of any type or cause;
19. Charges for Psychiatric Care or psychological counseling for marital, occupational, recreational, milieu or group therapy or counseling, unless specifically provided for in any benefit section of this Plan;
20. Charges resulting from or in connection with the reversal of a sterilization procedure;
21. Charges for Experimental and/or Investigational procedures, drugs, or research studies, or for any services or supplies not considered legal in the United States. Exceptions to this Exclusion are:;
 - a) Chemotherapy treatment using drugs not specifically covered by an FDA approval if:
 - i. The Covered Person is not part of any study or non-Qualified Clinical Trial, and
 - ii. The Covered Person is being treated for cancer, and
 - iii. The drug, device, treatment or procedure has been granted investigational new drug (IND) or Group C treatment IND status OR is being studied in a Phase III level national clinical trial sponsored by the National Cancer Institute, and
 - iv. Based on available scientific evidence, is effective or shows promise of being effective for Illness, as determined by the Plan;
22. Charges Incurred in connection with surgical procedures for weight loss reduction (including reversals or complications from these surgeries) and services or supplies provided for the treatment of obesity and weight reduction (regardless of diagnosis);
23. Treatment of and services related to Myofascial Pain Dysfunction, Temporomandibular Joint Dysfunction (TMJ) and other jaw disorders;
24. Travel expenses, a) whether or not recommended by a Physician, b) Incurred by a Physician attending a Covered Person, or c) for a person accompanying a Covered Person except as specifically provided;
25. Charges for missed or cancelled appointments, for telephone consultations, mailing and/or shipping and handling expenses, expenses for preparing medical reports, itemized bills or claim forms;
26. Charges for acupuncture, naturopathy, holistic medical procedures, or rolfing;
27. Hair transplant procedures, wigs, artificial hair pieces or drugs which are prescribed to promote hair growth;

28. Charges for diagnosis or any services, care or treatment including drugs, medications, surgery, medical, or Psychiatric Care or treatment, for sexual dysfunction, trans-sexualism, gender dysphoria or sexual reassignment;
29. Services related to any surgical procedure to correct near-sightedness or far-sightedness, including any related hardware;
30. Charges for Injuries related to professional or Semi-Professional Athletics, including practice;
31. Charges for hospitalization for minor conditions such as common colds, removal of small tumors, etc. unless such hospitalization is deemed Medically Necessary by the utilization review organization;
32. Charges Incurred as a result of a self-inflicted Injury or charges for any Injury to a Covered Person sustained by the Covered Person's own actions while under the influence of alcohol or illegal drugs, unless such Injuries are the result of a medical condition or domestic violence;
33. Charges for services and supplies for smoking cessation;
34. Charges from a Skilled Nursing Facility or Hospice unless admission is immediately following covered hospitalization and American Health Holding is notified in advance (see Pre-Certification of Hospital Admission);
35. Charges Incurred for or related to the removal of breast or other prosthetic implants that were (a) inserted in connection with a Cosmetic Procedure, regardless of the reason for removal, or (b) not inserted in connection with Cosmetic Procedure, the removal of which is not currently Medically Necessary;
36. Charges for air transportation such as Medivac (except as specifically provided);
37. Counseling, education or training services. This includes vocational assistance, outreach, non-medical self-help such as "Outward Bound" or "Wilderness Survival"; recreational, social or cultural therapy; gym or swim therapy; work hardening; exercise; maintenance-level programs; and family, marital, social, sexual, lifestyle, nutritional, and fitness counseling, unless specifically provided in any benefit section of this Plan;
38. Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor or social skills. However, this Exclusion does not apply to evaluations or treatment of developmental disabilities in children under age seven (7) as stated under the Neurodevelopmental Therapy Benefit (see "XI. Other Benefits" above, at D. 9.);
39. Therapy designed to provide a changed or controlled environment (Milieu therapy);
40. Routine or palliative foot care, including hygienic care, care of corns, bunions (except for bone surgery), calluses, and toenails (except for ingrown toenail surgery), and other symptomatic foot problems, except as specifically provided;
41. Any care connected with a dependent Child's Pregnancy, except care furnished for the treatment of a Complications of Pregnancy;
42. Pregnancies that are the result of or for the purposes of surrogate maternity;
43. Charges for services Incurred as a result of a court order;
44. Private duty nursing;
45. Care rendered by any medical facility that is owned or operated by a government agency, except when: a) the Plan refers the Covered Person to the facility, b) the facility's covered services are to treat a medical Emergency or an Injury that is treated within 72 hours of the Injury, or c) the Plan is required by law to provide available benefits for covered services rendered by the facility;
46. Services and supplies to the extent that benefits are payable under the terms of any contract or insurance offering, including, but not limited to, motor vehicle medical, motor vehicle no-fault, or other personal Injury protection (PIP) coverage and commercial premises or homeowner's medical premises coverage, or similar type of coverage or insurance. Any benefits provided by this Plan contrary to this Exclusion are provided solely to assist the Covered Person. By providing such benefits, this Plan is not waiving any right to reimbursement, recovery, or to subrogation as provided in this Plan;

47. Services and supplies that are payable by any public program, government, foundation, or charitable grant, except as otherwise required by law;
48. Upper or lower jaw augmentation or reduction procedures (orthognathic surgery), except in the case of a Covered Person covered continuously under this Plan or the prior City-sponsored plan from birth or from the date of placement for adoption;
49. Sanitarium or rest cures;
50. Any charge for care, supplies, treatment, and/or services required as a result of unreasonable provider error;
51. Negligence: Any charge for care, supplies, treatment, and/or services for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician;
52. Error: Any charge for care, supplies, treatment, and/or services that are required to treat injuries that are sustained or an illness that is contracted, including infections and complications, while the Plan Participant was under, and due to, the care of a Provider wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense;
53. Provider Error: Any charge for care, supplies, treatment, and/or services required as a result of unreasonable provider error;
54. Subrogation, Reimbursement, and/or Third Party Responsibility. Any charge for care, supplies, treatment, and/or services of an Injury or Illness not payable by virtue of the Plan's Third Party Recovery, Subrogation and Reimbursement provisions, which appear elsewhere in this Plan Document;
55. Any services or supplies that are not specifically listed as a benefit of this Plan or an exception to these Medical Plan Limitations and Exclusions.

PRE-CERTIFICATION OF INPATIENT ADMISSION

City of Bethel has contracted with American Health Holding to be its medical reviewing agency to review for medical or surgical necessity when Inpatient admission is recommended. **PRE-CERTIFICATION DOES NOT GUARANTEE PAYMENT OF BENEFITS.** Pre-certification is to determine that Inpatient admission is necessary, payment of benefits is subject to Eligibility and other plan provisions.

The following program(s), administered by American Health Holding will assist the patient in becoming better informed about the proposed treatment while assuring quality of care and cost containment.

PRE-CERTIFICATION OF INPATIENT ADMISSION

When a Physician recommends Inpatient admission, the Covered Person, the Physician, or the facility must call American Health Holding as soon as possible but no later than 48 hours before the scheduled admission.

Pre-certification is required for the following Inpatient admissions: all acute Hospital admissions (including maternity, mental health, chemical dependency and Inpatient Rehabilitation).

Pre-certification is not required for the following Inpatient admissions: Inpatient Hospice (not a covered benefit unless admission is immediately following a pre-certified Inpatient hospitalization), Skilled Nursing Facility (not a covered benefit unless admission is immediately following a pre-certified Inpatient hospitalization), Psychiatric Health Facility, Residential Treatment Facility and Inpatient Hospital stays in connection with childbirth for the mother or Newborn child that is less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section.

If American Health Holding determines that an Inpatient admission is not medically or surgically necessary, they will recommend alternate health care settings or treatment that will maintain both quality health care and cost-effective options. The Covered Person will also be notified of his right to appeal such a decision.

The telephone number for American Health Holding is 1-888-877-7994.

EMERGENCY INPATIENT ADMISSION

If Emergency Inpatient admission is necessary, the Covered Person, a Family member, the Physician or the facility must contact American Health Holding within 48 hours following admission.

If the call to American Health Holding occurs on the weekend or at night, a message should be left on the voice mail answering machine. The message should include:

1. The Covered Person's name;
2. Patient's name, if other than the Covered Person;
3. Identify the patient as a Covered Person with the City of Bethel Plan;
4. Telephone number where the Covered Person or a Family member can be reached;
5. Name of facility where patient is being admitted;
6. Reason for Inpatient admission; and
7. Date of admission.

The telephone number for American Health Holding is 1-888-877-7994.

CONTINUED STAY REVIEW

The American Health Holding health care professionals will continue to monitor the patient's Inpatient stay to the designated discharge date. If the patient's condition requires a longer stay than initially designated, they will review the patient's medical situation to determine if the additional days are Medically Necessary.

HEALTH MANAGEMENT PROGRAM

The Health Management Program is a confidential program that provides Covered Persons with access to educational materials and individualized care plans designed to help them manage a chronic medical condition such as asthma, chronic pain, diabetes and coronary disease. The program is staffed by specially trained nurses who are available by calling (800) 451-6123.

Patients who may benefit from this program are identified through a variety of means, such as medical and/or pharmacy claims, health risk assessments, pre-notification of hospital admission, physician referrals and self-referrals. Each patient who participates receives tailored educational material depending on their condition, and nurse care managers will assist in setting clinical goals and monitoring adherence to goals. Nurse care managers may also schedule ongoing telephonic or e-mail contact to assist the patient in managing their health.

CARELINE (NURSELINE) PROGRAM

The Plan provides Covered Persons with telephonic health and wellness information and other resources that enable patients to more easily and effectively obtain information about health-related topics. This includes the latest medical advances and a variety of information about such topics as healthy eating, exercise and smoking cessation.

A call to *CareLine* lets the caller:

1. Talk to a nurse, who will listen to all questions and help the caller decide what to do.
2. Get general information about health topics. There are 1,100 different topics to choose from.
3. Ask about available health care resources.

CareLine is available 24 hours a day, 7 days a week by calling (888) 877-8050.

MEDICAL CASE MANAGEMENT

The Plan also provides case management services to address catastrophic Injuries or disabilities. The case manager cooperates with the patient and the entire health care team to promote quality of care and the best use of the patient's health care dollars.

The case manager assesses information from the patient, his Family and his Physician to develop a formal treatment plan to meet the patient's specific Medically Necessary and appropriate needs. This treatment plan outlines specific goals and suggests alternative treatments to achieve them, if appropriate. (Determination of benefits for such alternative treatments will be made by mutual agreement of the Plan Sponsor and the reinsurance carrier.) All treatments are closely monitored by the case manager to ensure that the service is appropriate and cost-effective. This allows the patient to get the most from the patient's health care dollars without compromising the quality or integrity of his care.

VISION PLAN

The following are vision benefits under this program, which are subject to the Vision Plan Limitations and Vision Plan Exclusions shown below. Services may be received from the vision provider of your choice; there is no vision provider network. Some services are limited to a Usual & Customary and/or Reasonable (UCR) allowance (as defined) as shown in the VISION SUMMARY OF BENEFITS.

COVERED VISION SERVICES

1. Eye examination. Coverage is as shown on the VISION SUMMARY OF BENEFITS.
2. Single vision, bifocal, trifocal and lenticular lenses (including eyeglass lens fitting). Coverage is limited as shown on the VISION SUMMARY OF BENEFITS.
3. Contact lenses (including contact lens fitting). Coverage is limited as shown on the VISION SUMMARY OF BENEFITS.
4. Frames. Coverage is limited as shown on the VISION SUMMARY OF BENEFITS.
5. Special features for eyeglass lenses (such as tinting or coating). Coverage is limited as shown on the VISION SUMMARY OF BENEFITS.

VISION PLAN LIMITATIONS

1. Benefit is available for eyeglass lenses and frames OR contacts, not both.
2. Eye examination is limited to Usual & Customary and/or Reasonable (UCR) allowance.
3. Eye examination is limited to one (1) exam per Calendar Year.
4. Vision hardware is limited as shown in the VISION SUMMARY OF BENEFITS.
5. Coverage is limited to services provided by optometrists, ophthalmologists and opticians, to the extent that such services are within the scope of their license.

VISION PLAN EXCLUSIONS

1. Services or supplies that are not named above as covered, or that are covered under other provisions of this Plan, or services or supplies that are not furnished by a licensed ophthalmologist, optometrist, or optician.
2. Nonprescription glasses.
3. Other special purpose vision aids (such as magnifying attachments), sunglasses, safety glasses or light-sensitive lenses, even if prescribed.
4. Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), or pleoptics.
5. Supplies used for the maintenance of contact lenses.
6. Drugs or medications of any kind.
7. Charges for services or supplies which are received while the individual is not covered.
8. 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.
9. 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.

DENTAL PLAN

ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan Administrator reserves the right to allocate any applicable Deductible amount to any eligible charges and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

BENEFIT LIMITATIONS

- A. All services are limited to a Usual & Customary and/or Reasonable (UCR) Allowance as determined by the Plan Administrator.
- B. Benefits for dental treatment, services and supplies for Class III (Major) and Class IV (Orthodontia) will not be provided until the Individual has been continuously enrolled in the Plan for six (6) consecutive months.

CALENDAR YEAR MAXIMUM

Dental benefits are payable at the coinsurance level shown in the DENTAL SUMMARY OF BENEFITS up to the Calendar Year maximum amount listed in the DENTAL SUMMARY OF BENEFITS.

COINSURANCE

Coinsurance is the percentage share payable by the Covered Person on claims for which the Plan provides benefits at less than 100% of the allowed amount.

DEDUCTIBLE

The Deductible for covered dental expenses is shown in the DENTAL SUMMARY OF BENEFITS. This amount must be satisfied, unless otherwise noted, before benefits are payable.

DENTAL PLAN EXPENSES INCURRED

For root canal therapy, an expense is considered Incurred at the time the pulp chamber is opened. For full or partial dentures, an expense is considered Incurred on the date on which the final impression is made. For fixed Bridges, Crowns, Inlays and Onlays, an expense is considered Incurred on the date on which teeth are prepared. All other expenses are considered Incurred at the time a service is rendered, completed, or a supply furnished.

Benefits will be extended after termination of coverage, if completed within 31 days for: (a) a crown, Bridge or cast restoration, if the tooth is prepared prior to termination; (b) prosthetic devices, if the master impression is made prior to termination; or (c) root canal treatment, if the pulp chamber is opened prior to termination.

DENTAL PLAN LIMITATIONS

The following services will be considered an integral part of the entire dental service rather than a separate service: local anesthesia, pulp caps, diagnostics casts and treatment plans.

BENEFITS PROVIDED BY YOUR DENTAL PROGRAM

The following are Class I, Class II, Class III, Class IV and Class V covered dental benefits under this program, which are subject to the Limitations and Exclusions contained in this Plan. Services may be received from the Covered Person's dental provider of choice; there is no dental provider network.

— CLASS I BENEFITS—

A. COVERED DIAGNOSTIC BENEFITS

- 1. Routine examinations.
- 2. X-rays.
- 3. Examination by a specialist in an American Dental Association-recognized specialty.

B. COVERED PREVENTIVE BENEFITS

1. Prophylaxis (cleaning).
2. Topical application of Fluoride.
3. Pit and fissure sealants.

C. CLASS I LIMITATIONS

1. Routine examination is covered once in a consecutive six (6) month period.
2. Complete mouth or Panorex X-rays are covered once in a three (3) Calendar Year period and include Bitewings and 10 to 14 periapical x-rays.
3. Supplementary Bitewing X-Rays are limited to four (4) films in any six (6) consecutive month period.
4. Prophylaxis is covered once in a consecutive six (6) month period.
5. Topical application of Fluoride is covered once per consecutive six (6) month period when performed in conjunction with a Prophylaxis, up to a patient's eighteenth (18th) birthday.
6. Pit and fissure sealants are limited to unrestored molars, up to the patient's eighteenth (18th) birthday and are limited to one (1) treatment per tooth in any consecutive thirty-six (36) month period.

D. CLASS I EXCLUSIONS

1. Diagnostic services and x-rays related to Temporomandibular Joints (jaw joints) - see TMJ benefit.
2. Consultations.
3. Study models.
4. Caries susceptibility tests.
5. Plaque control program (oral hygiene instruction, dietary instruction and home Fluoride kits).
6. Cleaning of a Prosthetic Appliance.

— CLASS II BENEFITS—

A. COVERED BASIC BENEFITS

1. Emergency examination and consultation.
2. Space Maintainers.
3. Harmful habit-breaking devices.
4. General anesthesia and I.V. Sedation.

B. COVERED RESTORATIVE BENEFITS

1. Amalgam, synthetic, porcelain and plastic restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure.

C. COVERED ORAL SURGERY BENEFITS

1. Removal of teeth and surgical extractions, preparation of the Alveolar ridge and soft tissue of the mouth for insertion of dentures.
2. Treatment of pathological conditions and traumatic facial Injuries.

D. COVERED PERIODONTIC BENEFITS

1. Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth. Services covered include Root Planing, Subgingival Curettage, gingivectomy and limited adjustments to occlusion (8 teeth or less) such as smoothing of teeth or reducing of cusps.
2. Periodontal Prophylaxis.
3. Debridement.

E. COVERED ENDODONTIC BENEFITS

1. Procedures for pulpal and root canal therapy.
2. Services covered include pulp exposure treatment, pulpotomy and apicoectomy.

F. CLASS II LIMITATIONS

1. Emergency exams and consultations are covered to a combined maximum of two (2) in a Calendar Year.
2. Space Maintainers when used to maintain space for eruption of permanent teeth, limited to the initial appliance only (including adjustment during first 6 months) and only up to the patient's eighteenth (18th) birthday.
3. Restorations on the same surface(s) of the same tooth are covered once in a two (2) year period.
4. If a Composite or plastic restoration is placed on a Posterior Tooth, an Amalgam allowance will be made for such procedure.
5. Refer to Class III limitations if teeth are restored with Crowns, Inlays or Onlays.
6. General anesthesia and I.V. Sedation are covered only when administered by a Dentist who meets the educational guidelines established by the Washington State Dental Disciplinary Board in conjunction with a covered oral surgery procedure.
7. Root Planing or Subgingival Curettage (but not both) are covered once in a twelve (12) month period.
8. Periodontal Prophylaxis is covered once in a consecutive six (6) month period. Benefit is limited to periodontal Prophylaxis or standard Prophylaxis, not both.
9. Root canal treatment on the same tooth is covered only once in a two (2) Calendar Year period.
10. Refer to Class III Limitations if the root canals are placed in conjunction with a Prosthetic Appliance.

G. CLASS II EXCLUSIONS

1. Restorations Necessary to correct vertical dimension or to restore the occlusion.
2. Overhang removal, re-contouring, or polishing of restoration.
3. Extraoral grafts (grafting of tissues from outside the mouth or use of artificial materials).
4. Ridge extension for insertion of dentures (vestibuloplasty).
5. Tooth transplants.
6. Nightguards and occlusal splints.
7. Periodontal splinting and/or Crown and bridgework in conjunction with periodontal splinting.
8. Major (complete) Occlusal Adjustment.
9. Bleaching of teeth.

— CLASS III BENEFITS—

A. COVERED RESTORATIVE BENEFITS

1. Crowns, Inlays and Onlays (whether gold, porcelain, plastic, gold substitute castings or combinations thereof) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of tooth decay). Verification must be provided by the attending Dentist that teeth cannot be restored with filling materials such as Amalgam, silicate or plastic.

B. COVERED PROSTHODONTIC BENEFITS

1. Dentures, Bridges, partial dentures, related items, and the adjustment or repair of an existing prosthetic device.

C. CLASS III LIMITATIONS

1. Crowns, Inlays or Onlays on the same teeth are covered once in a five (5) Calendar Year period. Stainless steel Crowns are covered once in a two (2) Calendar Year period. If a tooth can be restored with a filling material such as Amalgam, silicate or plastic, an allowance will be made for such a procedure toward the cost

of any other type of restoration that may be provided.

2. Replacement of an existing prosthetic device is covered only once every five (5) Calendar Years and only then if it is unserviceable and cannot be made serviceable.
3. Root canal therapy performed in conjunction with a prosthetic device is limited to two (2) teeth per arch and is paid at the Class III payment level.
4. Full or partial dentures - If a more elaborate or precision device is used to restore the case, this Plan will allow the cost of a cast chrome and acrylic full or partial denture toward the cost of any other procedure that may be provided.
5. Denture adjustments and relines - Denture adjustments and relines done more than six (6) months after the initial placement are covered. Subsequent relines and jump rebases, but not both, will be covered once in a thirty-six (36) month period.

D. CLASS III EXCLUSIONS

1. A Crown used as an abutment to a partial denture is not covered unless the tooth is decayed to the extent that a Crown would be required to restore the tooth whether or not a partial denture is required.
2. Duplicate dentures.
3. Cleaning of Prosthetic Appliances.
4. Temporary dental services.
5. Surgical placement or removal of Implants or attachments to Implants.
6. Crowns and copings in conjunction with Overdentures.

— CLASS IV BENEFITS—

A. COVERED NON-MEDICALLY NECESSARY ORTHODONTIA BENEFITS

1. X-rays.
2. Necessary extractions.
3. Initial banding and follow-up treatment.

B. NON-MEDICALLY NECESSARY ORTHODONTIA LIMITATIONS

1. Orthodontia treatment is subject to the Calendar Year maximum benefit as stated in the DENTAL SUMMARY OF BENEFITS.
2. 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 or his eligible dependent is covered under this benefit on that date.

C. COVERED MEDICALLY NECESSARY ORTHODONTIA BENEFITS

1. Panoramic radiographs (X-rays) when Medically Necessary.
2. Interceptive orthodontic treatment.
3. Limited transitional orthodontic treatment.
4. Comprehensive full orthodontic treatment.

D. MEDICALLY NECESSARY ORTHODONTIA LIMITATIONS

1. Interceptive orthodontic treatment is limited to once per Lifetime.
2. Limited transitional orthodontic treatment is limited to once per Lifetime. Treatment must be completed within twelve (12) months of the date of the original appliance placement.
3. Comprehensive full orthodontic treatment is limited to once per Lifetime. The treatment must be completed within thirty (30) months of the date of the original appliance placement.
4. **MEDICALLY NECESSARY ORTHODONTIA** is defined as orthodontic treatment and orthodontic-related services when Medically Necessary for the following conditions:

- a) Cleft lip and palate, cleft palate, or cleft lip with Alveolar process involvement; OR
 - b) One of the following craniofacial anomalies:
 - i. Hemifacial microsomia;
 - ii. Craniosynostosis syndromes;
 - iii. Cleidocranial dental dysplasia;
 - iv. Arthrogyrosis; or
 - v. Marfan syndrome.
5. If orthodontic treatment is required for any conditions other than those specified in Limitation 4. above, refer to the Non-Medically Necessary Orthodontia benefit.

— CLASS V BENEFITS—

A. COVERED TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ) BENEFITS

- 1. Surgical and non-surgical TMJ treatment.

B. CLASS IV LIMITATIONS

- 1. TMJ treatment is subject to the Lifetime maximum benefit as stated in the DENTAL SUMMARY OF BENEFITS.

DENTAL PLAN LIMITATIONS AND EXCLUSIONS

1. Services for Injuries or conditions which are compensable under Worker's Compensation or Employers' Liability laws, or arising out of, or in the course of, any work for wage or profit; or services which are provided to the eligible person by any federal, state or provincial government agency or provided without cost to the eligible person by any municipality, county or other political subdivision;
2. Dentistry for cosmetic reasons including, but not limited to, laminates or bleaching of teeth;
3. Restorations or appliances Necessary to correct vertical dimension or to restore the occlusion. Such procedures include restoration of tooth structure lost from attrition and restorations for malalignment of teeth;
4. Application of desensitizing medicaments;
5. Experimental and/or Investigational services or supplies. Experimental and/or Investigational services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are Experimental and/or Investigational, this Plan, in conjunction with the American Dental Association, will consider if: (1) the services are in general use in the dental community in the State of Alaska; (2) the services are under continued scientific testing and research; (3) the services show a demonstrable benefit for a particular dental condition; and (4) they are proven to be safe and effective. Any individual whose claim is denied due to the Experimental and/or Investigational Exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request;
6. Analgesics (such as nitrous oxide) or any other euphoric drugs;
7. Hospitalization or outpatient surgical center charges and any additional fees charged by the Dentist for Hospital treatment, except as needed for disabled dependents, or if—based on the individual needs or circumstances of the patient—such hospitalization or outpatient surgical center treatment is deemed Medically Necessary by the attending Physician and/or Licensed Health Care Provider;
8. Dental services started prior to the date the person became eligible for services under this Plan, or the City-sponsored plan this Plan replaces;
9. Charges for preparing dental reports, itemized bills or claim forms;
10. Missed and broken appointments, and for telephone or electronic consultations;
11. Patient management problems;
12. Laboratory examination of tissue specimen;
13. Charges for facings or veneers;
14. Customized dental procedures;
15. Replacement of dental appliances or prosthetic devices which have been lost, mislaid or stolen;
16. Dental care that does not have ADA endorsement;
17. That part of any covered dental expense that is payable under any other section of this Plan, unless:
 - a) Benefits are payable under both this Dental benefit and any Medical benefits; and
 - b) It is to the Covered Person's advantage to have benefits paid under Dental benefits rather than under Medical benefits.
18. Orthognathic surgery (augmentation or reduction of the upper or lower jaw);
19. Provisional or periodontal splints;
20. Services and supplies that are not Necessary for treatment of a dental Injury or disease or that are not recommended and approved by the licensed Dentist attending the patient;

21. Charges by any person other than a licensed Denturist or a licensed Dental Hygienist and whose services are included in that Dentist's charge;
22. Charges for precision or other elaborate attachments for any appliance;
23. Charges for congenital malformation, except as specifically provided for in the Medically Necessary Orthodontia benefit above;
24. Charges for services rendered by any provider that is a Close Relative of the Covered Person, or that resides in the same household of the Covered Person;
25. Charges in excess of the Usual & Customary and/or Reasonable (UCR) charge 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 the dental condition;
26. 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;
27. Prescription drugs;
28. Charges Incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining dental services, drugs, or supplies;
29. Charges Incurred for which the Covered Person is not, in the absence of this coverage, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage;
30. Services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage;
31. Charges Incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country. An act of terrorism will not be considered an act of war, declared or undeclared;
32. Any charge for care, supplies, treatment, and/or services for dental Injury or Illness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a Reasonable doubt is not required to be deemed an illegal act. This Exclusion does not apply if the Injury: (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions);
33. All other services not specifically included in this Plan as covered dental benefits.

CLAIMS PROCEDURES

The procedures outlined below must be followed by Covered Persons ("claimants") to obtain payment of health benefits under this Plan.

HEALTH CLAIMS

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

Each claimant 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 claimant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

TYPES OF CLAIMS

Under the Plan, there are three (3) types of claims: Pre-Service (Urgent and Non-Urgent) that applies to transplants only, and Post-Service.

Pre-Service Non-Urgent Care Claims—A "Pre-service Non-Urgent Care Claim" is a claim for transplant benefits 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.

Unless a response is needed sooner due to the urgency of the situation, a Pre-service Non-Urgent Care Claim preauthorization review will be completed and notification made to the Covered Person and his Physician as soon as possible, generally within two (2) working days, but no later than fifteen (15) days after receipt of the request.

Pre-Service Urgent Care Claims—A "Pre-service Urgent Care Claim" is any claim for transplant benefits 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 claimant or the claimant's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the time period for making a non-urgent care determination could seriously jeopardize the Covered Person's life, health or ability to regain maximum function, or would subject him to severe pain that cannot be adequately managed without the care or treatment that is proposed, a Pre-service Urgent Care Claim preauthorization review will be completed as soon as possible, but no later than twenty-four (24) hours (or as otherwise required by law) after receipt of the request.

Post-Service Claims—A "Post-Service Claim" is a claim for a benefit under the Plan after the services have been rendered. A claim determination that involves only the payment of reimbursement of the cost of medical care that has already been provided will be made as soon as reasonably possible but no later than thirty (30) days from the day after receiving the claim.

WHEN HEALTH CLAIMS MUST BE FILED

Health claims must be filed with the Claims Administrator within six (6) months of the date charges for the service were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. Charges are considered Incurred when treatment or care is given or supplies are provided. **Claims filed later than that date will be denied.** However, on termination of the Plan, final claims must be received within ninety (90) days of termination.

HOW TO FILE A CLAIM

Most Health Care Providers will file claims on the claimant's behalf. Electronically submitted claims are processed most efficiently. If unable to file electronically, the Covered Person, his Physician and/or Licensed Health Care Provider, or an authorized representative must file the claim using HCFA-1500 (revision 12/90 and later), UB92, or ADA (revision 12/90 and later) forms, or an itemized statement. These forms are available from Health Care Providers, the Plan Administrator or the

Claims Administrator.

A claim will be considered filed when it is received by Trusteed Plans Service Corporation at the address listed below:

Trusteed Plans Service Corporation
P.O. Box 2950
Tacoma, Washington 98401-2950
FAX: (253) 564-5881
Phone: (800) 426-9786, Ext. 210

The following information is required in order to qualify a request for benefits as a Clean Claim (as defined in this section):

1. The City / Employer name;
2. The Plan Participant's name, ID number and current address;
3. The patient's name, ID number and address if different from the Participant's;
4. The Physician and/or Licensed Health Care Provider's name, tax identification number, address, degree and signature;
5. Date(s) of service(s);
6. Place of service(s);
7. Diagnostic Code;
8. Procedure Codes (describes the treatment or services rendered);
9. Assignment of Benefits (as defined in this section), signed (if payment is to be made to the Physician and/or Licensed Health Care Provider);
10. Release of Information Statement, signed; and
11. Explanation of Benefits (EOB) information if another plan is the primary payer.

A "Clean Claim" is defined as one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety includes a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review to establish Usual & Customary, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

"Assignment of Benefits" means an arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a provider. If a provider accepts said arrangement, providers' rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this Plan Document, unless otherwise required by a signed Preferred Provider participant agreement. A provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

Upon receipt of this information, the claim will be deemed to be filed with the Plan.

Provider Filing of a Clean Claim. A provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

Claims must be submitted individually for each claimant. Claims should not be stapled together. Completed information should be sent to:

Trusteed Plans Service Corporation
P.O. Box 2950
Tacoma, Washington 98401-2950
FAX: (253) 564-5881

If a Covered Person has any questions regarding eligibility, benefits or claims information, Trusteed Plans Service Corporation should be contacted at: (800) 426-9786, Ext. 210.

All submitted claims and appeals will fall into one of the types described previously. The handling of an initial claim or later appeal will be governed, in all respects, by the appropriate type of claim or appeal, and each time a claim or appeal is examined, a new determination will be made regarding the type into which the claim or appeal falls at that particular time.

EXTENSION OF TIME

Unless additional information is needed to process a claim, the Plan will make every effort to meet the timeframes stated above. If a claim cannot be paid within the stated timeframes due to matters beyond the control of the Plan, the Claims Administrator will acknowledge receipt of the claim and explain why payment is delayed. No extension is available for Pre-Service Urgent Care Claims. Processing of Pre-Service Non-Urgent Care Claims and Post-Service Claims may be extended by the Plan for up to 15 days.

ADVERSE BENEFIT DETERMINATIONS

An adverse benefit determination is any denial, reduction or termination of, or failure to provide or make a payment for a benefit based on:

1. A determination that the Covered Person is not eligible to participate in the Plan;
2. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a claimant's eligibility to participate in the Plan;
3. A determination that the service rendered is not covered by the Plan;
4. The imposing of limits;
5. A determination that the benefit is Experimental and/or Investigational or not Medically Necessary or medically appropriate;
6. A denial of benefits;
7. A reduction in benefits;
8. A rescission of coverage; or
9. A termination of benefits.

An adverse benefit determination made to reduce or deny benefits applied for a Pre-Service or Post-Service Care claim may be appealed in accordance with the Plan's appeals procedures described later in this section.

INCOMPLETE CLAIMS

If any information needed to process a claim is missing, the claim will be treated as an incomplete claim. More information may be requested as provided herein. This additional information must be received by the Claims Administrator within forty-five (45) days (48 hours in the case of Pre-service Urgent Care Claims) from receipt by the claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Incomplete Pre-Service Urgent Care Claims—If a claim is incomplete but is properly filed, the claimant will be notified orally and/or by written notification (if requested by the claimant) as soon as possible (but not later than 24 hours, unless otherwise required by law) after receipt of the claim, of the specific information necessary to complete the claim. The Covered Person will have forty-eight (48) hours to provide the specified information necessary to complete the claim submission. The Plan's time limit for making a determination will be suspended from the time that it provides notice of the incomplete claim until the date on which the claimant responds to the request for additional information. The claimant will be notified of the Plan's decision as soon as possible, but no later than forty-eight (48) hours after the earlier of either the time the Plan receives the specified information or the expiration of the time given the claimant to provide the specified information.

All Other Incomplete Claims—If a Pre-Service Non-Urgent Care or a Post-Service claim is incomplete, the Plan may deny the claim or may take an extension of time, as described above. If the Plan takes an extension of time, the extension notice shall include a description of the missing information and shall specify a timeframe, no less than forty-five (45) days, in which the necessary information must be provided. The timeframe for deciding the claim will be suspended from the date the extension notice is received by the claimant until the date the necessary missing information is provided to the Plan. If the requested information is provided, the Plan will decide the claim within the extension period specified in the extension notice. If the requested information is not provided within the time specified, the claim may be decided without that information.

If the claimant fails to follow the Plan's filing procedures because the request for benefits does not: 1) identify the patient; 2) note a specific medical condition or symptom; 3) describe a specific treatment, service, or product for which approval is requested; or 4) is not sent to the correct address, the claimant will not have submitted a claim. The claimant will be notified orally and/or by written notification (if requested by the claimant) within twenty-four (24) hours, that the claimant have failed to follow the filing procedures, and the claimant will be reminded of the proper filing procedures.

NOTIFICATION OF BENEFIT DETERMINATION

The Plan will pay benefits according to Plan provisions. This may mean that less than 100% of the claim is payable by the Plan. In each case where the Plan pays benefits or determines that it is not responsible for a medical claim, the Covered Person will receive an Explanation of Benefits, which will outline the basis for the Plan's payment. If the claim is denied or payable at a level less than outlined in the Summary of Benefits, the claimant is entitled to appeal the decision under the rules governing adverse claim determination.

ADVERSE CLAIM DETERMINATION

Written notification will be provided to the claimant of the Plan's adverse claim determination (as defined in the "How to File a Claim" section above) and will include the following:

1. Information sufficient to identify the claim involved, including the date of service, the Health Care Provider, and the claim amount (if applicable), as well as the diagnosis code, the treatment code, and the corresponding meanings of these codes.
2. A statement of the specific reason(s) for the decision;
3. Reference(s) to the specific Plan provision(s) on which the determination is based;
4. A description of any additional material or information necessary to perfect the claim and why such information is necessary;
5. A description of the Plan procedures and time limits for appeal of the determination;
6. A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination or a statement that such information will be provided free of charge upon request;
7. If the determination involves scientific or clinical judgment, the Plan will disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request;
8. In the case of Pre-service Urgent Care Claims, an explanation of the expedited review methods available for such claims;
9. A statement regarding the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman; and
10. The following statement: "All claim review procedures provided for in the Plan must be exhausted before any legal action is brought."

Notification of the Plan's adverse determination on Pre-service Urgent Care Claims may be provided orally, but written notification shall be furnished not later than three (3) days after the oral notice.

The claimant may call the Claims Administrator's Claims Manager at 1-800-426-9786, Ext. 211 to discuss the adverse claim determination if there are concerns. The claimant may also express those concerns in writing and, if needed, may submit additional information that he believes would clarify any of the circumstances that led to the adverse claim determination. The Claims Administrator will not consider any of these questions or clarifications to be a formal appeal unless the claimant specifically states it as such. The process for filing a formal appeal is listed below.

RIGHT TO APPEAL

The Covered Person has the right to appeal an adverse benefit determination under these claims procedures. If the Covered Person chooses to appeal the Plan's adverse benefit determination, the appeal will be governed by rules that assure a full and fair review.

If the Covered Person is denied benefits based upon the Plan's finding that he is/was ineligible for benefits, the denial of benefits will give the opportunity to appeal the Plan's decision.

If the Plan decides to reduce or terminate benefits for a previously-approved course of treatment, the Plan's decision will be treated as an adverse benefit determination, and the Plan will provide the claimant with reasonable advance notice of the reduction or termination to allow him to appeal the Plan's decision before the benefit reduction or termination takes place. If the

claimant decides to appeal the Plan's decision, he must follow the rules for appealing a Plan's decision.

No lawsuit can be instituted until the claimant has exhausted the Plan's internal and external claims review and appeals procedures. No lawsuit can be instituted more than one (1) year after that of the notice to the claimant that a claim appeal has been denied.

Appealing an Initial Claim Determination—The Covered Person must submit a written request to the Plan within 180 days of receipt of an adverse benefit determination in order to initiate an appeal. An oral request for review is acceptable for Pre-Service Urgent Care Claims and may be made by calling the Claims Administrator's Claims Manager at 1-800-426-9786, Ext. 211 and asking the Plan to register the oral appeal.

When the claimant appeals an adverse determination, the Plan will provide a full and fair review that will include the following features:

1. The Covered Person will have the opportunity to submit written comments, documents, records, and other information related to the claim.
2. At the Covered Person's request (and free of charge), the Covered Person will be provided with reasonable access to (and copies of) all documents, records, and other information relevant to his claim for benefits. Included in this category are any documents, records or other information in his claim file, whether or not those materials were relied upon by the Plan in making its adverse determination. The Covered Person also has the right to review documentation showing that the Plan followed its own internal processes for ensuring appropriate decision-making.
3. The review of the Covered Person's claim will take into account all comments, documents and other information without regard to whether such information was submitted or considered in the initial benefit determination.
4. Any appeal of an adverse determination will not give deference to the initial decision on the Covered Person's claim, and the review will be conducted by a designated Plan representative who did not make the original determination and does not report to the Plan representative who made the original determination.
5. In deciding an appeal of any adverse benefit determination that is based on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is Experimental and/or Investigational or not Medically Necessary or appropriate), the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the particular field of medicine involved in the medical judgment. This health care professional will not be the same professional who was originally consulted in connection with the adverse determination; neither will this health care professional report to the health care professional who was consulted in connection with the adverse determination. The Plan will uphold the findings of the independent review in responding to the appeal.
6. The Plan will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination of the Covered Person's claim, whether or not that advice was relied upon in making the benefit determination.

The Covered Person must first follow this appeal process before taking any outside legal action. After the Covered Person submits the claim for appeal, the Plan will make a decision on the appeal as follows:

Appeal of Pre-Service Urgent Care Claims—The Plan's expedited appeal process for Pre-Service Urgent Care Claims will allow the Covered Person to request (orally or in writing) an expedited appeal, after which, all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Covered Person by telephone, fax, or other expeditious method. The Covered Person will be notified (in writing or electronically) of the appeal decision as soon as possible, but not later than twenty-four (24) hours (or as otherwise required by law) after the Plan receives the request for review of the prior benefit determination.

Appeal of Pre-Service Non-Urgent Claims—For Pre-Service Non-Urgent Claims, the Covered Person will be notified (in writing or electronically) of the appeal decision within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) days.

Appeal of Post-Service Claims—For Post-Service Claims, the Covered Person will be notified (in writing or electronically) of the appeal decision within a reasonable period of time, but not later than thirty (30) days.

Denial of Claim on Appeal—If the Covered Person's appealed claim is denied, the Plan will send him written or electronic notification that explains why the appealed claim was denied and will include the following:

1. A statement of the specific reason(s) for the decision;
2. Reference(s) to the specific Plan provision(s) on which the determination is based;

3. A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination or a statement that such information will be provided free of charge upon request;
4. If the determination involves scientific or clinical judgment, the Plan will disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant's medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request;
5. A statement indicating the Covered Person's right to receive, upon request (and free of charge), reasonable access to (and copies of) all documents, records, and other information relevant to the determination. Included in this category are any documents, records or other information in his claim file, whether or not those materials were relied upon by the plan in making its adverse determination; and
6. The following statement: "All claim review procedures provided for in the Plan must be exhausted before any legal action is brought."

Final Appeal—If the Covered Person is dissatisfied with the outcome of the first appeal, he may request a second and final review. To initiate a second appeal, the Covered Person should follow the same process required for the first appeal. The Covered Person must submit a written request for appeal **within sixty (60) days** following the receipt of the first appeal decision.

When the Covered Person submits a second appeal of an adverse determination, the Plan will provide a full and fair review which will include the following features:

1. The Covered Person will have the opportunity to submit written comments, documents, records, and other information related to the claim.
2. At the Covered Person's request (and free of charge), the Covered Person will be provided with reasonable access to (and copies of) all documents, records, and other information relevant to his claim for benefits. Included in this category are any documents, records or other information in his claim file, whether or not those materials were relied upon by the Plan in making its adverse determination. The Covered Person also has the right to review documentation showing that the Plan followed its own internal processes for ensuring appropriate decision-making.
3. The review of the Covered Person's claim will take into account all comments, documents and other information without regard to whether such information was submitted or considered in the initial benefit determination.
4. A second appeal will not afford deference to the initial appeal determination, and the review will be conducted by a designated Plan representative who did not make the original determination and does not report to the Plan representative who made the original determination.
5. In deciding an appeal of any adverse benefit determination that is based on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is Experimental and/or Investigational or not Medically Necessary or appropriate), the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the particular field of medicine involved in the medical judgment. This health care professional will not be the same professional who was originally consulted in connection with the adverse determination; neither will this health care professional report to the health care professional who was consulted in connection with the adverse determination. The Plan will uphold the findings of the independent review in responding to the appeal.
6. The Plan will identify medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination of the Covered Person's claim, whether or not that advice was relied upon in making the benefit determination.

After the Covered Person submits the claim for appeal, the Plan will make a decision on the appeal as follows:

Final Appeal of Pre-Service Urgent Care Claims—The Plan's expedited appeal process for Pre-Service Urgent Care Claims will allow the Covered Person to request (orally or in writing) an expedited appeal, after which, all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Covered Person by telephone, fax, or other expeditious method. The Covered Person will be notified (in writing or electronically) of the appeal decision as soon as possible, but not later than thirty-six (36) hours after the Plan receives the second appeal.

Final Appeal of Pre-Service Non-Urgent Care Claims—For Pre-Service Non-Urgent Care Claims, the Covered Person will be notified (in writing or electronically) of the appeal decision within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days.

Final Appeal of Post-Service Claims—For Post-Service Claims, the Covered Person will be notified (in writing or electronically) of the appeal decision within a reasonable period of time, but not later than sixty (60) days.

Denial of Claim on Final Appeal—If the Covered Person’s second appeal is denied, the Plan will send the Covered Person written or electronic notification that explains why the appeal was denied and will include the following:

1. A statement of the specific reason(s) for the decision;
2. Reference(s) to the specific Plan provision(s) on which the determination is based;
3. A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination or a statement that such information will be provided free of charge upon request;
4. If the determination involves scientific or clinical judgment, the Plan will disclose either (a) an explanation of the scientific or clinical judgment applying the terms of the Plan to the claimant’s medical circumstances, or (b) a statement that such explanation will be provided at no charge upon request;
5. A statement indicating the Covered Person’s right to receive, upon request (and free of charge), reasonable access to (and copies of) all documents, records, and other information relevant to the determination. Included in this category are any documents, records or other information in his claim file, whether or not those materials were relied upon by the plan in making its adverse determination; and
6. The following statement: "All claim review procedures provided for in the Plan must be exhausted before any legal action is brought."

RECOVERY OF PAYMENTS

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

A Covered Person, provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within thirty (30) days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable under the Plan (including payment of future benefits for other Injuries or Illnesses) by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agrees to submit claims for reimbursement in strict accordance with their State’s health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan’s attorneys’ fees and costs, regardless of the action’s outcome.

Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) is entitled, for or in relation to facility-acquired condition(s), provider error(s), or damages arising from another party’s act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;

2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two (2) years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6.) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his covered dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a dependent of the Plan Participant.

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

CLAIMS AUDIT

The Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit. The analysis will be employed to identify charges billed in error and/or charges that are not "Usual & Customary and/or Reasonable" (UCR) and/or Medically Necessary, if any, and may include a "patient medical billing records review" and/or audit of the patient's medical charts and records. Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the UCR amounts or other applicable provisions, as outlined in this Plan Document. Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a UCR charge, in accordance with the terms of this Plan Document.

GENERAL PROVISIONS

ALTERNATE BENEFITS

Alternate benefits means payment for those services or supplies which are not otherwise Covered Expenses of the Plan, but that the Plan Administrator believes to be Medically Necessary and cost-effective. If payment for alternate benefits is approved by the Plan Administrator, the Covered Person will be notified of such approval and the duration of such approval.

The fact that alternate benefits are paid by the Plan shall not obligate the Plan to pay such benefits for other Covered Persons, nor shall it obligate the Plan to pay continued or additional alternate benefits for the same Covered Person. Payments for alternate benefits are Covered Expenses for all purposes under the Plan.

AVAILABILITY OF BENEFITS

Benefits quoted to providers 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.

For a written pre-treatment estimate, a provider of service must submit to the Claim Administrator 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 estimate of benefits.

CONFORMITY WITH LAW

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby deemed amended to conform to the minimum requirements thereto.

EXAMINATION

If necessary to assist in making a benefit determination, the Plan may request that the patient be examined by a Physician selected and paid by the Plan. If the patient chooses not to comply with this request, benefits will be denied.

FREE CHOICE OF PROVIDER

The Covered Person shall have free choice of any legally qualified Physician or surgeon and the Physician-patient relationship shall be maintained.

MISCELLANEOUS

Section titles are for conveniences of reference only, and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.

STATEMENTS

In the absence of fraud, all statements made by a Covered Person will be deemed representations and not warranties. No such representations will void the Plan benefits or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Person.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

Payment Condition:

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

2. Plan Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, the Plan Participant(s) agrees the Plan shall have an equitable lien on any funds received by the Plan Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Plan Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.
3. In the event a Plan Participant(s) settles, recovers, or is reimbursed by any Coverage, the Plan Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Plan Participant(s). If the Plan Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.
4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Plan Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

Subrogation:

1. As a condition to participating in and receiving benefits under this Plan, the Plan Participant(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Plan Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.
2. If a Plan Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Plan Participant(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus Reasonable costs of collection.
3. The Plan may, at its discretion, in its own name or in the name of the Plan Participant(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. If the Plan Participant(s) fails to file a claim or pursue damages against:
 - a) the responsible party, its insurer, or any other source on behalf of that party;
 - b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - c) any policy of insurance from any insurance company or guarantor of a third party;
 - d) workers' compensation or other liability insurance company; or
 - e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage,

the Plan Participant(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Plan Participant(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan Participant(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement:

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Plan Participant(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Plan Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Plan Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Plan Participant(s).
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, disease or disability.

Excess Insurance:

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

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

Separation of Funds:

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

Wrongful Death:

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

Obligations:

1. It is the Plan Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions and/or cooperating in trial to preserve the Plan's rights;
 - b) to provide the Plan with pertinent information regarding the Illness, disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;
 - c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

- f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or Coverage.
2. If the Plan Participant(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Plan Participant(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Participant(s).
3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

Offset:

Failure by the Plan Participant(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the Plan Participant(s) may be withheld until the Plan Participant(s) satisfies his or her obligation.

Minor Status:

1. In the event the Plan Participant(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

Language Interpretation:

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

Severability:

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

TIME LIMITATION

If any time limitation of the Plan with respect to giving notice of claim or furnishing proof of loss, or the bringing of an action at law or in equity, is less than that permitted by the law of the state in which the Plan is existent, such limitation is hereby extended to agree with the minimum period permitted by such law.

WORKER'S COMPENSATION NOT AFFECTED

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

COORDINATION OF BENEFITS

The coordination of benefits provision is intended to prevent the payment of benefits which exceed Allowable Expenses. It applies when the Participant or any eligible dependent who is covered by the Plan is also covered by any other plan or plans. When more than one coverage plan exists, one Plan normally pays its benefits in full and the other plans pay reduced benefits. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed one hundred percent (100%) of Allowable Expenses. Only the amount paid by the Plan will be charged against the Plan maximums.

The coordination of benefits provision applies whether or not a claim is filed under the other plan or plans. If needed, authorization must be given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

EXCESS INSURANCE

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

This Plan's benefits will be excess to, whenever possible:

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

FACILITY OF PAYMENT

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other plan or plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

RIGHT OF RECOVERY

In accordance with the Recovery of Payments provision (in the section titled CLAIMS PROCEDURES), whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her dependents.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this provision or any provision of similar purpose of any other plan, this Plan may, without the consent of or notice to any person, release to or obtain from any insurance company, or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Plan such information as may be necessary to implement this provision.

VEHICLE LIMITATION

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

COORDINATION OF BENEFITS DEFINITIONS

NOTE: When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

"Plan" as used in this Section will mean any plan providing benefits or services for or by reason of medical, dental or vision treatment, or Outpatient prescription drugs and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group, whether on an insured or uninsured basis, including but not limited to:
 - a. Hospital indemnity benefits; and
 - b. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of claims;
2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
4. A licensed Health Maintenance Organization (H.M.O.);
5. Any coverage for students which is sponsored by, or provided through, a school or other educational institution; or
6. Any coverage under a governmental program and any coverage required or provided by any statute.

"Plan" will be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

"Allowable Expenses" means the Usual & Customary charge for any Medically Necessary, Reasonable, and eligible item of expense, at least a portion of which is covered under a plan. When some other plan pays first in accordance with the Coordination Order of Benefit Determinations provision (below), this Plan's Allowable Expenses shall in no event exceed the other plan's Allowable Expenses. When some other plan provides benefits in the form of services rather than cash payments, the Reasonable cash value of each service rendered—in the amount that would be payable in accordance with the terms of this Plan—shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had claim been duly made therefore.

"Claim Determination Period" means a Calendar Year or that portion of a Calendar Year during which the Covered Person for whom claim is made has been covered under this Plan.

COORDINATION ORDER OF BENEFIT DETERMINATION

Certain rules are used to determine which of the plans will pay benefits first. A plan with no Coordination of Benefits provision will determine its benefits before a plan with a Coordination of Benefits provision.

If the plans do contain a Coordination of Benefits provision, the following rules will apply:

1. A plan that covers a person as other than a dependent will determine its benefits before a plan that covers a person as a dependent.
2. A plan that covers a person as a laid-off Employee, a retired Employee or the dependent of a laid-off or a retired Employee will determine its benefit after the plan that does not cover such person as a laid-off Employee, a retired Employee or the dependent of a laid-off or a retired Employee. If one of the plans does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule will not apply.
3. When a claim is made for a dependent child who is covered by more than one plan,
 - a) If there is a decree establishing financial responsibility for medical expenses of the dependent child (that is, a "Qualified Medical Child Support Order"), benefits as a dependent of the parent with financial responsibility are determined before benefits as a dependent of the parent without financial responsibility **for the duration of the decree.**

- b) If there is no decree establishing financial responsibility for medical expenses of the dependent child, these are the rules for determining which plan pays first:
- i. If the child resides with both parents:
 - 1. The benefits as a dependent of the parent whose birthday falls earlier in the Calendar Year are determined before those of the plan of the parent whose birthday falls later in that year; except,
 - 2. If both parents have the same birthday, the benefits of the plan that has covered the parent longer are determined before those of the plan that has covered the other parent for a shorter period;
 - 3. If the other plan does not have the rules stated in this item 3. i. 1. or 2., but instead has the rule based on gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rules in the other plan will determine the order of benefits.
 - ii. If the child resides with only one (1) of the parents, these are the rules for determining which plan pays first:
 - 1. The plan of the parent with custody, then
 - 2. The plan of the spouse of the parent with custody, then
 - 3. The plan of the parent without custody; then
 - 4. The plan of the spouse of the parent without custody.
4. When the above rules do not establish an order, benefits are determined first under the plan that has covered the person for the longest period of time.
5. If the above rules still do not establish an order, benefits are determined first under the plan that has covered the Employee for the longest period of time.

COORDINATION WITH MEDICARE

Coverage under this Plan will be primary and Medicare will be a secondary payor of benefits for any Employee and his covered dependents who **remain actively employed after becoming eligible for Medicare**, unless such Employee elects to have Medicare as his or her primary coverage—in which case coverage under this Plan will terminate.

The Plan also coordinates with Medicare as follows:

1. End-stage renal disease—The Plan will be primary coverage for the first thirty (30) months of dialysis treatment; after this period, the Plan will be secondary to Medicare for this disease only;
2. Mandated coverage under another group plan—If a Participant is covered under another group plan and Federal law requires the other group plan to pay primary to Medicare, this Plan will be tertiary (third payer) to both the other plan and Medicare.

If any Covered Person eligible for Medicare fails to enroll in Medicare, the benefits of this Plan will be paid as though he had enrolled.

EXCHANGE OF INFORMATION

This Plan and other plans may exchange information needed in order to coordinate benefits. No consent or notice is required. Covered Persons must furnish needed information.

SECONDARY COVERAGE

Plan beneficiaries who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the beneficiary incurring costs which are not covered by this Plan, which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by this Plan.

PLAN ADMINISTRATION

The Plan is administered by the Plan Administrator. The Plan Administrator has retained the services of the Claims Administrator to provide certain claims processing and other technical services.

Plan Administrator An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (for example, the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The Plan Administrator has the discretionary authority to decide whether a charge is Usual & Customary and/or Reasonable (UCR). The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

Duties of the Plan Administrator The duties of the Plan Administrator include (but are not limited to) the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan Documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting as required by applicable law;
10. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any).

Any such amendment, suspension or termination shall be enacted in accordance with applicable federal and state law and any applicable governing documents.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Plan Document for that information.**

ALCOHOLISM

"Alcoholism" means a morbid state caused by excessive and compulsive consumption of alcohol that interferes with the patient's health and social or economic functioning.

ALCOHOLISM TREATMENT CENTER, DRUG ADDICTION TREATMENT FACILITY OR RESIDENTIAL TREATMENT FACILITY

"Alcoholism Treatment Center", "Drug Addiction Treatment Facility" or "Residential Treatment Facility" means a treatment facility that is approved by the Washington State Department of Social and Health Services (or another state) for treatment of Alcoholism, drug addiction and/or mental illness. It must meet the following criteria:

1. Has a Physician and/or Licensed Health Care Provider on site twenty-four (24) hours per day;
2. Provides a comprehensive patient assessment (preferably before admission, but at least upon admission);
3. Patient must be admitted by a Physician and/or Licensed Health Care Provider;
4. Has medical treatment available twenty-four (24) hours per day/seven (7) days a week, actively supervised by an attending Physician;
5. Has the ability to assess and recognize medical complications that threaten life or bodily functions, and to obtain needed services either on-site or externally;
6. Has twenty-four (24) hour supervision with evidence of close and frequent observation;
7. Provides living arrangements that foster community living and peer interaction and are consistent with developmental needs;
8. Offers group therapy sessions with at least a licensed, Registered Nurse, R.N. or licensed Masters Level health professional;
9. Has the ability to involve family and other support systems in therapy (required for children and adolescents, encouraged for adults);
10. Has individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
11. Provides a level of skilled intervention consistent with patient risk;
12. Provides active discharge planning initiated upon admission to the program;
13. Provides access to at least weekly sessions with a psychiatric Physician for individual psychotherapy;
14. Charges patients for its services;
15. Services are managed by a Physician and/or Licensed Health Care Provider that functions under the direction/supervision of a licensed Psychiatrist (Medical Director);
16. Meets any applicable licensing standards established by the jurisdiction in which it is located; and
17. Is not a Wilderness Treatment Program or any such related or similar program, school and/or education service.

Recovery Houses are not covered. Residential Crisis Treatment Centers or Residential Treatment Facilities designed to provide **only** a substance-free residential setting are not covered.

ALVEOLAR

"Alveolar" means pertaining to the ridge, crest or process of bone which projects from the upper and lower jaw and supports the roots of the teeth.

AMALGAM

"Amalgam" means a mostly silver filling often used to restore decayed teeth.

AMBULANCE

"Ambulance" means a specifically designed and equipped automobile or other vehicle such as an airplane, boat or helicopter

which meets all local, state and federal regulations for transporting the sick and injured.

AMBULATORY SURGICAL CENTER

"Ambulatory Surgical Center" means an institution or facility, either free standing or as part of a Hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a Physician for the practice of medicine or Dentistry, or for the primary purpose of performing terminations of Pregnancy, shall not be considered to be an Ambulatory Surgical Center.

BENEFIT PERIOD

"Benefit Period" means a time period of one (1) year, as shown on the Summary of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the one (1) year period so established; or
2. The day the Covered Person ceases to be covered for benefits of this Plan.

BIRTHING CENTER

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Center in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop Complications of Pregnancy or require pre- or post-delivery confinement.

BITEWING X-RAY

"Bitewing X-Ray" means an x-ray that reveals the condition of the top visible part of the upper and lower molar teeth.

BRAND NAME DRUG

"Brand Name Drug" means a drug manufactured by a pharmaceutical company which has chosen to patent the drug's formula and register its brand name.

BRIDGE

"Bridge" means a replacement for a missing tooth or teeth. The Bridge consists of the artificial tooth (pontic) and attachments to the adjoining abutment teeth (retainers). Bridges are cemented (fixed) in place and therefore are not removable.

CALENDAR YEAR

"Calendar Year" means a period of time commencing on January 1 and ending on December 31 of the same given year.

CARIES

"Caries" means a disease process initiated by bacterially produced acids on the tooth surface.

CENTER/CENTERS OF EXCELLENCE

"Center/Centers of Excellence" means medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator will determine what network Centers of Excellence are to be used.

CLAIMS ADMINISTRATOR

"Claims Administrator" means the person or firm retained by the Plan Administrator who is responsible for performing certain ministerial functions for the Plan.

CLOSE RELATIVE

"Close Relative" means the spouse, parent, brother, sister, child, aunt, uncle or grandparent of the Covered Person or the Covered Person's spouse.

COBRA

"COBRA" means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

CITY

"City" means the City of Bethel, Alaska.

COMPLICATIONS OF PREGNANCY

Benefits are available to a covered Employee, Spouse or dependent Child for services rendered to treat the following Complications of Pregnancy:

1. Severe hemorrhage from any cause.
2. Spontaneous/missed abortions (miscarriages).
3. Severe cardiac disease.
4. Severe infection.
5. Severe renal disease.
6. Pulmonary edema and maternal cardiovascular accident (CVA).

In no event will the term Complication of Pregnancy include cesarean section delivery as an alternative to vaginal delivery, false labor, occasional spotting, Physician-prescribed rest, morning sickness, hyperemesis gravidarum, pre-eclampsia, or similar conditions associated with the management of a difficult pregnancy but not constituting a classifiably distinct Complication of Pregnancy.

COMPOSITE

"Composite" means a tooth-colored filling, made of a combination of materials, used to restore teeth.

CORONARY CARE UNIT

"Coronary Care Unit" means a section, ward, or wing within the Hospital which is separated from other facilities and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill coronary patients;
2. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and
3. Provides constant observation and treatment by Registered Nurses or other highly trained Hospital personnel.

COSMETIC PROCEDURE

"Cosmetic Procedure" means a procedure performed solely for the improvement of a Covered Person's appearance rather than for the restoration of bodily function.

COVERED EXPENSES

"Covered Expenses" means the Usual & Customary and/or Reasonable (UCR) charges or the Preferred Provider allowance for Necessary or Medically Necessary treatments, services, or supplies that are listed as a covered benefit of the Plan. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of a Covered Expense.

COVERED PERSON

"Covered Person" means any Participant or dependent of a Participant meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

CROWN

"Crown" means that portion of the human tooth covered by enamel.

CUSTODIAL CARE

"Custodial Care" means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not Totally Disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

DEBRIDEMENT

"Debridement" means the removal of excessive amounts of Plaque and tartar from your teeth.

DENTAL HYGIENIST

"Dental Hygienist" means a person who is licensed to practice dental hygiene and who is practicing within the scope of their license.

DENTIST

"Dentist" means a person duly licensed to practice Dentistry by the governmental authority having jurisdiction over the licensing and practice of Dentistry in the locality where the service is rendered.

DENTURIST

"Denturist" means a person who is licensed to make, fit and repair dentures and who is practicing within the scope of their license.

DEPENDENT COVERAGE

"Dependent Coverage" means eligibility under the terms of the Plan for benefits payable as a consequence of Covered Expenses Incurred for an Illness or Injury of a dependent.

DRUG ADDICTION TREATMENT FACILITY

See definition of Alcoholism Treatment Center, Drug Addiction Treatment Facility or Residential Treatment Facility.

DURABLE MEDICAL EQUIPMENT

"Durable Medical Equipment" means equipment that is:

1. Able to withstand repeated use;
2. Primarily and customarily used to serve a medical purpose; and
3. Not generally useful to a person in the absence of Illness or Injury.

EMERGENCY

"Emergency" means an Illness or Injury of sudden, acute onset resulting in a situation requiring immediate Physician and Hospital attention. Examples of a medical Emergency are heart attacks or suspected heart attacks, coma, loss of respiration, stroke, acute appendicitis, etc.

EMPLOYEE

See definition of Covered Person.

EMPLOYER

See definition of City.

ENDODONTICS

"Endodontics" means that branch of Dentistry that deals with the diagnosis and treatment of diseases of the dental pulp and tissues around the root end.

ENROLLMENT DATE

"Enrollment Date" means the earlier of: a) the first day of coverage, or b) if there is an eligibility Waiting Period for benefits, the first day of the eligibility Waiting Period.

ESSENTIAL HEALTH BENEFITS

"Essential Health Benefits" means, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency services; hospitalization; maternity and Newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative (neurodevelopmental therapy) services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

EXCLUSIONS

"Exclusions" means services and charges not covered under this Plan.

EXPERIMENTAL AND/OR INVESTIGATIONAL

The Plan Administrator or its designee has the discretion and authority to determine if a medical, surgical, diagnostic, psychiatric, substance abuse or other health care service, technology, supply, treatment, procedure, drug therapy or device is or should be classified as Experimental and/or Investigational. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for preauthorization under the Plan's utilization management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:**

1. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.
2. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical or scientific literature on the subject, or a preponderance of such literature published in the United States and written by experts in the field; that shows that recognized medical or scientific experts classify the service or supply as Experimental and/or Investigational or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.

Authoritative peer reviewed medical or scientific writings that will be considered include the following publications or sources of publications:

- a) "United States Pharmacopoeia Dispensing Information";
 - b) "American Hospital Formulary Service";
 - c) "American Medical Association (AMA), Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, or similar publications of the AMA;
 - d) specialty organizations recognized by the AMA;
 - e) the National Institutes of Health (NIH);
 - f) the Center for Disease Control (CDC);
 - g) the Agency for Health Care Policy and Research (AHCPR)
 - h) opinions of other agency review organizations, e.g. ECRI Health Technology Assessment Information Service or HAYES New Technology Summaries;
 - i) the American Dental Association (ADA), with respect to dental services or supplies;
 - j) the latest edition of "The Medicare Coverage Issues Manual."
3. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered Experimental and/or Investigational if it is approved by the FDA as an "investigational new drug for treatment use"; or classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; or approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug

was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.

4. The prescribed service or supply is available to the Covered Individual only through participation in Phase I or Phase II clinical trials; or Phase III Experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

FAMILY

"Family" means a Participant and his eligible dependents.

FLUORIDE

"Fluoride" means a substance when topically applied or applied to drinking water is effective in resisting tooth decay.

FOOT ORTHOTICS

"Foot Orthotics" means medical devices employed to support and align the foot, to prevent or correct foot deformities, or to improve the functions of the foot.

GENERAL ANESTHESIA

"General Anesthesia" means a drug or gas which produces unconsciousness and insensibility to pain.

GENERIC DRUG

"Generic Drug" means a drug that is generally equivalent to a higher-priced Brand Name Drug that meets all FDA bioavailability standards.

GENETIC INFORMATION

"Genetic Information" means information about genes, gene products, and inherited characteristics that may derive from an individual's laboratory tests or medical examination.

HIPAA

"HIPAA" means the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), which was enacted as part of a broad Congressional attempt at incremental health care reform. HIPAA required the Department of Health and Human Services to create standards for the electronic exchange, privacy and security of health information. The "HIPAA Privacy Rule" grants health care consumers a greater level of control over the use and disclosure of personally identifiable health information. In general, health care providers, health plans, and clearinghouses are prohibited from using or disclosing health information except as authorized by the patient or specifically permitted by the regulation.

HOME HEALTH CARE AGENCY

"Home Health Care Agency" means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

1. It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.
2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at least one Registered Nurse to govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Nurse.
3. It maintains a complete medical record on each individual.
4. It has a full-time administrator.

HOME HEALTH CARE PLAN

"Home Health Care Plan" means a program for continued care and treatment of the Covered Person established and approved in writing by the Covered Person's attending Physician. The attending Physician must certify in the Home Health Care Plan that the proper treatment of the Illness or Injury would require confinement as a resident Inpatient in a Hospital in the absence of the

services and supplies provided as part of the Home Health Care Plan.

HOME INFUSION THERAPY

"Home Infusion Therapy" means administration of fluids into a vein by means of a needle or catheter, most often used for the following purposes: a) to maintain fluid and electrolyte balance; b) to correct fluid volume deficiencies after excessive loss of body fluids; c) for those unable to take sufficient volumes of fluids orally; or d) to provide prolonged nutritional support to those with gastrointestinal dysfunction.

HOSPICE

"Hospice" means a health care program providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse, and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

HOSPITAL

"Hospital" means an institution that meets all of the following conditions:

1. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense;
2. It is constituted, licensed, and operated in accordance with the laws of jurisdiction in which it is located which pertain to Hospitals;
3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an Illness or an Injury;
4. Such treatment is provided for compensation by or under the supervision of Physicians with continuous twenty-four (24) hour nursing services by Registered Nurses;
5. It qualifies as a Hospital, a psychiatric Hospital, or a tuberculosis Hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations;
6. It is a provider of services under Medicare; and
7. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

HOSPITAL MISCELLANEOUS EXPENSES

"Hospital Miscellaneous Expenses" means the actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

ILLNESS

"Illness" means a bodily disorder, disease, physical sickness, mental infirmity, or functional nervous disorder of a Covered Person. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Illness.

IMPLANT

"Implant", as used in the Dental Plan, means 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.

INCURRED

"Incurred" means the time or date a service or supply is actually provided to a Covered Person. With respect to a course of treatment or procedure that includes several stages or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon

commencement of the first stage of the procedure or course of treatment.

INJURY

"Injury" means trauma or damage to the Covered Person's body from an external force.

INLAY

"Inlay" means a dental filling shaped to the form of a cavity and then inserted and secured with cement.

INPATIENT

"Inpatient" means the classification of a Covered Person when that person is admitted to an institution such as a Hospital, Hospice, Skilled Nursing Facility or other facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such treatment.

INTENSIVE CARE UNIT

"Intensive Care Unit" means a section, ward, or wing within the Hospital which is separated from other facilities and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;
2. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and
3. Provides constant observation and treatment by Registered Nurses or other highly trained Hospital personnel.

I.V. SEDATION

"I.V. Sedation" means a form of sedation where the patient experiences a lowered level of consciousness but is still awake and can respond.

LICENSED PRACTICAL NURSE

"Licensed Practical Nurse" (L.P.N.) means an individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

LIFETIME

"Lifetime" as it appears in this Plan means benefit maximums and is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

LIMITATIONS

"Limitations" means restrictions such as age, period of time covered and Waiting Periods, which may limit coverage or benefits under this Plan.

MAXIMUM ALLOWABLE CHARGE

"Maximum Allowable Charge" means the benefit payable for a specific coverage item or benefit under the Plan.

For Preferred Providers, the Maximum Allowable Charge(s) will be the lesser of:

1. The allowable charge specified under the terms of the Plan;
2. The negotiated rate established in a contractual arrangement with a provider; or
3. The actual billed charges for the covered services.

For Non-Preferred Providers, Maximum Allowable Charge(s) will be the lesser of:

1. The Usual & Customary and/or Reasonable (UCR) amount;
2. The allowable charge specified under the terms of the Plan;

3. The negotiated rate established in a contractual arrangement with a provider; or
4. The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual & Customary and/or Reasonable (UCR) amount. The Plan has the discretionary authority to decide if a charge is Usual & Customary and/or Reasonable (UCR) and/or a Medically Necessary service.

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

MEDICALLY NECESSARY or MEDICAL NECESSITY

“Medically Necessary” or “Medical Necessity” means a medical service or supply that:

1. is provided by or under the direction of a Physician or other duly licensed health care practitioner who is authorized to provide or prescribe it **and**
2. is determined by the Plan Administrator or its designee to meet **all** of the following requirements:
 - a) It is consistent with the symptoms or diagnosis and treatment of the illness or injury; **and**
 - b) It is not provided primarily for the convenience of the patient, Physician, Hospital, Health Care Provider,
 - c) or health care facility; **and**
 - d) It is an “appropriate” service or supply given the patient’s circumstances and condition; **and**
 - e) It is a “cost-efficient” supply or level of service that can be safely provided to the patient; **and**
 - f) It is safe and effective for the Illness or Injury for which it is used.

A medical service or supply will be considered to be “appropriate” if:

- a) It is a diagnostic procedure that is called for by the health status of the patient, and is (a) as likely to result in information that could affect the course of treatment and (b) no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient’s overall health condition.
- b) It is care or treatment that is (a) as likely to produce a significant positive outcome and (b) no more likely to produce a negative outcome than any alternative service or supply, both with respect to the Illness or Injury involved and the patient’s overall health condition.

A medical service or supply will be considered to be “cost-efficient” if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses Incurred in connection with the service or supply.

The fact that the Physician may provide, order, recommend or approve a service or supply **does not mean** that the service or supply will be considered to be Medically Necessary for the medical coverage provided by the Plan.

A hospitalization or confinement to a Skilled Nursing Facility or other specialized health care facility will **not** be considered to be Medically Necessary if the patient’s Illness or Injury could safely and appropriately be diagnosed or treated while not confined.

MEDICARE

"Medicare" means the programs established by Title I of Public Law 89-98 (79 Statutes 291) as amended entitled "Health Insurance for the Aged Act", and which includes Parts A, B and D and Title XVIII of the Social Security Act (as amended by Public Law 89-97, 79), as amended from time to time.

MINOR EMERGENCY MEDICAL CLINIC

"Minor Emergency Medical Clinic" means a free-standing facility which is engaged primarily in providing minor Emergency and episodic medical care to a Covered Person. A board-certified Physician, a Registered Nurse, and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be a Minor Emergency Medical Clinic, by whatever actual name it may be called; however, a clinic located on or in conjunction with or in

any way made a part of a regular Hospital shall be excluded from the terms of this definition.

NAMED FIDUCIARY

"Named Fiduciary" means the City, as the Plan Administrator.

NECESSARY

"Necessary" in regards to dental treatment means that, as determined by the Claims Administrator:

1. There is a condition which requires treatment; and
2. The service or supply used to treat the condition is:
 - a. Required;
 - b. Generally professionally accepted as the Usual & Customary and effective means of treating the condition in the United States; and
 - c. Approved by regulatory authorities such as the American Dental Association.
 - d. Not performed mainly for the convenience of the patient or the provider of dental services;
 - e. Not conducted for research purposes; and
 - f. The most appropriate level of services that can be safely provided to the patient.

All of these criteria must be met; merely because a Dentist recommends or approves certain care does not mean that it is Necessary.

NEWBORN

"Newborn" means an infant from the date of his birth until the initial Hospital discharge or until the infant is fourteen (14) days old, whichever occurs first.

NIGHTGUARD

"Nightguard" means an appliance used to treat the unconscious habit of gnashing or grinding teeth during the sleeping period or at times of stress.

OCCLUSAL ADJUSTMENT

"Occlusal Adjustment" means a 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.

OCCUPATIONAL THERAPY

"Occupational Therapy" means therapy designed to help the Covered Person attain the maximum level of physical and psycho-social independence following Illness or Injury. This includes fine motor coordination, perceptual-motor skills, sensory testing, adaptive/assistive equipment, activities of daily living and specialized upper extremity and hand therapies.

ONLAY

"Onlay" means a restoration of the contact surface of the tooth that covers the entire surface.

ORTHOPEDIC APPLIANCE

"Orthopedic Appliance" means a rigid or semi-rigid support used to restrict or eliminate motion in a diseased, injured, weak or deformed body member.

OUTPATIENT

"Outpatient" means the classification of a Covered Person when that Covered Person receives medical care, treatment, services or supplies at a clinic, a Physician's office, or at an institution where the patient is not a registered bed patient, such as a Hospital, an Outpatient Psychiatric facility or an Outpatient Alcoholism Treatment Center or Drug Addiction Treatment Facility.

OVERDENTURE

"Overdenture" means a removable denture constructed over existing natural teeth or implanted studs.

PANOREX X-RAY

"Panorex X-Ray" means an x-ray system using two points of rotation to obtain a panoramic view of the dental arches.

PARTIAL CONFINEMENT TREATMENT

"Partial Confinement Treatment" means medical, psychiatric, nursing, counseling, or therapeutic services provided in a facility for the intermediate short-term or medically-directed intensive treatment of an Illness or Injury and must meet the following conditions:

1. It is carried out in a Hospital, Psychiatric Health Facility, Alcoholism Treatment Center, Drug Addiction Treatment Facility, Residential Treatment Facility or Skilled Nursing Facility;
2. It consists of Medically Necessary treatment for the condition of the patient in accordance with the written Partial Confinement Treatment Plan;
3. It does not require full-time confinement; and
4. It is supervised by a Physician who reviews and evaluates its effect on a weekly basis.

PARTIAL CONFINEMENT TREATMENT PLAN

"Partial Confinement Treatment Plan" means a program for continued care and treatment of the Covered Person established and approved in writing by the Covered Person's attending Physician. The attending Physician must certify in the Partial Confinement Treatment Plan that the proper treatment of the Illness or Injury would require Inpatient confinement in the absence of the services provided as part of the Partial Confinement Treatment Plan.

PARTICIPANT

"Participant" means an eligible Employee of the City who meets the qualifications as stated in this Plan.

PARTICIPANT COVERAGE

"Participant Coverage" means coverage hereunder providing benefits payable as a consequence of an Injury or Illness of a Participant.

PERIODONTAL APPLIANCE

"Periodontal Appliance" means an appliance prescribed by a periodontist to stop teeth from shifting during periodontal treatment.

PERIODONTICS

"Periodontics" means that branch of Dentistry that deals with the prevention and treatment of diseases of the bone and soft tissues surrounding the teeth.

PHYSICAL THERAPY

"Physical Therapy" means therapy designed to help the Covered Person improve physical capabilities in an attempt to restore such individual: a) to a previous level of good health; or b) to the level of health that existed prior to Illness or Injury.

PHYSICIAN AND/OR LICENSED HEALTH CARE PROVIDER

"Physician" means a legally licensed Physician or Surgeon, M.D. or D.O., Physician Assistant P.A., Osteopathic Physician Assistant O.P.A., Podiatrists D.P.M., Dentist D.D.S. or D.M.D. and Advanced Registered Nurse Practitioner A.R.N.P.

"Licensed Health Care Provider" means legally licensed medical or dental providers, including but not limited to: Certified Nurse Midwife C.N.M. if an A.R.N.P./C.N.M., Alcoholism Treatment Center, Drug Addiction Facility or Residential Treatment Facility,

Ambulatory Surgical Center, Audiologist, Birthing Center, Chiropractor D.C., community mental health center including those persons with the designation M.S.W., Dentist D.D.S. or D.M.D., Dietician D., R.D. or C.D., Durable Medical Equipment Supplies, Home Health Agency, Home Infusion Therapist, Hospice, Hospital, Laboratory, Licensed Massage Therapist, Licensed Practical Nurse L.P.N., Certified Nutritionist C.N., Occupational Therapist O.T., Optometrist O.D., Physical Therapist P.T., Psychiatric Health Facility, Psychologist, Radiologic Technologists, Registered Nurse R.N., Respiratory Care Practitioners, Skilled Nursing Facility, Speech Therapist S.T., and Surgical Assistant R.N., **to the extent that same, within the scope of their license, are permitted to perform services provided in this Plan.**

A Physician and/or Licensed Health Care Provider shall not include the Covered Person, any Close Relative of the Covered Person, or one who resides in the same household as the Covered Person.

PLAN

"Plan" means this City of Bethel Health Care Benefits Plan.

PLAN DOCUMENT

"Plan Document" means this Plan Document.

PLAN SPONSOR

"Plan Sponsor" means the City.

PLAQUE

"Plaque" means flat masses of bacteria and debris on tooth surfaces.

POSTERIOR TOOTH

"Posterior Tooth" means any one of the last five (5) teeth (bicuspid, molars and pre-molars) at the back of the upper (maxillary) or the lower (mandibular) jaw.

PREFERRED PROVIDER

"Preferred Provider" means a provider within the Preferred Provider Service Area who has signed a Preferred Provider participant agreement with a Preferred Provider organization that has been contracted by the Plan or any other reciprocal provider network. These participating providers have agreed to offer their services at special rates to enrollees of this Plan.

Services of Non-Preferred Providers will be processed as if a Preferred Provider had been used, subject to Usual & Customary and/or Reasonable (UCR) charges, if the Participant or his covered Family member:

- a) receives Inpatient care and services from a Non-Preferred Provider immediately following Emergency room care and until the patient is stabilized. Following the patient's stabilization, benefits will be paid at Non-Preferred Provider benefit levels unless the patient chooses to move to a Preferred Provider facility;
- b) uses the services of a Preferred Provider X-ray facility who subsequently uses a Non-Preferred Provider radiologist for reading the x-ray;
- c) uses the services of both a Preferred Provider facility and a Preferred Provider surgeon and receives services from a Non-Preferred Provider anesthesiologist;
- d) uses the services of both a Preferred Provider facility and a Preferred Provider surgeon and receives services from a Non-Preferred Provider assistant surgeon; or
- e) uses the services of a Preferred Provider which subsequently uses a Non-Preferred Provider laboratory to process test material; or
- f) in the case of a medical Emergency, uses a Preferred Provider facility and receives care from a Non-Preferred Provider surgeon, anesthesiologist or other ancillary provider.

If a Preferred Provider ceases to be a Preferred Provider (for reasons other than quality of care, fraud or failure to adhere to the network's policies and procedures), coverage may be continued for a specified time period for treatment in progress for a Covered Person who is:

- a) In her 3rd trimester of pregnancy; or

- b) Receiving care for end-stage renal disease and dialysis; or
- c) Receiving Outpatient mental health treatment; or
- d) Terminally ill, with anticipated life expectancy of six (6) months or less; or
- e) Undergoing an active course of treatment for which changing to a different provider would be likely to cause significant risk of harm to the Cover Person's health; or
- f) Undergoing chemotherapy or radiation therapy for treatment of cancer; or
- g) A candidate for a solid organ or bone marrow transplant.

The Claims Administrator should be informed by the Covered Person of the provider's termination within sixty (60) days of such termination.

PREFERRED PROVIDER SERVICE AREA

Preferred Provider Service Area is defined as the State of Alaska.

1. If the Participant, or his covered Family member, does not reside within the Preferred Provider Service Area and services are received from a Non-Preferred Provider, benefits will be provided as if the services of a Preferred Provider had been used (limited to the Usual & Customary and/or Reasonable [UCR] allowance).
2. If the Participant, or his covered Family member, resides within the Preferred Provider Service Area and services are obtained from a Non-Preferred Provider, benefits will be provided at the non-Preferred Provider level unless:
 - a) The claimant has traveled outside of the Preferred Provider Service Area and Emergency medical services are required; OR
 - b) There is no Preferred Provider facility within the Preferred Service Area which is able to render a Medically Necessary treatment. If this is the case, documentation must be provided and is subject to approval of the Claims Administrator.

PREGNANCY

"Pregnancy" means that physical state which results in childbirth, abortion, or miscarriage.

PROPHYLAXIS

"Prophylaxis" means the control of dental and oral diseases by preventive measures, especially the mechanical cleaning of the teeth.

PROSTHETIC APPLIANCE

"Prosthetic Appliance" means a device or appliance that is designed to replace a natural body part lost or damaged due to Illness or Injury, the purpose of which is to restore full or partial bodily function or appearance, or in the case of covered dental expenses, shall mean any device which replaces all or part of a missing tooth or teeth.

PROSTHODONTICS

"Prosthodontics" means that branch of Dentistry which deals with the replacement of missing teeth or oral tissues by artificial means, such as Crown, Bridges and dentures.

PSYCHIATRIC CARE

"Psychiatric Care", also known as psychoanalytic care, means treatment for a mental Illness or disorder, a functional nervous disorder, Alcoholism or drug addiction by a duly licensed psychiatrist, Psychologist, licensed social worker or licensed professional counselor acting within the scope and Limitations of their respective license, provided that such treatment is Medically Necessary, and within recognized and accepted professional psychiatric and psychological standards and practices.

PSYCHIATRIC HEALTH FACILITY

"Psychiatric Health Facility" means an administratively distinct governmental, public, private or independent unit or part of such unit that is licensed and certified by the state of locality's Department of Health or Department of Mental Health. A Psychiatric Health Facility provides short-term, acute Psychiatric Care on either a voluntary or involuntary basis to mentally ill persons. This care shall include, but not be limited to, the following basic services: psychiatry, clinical psychology, psychiatric nursing,

social work, rehabilitation and drug administration and which provides for a licensed psychiatrist (M.D. or D.O.) who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

The term Psychiatric Health Facility does not include an institution, or that part of an institution, used mainly for nursing care, rest care, convalescent care, a Recovery House, care of the aged, Custodial Care or educational care.

PSYCHOLOGIST

"Psychologist" means an individual holding the degree of Ph.D. and acting within the scope of his license.

QUALIFIED BENEFICIARY

"Qualified Beneficiary" means a covered Employee or dependent that is eligible to continue coverage under the Plan in accordance with applicable provisions of COBRA due to a COBRA qualifying event.

REASONABLE AND/OR REASONABLENESS

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

This determination will consider, but will not be limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, service(s) and/or fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

Services, supplies, care and/or treatment that result from errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

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

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

RECOVERY HOUSE

"Recovery House" means living arrangements that allow those who traditionally face marginalization a place to restore from the effects of alcohol or drug abuse as well as domestic conflict and mental illness. It may also be referred to as a "sober house" or "halfway house". It is primarily designed to provide only a substance-free residential setting and may involve strict codes of conduct, often reinforced by living arrangement contracts. Residents stay while they establish a sober support network, secure new employment and find new housing. Residents are typically only asked to remain sober and comply with a minimal recovery program. Recovery Houses are not covered.

REGISTERED NURSE

"Registered Nurse" means an individual who has received specialized nursing training and is authorized to use the designation of "R.N.", and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

RESIDENTIAL CRISIS TREATMENT CENTER

"Residential Crisis Treatment Center" means a temporary alternative for people experiencing an acute psychiatric episode or intense emotional distress who might otherwise face voluntary or involuntary commitment. It provides crisis stabilization, medication monitoring, and evaluation to determine the need for the type and intensity of additional services. It often includes treatment for co-occurring disorders based on either harm-reduction or abstinence-based approach to wellness and recovery. Residential Crisis Treatment Centers that do not provide Psychiatric Care or are designed to provide only a substance-free

residential setting are not covered. Residential Crisis Treatment Centers that do provide Medically Necessary treatment must also meet the qualifications of a Hospital, Psychiatric Health Facility, Alcoholism Treatment Center, Drug Addiction Treatment Facility, Residential Treatment Facility or Skilled Nursing Facility in order to be eligible for facility benefits.

RESIDENTIAL TREATMENT FACILITY

See definition of Alcoholism Treatment Center, Drug Addiction Treatment Facility or Residential Treatment Facility.

RESPIRATORY THERAPY

"Respiratory Therapy" means introduction of dry or moist gasses into the lungs for treatment purposes.

RESTORATIVE

"Restorative" means, in the case of covered dental expenses, 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.

ROOM AND BOARD

"Room and Board" means all charges by whatever name called which a Hospital, Hospice, Skilled Nursing Facility or other facility makes as a condition of occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care by whatever name called.

ROOT PLANING

"Root Planing" means a procedure done to smooth roughened root surfaces.

SEMI-PRIVATE

"Semi-Private" means a class of accommodations in a Hospital or convalescent nursing facility in which at least two patients' beds are available per room.

SEMI-PROFESSIONAL ATHLETICS

"Semi-Professional Athletics" means athletic activities for gain or pay that require an unusually high level of skill and a substantial time commitment from the participants, who are nevertheless not engaged in the activity as a full-time occupation.

SKILLED NURSING FACILITY

"Skilled Nursing Facility" means an institution or distinct part thereof operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an Inpatient basis, for persons convalescing from Injury or Illness, professional nursing services rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities;
2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse;
3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse;
4. It maintains a complete medical record on each patient;
5. It has an effective utilization review plan;
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, education or Custodial Care, or care of mental disorders; and
7. It is approved and licensed by Medicare.

This term also applies to expenses Incurred in an institution referring to itself as a convalescent nursing facility, extended care facility, convalescent nursing home, or any such other similar nomenclature **if:**

1. Such confinement must commence within fourteen (14) days of being discharged from a Hospital;

2. Said Hospital confinement must have been for a period of not less than three (3) consecutive days; and
3. Both the Hospital and convalescent confinements must have been for the care and treatment of the same Illness or Injury.

SOUND NATURAL TEETH

“Sound Natural Teeth” means teeth without disease, fillings or crowns.

SPACE MAINTAINER

“Space Maintainer” means an appliance designed to preserve the space between teeth that is caused by the premature loss of a primary tooth.

SPEECH THERAPY

“Speech Therapy” means restoration of speech lost due to impairment following an Illness or Injury including, but not limited to, cardiovascular accident, tracheotomy, swallowing disorders, laryngectomy and neuromuscular disease.

SUBGINGIVAL CURETTAGE

“Subgingival Curettage” means the process of removing or cutting diseased soft tissue surrounding the tooth.

TEMPOROMANDIBULAR JOINT

“Temporomandibular Joint” means the joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

A Temporomandibular Joint disorder has one or more of the following characteristics: pain in the musculature associated with the Temporomandibular Joint, internal derangements of the Temporomandibular Joint, arthritic problems with the Temporomandibular Joint, or an abnormal range of motion or limitation of motion of the Temporomandibular Joint.

TOTALLY DISABLED

"Totally Disabled" means a physical state of a Covered Person resulting from an Illness or Injury which wholly prevents:

1. In the case of a Participant, from engaging in any and every business or occupation and from performing any and all work for compensation or profit; and
2. In the case of a dependent, from performing the normal activities of a person of like age and sex in good health.

URGENT CARE CENTER

"Urgent Care Center" means a free-standing facility which is engaged primarily in providing minor Emergency and episodic medical care to a Covered Person. A board-certified Physician, a Registered Nurse, and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be an Urgent Care Center, by whatever actual name it may be called; however, a clinic located on or in conjunction with or in any way made a part of a regular Hospital shall be excluded from the terms of this definition.

USUAL & CUSTOMARY

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

The term “Usual” refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or

health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred.

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

The term "Usual & Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Plan Participant by a provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

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

WAITING PERIOD

A "Waiting Period" means the time between the first day of employment in an eligible class and the first day of coverage under the Plan.

WELL-CHILD CARE

"Well-Child Care" means medical treatment, services or supplies rendered to a child through age six (6) or a Newborn solely for the purpose of health maintenance and not for the treatment of an illness or injury.

PLAN INFORMATION

1. Name of Plan:
City of Bethel Health Care Benefits Plan
2. Employer Identification Number (EIN) Assigned by the Internal Revenue Service and Plan Number Assigned by the Plan Sponsor:

EIN: 92-6001644
Plan Number: 501
3. Type of Plan:
Self-Funded Medical, Prescription Drugs, Vision and Dental Plan
4. Type of administration:
Contract administration with the Claims Administrator. The funding for the benefits is derived from the funds of the Plan Sponsor (and contributions made by covered Employees, if any). The Plan is self-insured.
5. Name, business address and telephone number of the Plan Sponsor:
City of Bethel
300 State Highway
Bethel, AK 99559
(907) 543-2087
6. Name, business address and telephone number of the Plan Administrator (Named Fiduciary):
City of Bethel
300 State Highway
Bethel, AK 99559
(907) 543-2087
7. Legal Entity; Service of Process: The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator. Name and address for service of legal process: Same as shown in #5.
8. Name, business address and telephone number of the Claims Administrator:
Trusted Plans Service Corporation
P.O. Box 1894
Tacoma, Washington 98401-1894
(253) 564-5850
9. Plan Year: The Plan Year for the Plan is April 1st through March 31st.
10. Participating Employers: City of Bethel

Supplemental Information Item A

 **This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the plan document at www.trustedplans.com or by calling 1-800-426-9786.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$100 per person/\$300 per family. Does not apply to hospitalization, chemical dependency/mental health treatment, air transportation and outpatient prescription drugs.	You must pay all the costs up to the deductible amount before this plan begins to pay for covered services you use. Check your plan document to see when the deductible starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the deductible .
Are there other <u>deductibles</u> for specific services?	No	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$600 per person/\$1,800 per family.	The out-of-pocket limit is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the <u>out-of-pocket limit</u> ?	Premiums, balance-billed charges, healthcare this plan doesn't cover, and amounts in excess of maximum allowable charges.	Even though you pay these expenses, they don't count toward the out-of-pocket limit .
Is there an overall annual limit on what the plan pays?	No	The chart starting on page 2 describes any limits on what the plan will pay for specific covered services, such as office visits.
Does this plan use a <u>network of providers</u> ?	Yes. For a list of Preferred Providers, see www.multiplan.com or call 800-557-8794.	If you use an in-network doctor or other health care provider , this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network provider for some services. Plans use the term in-network, preferred , or participating for providers in their network. See the chart starting on page 2 for how this plan pays different kinds of providers .
Do I need a referral to see a <u>specialist</u> ?	No	You can see the specialist you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your plan document for additional information about excluded services .

**City of Bethel believes this Plan is a "grandfathered health plan" under the Patient Protection & Affordable Care Act. For questions or complaints, contact City of Bethel, 300 State Highway, Bethel, AK 99559, Phone (907) 543-2087.*

Questions: Call 1-800-426-9786 or visit us at www.trustedplans.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-800-426-9786 to request a copy.



- **Copayments** are fixed dollar amounts (for example, \$15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is \$1,000, your **coinsurance** payment of 20% would be \$200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges \$1,500 for an overnight stay and the **allowed amount** is \$1,000, you may have to pay the \$500 difference. (This is called **balance billing**.)
- This plan may encourage you to use preferred **providers** by charging you lower **deductibles, copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	20% Coinsurance	20% Coinsurance	----none----
	Specialist visit			
	Other practitioner office visit			
	Preventive care/screening/immunization	20% Coinsurance	20% Coinsurance	Coverage is limited to 1 Physical Exam & related tests/year; mammogram; and screening colonoscopy. Immunizations limited to children up to age 7.
If you have a test	Diagnostic test (x-ray, blood work)	20% Coinsurance	50% Coinsurance	----none----
	Imaging (CT/PET scans, MRIs)	20% Coinsurance	50% Coinsurance	----none----
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.express-scripts.com .	Generic drugs	<u>Retail</u> : \$10 Copay/ Prescription <u>Mail-Order</u> : \$20 Copay/ Prescription	<u>Retail</u> : \$10 Copay/ Prescription	<u>Retail</u> : Limited to a 34-day supply. <u>Mail-Order</u> : Limited to 35-90 day supply.
	Preferred brand drugs	<u>Retail/Mail-Order</u> : 20% Coinsurance	<u>Retail</u> : 20% Coinsurance	Non-preferred brand and specialty drugs require pre-authorization.
	Non-preferred brand drugs	<u>Retail/Mail-Order</u> : 20% Coinsurance	<u>Retail</u> : 20% Coinsurance	No Mail-Order coverage available for Non-Preferred Providers.
	Specialty drugs	20% Coinsurance		

Questions: Call 1-800-426-9786 or visit us at www.trustedplans.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-800-426-9786 to request a copy.

City of Bethel Health Care Benefits Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 4/1/2016-3/31/2017

Coverage for: Individual + Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% Coinsurance	50% Coinsurance	----none----
	Physician/surgeon fees	20% Coinsurance	20% Coinsurance	
If you need immediate medical attention	Emergency room services	20% Coinsurance	50% Coinsurance	----none----
	Emergency medical transportation	20% Coinsurance	20% Coinsurance	Air Transport: No charge for air transport, and deductible waived. Limited to 2 round-trips/year <u>each</u> for diagnostic care and for surgical care.
	Urgent care	20% Coinsurance	20% Coinsurance	----none----
If you have a hospital stay	Facility fee (e.g., hospital room)	\$50 Copay/Admission, then 20% Coinsurance	\$50 Copay/Admission, then 50% Coinsurance	Deductible waived.
	Physician/surgeon fee	20% Coinsurance	20% Coinsurance	----none----
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% Coinsurance		----none----
	Mental/Behavioral health inpatient services	\$50 Copay/Admission, then 20% Coinsurance	\$50 Copay/Admission, then 50% Coinsurance	Deductible waived.
	Substance use disorder outpatient services	20% Coinsurance		----none----
	Substance use disorder inpatient services	\$50 Copay/Admission, then 20% Coinsurance	\$50 Copay/Admission, then 50% Coinsurance	Deductible waived.
If you are pregnant	Prenatal and postnatal care	20% Coinsurance		Coverage is limited to employees and spouses only. Deductible is waived for delivery and all inpatient services.
	Delivery and all inpatient services	\$50 Copay/Admission, then 20% Coinsurance	\$50 Copay/Admission, then 50% Coinsurance	

Questions: Call 1-800-426-9786 or visit us at www.trustedplans.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-800-426-9786 to request a copy.

City of Bethel Health Care Benefits Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 4/1/2016-3/31/2017

Coverage for: Individual + Family | Plan Type: PPO

Common Medical Event	Services You May Need	Your Cost If You Use a Preferred Provider	Your Cost If You Use a Non-Preferred Provider	Limitations & Exceptions
If you need help recovering or have other special health needs	Home health care	20% Coinsurance	20% Coinsurance	Limited to 130 visits/year.
	Rehabilitation services	20% Coinsurance	20% Coinsurance	Cardiac & pulmonary rehab is limited to 1 visit/assessment/year.
	Habilitation services	20% Coinsurance	20% Coinsurance	Coverage is limited to children up to age 7 and to 6 visits (days)/year.
	Skilled nursing care	Not covered		No coverage for skilled nursing care, unless admitted immediately following covered hospitalization.
	Durable medical equipment	20% Coinsurance	20% Coinsurance	-----none-----
	Hospice service	Not covered		No coverage for hospice care, unless admitted immediately following covered hospitalization.
If your child needs dental or eye care	Eye exam	No charge		Limited to 1 exam/year.
	Glasses	No charge		Limited to 1 pair of frames and 2 lenses/ year.
	Dental check-up	10% Coinsurance		Limited to 1 exam/6 months.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your plan document for other <u>excluded services</u> .)		
• Acupuncture	• Bariatric Surgery	• Cosmetic Surgery
• Hearing Aids	• Hospice Care	• Infertility Treatment
• Long-Term Care	• Non-emergent care when traveling outside the U.S.	• Private-Duty Nursing
• Routine Foot Care	• Skilled Nursing Care	• Weight Loss Programs

Questions: Call 1-800-426-9786 or visit us at www.trustedplans.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-800-426-9786 to request a copy.

Other Covered Services (This isn't a complete list. Check your plan document for other covered services and your costs for these services.)

- Chiropractic Care
- Dental Care (Adult)
- Routine Eye Care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at: TPSC at (800) 426-9786, or visit us at www.trustedplans.com. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: TPSC at (800) 426-9786 or visit us at www.trustedplans.com; or refer to the appeals processes in the CLAIMS PROCEDURES section of your plan document. You may also contact the U.S. Department of Labor's Employee Benefit Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-426-9786.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-426-9786.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-426-9786.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-426-9786.

----- *To see examples of how this plan might cover costs for a sample medical situation, see the next page.* -----

Questions: Call 1-800-426-9786 or visit us at www.trustedplans.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-800-426-9786 to request a copy.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.



This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby

(normal delivery)

- Amount owed to providers: \$7,540
- Plan pays \$6,830
- Patient pays \$ 710

Sample care costs:

Hospital charges (mother)	\$2,700
Routine obstetric care	\$2,100
Hospital charges (baby)	\$900
Anesthesia	\$900
Laboratory tests	\$500
Prescriptions	\$200
Radiology	\$200
Vaccines, other preventive	\$40
Total	\$7,540

Patient pays:

Deductibles	\$100
Copays	\$40
Coinsurance	\$500
Limits or exclusions	\$70
Total	\$710

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

- Amount owed to providers: \$5,400
- Plan pays \$4,610
- Patient pays \$ 790

Sample care costs:

Prescriptions	\$2,900
Medical Equipment and Supplies	\$1,300
Office Visits and Procedures	\$700
Education	\$300
Laboratory tests	\$100
Vaccines, other preventive	\$100
Total	\$5,400

Patient pays:

Deductibles	\$100
Copays	\$200
Coinsurance	\$310
Limits or exclusions	\$180
Total	\$790

Questions: Call 1-800-426-9786 or visit us at www.trustedplans.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-800-426-9786 to request a copy.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include premiums.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network providers. If the patient had received care from out-of-network providers, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how deductibles, copayments, and coinsurance can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

- ✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

- ✘ **No.** Coverage Examples are not cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your providers charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

- ✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

- ✓ **Yes.** An important cost is the premium you pay. Generally, the lower your premium, the more you'll pay in out-of-pocket costs, such as copayments, deductibles, and coinsurance. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-426-9786 or visit us at www.trustedplans.com.

If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.dol.gov/ebsa/healthreform or www.cciio.cms.gov or call 1-800-426-9786 to request a copy.

Supplemental Information Item B

SUMMARY OF BENEFITS

CITY OF BETHEL HEALTH CARE BENEFITS PLAN

**EFFECTIVE DATE:
APRIL 1, 2016**

TPSC GROUP #45330

STATEMENT OF GRANDFATHERED STATUS

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at the City of Bethel, 300 State Highway, Bethel, AK 99559, (907) 543-2087.

Covered Persons may also contact the Employee Benefits Security Administration, U. S. Department of Labor at 1-866-444-3272, or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered plans.

MEDICAL SUMMARY OF BENEFITS

BENEFIT PERIOD	Calendar Year	
BENEFIT LIMITATIONS	Services received from Non-Preferred Providers are limited to a Usual & Customary and/or Reasonable (UCR) allowance.	
PRE-CERTIFICATION	Pre-certification is required for certain Inpatient admissions. Refer to the section PRE-CERTIFICATION OF INPATIENT ADMISSIONS for details.	
LIFETIME MAXIMUM BENEFIT	Unlimited	
	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
DEDUCTIBLE— <i>Applies to all services, unless otherwise noted.</i>	\$100 per person per Calendar Year \$300 per Family per Calendar Year	
OUT-OF-POCKET MAXIMUM	100% payment when an Individual's out-of-pocket expenses for allowable Deductibles and Coinsurance reach \$600 in a Calendar Year (\$1,800 per Family). Copays, non-covered charges, expenses over the maximum allowable charge, expenses payable at 50% and Outpatient Prescription Drugs, do not apply to the Out-of-Pocket Maximum and do not increase to the 100% benefit level.	
PRIMARY BENEFITS		
I. PHYSICIAN SERVICES		
<u>Inpatient</u>	Hospital Visit Surgery	Paid at 80% Paid at 80%
<u>Outpatient</u>	Office Visit/Office Surgery X-ray and Lab Surgery	Paid at 80% Paid at 80% Paid at 80%
II. PREVENTIVE CARE SERVICES		
	Routine Physical Exam & Related Tests— <i>Limited to one (1) exam per Calendar Year.</i> Mammogram Screening Colonoscopy Well-Child Care & Immunizations (to Age 7)	Paid at 80% Paid at 80% Paid at 80% Paid at 80%
III. HOSPITAL SERVICES		
<u>Inpatient</u>	Room & Board Intensive Care & Coronary Care Unit Prescription Drugs X-ray and Lab Hospital Miscellaneous Expenses	Deductible Waived, \$50 Copay per admission, then Paid at 80% Deductible Waived, Paid at 80% Deductible Waived, Paid at 80% Deductible Waived, Paid at 80% Deductible Waived, Paid at 80%
<u>Outpatient</u>	Outpatient Department/Ambulatory Surgical Center/Birthing Center	Paid at 80% Paid at 50%
<u>Emergency Room</u>	Services & Supplies X-ray and Lab	Paid at 80% Paid at 80%
		Deductible Waived, \$50 Copay per admission, then Paid at 50% Deductible Waived, Paid at 50% Deductible Waived, Paid at 50% Deductible Waived, Paid at 50% Deductible Waived, Paid at 50%
IV. OUTPATIENT DIAGNOSTIC SERVICES—Including interpretations, non-routine/non-preventive scans, imaging and labs; non-routine cancer screenings		
		Paid at 80% Paid at 50%
V. MATERNITY <i>Limited to Employees and Spouses only.</i>		
		Paid same as any other condition.

MEDICAL SUMMARY OF BENEFITS (continued)

PRIMARY BENEFITS (continued)	PREFERRED PROVIDER	NON-PREFERRED PROVIDER
VI. CHEMICAL DEPENDENCY & MENTAL HEALTH TREATMENT		
Inpatient Facility	Deductible Waived, \$50 Copay per admission, then Paid at 80%	Deductible Waived, \$50 Copay per admission, then Paid at 50%
Inpatient Physician	Paid at 80%	Paid at 80%
Outpatient Physician/Facility	Paid at 80%	Paid at 80%
VII. HOME HEALTH CARE <i>Limited to 130 visits per Calendar Year.</i>		
	Paid at 80%	Paid at 80%
VIII. TRANSPLANT BENEFIT		
	Paid at 80%	Paid at 50%
IX. OTHER BENEFITS		
Allergy Testing & Injections— <i>Testing is limited to one (1) test per Calendar Year.</i>	Paid at 80%	Paid at 80%
Ambulance	Paid at 80%	Paid at 80%
Air Transportation— <i>Limited to two (2) round-trips per Calendar Year for diagnostic care and two (2) round-trips per Calendar Year for surgical care.</i>	Deductible Waived , then Paid at 100%	Deductible Waived , then Paid at 100%
Cardiac Rehabilitation <i>Limited to one (1) visit/assessment per Calendar Year.</i>	Paid at 80%	Paid at 80%
Diabetes Care Training <i>Limited to one (1) visit/assessment per Calendar Year.</i>	Paid at 80%	Paid at 80%
Durable Medical Equipment, Supplies and Prosthetic and Orthopedic Appliances	Paid at 80%	Paid at 80%
Home Infusion Therapy	Paid at 80%	Paid at 80%
Manipulations & Related Modalities— <i>Chiropractic or spinal manipulations or massage therapy. Limited to \$3,600 per Calendar Year for all services combined.</i>	Paid at 80%	Paid at 80%
Neurodevelopmental Therapy— <i>Limited to age 7 and six (6) days/visits per Calendar Year</i>	Paid at 80%	Paid at 80%
PKU Formula	Paid at 80%	Paid at 80%
Physical, Occupational & Speech Therapy	Paid at 80%	Paid at 80%
Pulmonary Rehabilitation— <i>Limited to one (1) visit/assessment per Calendar Year.</i>	Paid at 80%	Paid at 80%
X. OUTPATIENT PRESCRIPTION DRUGS--<i>Deductible Waived.</i>		
	<u>Express Scripts Pharmacies</u>	<u>Non-Participating Pharmacies</u>
<u>Retail</u> — <i>Limited to a 34-day supply.</i>		
Generic Drugs	\$10 Copay	\$10 Copay
Brand Name Drugs	Paid at 80%	Paid at 80%
<u>Mail Order</u> — <i>Limited to a 90-day supply.</i>		
Generic Drugs	\$20 Copay	Not Covered
Brand Name Drugs	Paid at 80%	Not Covered

DENTAL SUMMARY OF BENEFITS

BENEFIT PERIOD	Calendar Year
BENEFIT LIMITATIONS	Services are limited to a Usual & Customary and/or Reasonable (UCR) allowance.
LIFETIME MAXIMUM BENEFIT	Unlimited Exception: Class IV and V benefits (see below)
ANNUAL MAXIMUM BENEFIT — <i>Class I, II, III and IV benefits for dependent Children age 18 & younger are excluded from Annual Maximum.</i>	\$3,000 per person per Calendar Year
DEDUCTIBLE — <i>Deductible waived for Class I and V benefits.</i>	\$50 per person per Calendar Year

DENTAL BENEFITS¹					
Class I Diagnostic & Preventive Services	Class II Restorative Services	Class III Major Services	Class IV		Class V TMJ
			Non-Medically Necessary Orthodontia	Medically Necessary Orthodontia	
Paid at 90%	Paid at 90%	Paid at 50%	Paid at 70%	Paid at 70%	Paid at 80%
Cleanings	Anesthesia	Bridgework	Banding	Banding	
Exams	Emergency Exam	Crowns	Necessary Extractions	Necessary Extractions	
Fluoride	Endodontics	Dentures	X-Rays	X-Rays	
Sealants	Fillings	Inlays & Onlays		<i>Limited to one (1) comprehensive course of treatment per Lifetime and to Dependent Children age eighteen (18) & younger.</i>	
X-Rays	Oral Surgery				
	Pathology				
	Periodontics				
	Space Maintainers				<i>Limited to \$1,000 per Lifetime.</i>

¹NOTE: Persons are not eligible for Class III Major Services and Class IV Orthodontia benefits until the person has been enrolled in the Plan for six (6) consecutive months.

Public Safety Classification Plan



CITY OF BETHEL

Post Office Box 1388
Bethel, Alaska 99559
Phone: 907-543-2047

TO: City Council
FROM: City Manager
SUBJECT: Public Safety Classification Group

DATE: June 6, 2016

Purpose: Create a new Classification Group for sworn, public safety non-management positions.

Authority: Collective Bargaining Agreement between the City of Bethel and the City of Bethel Employees Association, Local 6055, APEA/AFT:

ARTICLE 4 JOB CLASSIFICATION AND JOB DESCRIPTIONS

Section 4.1 Classification Rights and Duty (in part)

A. The City shall have sole authority and duty to establish, decide, determine and designate all occupational classifications it has to offer Employees, including the right to establish new classifications, reclassify, change, consolidate, or abolish existing classifications at any time, and to determine job content, duties and responsibilities. The City shall also have the authority to allocate and reallocate positions.

ARTICLE 11 MANAGEMENT RIGHTS

Section 11.1 Management Rights

In addition to the rights and authority provided to management elsewhere in this Agreement and under state, federal, or local law, the City shall remain vested with all management authority and rights unless specifically restricted by an express provision of this Agreement. Such rights and authority, include, but are not limited to the following: (in part)

- To determine all job classifications, develop all job descriptions
- To assign positions to classes and assign classes to pay ranges

Justification: The separation of sworn public safety personnel into a separate employee classification group is not unique to Bethel, and can be seen in many other communities. Such a separation recognizes that these sworn positions are unique and vested with the direct authority to enforce the law and/or make decisions that directly impact public safety and the preservation of life. The positions require advanced training, state-level certifications and the ability to meet specific physical requirements. The positions support 24/7 operations, which create payroll distinctions from other employees.

1. At several levels, this broad class of Public Safety employees is identified as distinct from other non-management employee classes.

- a. The federal Fair Labor Standards Act includes overtime provisions specific to Fire and Police operations. These provisions recognize the unique payroll situations that results from 24/7 operations, such as Kelly Shift firefighters (continuous duty for 24-hour periods) and extended shifts not found in other City service/operational areas.
 - b. The State of Alaska Public Employees Retirement System (PERS) includes a distinct component of the retirement plan entitled *Peace Officer/Firefighter Plan*. This component established differing contribution rates and retirement criteria for those employees service in police or fire positions.
 - c. The agreement between the City and the Union (cited previously) has already set precedent by adding sections within the current Union Agreement that specify unique terms of employment for police and fire positions. These provisions include probation period length, overtime eligibility and training pay.
2. The Alaska Police Standards Council is responsible for issuing police certifications in the State – an individual cannot serve as a sworn officer without meeting the State’s criteria for certification. The City does not have the authority to certify an individual to serve as a sworn police officer in the state.
 3. Fire protection personnel have the legal authority *and responsibility* to engage in fire suppression. Law enforcement officers have the legal authority *and responsibility* to enforce laws designed to maintain peace and order, protect life and property, and to prevent and detect crimes. They have the authority to arrest, detain and charge citizens. Unlike essential functions of other positions, the very nature of these responsibilities are such that an employee serving in a public safety capacity is potentially endangered by the very act of performing his or her position responsibilities.
 4. Unlike the City’s other non-management positions, those identified for the Public Safety Classification are sworn positions with specific responsibilities to the public – to enforce the law and protect and serve the public.

Proposed Public Safety Classification Plan:

Position	Range
Officer Candidate (Police)	PS 1
Firefighter/EMT	PS 2
Certified Officer (Police)	PS 3
Corporal (Police)	PS 4
Sergeant (Police)	PS 5
Captain (Fire)	PS 6
Lieutenant (Police)	PS 6

Excluded: Specifically excluded from the Public Safety Classification are the Fire and Police Chief positions, which are included in the Management Classification Plan in BMC Title 3.

Officer Candidate (PS 1): An employee not currently certified in Alaska or another state. The individual may have law enforcement experience as a CSO, VPSO, etc, or may have no experience in law enforcement at all. The individual must attend an approved training academy and complete the Field Training requirements as well as meet any probationary requirements before being eligible for the Certified Officer range (PS 3).

Firefighter/EMT (PS 2): An employee hired as a Firefighter/EMT by the City of Bethel. Personnel actions related to these positions are not reported to a state oversight authority. Their responsibilities do potentially endanger the individuals in these positions, but because they are not legally authorized by the state to arrest and charge citizens with violating the law, their range is lower than that of a Certified Police Officer.

Certified Officer (PS 3): An employee holding a valid police certification from Alaska or another state, with the ability to become certified in Alaska within the probationary period.

Corporal – Lieutenant (PS 4 -6): These ranges recognize increasing levels of responsibility within the Police Department.

Captain (PS 6): Akin to the Police Lieutenant, this position is the highest level non-managerial staff member within the Department. Responsibilities and functions are equivalent to those of the Police Lieutenant, resulting in an equivalent range of PS 6.

Wage Scale: The proposed wage scale (attached) is based on previous discussions that the desired wage of the Police Officers and Sergeants to be roughly 25% higher than currently-paid wages.

Because of the justification above, two new ranges were added for the Officer Candidate and the Firefighter/EMT. The Officer Candidates and Firefighters are currently paid at the same range as the Certified Police Officer. These new ranges accurately reflect the differences in responsibility and authority between an Officer Candidate, Firefighter/EMT and Certified Officer, and allow for appropriate variances in hourly wages relative to those differences.

The Police Officer, Corporal and Sergeant positions were realigned to ranges PS 3, PS 4 and PS 5, respectively, and the Step A wage for each range adjusted to 25% higher than the current Step A amount. All subsequent steps arose out of a formula reflecting 2.5% increase between steps, as negotiated with the Union.

As part of the realignment to the new classification, the Department Heads must complete a Personnel Action Request for each current employee, reclassifying them to the appropriate step within the new range.

Of Note: The Fire and Police Chief positions are both identified in BMC 3.12.070 as Range III positions. The salary for these management positions tops out at \$95,007 per year and the positions are not eligible for overtime, shift pay, or other hourly compensation.

**Proposed
CITY OF BETHEL PUBLIC SAFETY WAGE SCALE FOR JULY 1, 2016 THROUGH JUNE 30, 2017**

STEP	<u>A</u>		<u>B</u>		<u>C</u>		<u>D</u>		<u>E</u>		<u>F</u>		<u>G</u>		<u>H</u>		<u>I</u>		<u>J</u>	
RANGE	Annual	Hourly																		
PS 6	70,016	33.66	71,767	34.50	73,561	35.37	75,400	36.25	77,285	37.16	79,217	38.09	81,198	39.04	83,227	40.01	85,308	41.01	87,441	42.04
PS 5	67,516	32.46	69,204	33.27	70,934	34.10	72,708	34.96	74,525	35.83	76,388	36.73	78,298	37.64	80,256	38.58	82,262	39.55	84,319	40.54
PS 4	62,529	30.06	64,092	30.81	65,694	31.58	67,337	32.37	69,020	33.18	70,746	34.01	72,514	34.86	74,327	35.73	76,185	36.63	78,090	37.54
PS 3	57,898	27.84	59,345	28.53	60,829	29.24	62,349	29.98	63,908	30.73	65,506	31.49	67,143	32.28	68,822	33.09	70,542	33.91	72,306	34.76
PS 2	48,634	23.38	49,850	23.97	51,096	24.57	52,373	25.18	53,683	25.81	55,025	26.45	56,400	27.12	57,810	27.79	59,256	28.49	60,737	29.20
PS 1	46,318	22.27	47,476	22.82	48,663	23.40	49,879	23.98	51,126	24.58	52,405	25.19	53,715	25.82	55,058	26.47	56,434	27.13	57,845	27.81

STEP	<u>K</u>		<u>L</u>		<u>M</u>		<u>N</u>		<u>O</u>		<u>P</u>		<u>Q</u>		<u>R</u>		<u>S</u>		<u>T</u>	
RANGE	Annual	Hourly																		
PS 6	89,627	43.09	91,868	44.17	94,164	45.27	96,518	46.40	98,931	47.56	101,405	48.75	103,940	49.97	106,538	51.22	109,202	52.50	111,932	53.81
PS 5	86,427	41.55	88,587	42.59	90,802	43.65	93,072	44.75	95,399	45.86	97,784	47.01	100,228	48.19	102,734	49.39	105,302	50.63	107,935	51.89
PS 4	80,042	38.48	82,043	39.44	84,094	40.43	86,197	41.44	88,351	42.48	90,560	43.54	92,824	44.63	95,145	45.74	97,524	46.89	99,962	48.06
PS 3	74,114	35.63	75,967	36.52	77,866	37.44	79,812	38.37	81,808	39.33	83,853	40.31	85,949	41.32	88,098	42.35	90,300	43.41	92,558	44.50
PS 2	62,256	29.93	63,812	30.68	65,407	31.45	67,042	32.23	68,718	33.04	70,436	33.86	72,197	34.71	74,002	35.58	75,852	36.47	77,749	37.38
PS 1	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-

Notes:

This scale is based on the previously-adopted wage scale for July 1, 2016 through June 30, 2017. It includes any union-negotiated increases from the 2015-16 hourly rates (1%) and reflects 2.5% increases between steps.

PS 1: This Range (Officer Candidates) is the same as the General Employee Range 6 hourly wage. It represents no wage increase. It caps at Step J as an employee that attains certification as an Officer would promote to the PS 3 range.

PS 2: This Range (Firefighter/EMT) reflects a 5% increase over the current wage scale to recognize legal authority and responsibilities greater than those of an Officer Candidate.

PS 3: This Range (Certified Officers) reflects a 25% increase over the current wage scale for Police Officers. The resulting wages are competitive with other Alaskan communities.

PS 4 and PS 5: These Ranges reflect a 25% increase over the currently-negotiated wages.

PS 6: This Range (Fire Captain and Police Lieutenant) reflect a 20% increase over the currently-negotiated wages.