VANCOUVER FIREFIGHTERS UNION HEALTH & TRUST HEALTH CARE PLAN

VANCOUVER
FIREFIGHTERS UNION
HEALTH & WELFARE TRUST

Plan Document / Summary Plan Description As Amended and Restated Effective October 1, 2024

VANCOUVER FIREFIGHTERS UNION HEALTH & TRUST
HEALTH CARE PLAN
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INTRODUCTION: GENERAL PLAN INFORMATION

Introduction

The Plan Sponsor has established the Plan for the benefit of eligible Employees and their eligible dependents, in accordance with the terms and conditions described herein. Covered Persons in the Plan may be required to contribute toward their benefits. Contributions received from Covered Persons are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to protect eligible Employees and their dependents against certain health expenses and to help defray the financial effects arising from Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be mindful of the need to control and minimize health care costs through innovative and efficient plan design and cost containment provisions, and of abiding by the terms of this Document, to allow the Plan Sponsor to effectively assign the resources available to help Covered Persons in the Plan to the maximum feasible extent.

The Plan Sponsor is required under ERISA to provide to Covered Persons a Plan Document and a Summary Plan Description; a combined Plan Document and Summary Plan Description, such as this document, is an acceptable structure for ERISA compliance. The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by Vancouver Firefighters Union Health & Trust and may be reviewed at any time during normal working hours by any Covered Person.

This document describes the Medical, Vision and Prescription Drug benefits available to employees of Vancouver Firefighters Union Health & Trust. The benefits described in this Document become effective on October 1, 2024. This Document summarizes the Plan rights and benefits for covered employees and their dependents. So know the Plan, what it requires of you, how to become eligible for benefits, and what steps you can take to assure that you will receive your earned benefits.

General Plan Information

When you become a Covered Person, you will have available to you a listing of the participating hospitals and physicians of the Preferred Provider Organization (PPO). At the time of service, it is your responsibility to confirm with the medical provider and/or facility that they continue to participate in the PPO. A telephone number is provided on the front of your Identification Card to contact the network to assist you with locating providers in your area. Additionally, The Loomis Company website www.loomisco.com contains links to many online provider directories. Printed provider directories are also available to you free of charge; however, due to changes the printed directories become obsolete quickly.

If you live within the geographic service area of your PPO network and utilize the services of network providers, the Vancouver Firefighters Union Health & Trust Health Care Plan will provide higher levels of benefits to you.

The participating Hospitals and physicians of the network have agreed to extend a discount to those employees and covered dependents that utilize their facilities. When your claims for Hospital services are processed, you will see the amount of the discount on the Explanation of Benefits (EOB). This helps reduce your liability for the cost of the services.

Non-English Language Notice
This Document contains a summary in English of a Covered Person's plan rights and benefits under the Plan. If a Covered Person has difficulty understanding any part of this Plan Document, he or she may contact the Plan Administrator at the contact information above.

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

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

Mental Health Parity
Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, 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.

Non-Discrimination
No eligibility rules or variations in contribution amounts will be imposed based on an eligible Employee's and his or her dependent's/dependents' health status, medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability, disability, or any other health status related factor. Coverage under this Plan is provided regardless of an eligible Employee's and his or her dependents' race, color, national origin, disability, age, sex, gender identity or sexual orientation. Variations in the administration, processes or benefits of this Plan that are based on clinically indicated reasonable medical management practices, or are part of permitted wellness incentives, disincentives and/or other programs do not constitute discrimination.

Applicable Law
This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

IMPORTANT HIGHLIGHTS

(1) **PATIENT PROTECTION AND AFFORDABLE CARE ACT**

Vancouver Firefighters Union Health & Trust believes this plan is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). Questions regarding what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers. This website (in the Regulations and Guidance/Grandfathered Health Plans section) has a table summarizing which protections do and do not apply to Grandfathered Health Plans.www.dol.gov/ebsa/healthreform.

(2) **MANDATORY PRE-NOTIFICATION**

Refer to the *Pre-notification Review* Section of this document.

(3) **YOU MUST NOTIFY THE HUMAN RESOURCES DEPARTMENT / BENEFITS PERSONNEL WHEN ONE OF THE FOLLOWING EVENTS OCCURS.**

- Birth of a child. *(Within 30 days).*
- Your covered child turns 26. *(Within 60 days).*
- Divorce. *(Within 60 days).*
- Marriage. *(Within 30 days).*
- Adoption of a child. *(Within 30 days).*

Failure to notify the Human Resources Department / Benefits Personnel of these events could result in loss of eligibility and claims being denied.

(4) **YOU MUST BE SURE PROVIDERS HAVE CURRENT BILLING INSTRUCTIONS PROVIDED ON YOUR IDENTIFICATION CARD. FAILURE TO SUBMIT CLAIMS PROPERLY WILL RESULT IN DELAYED CLAIMS PROCESSING.**

(5) **BILLS SHOULD BE SUBMITTED FOR PAYMENT ON A TIMELY BASIS**.

Claims filed more than 12 months after the date of service will not be eligible for payment.

(6) **BALANCE BILLING**

In the event that a claim submitted by a PPO or Non-PPO Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Covered Person should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance billing is legal in many jurisdictions, and the Plan has no control over Non-PPO Providers that engage in balance billing practices.

In addition, with respect to services rendered by a PPO Provider being paid in accordance with a discounted rate, it is the Plan's position that the Covered Person should not be responsible for the difference between the amount charged by the PPO Provider and the amount determined to be payable by the Plan Administrator, and should not be balance

billed for such difference. Again, the Plan has no control over any PPO Provider that engages in balance billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the PPO Provider.

The Covered Person is responsible for any applicable payment of coinsurances, deductibles, and out-of-pocket maximums and may be billed for any or all of these.

(7) **CLAIMS AUDIT**

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, 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 Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Document.

The terms under which the Plan administers benefits are contained in this booklet.

HEALTHCARE BLUEBOOK PROGRAM

Healthcare Bluebook provides a web-based resource for assisting Employees and their Dependents in making good decisions for their health while enabling you to become an informed healthcare consumer. Specific resources assist with:

- Using Healthcare Bluebook to understand the Fair Price for a specific healthcare service;
- Finding a Fair Price provider in your area;
- Identifying Provider Quality Resources.

You may access these web-based resources under Healthcare Bluebook at www.loomisco.com or by contacting (866) 873-6616.

Employees and their Dependents can earn cash rewards by choosing a green provider for specific procedures available through Healthcare Bluebook. You may access the list of eligible services and green providers under Healthcare Bluebook at www.loomisco.com or by contacting (866) 873-6616.

Go Green to Get Green!
Selecting a green provider for select procedures qualifies you for a reward. Healthcare Bluebook will identify your reward eligibility and the reward amount and send the reward directly to you. You do not have to submit any forms.

Eligible Services & Reward Amounts
Below is a sample of procedures along with the incentive award for using a green provider. Cash rewards range from $25 to $100 per procedure. Note this is not a complete list of eligible services and reward amounts. You may obtain a complete list of eligible services and reward amounts by visiting the website and/or calling the telephone number listed above.

Type	Procedure Name	Cash Award
Diagnostic	Colonoscopy	$100
Diagnostic	Endoscopy – Upper GI	$100
Diagnostic	Sleep Study (only if eligible benefit under the Plan)	$50
Imaging	Most CTs	$50
Imaging	Most MRIs	$50
Cardiac	Transthoracic Echocardiogram	$25
Cardiac	Heart Perfusion Imaging	$50
Outpatient	Remove Tonsils & Adenoids	$50
Outpatient	Ear Tubes	$50
Outpatient	Cataract Surgery	$50
Outpatient	Laparoscopic Cholecystectomy	$50
Outpatient	Lithotripsy	$50
Outpatient	Knee Arthroscopy	$100
Outpatient	Shoulder Arthroscopy	$100

***GreenPlus* Rewards Processing**

(1) Healthcare Bluebook will determine eligibility.

(2) Rewards are processed on a quarterly basis. Rewards usually arrive between 30 and 90 days after you have received a service. Rewards for services received at or near the end of the processing period may not appear until the following rewards cycle.

(3) Confidential: No information about individual rewards is disclosed to anyone.

(4) This will be considered taxable income. Healthcare Bluebook will provide tax documentation as required for 1099 income.

(5) Rewards are mailed to the Covered Person's address.

(6) Patients may receive multiple rewards for procedures rendered on the same day (e.g., if a patient needs 2 knee MRIs (left and right), he/she would receive 2 separate rewards for using a high value provider).

(7) Rewards are paid to the Employee (including rewards earned by family members).

(8) If you have any questions, *GreenPlus* support can be accessed at any time by sending an email to staff@healthcarebluebook.com. The email link can be accessed from any price page within the application. A Healthcare Bluebook representative will respond to your email Monday-Friday during regular business hours (8 a.m. to 5 p.m. CT).

(9) Rewards are provided to any Covered Person who uses a green provider for select procedures, regardless of whether or not they used Healthcare Bluebook.

VANCOUVER FIREFIGHTERS UNION HEALTH & TRUST
HEALTH CARE PLAN

SCHEDULE OF MEDICAL BENEFITS

Maximum Annual Benefit for Medical Care — Unlimited

	PPO	Non-PPO	Comments
Calendar Year Deductible: Per Covered Person Per Family	 $250 $500	 $250 $500	Deductibles for PPO and Non-PPO accumulate to one another. **The prescription drug section of this Plan contains a deductible.**
Benefit Percentage: Medical Plan Pays Covered Person Pays	 90% *(unless otherwise stated)* 10%	 90% *(unless otherwise stated)* 10%	
Calendar Year Out-of-Pocket Maximum: *(Including Deductible)* Per Covered Person Per Family	 $1,750 $3,500	 $1,750 $3,500	Out-of-pocket maximums for PPO and Non-PPO accumulate to one another. **The prescription drug section of this Plan contains a separate out-of-pocket maximum.**
The charges for the following do not accrue to the Out-of-Pocket Maximum: • Non-Network transplant expenses. • Cost containment penalties • Expenses incurred for Non-Covered Services			

Benefits and Services	PPO Plan Pays Allowable Charge* *(After Deductible)*	Non-PPO Plan Pays Allowable Charge* *(After Deductible)*	Comments
HOSPITAL BENEFIT			
Inpatient Hospital Services	90%	90%	*Pre-notification required.* Benefit based on Semi-private room rate.
Outpatient Hospital	90%	90%	
Skilled Nursing Facility	90%	90%	*Pre-notification required.* Limited to 60 days per calendar year.
Emergency Room	$200 Co-Pay, then 90%	Paid at Network Benefit Level	Co-pay is waived if admitted. Emergent and non-emergent care.
MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS ***Refer to the non-PPO payable at the PPO rate section for a listing of providers covered at 100%***			
Inpatient Mental Health Treatment	90%	90%	*Pre-notification required.*
Outpatient Mental Health Treatment	$25 Co-Pay, then 100% *(Deductible Waived)*	$25 Co-Pay, then 100% *(Deductible Waived)*	

Benefits and Services	PPO Plan Pays Allowable Charge* *(After Deductible)*	Non-PPO Plan Pays Allowable Charge* *(After Deductible)*	Comments
MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS *(continued)* ***Refer to the non-PPO payable at the PPO rate section for a listing of providers covered at 100%***			
Inpatient Substance Abuse Treatment	90%	90%	*Pre-notification required.*
Outpatient Substance Abuse Treatment	$25 Co-Pay, then 100% *(Deductible Waived)*	$25 Co-Pay, then 100% *(Deductible Waived)*	
Partial Hospitalization	90%	90%	*Pre-notification required.*
Neurobiological Disorders *(Autism)*	Paid According to Service Rendered	Paid According to Service Rendered	
MISCELLANEOUS SERVICES AND SUPPLIES			
Home Health Care	90%	90%	*Pre-notification required.* Limited to 130 visits per calendar year.
Hospice Care	90%	90%	*Pre-notification required*
Ambulance Service	90%	Paid at Network Benefit Level	
Durable Medical Equipment	90%	90%	*Pre-notification required*
Clinical Trials	Paid as any other benefit	90%	Refer to *Clinical Trials* in the *Covered Medical Expense* section.
Biofeedback	90%	90%	Limited to 10 visits per lifetime and only when for treatment of tension or migraine headaches.
Prosthetics and Orthotics	90%	90%	
Hearing Aids	100% *(Deductible Waived)*	100% *(Deductible Waived)*	Limited to $2,000 per calendar year.
Other Covered Expenses	90%	90%	
PROFESSIONAL SERVICES BENEFIT			
Physician's Office Visits	$25 Co-Pay, then 100% *(Deductible Waived)*	$25 Co-Pay, then 100% *(Deductible Waived)*	Office visit co-pay does not include other services rendered in the office. The co-pay applies only to the office visit charge.
Urgent Care	$25 Co-Pay, then 100% *(Deductible Waived)*	$25 Co-Pay, then 100% *(Deductible Waived)*	Office visit co-pay does not include other services rendered in the office. The co-pay applies only to the office visit charge.
Inpatient Hospital Visit or Consultation	90%	90%	
Second Surgical Opinion	$25 Co-Pay, then 100% *(Deductible Waived)*	$25 Co-Pay, then 100% *(Deductible Waived)*	

Benefits and Services	PPO Plan Pays Allowable Charge* *(After Deductible)*	Non-PPO Plan Pays Allowable Charge* *(After Deductible)*	Comments
PROFESSIONAL SERVICES BENEFIT *(continued)*			
Transplant Services	90%	90%	Expenses for travel or lodging will not be covered.
Allergy Treatment Office Visit Testing / Injections	 $25 Co-Pay, then 100% *(Deductible Waived)* 90%	 $25 Co-Pay, then 100% *(Deductible Waived)* 90%	
Surgical Services	90%	90%	*Pre-notification required for all In-patient and Outpatient surgical procedures.* Pre-notification not required for office surgery.
Orthopedic Surgery *Stem Cell treatment at Regenexx Clinical provider*	90%	Paid at Network Benefit Level	Refer to the *Covered Medical Expenses* section under *Stem Cell Orthopedic Procedure*.
Diagnostic X-ray & Laboratory Expenses *Outpatient/office setting*	90% *(Deductible Waived)*	90% *(Deductible Waived)*	
Advanced Imaging	90%	90%	Including, but not limited to, MRI, MRA, CT & PET Scans.
REHABILITATION THERAPY			
Dialysis *Outpatient*	90%	90%	
Refer to the Covered Medical Expenses section under "Dialysis" for more information. Outpatient Dialysis Treatment claims are subject to specific conditions which do not apply to other types of claims. 100% of the Usual and Reasonable Charge after all applicable deductibles and coinsurance.			
Chiropractic Care	$25 Co-Pay, then 100% *(Deductible Waived)*	$25 Co-Pay, then 100% *(Deductible Waived)*	Limited to 20 visits per calendar year.
Acupuncture Treatment	$25 Co-Pay, then 100% *(Deductible Waived)*	$25 Co-Pay, then 100% *(Deductible Waived)*	Limited to 12 visits per calendar year.
Naturopathic Treatment *Treatment for clinical nutrition and homeopathy care*	$25 Co-Pay, then 100% *(Deductible Waived)*	$25 Co-Pay, then 100% *(Deductible Waived)*	Limited to 20 visits per calendar year.
Cardiac Rehabilitation *Inpatient* *Outpatient*	 90% $25 Co-Pay, then 100% *(Deductible Waived)*	 90% $25 Co-Pay, then 100% *(Deductible Waived)*	**Inpatient** limited to 36 sessions per calendar year for phase I and II treatment only. **Outpatient** limited to 36 visits per calendar year.

Benefits and Services	PPO Plan Pays Allowable Charge* *(After Deductible)*	Non-PPO Plan Pays Allowable Charge* *(After Deductible)*	Comments
REHABILITATION THERAPY *(continued)*			
Temporomandibular Joint Disorders (TMJ)	90%	90%	Limited to $1,000 per calendar year, not to exceed $5,000 paid per lifetime.
Chemotherapy	90%	90%	*Pre-notification required*
Radiation Therapy	90%	90%	*Pre-notification required*
Speech Therapy	$25 Co-Pay, then 100% *(Deductible Waived)*	$25 Co-Pay, then 100% *(Deductible Waived)*	*Pre-notification required after initial five visits.* Limited to 30 visits per calendar year.
Physical Therapy	$25 Co-Pay, then 100% *(Deductible Waived)*	$25 Co-Pay, then 100% *(Deductible Waived)*	Limited to 30 visits per calendar year.
Occupational Therapy	$25 Co-Pay, then 100% *(Deductible Waived)*	$25 Co-Pay, then 100% *(Deductible Waived)*	*Pre-notification required after initial five visits.* Limited to 30 visits per calendar year.
Aural Therapy *Post Cochlear Implant*	$25 Co-Pay, then 100% *(Deductible Waived)*	$25 Co-Pay, then 100% *(Deductible Waived)*	Limited to 30 visits per calendar year.
Behavioral Therapy	$25 Co-Pay, then 100% *(Deductible Waived)*	$25 Co-Pay, then 100% *(Deductible Waived)*	Limited to 30 visits per calendar year.
Massage Therapy	$25 Co-Pay, then 100% *(Deductible Waived)*	$25 Co-Pay, then 100% *(Deductible Waived)*	Limited to 20 visits per calendar year.
Respiration Therapy	$25 Co-Pay, then 100% *(Deductible Waived)*	$25 Co-Pay, then 100% *(Deductible Waived)*	
PREVENTIVE CARE			
Preventive Services *As established by section 2713 of the Affordable Care Act (ACA)*	100% *(Deductible Waived)*	100% *(Deductible Waived)*	Refer to the *Covered Medical Expense* section under *Preventive* for additional information.
Well Child Care	100% *(Deductible Waived)*	100% *(Deductible Waived)*	
Well Adult Care	100% *(Deductible Waived)*	100% *(Deductible Waived)*	
Mammogram	100% *(Deductible Waived)*	100% *(Deductible Waived)*	Includes 3D mammograms.

Benefits and Services	PPO Plan Pays Allowable Charge* *(After Deductible)*	Non-PPO Plan Pays Allowable Charge* *(After Deductible)*	Comments
PREVENTIVE CARE *(continued)*			
GYN & Pap	100% *(Deductible Waived)*	100% *(Deductible Waived)*	
PSA Testing	100% *(Deductible Waived)*	100% *(Deductible Waived)*	
Colonoscopy *Routine / Diagnostic*			
Employee	100% *(Deductible Waived)*	Not Covered	No limitation for an employee.
Dependents	100% *(Deductible Waived)*	Not Covered	Dependents: Under age 50 limited to Medical Necessity and/or family history.
Pre-Natal Screening	100% *(Deductible Waived)*	Not Covered	*As established by section 2713 of the Affordable Care Act (ACA)*
Well Care includes reimbursement for the following services: office visits, physical examination, laboratory tests, x-rays, immunizations and cancer screenings.			

*Allowable Charge -The Plan will consider the Allowable Charge of the services based on the negotiated amount by the Preferred Provider Organization or as determined under the provisions as shown in the Defined Terms section.

This schedule is not all inclusive. Refer to the Covered Medical Expenses and Medical Exclusions and Limitations sections for more information.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

PRESCRIPTION DRUG BENEFITS *(Available through a separate Pharmacy Benefit Manager)*	
Calendar Year Deductible:	
Per Covered Person	**$0**
Per Family	**$0**
Calendar Year Out-of-Pocket Maximum:	
Per Covered Person	**$2,850**
Per Family	**$5,700**

Covered Prescription Drug Expenses

	Retail *1-30 day supply*	**Retail** *31-90 day supply*	**Mail-Order** *90 day supply*
Value	$2 Co-Pay, than 100%	$6 Co-Pay, than 100%	$6 Co-Pay, than 100%
Generic	$10 Co-Pay, than 100%	$30 Co-Pay, than 100%	$30 Co-Pay, than 100%
Preferred Brand	$30 Co-Pay, than 100%	$90 Co-Pay, than 100%	$90 Co-Pay, than 100%
Non Preferred	$50 Co-Pay, than 100%	$150 Co-Pay, than 100%	$150 Co-Pay, than 100%
Specialty Drugs* *Multi-sourced Drugs only*	Same copays as retail	N/A	N/A

***Specialty Pharmacy Program**

Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs may be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Manager. Refer to the Prescription Drug Card Program section for additional information for the Payer Matrix program for specialty drugs.

All Plan Participants using specialty drugs are required to meet prior authorization criteria and administrative review under the Payer Matrix program. You must enroll in the Payer Matrix program or you will be responsible for 100% co-insurance or the full cost of your medication.

The Plan will cover charges for any preventive care drugs as required by the ACA. The Plan may use reasonable medical management techniques to control costs and promote efficient delivery of care, such as covering a generic drug without cost sharing and imposing cost sharing for equivalent branded drugs.

When the individual and/or family out-of-pocket expenses reach the out-of-pocket maximum, the Plan will pay 100% of the Allowable Expenses for the remainder of the Calendar Year. No family member will be charged more than the individual out-of-pocket maximum.

SCHEDULE OF VISION BENEFITS

	Plan Payment Percent	
Eye Exam - *Includes eye refractions* *Limited to one exam per calendar year*	100%	
Frames Contacts All Other Covered Vision Hardware Benefits	Age 0 – 17 Years	Maximum benefit of $200 every calendar year for all vision hardware expenses combined
	Age 18 and Older	Maximum benefit of $200 every two calendar years for all vision hardware expenses combined

Covered Expenses
Subject to the limits in the Summary of Benefits, the Plan pays the Usual and Customary fees for vision care services, as follows:

Eye Refractions. Eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses.

Recommended. Recommended and approved by a Physician or optometrist.

Exclusions and Limitations
The following Exclusions and limitations are in addition to those set forth in the sections entitled "General Limitations and Exclusions," and "Summary of Benefits":

Consultations.

Enrolled in a Training Program. Services performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.

Glaucoma. Treatment of glaucoma, cataract surgery and one set of lenses (contacts or frame-type).

Greater Coverage. Any charges that are covered under a medical or health plan that reimburses a greater amount than this Plan.

Non Prescription Lenses. Charges for lenses ordered without a prescription or lenses that do not require a prescription.

Orthoptics. Charges for orthoptics (eye muscle exercises).

Radial Keratotomy. Radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses.

Safety Goggles or Sunglasses. Charges for eyewear not meant to address any medical purpose including but not limited to plain safety glasses or goggles. This Exclusion shall also apply to sunglasses, including prescription type.

Vision Training. Charges for vision training or subnormal vision aids.

IMPORTANT PLAN FACTS

This document has been compiled in accordance with Public Law 93-406 (known as the EMPLOYEE RETIREMENT SECURITY ACT OF 1974; "ERISA".)

PLAN NAME	Vancouver Firefighters Union Health & Trust Plan
PLAN ADMINISTRATOR & EMPLOYER (PLAN SPONSOR)	Vancouver Firefighters Union Health & Trust P. O. Box 570 Vancouver, WA 98666
EMPLOYER I.D. NUMBER	45-3280396
GROUP NUMBER	LBIVFU
PLAN NUMBER	535
TYPE OF PLAN	Self-Funded Medical, Vision and Prescription
FISCAL PLAN YEAR	January 1st to December 31st
BENEFIT PLAN YEAR	January 1st to December 31st
PLAN COSTS	Paid by Employer and Employees
AGENT FOR LEGAL PROCESS	Vancouver Firefighters Union Health & Trust P. O. Box 570 Vancouver, WA 98666
THIRD PARTY ADMINISTRATOR	The Loomis Company PO Box 7011 Wyomissing, PA 19610-6011 Customer Service Number (800) 367-3721
PLAN WAITING PERIOD	First of the month following the date of hire.
DEFINITION OF AN ELIGIBLE EMPLOYEE	An employee regularly scheduled to work at least 80 hours per month.
PHARMACY BENEFIT MANAGER	Refer to ID Card
UTILIZATION REVIEW ADMINISTRATOR ***(PRE-NOTIFICATION)***	Refer to ID Card

NON-PPO SERVICES WILL BE PAYABLE AT THE PPO RATE UNDER THE FOLLOWING CIRCUMSTANCES:

- Services rendered by a Non-PPO provider at a PPO facility. This is limited to radiologists, anesthesiologists, pathologists, and emergency room physicians.

- Medical Emergency.

- Charges for Mental Health/Substance Abuse from any Deer Hollow Recovery or Cottonwood Provider will be paid at 100%, deductible waived.

- Charges for Mental Health/Substance Abuse from any Advanced Recovery Systems (ARS) provider as shown in the list below will be paid at 100%, deductible waived.

Facility Name	**State**	**DBA**	**Facility Address(s)**
Central Florida Detox, LLC	FL	Orlando Recovery Center	6000 Lake Ellenor Drive, Orlando, FL 32809 - **Residential Treatment Facility** 100 East Sybelia Avenue, Suite 250, Maitland, Florida 32751 - **Outpatient**
Pacific North Recovery Center, LLC	WA	The Recovery Village Ridgefield	888 Hillhurst Road, Ridgefield, WA 98642 - **Residential Treatment Facility** 5114 NE 94th Ave., Vancouver, WA 98662 - **Detox Only Facility**
Recovery Village at Palmer Lake, LLC	CO	The Recovery Village Palmer Lake	443 S Highway 105, Palmer Lake, CO 80133 - **Residential Treatment Facility**
Recovery Village at Umatilla, LLC	DE	The Recovery Village Umatilla	633 - 635 Umatilla Boulevard, Umatilla, FL 32784 - **Residential Treatment Facility**
Sebring ACOP, LLC	DE	Next Generation Village	1062 Lake Sebring Drive, Sebring,FL 33870 - **Residential Treatment Facility (Adolescent)**
The Recovery Village Columbus, LLC	OH	None	3964 Hamilton Square Boulevard, Groveport, OH 43125 - **Residential Treatment Facility**
The Recovery Village Maryland, LLC	MD	IAFF Center of Excellence for Behavioral Healthcare and Recovery	13400 Edgemeade Road, Upper Marlboro, MD 20772 - **Residential Treatment Facility**

Note – Reimbursements for these providers will be subject to the Usual and Reasonable and Customary fee schedule. You may be billed for any amounts in excess of the Usual and Customary and Reasonable charges for services rendered by a Non-PPO provider.

If an employee or dependent was covered by Vancouver Firefighters Union Health & Trust Health Care Plan, which was in force immediately prior to this Plan, and if there was no lapse of coverage between this Plan and the prior Plan, the employee or dependents will be covered without interruption. If an employee or dependent was in the process of treatment by a provider of service that is not part of the Preferred Provider Organization (PPO) of this Plan, coverage will be provided

under this Plan at the PPO level of benefits for the continued treatment of that condition only. In the event another diagnosis or treatment begins after the effective date of this Plan, providers will be paid at the level of benefits according to their relationship to the PPO. If the provider does not participate in the Plan's PPO Network, benefits will be considered at the Out-of-Network level. The Plan Administrator will review all facts and documentation in determining the payment level of a Non-Participating Provider.

Your Rights and Protections against Surprise Medical Bills

When you get *emergency care* or get *treated by an out-of-network provider at an in-network hospital or ambulatory surgical center*, you are protected from surprise billing or balance billing.

Out-of-network describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

Surprise billing is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

Care you are protected from balance billing

Emergency services – If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center – When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or internist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections

You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

Your health plan generally must:

1. Cover emergency services without requiring you to get approval for services in advance (prior authorization).
2. Cover emergency services by out-of-network providers.
3. Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
4. Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed or require more information about your rights under federal law you can visit https://www.cms.gov/nosurprises.

PLAN PROVISIONS

Vancouver Firefighters Union Health & Trust Health Care Plan (the "Plan") has been designed to provide all eligible employees and covered eligible dependents with a program of Health Care Protection. The benefit plan is based on the calendar year. Deductibles are calculated based on expenses incurred during the 12 months of each calendar year.

Coinsurance: The percentage of the charge the Covered Person pays.

Co-pay: A fixed dollar amount the Covered Person pays for a service.

Deductibles: A deductible is the amount of covered expenses, which you ("Covered Persons") must pay before the Plan will pay. The individual deductible applies separately to each Covered Person. The family deductible applies collectively to all Covered Persons in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of the calendar year.

Out-of-Pocket Maximums: An out-of-pocket maximum is the amount of covered expenses that must be paid during a calendar year before the payment percentage of the Plan increases to 100%. This applies separately to each Covered Person. When a Covered Person reaches the annual out-of-pocket maximum, the Plan will pay 100% of additional covered expenses for the individual during the remainder of the calendar year.

The family out-of-pocket maximum applies collectively to all Covered Persons in the same family. When the annual family out-of-pocket maximum is satisfied, the Plan will pay 100% of covered expenses for any covered family member during the remainder of the calendar year.

Certain expenses do not apply toward the out-of-pocket maximum. Please refer to the schedule of benefits for a list of those items.

Deductible / Out-Of-Pocket Credit – If you are a Covered Person at the time of inception of this Plan *(or due to an acquisition)* that has transferred coverage mid-year from another Plan with no break in coverage, the amounts applied toward satisfaction of your annual deductible and/or out-of-pocket maximums will be credited under this Plan.

Lifetime Maximum: The *Schedule of Medical Benefits* section contains separate maximum benefit limitations for specified conditions. Any separate maximum benefit will include all such benefits paid by the Plan for the Covered Person during any and all periods of coverage under this Plan. No more than the maximum benefit will be paid for any Covered Person while covered by this Plan.

HOW TO FILE A CLAIM

For purposes of this Plan a filed claim for payment of benefits shall mean a completed paper or electronic claim form submitted to the Plan naming the specific claimant, the date of service, the specific medical condition or symptom, a specific treatment or service that was rendered or product provided by a qualified provider.

For purposes of this Plan, the term "Claimant" shall mean a Covered Person of the Plan, or entity acting on his or her behalf, authorized to submit claims to the Plan for processing, and/or appeal an adverse benefit determination.

In-Network (PPO) Claims

When you or a covered dependent utilize the services of PPO Hospitals, physicians and other providers, your involvement in the claims process will be minimal. After you identify yourself as covered through the Vancouver Firefighters Union Health & Trust Health Care Plan, bills incurred for covered expenses under this Plan will be sent directly to the address identified on your health plan ID card.

When the Hospital or other provider submits their bills, the payment will be sent to the providers directly. You will receive a copy of the Explanation of Benefits showing the payments made and any deductibles or co-insurance involved in the benefits calculation.

Please ensure the PPO Provider has the current billing instructions provided on your identification card. Failure to submit claims properly will result in delayed claims processing.

Non-Network Claims

When you or a covered dependent have incurred medical expenses for which you believe reimbursement is due under the terms of the Plan, you must file the necessary documentation. Refer to your Medical Benefits Identification Card for specific instructions as to where to submit claims. This may differ based upon the provider network that you utilize.

It is your responsibility to provide any information that is necessary for the Plan to make a prompt and fair evaluation of your claim. It is suggested that each time you file a claim the following information is provided:

- Identify yourself and your employer by using your Personal Identification Number and the Plan Number as shown on your Identification Card. If the claim is for a dependent, identify that individual in the same fashion as you did on your enrollment form.
- Have all charges presented on an original itemized bill listing dates of service, type of service and the charge for each service as rendered, including the provider's name, address, telephone number, and tax identification number.
- Either on the claim form or the bill have the attending physician identify the diagnosis for which treatment was rendered.

Non-U.S. Providers

Medical expenses for care, supplies or services which are rendered by providers whose principal place of business or address for payment is located outside of the United States are subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

- Benefits may not be assigned to a non-U.S. provider;
- The Covered Person is responsible for making all payments to non-U.S. providers and submitting receipts to the Plan for reimbursement;
- Benefit payments will be determined by the Plan based upon the exchange rate in effect on the incurred date;

- The non-U.S. provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
- Claims for benefits must be submitted to the Plan in English.

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 Claimant or dependent on whose behalf such payment was made.

A Claimant, dependent, 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 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 Claimant 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 Claimant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan 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 agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Claimant, Provider or other person or entity to enforce the provisions of this section, then that Claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Claimants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) 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 Claimant(s) are 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 for any of the following circumstances:

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 years after the date such coverage commences.
4. With respect to an ineligible person.
5. In anticipation of obtaining a recovery if a Claimant fails to comply with the Plan's Subrogation, Reimbursement & Third Party Recovery provisions.
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 Claimant or by any of his covered dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a dependent of the Claimant.

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 the 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 Claimant for any outstanding amount(s).

Limitation of Action

A Claimant cannot bring any legal action against the Plan to recover reimbursement until 90 days after the Claimant has properly submitted a request for reimbursement as described in this section and all required reviews of the Claimant's claim have been completed. If the Claimant wants to bring a legal action against the Plan, he or she must do so within three years from the expiration of the time period in which a request for reimbursement must be submitted or he or she loses any rights to bring such an action against the Plan.

A Claimant cannot bring any legal action against the Plan for any other reason unless he or she first completes all the steps in the appeal process described in this section. After completing that process, if he or she wants to bring a legal action against the Plan he or she must do so within three years of the date he or she is notified of the final decision on the appeal or he or she will lose any rights to bring such an action against the Plan.

Health Claims

According to Federal regulations which apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service. However, because of this Plan's design Pre-service Urgent Care claims will not be filed with the Plan; Post-service claims will instead be filed after the urgent care is provided.

1. Pre-service Claims. A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of pay-ability prior to the receipt of the applicable medical care; however, if the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim."

   Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Claimant's medical condition, pre-determination of pay-ability by the

Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the Claimant, hinder the Claimant's ability to regain maximum function (compared to treatment without delay), or subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, said claim may be deemed to be a "Pre-service Urgent Care Claim." In such circumstances, the Claimant is urged to obtain the applicable care without delay, and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

If, due to Emergency or urgency as defined above, a Pre-service claim is not possible, the Claimant must comply with the Plan's requirements with respect to notice required after receipt of treatment, and must file the claim as a Post-service Claim, as herein described.

Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Claimant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. If a Claimant requires an on-going course of treatment over a period of time or via a number of treatments, the Plan may approve of a "Concurrent Claim." In such circumstances, the Claimant must notify the Plan of such necessary ongoing or routine medical care, and the Plan will assess the Concurrent Claim as well as determine whether the course of treatment should be reduced or terminated. The Claimant, in turn, may request an extension of the course of treatment beyond that which the Plan has approved. If the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment, and the Claimant must simply comply with the Plan's requirements with respect to notice required after receipt of treatment, as herein described.

Post-service Claims. A "Post-service Claim" is a claim for benefits from the Plan after the medical services and/or supplies have already been provided.

Claim Timely Filing

If you or a covered dependent claim benefits, a proof of claim must be furnished to The Loomis Company within 12-months following the date of loss. If a written claim form is not furnished to the claims processor within 12-months, the claim may be denied or reduced. Benefits are based on the Plan's provisions at the time that the charges are incurred. Claims submitted after the 12-month period will not be considered for payment or may be reduced unless it is not reasonably possible to submit the claim in that time, such as the person is not legally capable of submitting the claim.

The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Covered Person seek a second medical opinion.

If a claim is wholly or partially denied, the Covered Person will be notified in writing, of the determination. The denial notification will state: (1) the specific reason(s) for the denial; (2) refer to the pertinent Plan provisions on which the denial is based; (3) describe any additional information needed to perfect the claim and explain why the additional information is necessary; and (4) describe the Plan's appeal procedures including its time limits.

Timing of Claim Decisions

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

1. Pre-service Urgent Care Claims:
    a. If the Claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
    b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
    c. The Claimant will be notified of a determination of benefits as soon as possible, but not later than 48 hours, taking into account the medical exigencies, after the earliest of:
        i. The Plan's receipt of the specified information.
        ii. The end of the period afforded the Claimant to provide the information.
    d. If there is an adverse benefit determination, a request for an expedited appeal may be submitted orally or in writing by the Claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Claimant may request an expedited review under the external review process.

2. Pre-service Non-urgent Care Claims:
    a. If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15 day extension period.
    b. If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).

3. Concurrent Claims:
    a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur before the end of such period of time or number of treatments. The Claimant will be notified sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.
    b. Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a Claimant to extend the course of treatment beyond the period of

time or number of treatments involving urgent care, notification will occur as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request with less than 24 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

c. Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the Claimant for a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent claim or a Post-service claim).

d. Request by Claimant Involving Rescission. With respect to rescissions, the following timetable applies:

i. Notification to Claimant	30 days
ii. Notification of adverse benefit determination on appeal	30 days

4. Post-service Claims:

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

b. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

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

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

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

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

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

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically (or, in the case of urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within three days), containing the following information:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the health care Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A reference to the specific portion(s) of the Plan Document upon which a denial is based.
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim.
4. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary.
5. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review.
6. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits.
7. Upon request, the identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request).
8. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request).
9. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request.
10. In a claim involving urgent care, a description of the Plan's expedited review process.

HOW TO APPEAL A CLAIM DENIAL

You or your representative has 180 days after receipt of an adverse benefit determination to appeal to the Plan Administrator. To appeal an adverse benefit determination or to review administrative documents pertinent to the claim, send a written request to The Loomis Company. *If any appeal is not filed on time, the right to appeal the adverse benefit determination will be lost.* A full and fair review of the claim will be made with no deference given to the initial benefit determination. As part of the review, you or your representative are allowed to review all Plan Documents and other information that affect the claim and are allowed to submit issues, comments, documents, records or other information that had not previously been submitted.

During the period that the claim is being reconsidered, if there is reason to believe that your medical records contain information that should be disclosed by a physician or other health professional, you or your representative will be referred to the physician for the information before the Plan will provide the requested documents directly to you or your representative.

Neither you nor your representative will be provided access to or copies of files of other Plan participants. For any appeal resulting in an adverse benefit determination, the identity of any medical or vocational expert consulted in connection with the appeal will be provided, without regard to whether the advice was relied upon in making the determination. However, the identity will not be provided unless requested by you or your representative.

All interpretations, determinations, and decisions of the reviewing entity with respect to any claim will be its sole decision based upon the Plan documents. All decisions of the Plan Administrator will be deemed final and binding. If appeal is denied, in whole or in part, however, you have a right to bring a civil action under Section 502(a) of ERISA.

No Plan Participant shall at any time, either during the time in which he or she is a Participant in the Plan, or following his or her termination as a Plan Participant, in any manner have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

Vancouver Firefighters Union Health & Trust believes this plan is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a non-grandfathered health plan provides additional appeal rights to members. Please see the information below regarding the appeal procedures.

What if a Covered Person needs help understanding an adverse benefit determination? Contact The Loomis Company via the customer service phone number on the back of the ID card for assistance in understanding an adverse benefit determination.

What if a Covered Person doesn't agree with the determination? A Covered Person has a right to appeal any adverse benefit determination.

How does a Covered Person file an initial appeal? To appeal an adverse benefit determination or to review administrative documents pertinent to the claim, send a written request to The Loomis Company within 180 days of receipt of the adverse benefit determination.

What if a situation is urgent? If the situation meets the definition of urgent under the law, the review will be conducted on an expedited basis. Generally, an urgent situation is one in which a Covered Person's health may be in serious jeopardy or, in the opinion of the physician, a Covered Person may experience pain that cannot be adequately controlled while waiting for a decision on the appeal. A Covered Person may request an expedited appeal by contacting customer service at the number on the back of the ID Card.

Who may file an appeal? A Covered Person or someone who is named to act for a Covered Person (an authorized representative) may file an appeal. An authorized representative is a person who is chosen by and identified to assist or authorized to represent the Covered Person, including a family member, provider, employer representative or attorney. An assignment of benefits by a Covered Person to a health care provider does not constitute designation of an authorized representative.

Can a Covered Person provide additional information about my claim? Yes, a Covered Person may supply additional information to The Loomis Company.

Can a Covered Person request copies of information relevant to my claim? Yes, a Covered Person may request copies (free of charge) by contacting The Loomis Company at the number on the back of the ID Card.

What happens when an initial appeal is filed? When an appeal is filed, the Plan Administrator will review the decision and provide a written determination. If the Plan Administrator continues to deny the payment, coverage, or service requested or a Covered Person does not receive a timely decision, the Covered Person may be able to request an external review of the claim by an independent third party, who will review the denial and issue a final decision.

How does a Covered person request an external review? You have four months from the date of receipt of the benefits denial notice to file your request for an external review. To request an external review, send a written request to The Loomis Company. An independent organization will review the decision and provide the Covered Person with a written determination. If this organization decides to overturn the Plan Administrator's decision, the Plan Administrator will provide coverage or payment for the Covered Person's health care item or service.

If the denial is upheld, there is no further review available under the appeals process. However, the Covered Person may have other remedies available under Federal law, such as filing a lawsuit.

Who may file a request for external review? A Covered Person or someone who is named to act for a Covered Person (an authorized representative) may file an appeal. An authorized representative is a person who is chosen by and identified to assist or authorized to represent the Covered Person, including a family member, provider, employer representative or attorney. An assignment of benefits by a Covered Person to a health care provider does not constitute designation of an authorized representative.

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a Claimant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process, in accordance with the current Affordable Care Act regulations, applies only to:

1. Any eligible Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer.
2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).

Standard external review

Standard external review is an external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

1. Request for external review. The Plan will allow a Claimant to file a request for an external review with the Plan if the request is filed within four months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would

fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. Preliminary review. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   a. The Claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided.
   b. The Adverse Benefit Determination or the Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination).
   c. The Claimant has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under the final regulations.
   d. The Claimant has provided all the information and forms required to process an external review. Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the Claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444- EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

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

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

1. Request for expedited external review. The Plan will allow a Claimant to make a request for an expedited external review with the Plan at the time the Claimant receives:
   a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Claimant for which the timeframe for completion of a standard internal appeal under the final regulations would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal appeal.

b. A Final Internal Adverse Benefit Determination, if the Claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility.

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

3. Referral to Independent Review Organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

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

Two Levels of Appeal

This Plan requires two levels of appeal by a Claimant before the Plan's internal appeals are exhausted. For each level of appeal, the Claimant and the Plan are subject to the same procedures, rights, and responsibilities as stated within this Plan. Each level of appeal is subject to the same submission and response guidelines.

Once a Claimant receives an Adverse Benefit Determination in response to an initial claim for benefits, the Claimant may appeal that Adverse Benefit Determination, which will constitute the initial appeal. If the Claimant receives an Adverse Benefit Determination in response to that initial appeal, the Claimant may appeal that Adverse Benefit Determination as well, which will constitute the final internal appeal. If the Claimant receives an Adverse Benefit Determination in response to the Claimant's second appeal, such Adverse Benefit Determination will constitute the Final Internal Adverse Benefit Determination, and the Plan's internal appeals procedures will have been exhausted.

Adverse Benefit Determination

Any denial, reduction, rescission of coverage (even if the rescission does not impact the current claim for benefits), or termination of a benefit, or failure to provide or make payment (in whole or in part) for a benefit. An adverse benefit determination includes denials made on the basis of

eligibility, utilization review, and restrictions involving services determined to be experimental or investigational, or not medically necessary or appropriate.

Compliance with Regulations

It is intended that the claims procedures be administered in accordance with the claims procedure regulations of the Department of Labor as set forth in 29 CFR § 2560.503-1. You have a right to these procedures free of charge. Please call The Loomis Company if you wish to obtain a copy of these procedures.

Autopsy

Upon receipt of a claim for a deceased Claimant for any condition, Sickness, or Injury is the basis of such claim, the Plan maintains the right to request an autopsy be performed upon said Claimant. The request for an autopsy may be exercised only where not prohibited by any applicable law.

Authorized Representative

A person who is chosen by and identified to assist or authorized to represent the Covered Person, including a family member, provider, employer representative or attorney. An assignment of benefits by a Covered Person to a health care provider does not constitute designation of an authorized representative.

Other Important Claims Information

If you or your representative fail to file a request for review in accordance with the claims procedures as described above, you or your representative will have no right to review and you or your representative will have no right to bring an action in any court. The denial of your claim will become final and binding except as otherwise provided by ERISA.

Right to Receive and Release Needed Information

Certain facts are needed to adjudicate claims in accordance with the provisions set forth in the Plan. The Plan Administrator has the right to decide which facts are required and may obtain the needed facts from or provide them to any other organization or persons. Each person claiming benefits under this Plan must provide any information required to pay the claim.

Medical Privacy

Medical information that is obtained and maintained in the course of processing claims will be secured and protected in accordance with state and federal laws regarding participant privacy rights.

Deemed Exhaustion of Internal Claims Procedures and De Minimis

Exception to the Deemed Exhaustion Rule

A Claimant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Claimant may proceed immediately to the External Review Program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Claimant must adhere to them before participating in the External Review Program or bringing a claim in court) in the event of a De Minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Claimant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant, and the violation is not reflective of a pattern or practice of non- compliance.

If a Claimant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Claimant may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "De Minimis" exception described above, the Plan will provide the Claimant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

CARE MANAGEMENT PROGRAM

Vancouver Firefighters Union Health & Trust desires to provide you and your family with a health care plan that financially protects you from significant health care expenses and assists you in locating quality care. While part of increasing health care costs results from new technology and important medical advances, another significant cause is the way health care services are used.

Some studies indicate that a significant percentage of the health care services rendered may be unnecessary. For example, Hospital stays can be longer than necessary. Some hospitalizations may be entirely avoidable, such as, when surgery could be performed on an outpatient basis with equal quality and safety. Also, surgery is sometimes performed when other treatment could be more effective. Unnecessary or avoidable health services increase costs for you and Vancouver Firefighters Union Health & Trust.

Vancouver Firefighters Union Health & Trust contracts with a professional Utilization Review Administrator to assist you in determining whether or not proposed services are appropriate for reimbursement under the Plan. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility. The medical professionals who conduct the program focus their review on the appropriateness of Hospital stays, proposed surgical procedures and excessive, costly procedures.

Case Management

When a catastrophic condition occurs, such as a spinal cord injury, a degenerative sickness, or a neurological paralytic disease, a person will require long-term, perhaps lifetime care. After the person's condition is stabilized in the Hospital, he or she might be able to be moved out of the Hospital and into another type of care setting - even to his or her home.

The Case Management program is designed to assist the patient and their family in coordinating all the aspects of care that may be required, and to find the most cost effective care while protecting the patient from undue expense. For example, sometimes specialized care or adaptations to the home are required, but are not covered under the Plan. *The Case Management program can help in these situations in which there could be a large cash outlay for non-covered expenses for catastrophic conditions, and appropriate high quality less expensive alternatives could be recommended that might not otherwise be covered.* If you believe you might benefit from case management please contact the Utilization Review Administrator listed on your ID card for further information.

The case manager will coordinate and implement the large case management program by providing guidance and information on available resources and suggesting appropriate treatment alternatives. The Plan Administrator, attending physician, patient and patient's family must all agree to the alternate treatment plan. Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for expenses as stated in the treatment plan, even if these normally would not be reimbursed by the Plan.

Please Note: Case Management is a voluntary service. There is no reduction of benefits and no penalties if the patient and family choose not to participate.

Alternative Care

In addition to the benefits specified in this booklet, the Plan may elect to offer benefits for services furnished by any Provider pursuant to an alternate treatment plan approved by the Plan and/or the Utilization Review Administrator for a Covered Person. Alternative care occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The Plan shall provide such alternative benefits for as long as the services are medically necessary and cost effective as determined by the Plan and/or Utilization Review Administrator. Once an

agreement has been reached, the Plan will reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

The fee, which may be generated due to realizing a savings as the result of utilizing a Cost Containment program or Alternate treatment plan, will be considered as a covered expense under the Plan.

If the Utilization Review Administrator makes a negotiation with a Non-PPO Provider and the discount provides a substantial savings to the Plan, benefits will be considered at the In-Network (PPO) level of benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for other Covered Persons under the Plan in any other instance. Nor shall it be construed as a waiver of the Plan Administrator's right to administer the Plan thereafter in strict assurance with its express terms.

PRE-NOTIFICATION REVIEW

Final interpretation and guidance on services that require pre-notification will be made by the Utilization Review Administrator. The Utilization Review Administrator's determination will be based on the specific procedure to be performed and not the general description in this Summary Plan Description. The specific procedures that require pre-notification may change without notice. Your provider should contact The Loomis Company at the customer service number listed on your ID card to determine if pre-notification is required. In no event shall The Loomis Company be liable for any direct or indirect disparity resulting from the use of the Pre-Notification Review process as outlined in this Summary Plan Description.

Vancouver Firefighters Union Health & Trust Health Care Plan provides pre-notification review programs through Utilization Review Administrators. **These are identified on your health plan ID cards.**

If a physician recommends any of the services listed below for any Covered Person, a call must be made to the Utilization Review Administrator. This program must be utilized for maximum benefits to be paid to the providers under the terms of Vancouver Firefighters Union Health & Trust Health Care Plan.

All Inpatient Admissions

- Acute Care
- Long-Term Acute Care
- Inpatient Rehabilitation
- Skilled Nursing Facility
- Mental Health and Substance Abuse

Outpatient – Surgery

Outpatient – Diagnostic Services

- MRI/MRA, PET, CT
- Capsule endoscopy
- Scintimammography
- Genetic Testing

Outpatient – Continuing Care Services

- Chemotherapy
- Radiation
- Dialysis
- Injectibles
- Experimental or Investigational Procedures
- Outpatient Rehab requiring more than five visits
    - Occupational Therapy
    - Speech Therapy
- Behavioral Therapy requiring more than five visits

- Outpatient Sub-Acute
    - Home Health Care
    - Hospice
    - Durable Medical Equipment

Outpatient – Mental Health and Substance Abuse

- Rehabilitation services requiring more than five visits

If a Covered Person receives (list services requiring pre-notification) or is admitted to the Hospital for an overnight stay on an <u>elective, non-emergency</u> basis without utilizing this program or in the case of an emergency admission, a contact to the Utilization Review Administrator was not made within 48 hours of confinement *(If the Covered Person is incapacitated, pre-notification must be obtained as soon as possible thereafter),* a 50% penalty on the allowed charges up to a maximum of $500 will be applied. This penalty cannot be used to satisfy remaining deductible or co-insurance payments due from the Covered Person.
The Utilization Review Administrator can be reached by dialing the phone numbers identified on your health plan I.D. cards.

After the initial contact by the Covered Person is made, all remaining communication in the review process will be between the Utilization Review Administrator and your physician. Upon completion of the review process, the Utilization Review Administrator will advise you of their recommendation. If a patient will be confined for a period longer than originally certified, contact to the Utilization Review Administrator must be made by the physician. Charges in excess of the approved treatment plan or for a period beyond an approved and pre-notified length of stay will be denied if the confinement was determined not medically necessary by the Utilization Review Administrator.

A positive determination from the Utilization Review Administrator is not a guarantee that the claim is allowable under the Plan.

Newborns' and Mothers' Health Protection Act
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 less than 48 hours (or 96 hours). However, this does not preclude a Plan or issuer from requiring pre-notification for any portion of a stay after 48 hours (96 hours), or from requiring pre-notification for the entire stay.

Required Second Surgical Opinion
At any time during the review process, the Covered Person may be asked to obtain a second surgical opinion to confirm the necessity for surgery. If the second opinion disagrees with the first opinion, a third surgical opinion will be required. Second and third surgical opinions will be given by a physician who is certified by the American Board of Medical Specialists in a field related to the proposed surgery. The physician giving the opinion will also be independent of the physician who first advised surgery.

ELIGIBILITY PROVISIONS

If you are an employee of Vancouver Firefighters Union Health & Trust, regularly scheduled to work at least 80 hours per month, you are eligible for coverage under the terms of Vancouver Firefighters Union Health & Trust Health Care Plan. This Plan does not cover non-citizens of the United States or those otherwise not authorized to work for Vancouver Firefighters Union Health & Trust. The effective date of coverage is enrollment in the plan upon completion of any applicable waiting period.

Each Employee who was covered under the prior plan, if any, will be eligible on the effective date of this Plan.

Reinstatement of Coverage
An Employee who is terminated and rehired will be treated as a new Employee upon rehire only if the Employee was not credited with an hour of service, as defined under the ACA, with the Employer (or any member of the controlled or affiliated group) for a period of at least 13 consecutive weeks immediately preceding the date of rehire or, if less, a period of consecutive weeks that exceeds the greater of (a) four weeks, or (b) the number of weeks of the Employee's immediately preceding period of employment.

Upon return, coverage will be effective on the first of the month following the date of rehire, so long as all other eligibility criteria are satisfied.

Eligibility for Retiree Coverage
A Participant may enroll and maintain retiree coverage if the following conditions are met:

1. The retired Participant terminated employment with the City of Vancouver on or after March 1, 2013 from a fire suppression or similar job classification;
2. The retired Participant completed five years of service (as measured under the Law Enforcement Officers and Fire Fighters Pension Plan 2 (LEOFF2) or the Public Employee Retirement System (PERS), i.e. pension system applicable to the employee's job classification), with the City of Vancouver in a job classification that is eligible for coverage under the Trust;
3. The retired Participant has:
    a. Attained age 53 (i.e. is eligible for a Normal Retirement benefit under the LEOFF2 Pension Plan); or
    b. Reached age 50 and completed 20 years of service under the LEOFF2 Pension Plan (i.e. is eligible for an early retirement benefit) or has reached age 53 and completed 20 years of service under the PERS plan (whichever is applicable to the Employee's job classification at retirement);
    c. Participant must be in "good standing" with the IAFF Local 452 and/or Local 4378 for their entire career; and
4. The retired Participant has maintained continuous coverage under this Trust between his or her termination of employment and enrollment under the Trust's retiree medical plan. (Coverage under another group insurance plan that allows the member to defer enrollment under the Trust's retiree medical plan or COBRA coverage under this Trust will be counted towards this continuous coverage requirement); and
5. The retired Participant timely pays any and all required premiums necessary to provide and maintain coverage; and
6. The retired Participant is not eligible for Medicare. NOTE: A member who does not participate in Medicare (because of a historic opt-out of the Medicare payroll tax program) shall be deemed eligible for Medicare upon the attainment of age 65 because of the Medicare self-payment rules.

Spouse and Dependent Eligibility
A retired Participant who enrolls in the Trust's retiree medical plan may also enroll his or her spouse, or other eligible Dependents under similar terms and conditions that apply to actively employed Participants. The Trustees may establish a separate premium amount applicable to enrolled spouses and enrolled Dependents.

A surviving spouse or a spouse of a member who becomes eligible for Medicare may continue to be enrolled in the Trust's retiree medical plan until such time as they become Medicare eligible, provided that they maintain continuous coverage under the Trust's medical plan and continue to timely pay the applicable premium for such coverage.

Right to Defer Enrollment
If a retired member has access to other group medical coverage (i.e. because of their own non-firefighter employment or a result of their spouse's employment), he or she may make an affirmative election to defer enrollment in the Trust's retiree medical plan. Such election must be made within 60 days (i.e. the COBRA election period) of his or her loss of such other group coverage, provided that they meet the eligibility for the Trust's retiree plan.

Acquired Companies
Eligible Employees of an acquired company who are Actively at Work and were covered under the Prior Plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Service Waiting Period of this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

Dependent Coverage

You may obtain coverage for you and your eligible dependents by completing the enrollment form and contributing any required amounts as defined by Vancouver Firefighters Union Health & Trust Health Care Plan. Dependent coverage is only available if the employee is also covered. If a husband and wife are employees, they may be covered as employees, and any eligible dependents may be covered as dependents of one parent but not both.

Spouses eligible for coverage under another group plan are not eligible for coverage under the Plan, except in the case of spouses who must wait to enroll during an open or special enrollment period of the other group plan. Such spouses may continue their coverage under the Plan until they are able to enroll in the other group plan at the time of an open or special enrollment period.

When you enroll a family member in the plan, you represent the following:
- *The individual is eligible under the terms of the plan; and*
- *You will provide evidence of eligibility on request.*

Further, you understand that:
- *The plan is relying on your representation of eligibility in accepting the enrollment of your family members;*
- *Your failure to provide required evidence of eligibility is evidence of fraud and material misrepresentation; and*
- *Your failure to provide evidence of eligibility will result in disenrollment of the individual, which may be retroactive to the date as of which the individual become ineligible for plan coverage, as determined by the plan administrator and subject to the plan's provisions on rescission of coverage.*

An eligible dependent shall mean any one or more of the following:

- The lawful spouse of the employee under a legally existing marriage who is a United States citizen.

An Employee's spouse must meet the following requirements:

1. Employee and spouse shall not have been engaged in a trial separation for more than 12 consecutive months upon the date a Clean Claim for Covered Expense(s) provided to spouse are received by the Plan.
2. Employee and spouse shall have been cohabitating at the same residence for the majority of the applicable Calendar Year. When an Employee or spouse is traveling or residing elsewhere as part of their profession, to care for a family member (due, for instance, to Illness or Injury), and/or is residing elsewhere due to their own Illness or Injury, for more than half of the applicable Calendar Year (and thus residing with each other for less than the majority of the applicable Calendar Year), but the primary residence of the Employee is also the spouse's primary residence for all legal, regulatory, and statutory purposes, this constitutes cohabitation as required by this provision.

The Plan Administrator has discretionary authority to interpret these terms, and determine spousal status as defined herein, to the extent allowed by law.

- Children of the employee, who are under the age of 26 including legally adopted children, children legally placed for adoption, step-children, foster children, and children for whom the employee and/or the employee's spouse has been appointed guardian by a court of competent jurisdiction.

  In addition, a spouse or biological child of a covered dependent child will not be eligible for coverage under this Plan.

- Children of the employee, including legally adopted children, children legally placed for adoption, step-children, and foster children as defined above who are primarily dependent upon the employee for support and maintenance and who are incapable of self-sustaining employment due to mental or physical disability, provided such disability started before the attainment of age 26. Also, such children must have been covered prior to the attainment of such age and covered continuously thereafter. The Plan Administrator may require proof of the dependents incapacity status. The Plan Administrator reserves the right to have such dependent examined by a physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

In order to continue a dependent child's coverage beyond age 26, you must furnish written verification of their incapacity for self-support within 60 days of the child's 26th birthday.

- Alternate recipients under qualified medical child support orders (QMCSO) required to be covered according to the provisions of ERISA Section 609 (a) (2) (A). Any child of a Covered Person who is an alternate recipient under a qualified medical child support order shall be considered as having a right to dependent coverage under this Plan. Under a QMCSO, the fact that the child is eligible for, is entitled to, or is provided benefits under Title XIX of the Social Security Act, will not affect the child or children's receipt of benefits under the QMCSO.

A **qualified medical child support order** (QMCSO) is a medical child support order issued by a court, which has jurisdiction, under state law requiring a non-custodial parent to provide medical coverage for his or her children that specifies the individuals involved, the type of coverage to be provided and the Plan that provides the coverage. The QMCSO may not require the Plan to provide any type or form of benefit, or any benefit option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act.

The phrase **primarily dependent upon** shall mean dependent upon the covered employee for support and maintenance as defined by the Internal Revenue Code and the covered employee must declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

The phrase **child placed with a covered employee in anticipation of adoption** refers to a child whom the employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such employee of legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

These persons are excluded as dependents: other individuals living in the covered employees' home, but who are not eligible as defined; the divorced former spouse of the employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an employee.

If a person covered under the Plan changes status from employee to dependent or dependent to employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Funding

Contribution Determinations

The Plan Sponsor will, from time to time, evaluate the costs of the Plan and determine the amount to be contributed by the employer and the amount to be contributed (if any) by each employee.

Employee Obligations

The coverage afforded to an employee by this Plan may require employee contributions but will be at least partially funded by the employer. If an employee elects to enroll dependents under the Plan, the employee may be responsible for payment of all or a portion of the dependent contributions suitable to cover such enrollment. For employees, the employer will deduct such costs on a regular basis from the employee's wages or salary.

ENROLLMENT

If for any reason eligible dependents are not enrolled within the 30 days following their initial eligibility date and coverage is subsequently desired, coverage may be requested during an Open Enrollment Period or if you qualify subject to the Special Enrollment provisions described herein.

Initial Enrollment Period

If you desire Plan benefits, you must enroll in the Plan by properly completing and returning an enrollment form to Vancouver Firefighters Union Health & Trust within 30 days of your eligibility date. If you also desire dependent coverage, you must enroll your eligible dependents by this deadline. If you do not have any eligible dependents at the time of initial enrollment but later acquire eligible dependents, including newborns, you may enroll them under a special enrollment period.

Failure to enroll by the deadline noted above may result in your and/or your dependents' inability to secure coverage under this Plan except as specified in the special enrollment and late enrollment provisions below.

Special Enrollment Periods

Those individuals who do not enroll in the Plan at the first opportunity and subsequently lose coverage may be able to enroll in the Plan in compliance with the Health Insurance Portability and Accountability Act of 1996. The enrollment date for anyone who enrolls under a special enrollment period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period.

An individual must be allowed to enroll/terminate under the Plan if:

- The employee or dependent had been covered under another group health plan or had an individual health policy at the time coverage was initially offered and if required by the Plan Administrator, the employee stated at the time initial enrollment was offered that other coverage was the reason for declining enrollment in the Plan;
- The individual lost coverage as a result of a certain event, such as the loss of eligibility for coverage, loss of eligibility due to the Plan no longer offering any benefits to a class of similarly situated individuals (e.g. part-time employees), expiration of COBRA continuation coverage, termination of employment, reduction in the number of hours of employment, or employer contributions towards such coverage were terminated;
- A new model notice of special enrollment rights is provided. This notice must be provided on or before the time an employee is initially offered the opportunity to enroll in a group health plan;
- The employee's or dependent's Medicaid or State Child Health Insurance Plan (SCHIP) coverage is terminated as a result of loss of eligibility; or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or SCHIP.

The individual must request special enrollment within 30 days of the date coverage is lost, except in the case of a qualifying event involving Medicaid or SCHIP (loss of eligibility or premium assistance eligibility). For these events, the individual must request special enrollment within 60 days of the event.

If the employee or dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a special enrollment right.

Dependent Special Enrollment Period
Since the Plan provides dependent coverage, when a person becomes a dependent through marriage, birth or adoption, legal guardianship or a foster child being placed with the employee, the Plan must provide a dependent special enrollment period of not less than 30 days. If an individual seeks to enroll a dependent during the first 30 days, coverage must become effective:

- In the case of marriage, no later than the first day of the first month beginning after the date the request was completed.
- In the case of a newborn born to the employee or the employee's spouse, the date of such birth.
- In the case of adoption or placement for adoption by either the employee or the employee's spouse, the date of such adoption, or placement for adoption.
- The date the employee or the employee's spouse is required to provide health coverage to a child under a Qualified Medical Child Support Order (QMCSO), National Medical Child Support Notice (NMCSN) or administrative order.
- In the case of a foster child being placed with the employee, on the date on which such child is placed with the employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction.
- The date on which legal guardianship status begins.

Newborn Enrollment
A newborn Child of a covered Employee will be considered eligible and will be covered from the moment of birth for Injury or Illness, including the Medically Necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and prematurity, newborn care and Preventive Care if written notification to add the Child is received by the Plan Administrator within 31 days following the Child's date of birth. The application must also be accompanied by any required contribution, ongoing, as the case may be. If written notification to add a newborn Child is received by the Plan Administrator after the 31 day period immediately following the Child's date of birth, the Child is eligible, but the Plan will not process any claims until an enrollment form is completed to add the Child and the Child is enrolled. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent. However, a newborn child of a covered Dependent daughter may be covered for the first 21 days after birth, provided that no other group coverage is available to the child.

Open Enrollment Period
Every September is the annual Open Enrollment Period. Employees and their dependents who are Late Enrollees will be able to enroll in the Plan. Also during this time employees will be eligible to change some of their benefit decisions based on which benefits and coverage are right for them.

Benefit choices made during the Open Enrollment Period will become effective October 1st. Covered Persons will receive detailed information regarding Open Enrollment from their Employer.

TERMINATION OF BENEFITS

Employee's coverage will terminate on the earliest of the following dates:

- The date of the termination of the Plan, the date the Plan ceases for the class of employees to which you belong, or the date the employer terminates its participation in the Plan;
- The end of the month an employee ceases to be an eligible employee as defined in the Eligibility Provisions section;
- The end of the month upon failure to make contributions as a regularly scheduled employee;
- The date of entry to the military service of any country or international organization on a full-time active duty basis other than scheduled drill or other training not exceeding one month in any calendar year *(Additional information regarding continuation of coverage can be found in the Military Leave of Absence section)*; or
- The last day of an approved leave of absence under the Family and Medical Leave Act, if the employee does not return to work *(Additional information can be found in the Family and Medical Leave Act section)*.

Termination Dates of Retiree Coverage

The coverage of any retiree who is covered under the Plan will terminate on the earliest to occur of the following dates:

- The date of termination of the Plan.
- The date of death of the covered retiree.
- The date of the expiration of the last period for which the retiree has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing.
- The date the covered retiree becomes eligible for Medicare coverage or becomes eligible for coverage under another Employer's health plan.

Dependent's coverage will terminate on the earliest of the following dates:

- The date an employee's coverage is terminated;
- The end of the month in which the dependent ceases to meet the definition of a dependent as defined in the Plan; or
- The date the dependent commences participation in the plan as an Employee.

Fraudulent Claim Filing

The following actions or knowledge of such actions constitute fraud and will result in immediate termination of all coverage under this Plan:

- Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;
- Attempting to file a claim for a Covered Person for services that were not rendered or drugs or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the Plan; or
- Providing false or misleading information to the Plan.

NOTE: It is the employee's responsibility to notify the Human Resources Department / Benefits Personnel in writing within the designated time frames as noted in the *Important Highlights* Section when an employee or a dependent has a qualifying event occur and that employee or dependent is no longer eligible for benefits. **Failure to notify the Human Resources Department / Benefits Personnel will result in coverage being terminated as of the original date of the occurrence. Any claims paid after that date must be reimbursed to the employer.**

COVERAGE FOR EMPLOYEES AND DEPENDENTS OVER THE AGE OF 65

If you remain an employee after reaching age 65, you and/or your spouse may elect or reject coverage under this Plan. If you elect to remain covered under Vancouver Firefighters Union Health & Trust Health Care Plan, this Plan will be the primary payer of benefits and Medicare will be secondary payer. However, if you choose Medicare to be your primary plan, coverage under this Plan will end. If you do not specifically choose one of the options, this Plan will continue to be primary.

If you choose Vancouver Firefighters Union Health & Trust Health Care Plan as your primary payer, this Plan will pay the same benefits as if you or your spouse were under age 65. If you have enrolled in Medicare, you may then also send any unpaid portion of your bills to Medicare. If you are under age 65 and your spouse is over age 65, he or she can make their own choice. Please contact the Human Resources Department / Benefits Personnel for further details in making this important decision.

CONTINUATION OF COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) requires that continuation of employer-sponsored health care coverage be made available to formerly covered employees and dependents for a specified period of time at their own expense. If you become ineligible for coverage as the result of a change in your employment status, your coverage ends on the date of termination. You may choose to continue coverage if you lose your group health coverage because of a reduction in hours scheduled or because of termination for reasons other than gross misconduct.

A covered spouse of an employee may elect to continue coverage under Vancouver Firefighters Union Health & Trust Health Care Plan on a self-pay basis if group health coverage is lost for any of the following reasons:

- The death of the employee;
- Reduction in the employee's hours of employment or termination of the employee's employment for other than gross misconduct or;
- Divorce or legal separation from the employee;
- The employee becomes entitled to Medicare; or
- The Employer files for re-organization under Chapter XI of the Bankruptcy Law (only relates to retiree plans).

In the case of a dependent child of an employee covered by Vancouver Firefighters Union Health & Trust Health Care Plan, he or she may choose to continue coverage on a self-pay basis if group health coverage under the Plan is lost for any of the following reasons:

- The death of the employee;
- The termination of the employee’s employment for other than gross misconduct or reduction in a parent's hours of employment;
- Parents divorce or legal separation;
- The employee becomes entitled to Medicare;
- The dependent ceases to be a "dependent child" as defined under Vancouver Firefighters Union Health & Trust Health Care Plan; or
- The Employer files for re-organization under Chapter XI of the Bankruptcy Law (only relates to retiree plans).

The employee or the eligible family member has the responsibility to inform the Human Resources Department / Benefits Personnel of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days of the event. It is the responsibility of the Human Resources Department / Benefits Personnel to notify the COBRA Administrator within 30 days of an employee's termination of employment, reduction in hours, *Medicare entitlement, or *death.

** If a second qualifying event is the death of the covered employee or the covered employee becoming entitled to Medicare benefits, a group health plan may require qualified beneficiaries to notify the Plan Administrator within 60 days of those events, as well. Ordinarily, the employer is responsible for notifying the Plan Administrator of an event that is the death of a covered employee or the covered employee becoming entitled to Medicare benefits. However, if the covered employee's employment has been terminated, the employer may not be in a position to be aware of those events. If the plan does not require qualified beneficiaries to notify the plan within 60 days of a second qualifying event that is the death of the covered employee or the covered employee becoming entitled to Medicare benefits, a qualified beneficiary should provide that notice by the later of the last day of the 18-month period or the date that is 60 days after the date of the second event.*

Children born to, or placed for adoption with a covered employee during a continuation coverage period also have the right to elect COBRA continuation coverage. Enrollment must be completed and submitted in writing within 30 days of the event and any additional premiums *(if applicable)* paid prior to eligibility. Coverage will be retroactive to the date of the event

You will be notified of your rights to continue coverage on a self-pay basis. You have at least sixty days from the date of the notice of your COBRA continuation of coverage rights to elect COBRA continuation coverage. If you do not choose continuation coverage, your group health insurance coverage will end as of the date you became ineligible to continue as a covered member of Vancouver Firefighters Union Health & Trust Health Care Plan.

If an employee becomes ineligible for employer paid health care coverage because of a reduction in hours scheduled or because of voluntary resignation, the employee's continuation of coverage on a self-pay basis may last for up to 18 months. The 18 months may be extended to 29 months if a qualified beneficiary is determined to be disabled under Title II or XVI of the Social Security Act at any time within the first 60 days of continuation coverage. To benefit from this extension, you must notify the Plan Administrator of the disability determination within 60 days after the determination, and prior to the expiration of the initial 18-month COBRA period. The affected individual also must notify the Plan Administrator within 30 days of any final determination that the individual is no longer disabled.

18 to 36-Month Period (Second Qualifying Event): A spouse and dependent children who experience a second qualifying event may be entitled to a total of 36 months of COBRA coverage. Second qualifying events may include the death of the covered employee, divorce or legal separation from the covered employee, the covered employee becoming entitled to Medicare benefits (under Part A, Part B or both), or a dependent child ceasing to be eligible for coverage as a dependent under the group health plan. The following conditions must be met in order for a second event to extend a period of coverage:

(1) The initial qualifying event is the covered employee's termination or reduction of hours of employment, which calls for an 18-month period of continuation coverage;

(2) The second event that gives rise to a 36-month maximum coverage period occurs during the initial 18-month period of continuation coverage (or within the 29-month period of coverage if a disability extension applies);

(3) The second event would have caused a qualified beneficiary to lose coverage under the plan in the absence of the initial qualifying event;

(4) The individual was a qualified beneficiary in connection with the first qualifying event and is still a qualified beneficiary at the time of the second event; and

(5) The individual meets any applicable COBRA notice requirement in connection with a second event, such as notifying the Plan Administrator of a divorce or a child ceasing to be a dependent under the plan within 60 days after the event.

If all conditions associated with a second qualifying event are met, the period of continuation coverage for the affected qualified beneficiary (or beneficiaries) is extended from 18 months (or 29 months) to 36 months.

18 to 36-Month Period (Special Rule): A special rule for dependents provides that if a covered employee becomes entitled to Medicare benefits (either Part A or Part B) before experiencing a qualifying event that is a termination of employment or a reduction of employment hours, the period of coverage for the employee's spouse and dependent children ends with the later of the 36-month period that begins on the date the covered employee became entitled to Medicare, or the 18- or 29-month period that begins on the date of the covered employee's termination of employment or reduction of employment hours. (Note that under this special rule, the employee's Medicare

entitlement is not a qualifying event because it does not result in loss of coverage for the employee's dependents; thus, the 36-month coverage period would be part regular plan coverage and part continuation coverage.)

Although an employee or eligible dependent may elect to continue coverage as outlined above, this period may be reduced because of any of the following events:

- The employer no longer provides group health coverage to any of its employees;
- The premium is not paid within the 45-day grace period following the election of COBRA continuation coverage;
- The premium for your continuation coverage is not paid; (the premium is due on the first of each month and will not be accepted after the thirtieth calendar day after the due date);
- You become an employee covered under another group health plan (the Covered Person may be able to maintain continuation of coverage if there is a pre-existing condition clause that would limit your coverage under the other group plan); However, if other group health coverage is obtained prior to the COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.
- You or a covered dependent becomes entitled to Medicare after the COBRA election. However, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.

  Additional information can be found regarding COBRA provisions for public-sector employees at www.cms.hhs.gov/ (The Center for Medicare and Medicaid Services).
- You were divorced from a covered employee and subsequently remarry, and are covered under your new spouse's group health plan.

If an employee or covered dependent elects to continue coverage on a self-pay basis, they may do so without proving insurability. However, if the election is not made within 60 days, health care coverage under the Plan will terminate retroactively to the day of the qualifying event. Further if the eligible employee or eligible dependent fails to make the initial COBRA continuation coverage premium payment within the 45-day grace period following the election of COBRA coverage they will be deemed ineligible for COBRA continuation coverage.

NOTE: Payment will not be considered made if a check is returned for non-sufficient funds.

The Plan Administrator reserves the right to terminate Plan coverage retroactively to the date the employee or covered dependent lost their eligibility under the terms of the employer-sponsored health care plan. This section of the document is a summary of a very complicated law. In the event of any inconsistency between this Notice and federal law, federal law will take precedence.

If You Have Questions

If you have questions about your COBRA coverage, you should contact the COBRA Administrator or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through the EBSA's website at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

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

FAMILY AND MEDICAL LEAVE ACT

The Family and Medical Leave Act (FMLA) provides leaves of absence up to 12 weeks for the birth or adoption of a child, care of an immediate family member with a serious health condition, or because of the employee's inability to perform the functions of his or her job due to the employee's own serious health condition. Health coverage benefits during your approved leave of absence under The Family and Medical Leave Act will continue as long as you pay any required contributions. If you do not return to work at the end of an approved leave, you will be required to reimburse the employer the difference between any required contributions and the total monthly premium.

Service Member Family Leave: An eligible employee who is the spouse, son, daughter, parent, or next of kin of a service member or covered veteran who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to 26 weeks of leave in a single 12-month period to care for the service member or covered veteran. This leave is available during a "single 12-month period" during which an eligible employee is entitled to a combined total of 26 weeks of all types of FMLA Leave combined.

If you have any questions concerning your rights under the Family and Medical Leave Act, or your employer's responsibilities under the Act, please contact the Human Resources Department.

MILITARY LEAVE OF ABSENCE

(The Uniformed Services Employment and Reemployment Rights Act of 1994)

In the event an employee is called to active duty, he may elect to continue Plan coverage for up to 24 months, beginning on the date the employee's absence starts. The employee may be required to pay up to 102% of the full premium cost for continuation coverage, except a person on active duty for 30 days or less will not be required to pay more than the employee's share, if any, for the coverage. These rights apply only to employees and their dependents covered under the Plan before leaving for military service. If you have any questions regarding military leave of absence, continuation of coverage, the cost of continued coverage or the maximum period of such coverage, please contact the Human Resources Department.

If your participation in this Plan is terminated by reason of service in the uniformed services, your coverage will be reinstated upon re-employment without any exclusions or waiting periods that would not have applied if coverage had not been terminated. However, applicable exclusions may be imposed with respect to coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during service in the military.

Uniformed services means the Armed Forces; the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty; the commissioned corps of the Public Health Service; and, any other category of person designated by the President in time of war or national emergency. Military fitness examinations also are considered service in the uniformed services. ROTC members are considered to be in uniformed services.

COORDINATION OF BENEFITS PROVISION

The purpose of this Plan is to provide you with reimbursement of your covered medical expenses based on the description of coverage as outlined in this document. In the event that you or any of your covered dependents incur expenses for which benefits are payable under this Plan and at the same time benefits are payable under any other plan, the Plan will coordinate benefits.

In coordinating benefits, one of the two or more Plans involved will be the primary Plan, and the other Plan(s) will be secondary to it. The primary Plan pays without regard to the other Plan(s). The secondary Plans will coordinate their payments so that the total paid from all plans shall not exceed 100% of the allowable expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary.

An allowable expense is the Maximum Allowable Charge for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations provision in the Coordination of Benefits section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses.

When some "Other Plan" provides benefits in the form of services (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any Other Plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

Benefits, however, will still be limited under this Plan such that it will pay no more than what the Plan would have paid in the absence of this coordination provision. The applicable deductible and co-insurance limits will be applied to those expenses for which this Plan is liable either as the primary Plan or the secondary Plan.

Examples of other types of coverage with which benefits will be coordinated are:

- Insurance or any other arrangement of benefits for individuals of a group, including coverage for students sponsored by or provided through a school or other educational institution.
- Pre-payment coverage or any other coverage toward the costs of which any employer makes contributions or payroll deductions or any labor union makes contributions.
- Any governmental program or coverage required by statute including Medicare.
- Liability, homeowner's or automobile insurance, which is subject to any Motor Vehicle Financial Responsibility Law. This Plan shall have secondary liability for those medical expenses incurred as a result of a motor vehicle accident, on behalf of a Covered Person subject to any state automobile insurance law, regardless of the terms and conditions of any specific automobile policy. Furthermore, if a Covered Person has no Personal Injury Protection or medical benefits coverage, in a state where such coverage is mandated, coverage under this Plan shall be reduced by the minimum coverage requirement of the state with jurisdiction. In addition to the above, for those Covered Persons subject to no-fault automobile insurance law or the law of any other state which permits issuance of a state mandated motor vehicle policy with an optional high personal injury protection deductible, this Plan shall not recognize as a covered expense, the personal injury protection deductible selected by any Covered Person.

Order of Benefit Determination

The rules establishing the order of benefit determination are as follows:

No Coordination of Benefit Provision

If the other plan contains no provision for coordination of benefits, then its benefits shall be paid before all other Plan(s).

Non-Dependent or Dependent

The Plan covering the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is the primary plan, and the plan covering the person as a dependent is the secondary plan.

Medicare rules provide one exception to this rule. If the person is a Medicare beneficiary and covered as a dependent by a group health plan then Medicare is secondary to the plan covering the person as a dependent.

Employee or Retiree

If an individual is covered under one plan as an employee and another plan as a retiree, the employee plan is primary. However, if an individual is covered both as a retiree under one plan and as a dependent under a spouse's employee plan, order of benefit determination is that the retiree plan pays first and the dependent plan pays second.

Continuation Coverage (COBRA)

If an individual has continuation coverage under the federal COBRA law or state continuation laws and also is covered under another group health plan as an employee or retiree, then the continuation coverage pays second.

The specific rules establishing the order of benefit determination for a child covered under more than one plan are as follows:

Birthday Rule

If the parents are married or if a court order awards joint custody without specifying which parent has responsibility for providing health care coverage, the primary plan is the plan of the parent whose birthday is earlier in the year.

Court Order

If a court order specifies that one parent is responsible for health coverage, the plan of that parent will be the primary plan.

Parents are Separated or Divorced

In the absence of a specific court order the order of benefit determination is as follows:

- The plan of the custodial parent.
- The plan of the spouse of the custodial parent.
- The plan of the non-custodial parent.
- The plan of the spouse of the non-custodial parent.

When the above referenced rules fail to establish an order of benefit determination, the plan that has covered the person for the longer period of time is the primary payer.

Coordination with Medicare

Individuals may be eligible for Medicare Part A at no cost if they: (i) are age 65 or older, (ii) have been determined by the Social Security Administration to be disabled, or (iii) have end stage renal disease. Participation in Medicare Part B and D is available to all individuals who make application and pay the full cost of the coverage.

1. When an employee becomes entitled to Medicare coverage (due to age or disability) and is still actively at work, the employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
2. When a dependent becomes entitled to Medicare coverage (due to age or disability) and the employee is still actively at work, the dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
3. If the employee and/or dependent is also enrolled in Medicare (due to age or disability), this Plan shall pay as the primary plan. If, however, the Medicare enrollment is due to end stage renal disease, the Plan's primary payment obligation will end at the end of the thirty (30) month "coordination period" as provided in Medicare law and regulations.
4. Notwithstanding Paragraphs 1 to 3 above, if the employer (including certain affiliated entities that are considered the same employer for this purpose) has fewer than one hundred (100) employees, when a covered dependent becomes entitled to Medicare coverage due to total disability, as determined by the Social Security Administration, and the employee is actively-at-work, Medicare will pay as the primary payer for claims of the dependent and this Plan will pay secondary.
5. If the employee and/or dependent elect to discontinue health coverage under this Plan and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.

This section is subject to the terms of the Medicare laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

Right to Receive or Release Necessary Information

To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of Payment

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of Recovery

This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY

Payment Condition

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

Covered Person(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. The Plan shall have an equitable lien on any funds received by the Covered Person(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 Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Covered Person(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 Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the

settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

The Plan may, at its discretion, in its own name or in the name of the Covered Person(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.

If the Covered Person(s) fails to file a claim or pursue damages against:

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

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's/Covered Persons' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(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

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, made whole doctrine, or any other similar legal or equitable theory, without regard to whether the Covered Person(s) is fully compensated by his or 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 Covered Person's/Covered Persons' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(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.

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 Covered Person(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, disease or disability.

Covered Person is a Trustee Over Plan Assets

Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Covered Person understands that he or she is required to:

1. Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts.
3. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorney's fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Excess Insurance

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

1. The responsible party, its insurer, or any other source on behalf of that party.

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

Separation of Funds
Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(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 Covered Person(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 Covered Person(s) and all others that benefit from such payment.

Obligations
It is the Covered Person's/Covered Persons' obligation at all times, both prior to and after payment of medical benefits by the Plan:

1. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.
2. To provide the Plan with pertinent information regarding the Sickness, disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.
3. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
4. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
5. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.
6. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
7. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.
8. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.

9. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
10. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

If the Covered Person(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 Covered Person(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 Covered Person(s).

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

Offset
If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

Minor Status
In the event the Covered Person(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.

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.

COVERED MEDICAL EXPENSES

Your benefit plan is designed to reimburse you for covered medical expenses you incur for treatment necessary because of an illness or an accident.

Abortions – Elective termination of pregnancy and all associated expenses.

Acupuncture – The insertion of needles into the human body to control the flow and balance of energy in the body and to cure and relieve any ailment or disease of the mind or body or any wound, bodily injury or deformity.

Ambulance – Professional ground ambulance service when used to transport the Covered Person from the place where they are injured or stricken by a Sickness to the nearest Hospital where treatment can be given.

The Plan will also cover air ambulance to transport the Covered Person to the nearest medical facility equipped to provide care when Medically Necessary.

Ambulance transportation is also covered when transportation is from one hospital or facility to another when deemed medically necessary.

Biofeedback – Care, services as related to Biofeedback.

Breast Reconstruction – In accordance with the Women's Health and Cancer Rights Act the following coverage is offered to a Covered Person who elects the following services in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Chiropractic Care – Modalities (hot, cold therapy, etc.) manipulation and adjunctive therapy by a Covered Provider to anatomically correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, abnormal spacing, sprain or strain.

Clinical Trials – Routine costs for a Covered Person who satisfies the requirements as a "Qualified Individual" in an "Approved Clinical Trial"

A *Qualified Individual* is defined as an individual who is enrolled or participating in a health plan or coverage and who is eligible to participate in an approved clinical trial according to the trial protocol with respect to treatment of cancer or another life-threatening disease or condition. To be a qualified individual, there is an additional requirement that a determination be made that the individual's participation in the approved clinical trial is appropriate to treat the disease or condition. That determination can be made based on the referring health care professional's conclusion or based on the provision of medical and scientific information by the individual.

Routine Costs as defined for purposes of these new federal requirements, with some important exceptions, generally include all items and services consistent with the coverage provided under the plan (or coverage) for a qualified individual (ex. for treatment of cancer or another life-threatening disease or condition) who is not enrolled in a clinical trial. However, costs associated with the following are excluded from that definition, and the plan or issuer is not required under federal law to pay for the following:

- The cost of the investigational item, device or service.
- The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management.

- The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

Approved Clinical Trial is defined in the statute as a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

- A federally funded or approved trial.
- A clinical trial conducted under an FDA investigational new drug application.
- A drug trial that is exempt from the requirement of an FDA investigational new drug application.

With respect to an individual's right to select providers, a plan or issuer may require the individual to participate in the approved clinical trial through a participating provider if the provider will accept the individual as a participant in the trial.

Cochlear (Auditory) Implants – Coverage is limited to charges for osseointegrated auditory implants (bone-anchored hearing aids) when deemed Medically Necessary. Coverage includes related services. Supplies and accessories are not covered by the Plan unless medically necessary. Batteries are specifically not covered.

A replacement device will be covered only if it is shown that:

- It is needed due to a change in the physical condition of the covered person to make the original device no longer functional
- It is needed due to normal wear and tear as determined by the manufacturer and the Plan; or
- It is likely to cost less to buy a replacement than to repair the existing device.

Charges for repair or medically necessary replacement of a device will be considered a covered charge, except when such repairs or replacement are necessary due to misuse, negligence, loss, or theft. Repair or replacement charges are not covered for devices when under warranty from the manufacturer.

Dental – Charges *(when due to accidental injury only)* made for a continuous course of dental treatment started within 12 months from the date of the Injury to sound natural teeth. Sound natural teeth are defined as natural teeth that are free of active clinical decay, have at least 50% bony support and are functional in the arch.

General anesthesia, nursing and related Hospital expenses in connection with an Inpatient or Outpatient dental procedure are covered, only when one of the five conditions listed below is met. Prior Authorization for Inpatient services is required.

- Complex oral Surgical Procedures that have a high probability of complications due to the nature of the Surgery;
- Concomitant systemic disease for which the patient is under current medical management and that significantly increases the probability of complications;
- Mental or Nervous Disorder that precludes dental Surgery in the office;
- Use of general anesthesia and the Participant's medical condition requires that such procedure be performed in a Hospital; or
- Dental treatment or Surgery performed on a Participant seven years of age or younger, where such procedure cannot be safely provided in a dental office setting.

Diabetic Management – The following diabetic education and self-management programs are covered:

- All Physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes; and

- Diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with gestational, Type I or Type II diabetes.

Diagnostic Services – Charges for professional fees from a physician, as well as outpatient / independent facility charges for diagnostic x-ray and laboratory services.

Dialysis Treatment *(Outpatient)* – This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:

1. the concentration of dialysis providers in the market in which Plan reside may allow such providers to exercise control over prices for dialysis-related products and services,
2. the potential for discrimination by dialysis providers against the Plan because it is a nongovernmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,
3. evidence of (i) significant inflation of the prices charged to Plan by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of non-governmental and non-commercial plans, such as the Plan, by dialysis providers as profit centers, and
4. the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the interests of Plan members, such as subsidies for other plans and discriminatory profit-taking.

Dialysis Program Components. The components of the Dialysis Program are as follows:

1. Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").
2. Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan for expenses incurred on or after January 1, 2015, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.
3. Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator shall consider factors including:
    a. Market concentration: The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

b. Discrimination in charges: The Plan Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

4. In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the member, to the following payment limitations, under the following conditions:
   a. Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.
   b. Maximum Benefit. Except as provided in the preceding subsection or where an acceptable provider agreement is entered into, the maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.
   c. Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.
   d. Additional Information related to Value of Dialysis-Related Services and Supplies. The member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.
   e. All charges must be billed by a provider in accordance with generally accepted industry standards.

5. Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider,

provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

6. Discretion. The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law. 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 this Section, to make determinations regarding issues which relate to eligibility for benefits under this Section, to decide disputes which may arise relative to a Plan's rights under this Section, and to decide questions of interpretation of this Section and those of fact relating to the application of this Section. The decisions of the Plan Administrator will be final and binding on all interested parties.
7. Provider Acceptance. A provider that accepts the payment from the Plan under this Section will be deemed to consent and agree that (i) such payment shall be for the full amount due for the provision of services and supplies to a Plan member, and (ii) it shall not "balance bill" a Plan member for any amount billed but not paid by the Plan.

Durable Medical Equipment – Rental of durable basic (i.e. non-luxury) medical equipment (not to exceed the purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. This will also include repair (no benefits are provided for repairs due to equipment misuse and/or abuse or for replacement of lost or stolen items), maintenance, delivery services and disposable supplies of such equipment. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or Accidental Injury.

The Plan also covers necessary maintenance and repairs of purchased durable medical equipment and loaner equipment used while repairs are being made. Replacement is covered only if (i) the patient has experienced a change in his or her physiological condition, or (ii) required repairs would exceed the cost of a replacement device or the parts that need to be replaced, or (iii) there has been irreparable change in the device's condition or in a part of the device due to normal wear and tear.

Durable medical equipment includes such items as braces, crutches, wheelchairs *(limited to one per calendar year for age birth to 18. Thereafter, limited to one every three calendar years)*, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment, etc. which:

- Can withstand repeated use.
- Are primarily and customarily used to serve a medical purpose.
- Generally are not useful to a person in the absence of Sickness or Accidental Injury.
- Are appropriate for use in the home.

Foot Disorders – Surgical treatment of foot disorders, including associated services, performed by a licensed Physician *(excluding routine foot care)*.

Growth Hormone Therapy – Expenses for or related to care and treatment for growth hormone therapy.

Home Health Care – These are the charges made by a licensed home health care agency for the following services and supplies furnished to a Covered Person in his/her home. A Physician must certify the services as medically necessary.

- Part-time or intermittent nursing care by a registered graduate nurse (RN) or by a licensed practical nurse (LPN).
- Part-time or intermittent home health aide services which consist primarily of caring for the patient.

- Therapy as deemed Medically Necessary.
- 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 such charges would have been covered if the covered person had remained in the hospital.

Each visit by a registered graduate nurse (R.N.) licensed practical nurse (L.P.N.) or therapist, will count as one home health care visit. Four hours of home health aide services shall be considered as one home health care visit.

Hospice Care Benefits – The Plan will cover as an eligible expense those charges incurred by a terminally ill patient and rendered by a Hospice care provider either in the patient's home or a Hospice facility. These services must be developed by a Hospice care program in consultation and in agreement with the patient's physician. The prognosis of the patient's life expectancy must be 6 months or less.

Hospice care shall consist of the following services and supplies:
- Room & Board, including special diets (not to exceed the semi-private room rate);
- Respite care to a maximum of 170 hours;
- Services of a Physician, RN, LPN, home health aide and nutritionist;
- Medical supplies, nutritional supplements, drugs and medicines prescribed by a physician, laboratory services, durable medical equipment, oxygen and any other eligible expenses normally covered under this Plan; and

Limitations

This benefit is limited by all the limitations as listed in this section, as well as all limitations of the Plan as a whole. No hospice care benefits will be provided for:
- Medical care rendered by a private physician not affiliated with the Hospice Care Agency.
- Volunteers who do not regularly charge for services.
- Pastoral services.
- Homemaker services.
- Food or home delivered meals.
- Family bereavement counseling.

Hospital Services – Inpatient and outpatient hospital expenses will be eligible for coverage if they are determined to be medically necessary and appropriate for the proper treatment of the covered person's condition. Inpatient hospital stays will be payable according to the average semi-private room rate. Also covered under hospital services are:

Ambulatory Surgical Center – Services and supplies provided by an ambulatory surgical center in connection with a covered outpatient surgery.

Birthing Center – Services and supplies provided by a birthing center in connection with a covered pregnancy.

Blood – Charges for whole blood or blood plasma, administration of blood, blood processing and materials and supplies of technicians. *Please note that the cost for blood or plasma replaced by or for the patient is not reimbursed under the Plan.*

Diagnostic X-ray and Laboratory – Inpatient Facility fees for diagnostic x-ray and laboratory examinations.

Emergency Medical Care – The initial treatment of a sudden onset of a medical condition or accidental injury with symptoms of sufficient severity to require immediate medical attention.

Intensive Care Unit – Hospital charges for intensive care accommodation.

Medical Care or Supplies – Special hospital charges for inpatient medical care or supplies received during any period room and board charges are made. This does not include personal supplies or convenience items.

Pre-Admission Testing – If a Participant is to be admitted to a Hospital for non-Emergency Surgery or treatment, one set of laboratory tests and x-ray examinations performed on an outpatient basis within seven days prior to such Hospital admission will be paid, as any other service, provided that the following conditions are met:

1. The tests are related to the performance of the scheduled Surgery or treatment.
2. The tests have been ordered by a Physician after a condition requiring Surgery or treatment has been diagnosed and Hospital admission has been requested by the Physician and confirmed by the Hospital.
3. The Participant is subsequently admitted to the Hospital, or confinement is cancelled or postponed because a Hospital bed is unavailable or if, after the tests are reviewed, the Physician determines that the confinement is unnecessary.
4. The tests are performed in the Hospital where the confinement will take place and accepted in lieu of duplicate tests rendered during confinement.

Private Room Allowance - If a Covered Person is confined to a hospital's private room, the Plan will allow the private room rate only if:

- The private room confinement is recommended by a physician and is medically essential for the necessary care and treatment of an injury or sickness; or
- A semi-private room is not available and the use of a private room is therefore necessary.

Otherwise, the Plan will pay the semi-private room rate.

Infertility Treatment – Charges for testing up to the diagnosis of infertility. *All other expenses for the promotion of conception including, but not limited to artificial insemination, in vitro fertilization, and GIFT are excluded by the Plan.*

Maternity – Expenses Incurred by all Covered Persons for:
(a) Pregnancy.
(b) Preventive prenatal and breastfeeding support.
(c) Services provided by a Birthing Center.
(d) One amniocentesis test per Pregnancy.
(e) Up to 2 ultrasounds per Pregnancy (more than 2 when determined to be Medically Necessary).

Maternity Home Health Care Visit – If you are discharged from inpatient care prior to 48 hours following a normal vaginal delivery or 96 hours following a cesarean delivery, you are entitled to one maternity home health care visit within 48 hours of discharge. Services include but are not limited to post partum care, parent education, assistance and training in breast and bottle feeding, infant screening and clinical tests and the performance of any necessary maternal and neonatal physical assessments.

Medical Services and Supplies – Disposable medical supplies such as casts, splints, crutches, orthopedic or prosthetic devices, surgical dressings, colostomy bags and related supplies, supplies used in the care and monitoring of diabetic patients and catheters.

Mental Health and Substance Abuse – Subject to the limitations and applicable exclusions. All licensed mental health providers acting within the scope of their license may bill the plan for covered mental health / substance abuse services. The Plan will pay Covered Expenses for:

1. Inpatient Benefits. These benefits are also available when receiving treatment during the day only or during the night only at a day/night Psychiatric Hospital or at a Substance Abuse Treatment Center and/or Rehabilitation Hospital:

a. Semi-private Hospital Room and Board.
b. Miscellaneous facility charges on days a Room and Board charge is covered.
c. Individual psychotherapy.
d. Group psychotherapy.
e. Psychological testing.
f. Family counseling.
g. Convulsive therapy treatment.

2. Outpatient Benefits:
   a. Individual psychotherapy.
   b. Group psychotherapy.
   c. Psychological testing.
   d. Family counseling.
   e. Convulsive therapy treatment.
   f. Prescription Drugs or medicines for the treatment of mental Illness or chemical dependency.

3. Applied Behavior Analysis:

Behavior Analysis is the scientific study of behavior. Applied Behavior Analysis (ABA) is the application of the principles of learning and motivation from Behavior Analysis, and the procedures and technology derived from those principles, to the solution of problems of social significance. Many decades of research have validated treatments based on ABA.

Applied Behavior Analysis (ABA) is the process of systematically applying interventions based upon the principles of learning theory to improve socially significant behaviors to a meaningful degree, and to demonstrate that the interventions employed are responsible for the improvement in behavior.

Socially significant behaviors" include reading, academics, social skills, communication, and adaptive living skills. Adaptive living skills include gross and fine motor skills, eating and food preparation, toileting, dressing, personal self-care, domestic skills, time and punctuality, money and value, home and community orientation, and work skills

ABA is an objective discipline. ABA focuses on the reliable measurement and objective evaluation of observable behavior

Behavioral intervention strategies based on ABA include, but are not limited to:

1. Chaining;
2. Functional analysis;
3. Functional assessment;
4. Functional communication training;
5. Modeling, including video modeling (also known as imitation training);
6. Procedures designed to reduce challenging and dangerous behaviors (e.g., differential reinforcement, extinction, time out, and response cost);
7. Prompting; and
8. Reinforcement systems, including differential reinforcement, shaping and strategies to promote generalization

“Related structured behavioral programs” are services delivered by a qualified practitioner that are comprised of multiple intervention strategies (that is, behavioral intervention packages) based upon the principles of ABA. These packages may include but are not limited to:

1. Activity schedules;
2. Discrete trial instruction;
3. Incidental teaching;
4. Natural environment training;
5. Picture exchange communication system;
6. Pivotal response treatment;
7. Script and script-fading procedures; and
8. Self-management

Midwife – Services of a registered nurse midwife when provided in conjunction with a Covered Pregnancy.

Morbid Obesity – Charges for the care and treatment of Morbid Obesity. *Surgical treatment for Morbid Obesity will not be covered.*

Naturopathic Treatment – Services for naturopathic treatment that emphasizes prevention and self-healing processes to treat each person holistically will include homeopathy and clinical nutrition services. *The Plan will not cover other variations of alternative treatment including, but not limited to, botanical medicine, hydrotherapy, bio-therapeutic drainage and anti-aging.*

Neurobiological Disorders – Neurobiological disorders (Autism Spectrum Disorder) benefits are provided for intensive behavioral therapies (educational/behavioral services that are focused on primarily building skills and capabilities in communication, social interaction and learning such as Applied Behavioral Analysis (ABA)).

Newborn Care – Hospital and Physician nursery care for newborns who are properly enrolled in the Plan, as set forth below. ***Benefits will be provided under the Child's coverage, and the Child's own Deductible and Coinsurance provisions will apply:***

1. Hospital routine care for a newborn during the Child's initial Hospital confinement at birth.
2. The initial newborn examination and a second examination performed prior to discharge from the newborn's initial Hospital confinement at birth.
3. For a circumcision either during the newborn's initial Hospital confinement at birth or within 14 days of newborn's birth performed at a physician's office.

NOTE: The Plan will cover Hospital and Physician nursery care for an ill newborn as any other medical condition, provided the newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage.

Orthotic Devices (Orthoses) – Charges for orthotic devices (a support, brace, or splint used to support, align, prevent, or correct the function of movable parts of the body) are covered. To be covered, a physician must provide certification that the device is medically necessary. Replacement will be covered only if it is shown that:

- It is needed due to a change in the physical condition of the covered person to make the original device no longer functional
- It is needed due to normal wear and tear as determined by the manufacturer and the Plan; or
- It is likely to cost less to buy a replacement than to repair the existing device.

Charges for repair or medically necessary replacement of an orthotic device will be considered a covered charge, except when such repairs or replacement are necessary due to misuse, negligence, loss, or theft. Repair or replacement charges are not covered for devices when under warranty from the manufacturer. Custom molded foot orthotics are not covered.

Orthopedic shoes are not covered unless they are an integral part of a leg brace and the cost is included in the orthotist's charge.

Partial Hospitalization – Partial hospitalization must be a medically necessary alternative to inpatient hospitalization and is designed for patients who do not require 24-hour care, but who would benefit from more intensive treatment than ordinarily offered on an outpatient basis.

Physician Services – Medical and surgical treatment by a physician (M.D. or D.O.) including office, home or Hospital visits, clinic care and consultations.

Allergy Testing and Treatment – Including coverage for allergy injections.

Hospital Visits – Physician consultation services during your Hospital confinement and expenses for inpatient visits by a physician.

Office Visits – Services performed in a Physician's office on the same day for the same or related diagnosis.

Preventive Care – The Plan will provide preventive health care services as described in the *Schedule of Medical Benefits*. Preventative care includes:

Health Care Reform Mandated Preventive Services – To comply with section 2713 of Affordable Care Act (ACA), and in accordance with the recommendations and guidelines, plans shall provide in-Network (PPO) coverage for all of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations.
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention.
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

NOTE:

1. *If your plan does not have in its network a provider who can provide a particular preventive service, then your plan must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service.*
2. *If the office visit and the preventive service are billed separately, cost-sharing cannot be charged for the preventive service but the insurer may still impose cost-sharing for the office visit itself.*
3. *If the primary reason for the visit is not the preventive service, patients may have to pay for the office visit.*
4. *If a treatment is given as the result of a recommended preventive service, but is not the recommended preventive service itself, cost-sharing may be charged.*

The Public Health Service (PHS) Act and federal regulations also allow "reasonable medical management" techniques to determine the frequency, method, treatment, or setting for a preventive item or service to the extent it is not specified in a recommendation or guideline.

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org or at https://www.healthcare.gov/coverage/preventive-care-benefits/. For more information, Covered Persons may contact the Plan Administrator / Employer.

Prosthetics – Charges for prosthetic devices (other than dental) to replace all or part of an absent body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body part are covered under the Plan. A replacement device will be covered only if it is shown that:

- It is needed due to a change in the physical condition of the covered person to make the original device no longer functional;
- It is needed due to normal wear and tear as determined by the manufacturer and the Plan; or
- It is likely to cost less to buy a replacement than to repair the existing device.

Charges for repair or medically necessary replacement of a prosthetic device will be considered a covered charge, except when such repairs or replacement are necessary due to misuse, negligence, loss, or theft. Repair or replacement charges are not covered for devices when under warranty from the manufacturer.

Second Surgical Opinion – A second surgical opinion consultation following a surgeon's recommendation for surgery. The Physician rendering the second opinion regarding the medical necessity of a proposed surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

A third opinion consultation will also be covered if the second opinion obtained does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

Skilled Nursing Facility – Charges made by a Skilled Nursing Facility or a convalescent care facility in connection with convalescence from an Illness or Injury *(excluding drug addiction, chronic brain syndrome, alcoholism, senility, intellectual disability or other Mental or Nervous Disorders)* for which the Covered Person is confined.

Sleep Disorders – Care and treatment for sleep disorders when deemed Medically Necessary.

Smoking Cessation – Care and treatment for smoking cessation programs as determined by The Department of Health and Human Services (HHS). Additional information can be found by visiting *https://www.healthcare.gov/coverage/preventive-care-benefits.* Note: It is advised to check this list regularly as it is subject to change without notice. *If your plan does not have in its network a provider who can provide a particular preventive service, then your plan must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service.*

Stem Cell Orthopedic Procedures (Regenexx) – Covered Participants may pursue alternative Regenexx stem cell treatment at Regenexx Clinical Providers through their Regenexx Corporate Provider Network as an alternative to other Surgical Procedures. Regenexx stem cell treatments through Regenexx Corporate contracted Providers will be covered as In-Network subject to normal Plan provisions. The Regenexx Procedures are not considered Investigational within the Plan.

Sterilization – Charges including medical history, physical examination, related laboratory tests, medical supervision in accordance with generally accepted medical practice, information and counseling on contraception, and after appropriate counseling, medical services connected with surgical therapies, including vasectomy and tubal ligation. NOTE FOR NON-GRANDFATHERED PLANS Food and Drug Administration approved contraceptive methods, sterilization procedures and patient education and counseling as prescribed by a health care provider for women with reproductive capacity (not including abortifacient drugs) will be covered by the plan with no network cost sharing to the member. *If your plan does not have in its network a provider who can provide a particular preventive service, then your plan must cover the item or service when performed by an out-of-network provider and not impose cost-sharing with respect to the item or service.*

Surgical Expenses – Professional service charges made by a physician for medical services including surgery

- Anesthesia – Anesthetics and services of a Physician or registered nurse anesthetist for the administration of anesthesia.
- Assistant Surgeon – The services of an assistant surgeon not to exceed 20% of the eligible charge of the surgical procedure.
- Co-Surgeons – The services of co-surgeons are eligible for consideration at 125% of the eligible charge divided evenly between the two surgeons. If more than one procedure is performed by the co-surgeons, multiple surgical reductions would apply as applicable.
- Bilateral Surgical Procedures – Which add significant time or complexity, which are provided at the same operative session, the amount eligible for consideration is 100% of the maximum eligible charge for the primary procedure, 50% for secondary procedure(s).
- Multiple Surgical Procedures – When two or more surgical procedures are performed during the same session, the amount eligible for consideration is 100% of the maximum eligible charge for the primary procedure and 50% of the eligible charge for all other procedures performed.
- Oral surgery in relation to the bone, including tumors, cysts and growths, not related to the teeth and extraction of soft tissue impacted teeth by a Physician or Dentist.
- Surgical Treatment of jaw. Surgical treatment of diseases, injuries, fractures and dislocations of the jaw by a Physician or Dentist.
- Primary Surgeon – Professional service charges made by a physician for medical services incurred related to the surgery.
- Surgical Dressings – Expenses related to surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.

No benefit will be payable for incidental procedures, such as appendectomy during an abdominal surgery, performed during a single operative session.

Telemedicine – Benefits are provided for the use of interactive audio, video, or other electronic media for the purpose of consultation, diagnosis, or treatment of the patient. Benefits for telemedicine services shall be provided by a provider to deliver health care services within the scope of the provider's practice at a site other than the site where the patient is located.

Temporomandibular Joint (TMJ) Syndrome – The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Therapy – The Plan covers the following services you receive from a professional provider:

- Cardiac Therapy – The services must be rendered in accordance with a Physician's written treatment plan and used for the treatment of a sickness or injury to promote recovery.
- Chemotherapy – The Plan covers the treatment of malignant disease by chemical or biological antineoplastic agents. Chemotherapy treatment is subject to review and medical necessity. Any Chemotherapy drugs that are deemed experimental or investigational, or are not FDA approved for the patients' diagnosis will not be covered.
- Dialysis – Charges for dialysis therapy when used for the treatment of a sickness or injury, and rendered in accordance with a Physician's written treatment plan. This includes, but is not limited to dialysis equipment rental, supplies, upkeep and the training of the covered individual (or the one who attends him or her) to run the equipment.

- Infusion Therapy – Coverage is available for infusion therapy, which is treatment by placing therapeutic agents into the vein, including intravenous feeding.
- Occupational Therapy – Coverage is available for occupational therapy, which is treatment to restore a physically disabled person's ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing.
- Physical Therapy – Coverage is available for physical therapy, which is treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb.
- Radiation Therapy – Radiation Therapy is covered including the rental or cost of radioactive materials. It covers the treatment of disease by x-ray, radium, cobalt, or high energy particle sources.
- Respiratory Therapy – Coverage for respiratory therapy that is the introduction of dry or moist gases into the lungs to treat illness or injury.
- Speech Therapy – Speech therapy is covered for the correction of a speech impairment that results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment.

Transplants – Eligible Expenses incurred by a Covered Person who is the recipient of a human organ or tissue transplant includes any replacement of tissue or organs that is determined to be non-investigational and non-experimental and is commonly and customarily recognized by the medical profession as appropriate treatment for a condition.

Covered Expenses will be considered the same as any other Sickness for Employees or Dependents as a recipient of an organ or tissue transplant. Covered Expenses include:

1. Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part.
2. Services and supplies furnished by a Provider.
3. Drug therapy treatment to prevent rejection of the transplanted organ or tissue.

Surgical, storage and transportation costs directly related to the procurement of an organ or tissue used in a transplant described herein will be covered. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue.

GENERAL EXCLUSIONS AND LIMITATIONS

Some health care services are not covered by the Plan. Coverage is not available from the Plan for charges arising from care, supplies, treatment, and/or services:

Administrative Costs. That are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.

After the Termination Date. That are Incurred by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Alcohol. Involving a Participant who has taken part in any activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. 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 documented medical condition (including both physical and mental health conditions).

Broken Appointments. That are charged solely due to the Participant's having failed to honor an appointment.

Complications of Non-Covered Services. That are required as a result of complications from a service not covered under the Plan, unless expressly stated otherwise.

Confined Persons. That are for services, supplies, and/or treatment of any Participant that were Incurred while confined and/or arising from confinement in a prison, jail or other penal institution.

Cosmetic Surgery. That are incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Illness; (c) because of congenital Disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality. The term "cosmetic services" includes those services which are described in IRS Code Section 213(d)(9).

Custodial Care. That do not restore health, unless specifically mentioned otherwise.

Deductible. That are amounts applied toward satisfaction of Deductibles and expenses that are defined as the Participant's responsibility in accordance with the terms of the Plan.

Excess. That exceed Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental. That are Experimental or Investigational.

Foreign Travel. That are received outside of the United States if travel is for the sole purpose of obtaining medical services, unless otherwise approved by the Plan Administrator.

Government. That the Participant obtains, but which is paid, may be paid, is provided or could be provided for at no cost to the Participant through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Participant to pay for such treatment or service in the absence of coverage. This Exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

Government-Operated Facilities. That meet the following requirements:
1. That are services furnished to the Participant in any veteran's Hospital, military Hospital, Institution or facility operated by the United States government or by any State government or any agency or instrumentality of such governments.
2. That are services or supplies which can be paid for by any government agency, even if the patient waives his rights to those services or supplies.
NOTE: *This Exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government Hospital to Dependents of active duty armed service personnel or armed service retirees and their Dependents. This Exclusion does not apply where otherwise prohibited by law.*

Illegal Acts. That arise from or are caused during the commission of any illegal act for which the participant could be incarcerated for any period of time. It is not necessary for an arrest to occur, charges to be filed, incarceration to occur, or a conviction to be had for this Exclusion to apply. 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 documented medical condition (including both physical and mental health conditions).

Illegal Drugs or Medications. That are services, supplies, care or treatment to a Participant for Injury or Sickness Incurred while the Participant was voluntarily taking or was under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Participants other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. 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 documented medical condition (including both physical and mental health conditions).

Immediate Family Member. That are rendered by a member of the immediate Family Unit or person regularly residing in the same household; whether the relationship is by blood or exists in law.

Incurred by Other Persons. That are expenses actually Incurred by other persons.

Long Term Care. That are related to long term care.

Medical Necessity. That are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

Military Service. That are related to conditions determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Negligence. That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

No Coverage. That are Incurred at a time when no coverage is in force for the applicable Participant and/or Dependent.

No Legal Obligation. That are for services provided to a Participant for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Participant or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Participant or the Plan, may be liable for necessitating the fees, care, supplies, or services.

Non-Prescription Drugs. For drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a nonprescription equivalent available. This does not apply to the extent the non-prescription drug must be covered under Preventive Care, subject to the Affordable Care Act.

Not Acceptable. That are not accepted as standard practice by the American Medical Association (AMA), American Dental Association (ADA), or the Food and Drug Administration (FDA).

Not Covered Provider. That are performed by Providers that do not satisfy all the requirements per the Provider definition as defined within this Plan.

Not Specified As Covered. That are not specified as covered under any provision of this Plan.

Occupational. That are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where workers' compensation or another form of occupational Injury medical coverage is available or would have been available had the participant sought to obtain it in accordance with applicable rules and/or procedures.

These claims will be treated as, and assumed to be, occupational (see RCW 51.32.185).

Other than Attending Physician. That are other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Disease, and performed by an appropriate Provider.

Postage, Shipping, Handling Charges, Etc. That are for any postage, shipping or handling charges which may occur in the transmittal of information to the Third Party Administrator; including interest or financing charges.

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

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

Prohibited by Law. That are to the extent that payment under this Plan is prohibited by law.

Provider Error. That are required as a result of unreasonable Provider error.

Self-Inflicted. That are incurred due to an intentionally self-inflicted Injury or Illness, not definitively (a) arising from being the victim of an act of domestic violence, or (b) resulting from a documented medical condition (including both physical and mental health conditions).

Subrogation, Reimbursement, and/or Third Party Responsibility. That are for an Illness, Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

Unreasonable. That are not "Reasonable" and are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This Exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense and are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

Vehicle Accident. For treatment of any Injury where it is determined that a Participant was involved in a motorcycle Accident while not wearing a helmet or in an automobile Accident while not wearing a seatbelt (or car seat), even if the cause of the Illness or Injury is not related to the failure of the Participant to wear a helmet or seatbelt (or car seat). This exclusion does not apply: (a) to Participants who were passengers on public transportation, ride for hire or livery services or (b) when a seatbelt or helmet is not required by law.

War/Riot. That Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country, or voluntary participation in a riot. This Exclusion does not apply to any Participant who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a documented medical condition. To the extent consistent with applicable law, this exception will not require this Plan to provide particular benefits other than those provided under the terms of the Plan.

MEDICAL EXCLUSIONS AND LIMITATIONS

Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in the General Limitations and Exclusion section, these include, but are not limited to, any charge for care, supplies, or services, which are:

Consultations. For consultations.

Education or Training Program. Performed by a Physician or other Provider enrolled in an education or training program when such services are related to the education or training program, except as specifically provided herein.

Eye Refractions. For eye refractions, eyeglasses, contact lenses, or the vision examination for prescribing or fitting eyeglasses or contact lenses (except for aphakic patients, and soft lenses or sclera shells intended for use in the treatment of Disease or Injury).

Hair Pieces. For wigs, artificial hair pieces, human or artificial hair transplants, or any Drug, prescription or otherwise, used to eliminate baldness.

Hearing Exam. Charges for hearing examinations.

Hypnosis. Related to the use of hypnosis.

Impregnation and Infertility. Charges related to treatment, drugs or procedures for infertility are not eligible expenses. Diagnosis of infertility is a Covered Expense.

Nicotine Addiction. For nicotine withdrawal programs, facilities, Drugs or supplies, except as specified under Preventive Care.

Nutritional Supplements. For nutritional supplements, except as specified under Preventive Care.

Obesity. Related to the care and treatment of obesity, weight loss or dietary control, unless related to morbid obesity (which is the lesser of 100 pounds over normal weight or twice normal weight). Specifically excluded, even if related to morbid obesity, are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including reversals. This Exclusion does not apply to obesity screening and counseling that are covered under the Preventive Care benefit.

Oral Surgery. For oral surgery or dental treatment, except as specifically provided in the Plan.

Organ Transplants. Related to donation of a human organ or tissue, except as specifically provided.

Orthopedic Shoes. For orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet.

Osseous Surgery. For osseous surgery.

Personal Convenience Items. For equipment that does not meet the definition of Durable Medical Equipment, including air conditioners, humidifiers and exercise equipment, whether or not recommended by a Physician.

Private Duty Nursing. Private duty nursing.

Radial Keratotomy. For radial keratotomy or other plastic surgeries on the cornea in lieu of eyeglasses.

Routine Physical Examinations. For routine or periodic physical examinations, related x-ray and laboratory expenses, and nutritional supplements, except as provided in the Summary of Benefits.

Sex Assignment/Reassignment. Related to a sex change operation except to the extent required by the Affordable Care Act (ACA) or Mental Health Parity Act (MHPA) of 1996. Any services must be preauthorized and determined to be Medically Necessary. Any charges for sex assignment/reassignment that are voluntary will not be considered as eligible expenses.

Sexual Dysfunction Therapy or Surgery. For sexual dysfunctions or inadequacies that do not have psychological or organic basis except to the extent required by the Affordable Care Act (ACA) or Mental Health Parity Act (MHPA) of 1996. Any services must be pre-authorized and determined to be Medically Necessary. Any charges for sexual dysfunction therapy or surgery that are voluntary will not be considered as eligible expenses.

Sterilization Reversal. For sterilization procedure reversal.

Travel. For travel, whether or not recommended by a Physician, except as specifically provided herein.

Vitamins. For vitamins.

PRESCRIPTION DRUG EXPENSE BENEFIT

Vancouver Firefighters Union Health & Trust Health Care Plan provides a Prescription Drug Plan. This prescription drug program is an independent program, separate from the medical plan. The cardholder is responsible for the applicable co-payment and/or coinsurance.

Prescription drug limitations:

- Refills only up to the number of times specified by a Physician.
- Refills up to one year from the date of order by a Physician.

Specialty Pharmacy Program

Specialty drugs are high cost drugs used to treat chronic diseases, including, but not limited to: HIV/Aids, Rheumatoid Arthritis, Cancer, Hepatitis, Hemophilia, Multiple Sclerosis, Infertility and Growth Hormone Deficiency. Specialty drugs may be obtained directly from the specialty pharmacy program. For additional information, please contact the Prescription Drug Card Program Manager.

Specialty Drug – Cost Avoidance Program

The Plan has a cost avoidance program, coordinated through Payer Matrix, for specialty drugs. You are eligible to participate in the Payer Matrix program if you are currently taking, or if you begin taking a specialty drug. The program will help you enroll in any applicable alternate funding programs for your eligible drug therapy, with the goal of helping you avoid any out-of-pocket expense for specialty medications.

If you are eligible to participate in the Payer Matrix program, you will receive a telephone call to your current telephone number on file with the Plan's office, outlining the enrollment process. As a first step, Plan members or their providers are required to send specialty medication prescriptions to their pharmacy vendor. While the pharmacy vendor conducts the clinical prior authorization to ensure the medication is medically necessary for you, Payer Matrix conducts an administrative review to locate an alternate payer for you and the specific specialty medication you need. Payer Matrix and/or your Plan will assist you throughout the process, from enrollment through your receipt and use of your medication.

If you are eligible for a Payer Matrix identified alternate funding program, and choose not to enroll in the program, you will be responsible for the full cost of your applicable specialty drug prescription, and this expense will not count toward your annual out-of-pocket maximum.

If you are not eligible for any alternate funding program through Payer Matrix, any Specialty Drug prescriptions covered by the Plan, you may file an appeal. If approved, Payer Matrix will work with the pharmacy vendor or The Loomis Company to place an override in the system so that you may receive your drugs from your pharmacy or your physician.

No benefits will be paid for charges incurred for:

In addition to the General Limitations and Exclusions section, the following are not covered by the Plan:

Acne Control. Drugs that help manage the severity and frequency of acne outbreaks that cannot be purchased over-the-counter.

Administration. Any charge for the administration of a covered Drug.

Allergy Sera. Charges for allergy sera.

Anorexiants. Anorexiants (weight loss Drugs).

Anti-Aging Products. Drugs intended to affect the structure or function of the skin that cannot be purchased over-the-counter.

Blood and Blood Plasma. Charges for blood and blood plasma.

Consumed Where Dispensed. Any Drug or medicine that is consumed or administered at the place where it is dispensed.

Devices. Devices of any type, even though such devices may require a prescription, including, but not limited to, therapeutic devices, artificial appliances, braces, support garments or any similar device.

Experimental Drugs. Experimental Drugs and medicines, even though a charge is made to the Participant.

Fertility Agents. Charges for fertility agents.

Immunologicals. Charges for immunologicals (vaccines).

Impotency. A charge for impotency medication, including Viagra.

Institutional Medication. A Drug or medicine that is to be taken by a Participant, in whole or in part, while confined in an Institution, including any Institution that has a facility for dispensing Drugs and medicines on its premises.

Investigational Use Drugs. A Drug or medicine labeled "Caution – limited by Federal law to Investigational use."

Medical Devices and Supplies. Charges for legend and over the counter medical devices and supplies.

No Charge. A charge for drugs which may be properly received without charge under local, State or Federal programs.

Non-Insulin Syringes/Needles. Charges for non-insulin syringes and needles unless required for a medication that is covered under the Plan.

Non-Prescription Drug or Medicine. A drug or medicine that can legally be bought without a prescription, except for injectable insulin.

Over-the-counter Drugs. Charges for over-the-counter drugs, except to the extent required by the Affordable Care Act.

Rogaine. Charges for Rogaine (topical minoxidil).

Steroids. Anabolic steroids.

Vitamins. Vitamins, except pre-natal vitamins.

Note: This list may not be all inclusive of the limitations as set forth under the terms and conditions of your prescription drug plan. Contact your pharmacy vendor at the number on your ID card for more information.

DEFINED TERMS

Accident – An event which takes place without one's foresight or expectation, or a deliberate act that results in unforeseen consequences.

Accidental Injury – An unforeseen and unintended injury.

Actively at Work / Active Employment – An Employee is "Actively at Work" or in "Active Employment" on any day the Employee performs in the customary manner all of the regular duties of employment. An Employee will be deemed Actively at Work on each day of a regular paid vacation or on a regular non-working day on which the covered Employee is not totally disabled, provided the covered Employee was Actively at Work on the last preceding regular work day. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor, as defined by HIPAA, subject to the Plan's Leave of Absence provisions. An Employee will not be considered under any circumstances Actively at Work if he or she has effectively terminated employment.

Allowable Charge – Allowable charges for a treatment, supply or other services rendered is determined by the Plan, at the Plan's discretion, by determining the amount established by a negotiated arrangement if one exists, or the lesser of:

- Specified Benefit Amount;
- Gross billed charge made by the provider;
- Usual, Customary and Reasonable payment for the same treatment, service, or supply;
- Prevailing fee charged in an area large enough to obtain a representative cross-section of providers rendering such treatment, supply or services for which the charge is made by Providers of similar skill and experience.

For Covered Charges rendered by a Physician or other professional provider in a geographic area where applicable law dictates the maximum amount that can be billed by the rendering provider, the Allowable Charge shall mean the amount established by applicable law for that Covered Charge.

The Allowable Charges shall not include:

- Charges for any items billed separately that are customarily included in a global billing procedure code in accordance with American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS;
- Charges for billing errors including, but not limited to, upcoding, duplicate charges, and charges for services not performed;
- Charges relating to clearly identifiable errors in medical care;
- Charges the Plan cannot identify or understand the item(s) being billed; or,
- Charges identified based upon a medical record review and audit, which determines that a different treatment or different quantity of a drug or supply was provided.

Nothing in this section shall be construed to limit the Plan's discretion to deem a greater amount payable than the lesser of any of the above-referenced amounts. Furthermore, the Plan is not obligated to consider all factors. In the event that the Plan determines that insufficient information is available to identify the Allowable Charge for a specific service or supply using the listed guidelines above, the Plan reserves the right, in its sole discretion, to determine any Allowable Charge amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Covered Person.

Ambulatory Surgical Center – A licensed facility that is used mainly for performing Outpatient surgery, has a staff of physicians, has continuous physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Amendment (Amend) – A formal document signed by the representatives of Vancouver Firefighters Union Health & Trust Health Care Plan. The amendment adds, deletes, or changes the provisions of the Plan and applies to all Covered Persons, including those persons covered before the amendment becomes effective, unless otherwise specified.

Assignment of Benefits – An arrangement whereby the Covered Person, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less deductibles, copayments and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Covered Person, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" and deductibles, copayments and the coinsurance percentage that is the responsibility of the Covered Person, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits previously issued to a Provider at its discretion and continue to treat the Covered Person as the sole beneficiary.

Biofeedback – Provides training to help an individual gain some element of voluntary control over autonomic body functions.

Birthing Center – 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 Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery (no more than 24 hours); 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 or require pre- or post-delivery confinement.

Business Associate – A person who, on behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement:

- Performs, or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management and repricing; or
- Provides, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

Chiropractic Care/Spinal Manipulation – Skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Clean Claim – A clean claim is 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 shall include 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 or other coverage criteria, or fees under review for application of the Maximum Allowable Charge, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing 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 Participant has failed to submit required forms or additional information to the Plan as well.

Clinical Nutrition – Clinical nutrition centers on the relationship between food and disease, principally in healthcare and disease research settings. Science-based techniques are used to identify, treat and prevent a disorder.

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Company – The Company is Vancouver Firefighters Union Health & Trust, and any affiliates who have adopted the Plan.

Cosmetic Surgery – Medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements.

Covered Entity – In terms of the HIPAA Privacy Regulations a Covered Entity includes a health plan; a health care provider who transmits any health information in electronic form in connection with a covered transaction; or a health care clearinghouse that handles electronic claims from a provider.

Covered Expenses – A service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Allowable Charge for an eligible Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is eligible for coverage in accordance with this Plan. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as set forth elsewhere in this document.

Covered Person – An employee / former employee and dependent(s) covered under this Plan.

Custodial Care – Care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication, which could normally be self-administered.

Dentist – A legally qualified dentist or a legally qualified physician authorized by their license to perform, at the time and place involved, the particular dental procedure rendered by them.

Durable Medical Equipment – Equipment that (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an illness or injury and (d) is appropriate for use in the home.

Eligible Charge – The negotiated amount a network provider has agreed upon for a specific service or the Allowable Charge for a non-network provider.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Services – Health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including pre-Hospital care and ancillary services routinely available to the emergency department of a Hospital.

Employee – A person directly employed in the regular business of, and compensated for services by Vancouver Firefighters Union Health & Trust on a regularly scheduled basis and regularly scheduled to work for the Employer in an Employee/Employer relationship.

Employer – Vancouver Firefighters Union Health & Trust.

End Stage Renal Disease (ESRD) – A condition that may qualify the Covered Person for Medicare benefits. Should a Covered Person become eligible for Medicare benefits because of ESRD, this plan will provide primary coverage or coordinate against Medicare benefits, in accordance with the rules promulgated by Medicare regarding the liability of Medicare to provide benefits for care related to ESRD, including but not limited to dialysis or transplant, when group coverage is available.

Enrollment Date – First day of coverage, or first day of waiting period if there is a waiting period.

ERISA – The Employee Retirement Income Security Act of 1974, as amended.

Excess Charges – Charges or portion of a charge or charges that exceed(s) Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge. This shall include charges that are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document;

Experimental/Investigational – Any treatment, procedure, facility, equipment, drugs, drug usage or supplies that are not recognized by the national board of the appropriate medical specialty as a generally accepted course of treatment for the medical condition being treated or which is performed for research or educational purposes or which has not been approved by a federal or state agency having jurisdiction and authority to approve such treatment, procedure, facility, equipment, drug or supplies.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable

interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The Plan Administrator will be guided by the following principles:

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Extended Care Facility, Skilled Nursing Facility – Any or all of these facilities shall mean an institution which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care, rehabilitation and treatment for individuals convalescing from an injury or illness. These services shall be under the supervision of a physician and/or registered graduate nurse (R.N.) while providing 24 hours per day of nursing services.

Fiduciary – The person or organization that has the authority to control and manage the operation and administration of the Plan. The fiduciary has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan. The named fiduciary for this Plan is the Plan Administrator for Vancouver Firefighters Union Health & Trust Health Care Plan.

Generic Drug – A prescription drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information – Information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Genetic Testing – The analysis of RNA, chromosomes, proteins and certain metabolites in order to detect heritable disease-related genotypes, mutations, phenotypes or karyotypes for clinical purposes.

Group Health Plan – Any individual or group plan, private or governmental, that provides or pays for medical care, to the extent specified in the HIPAA Privacy Regulations, 65 Fed. Reg. No. 250 (82463).

HIPAA – The Health Insurance Portability and Accountability Act of 1996.

Home Health Care Agency – An organization that meets all of these tests: its main function is to provide home health care services and supplies; it is federally certified as a home health care agency; and it is licensed by the state in which it is located, if licensing is required.

Homeopathic Treatment – Homeopathic medicine, or homeopathy, is a form of complementary and alternative medicine that uses very small amounts of natural substances, which in higher amounts may cause a disease or symptom. This type of treatment is generally overseen by a homeopathic practitioner.

Hospice Agency – An agency where its main function is to provide hospice care services and supplies and it is licensed by the state in which it is located, if licensing is required.

Hospital – An institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

To be deemed a "Hospital," the facility must be duly licensed if it is not a State tax supported Institution, and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution; or an Institution which is supported in whole or in part by a Federal government fund.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a physician in regular attendance; continuously provides 24-hour-a-day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness – Sickness or disease, including pregnancy, mental/nervous disorders, alcoholism and substance abuse, requiring treatment by a physician.

Incurred – A Covered Expense is "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps 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.

Infertility – This term means: (a) the inability to conceive after one year of unprotected sexual intercourse; or (b) the inability to sustain a successful pregnancy. As used here, "sexual intercourse" means sexual union between a man and woman.

Injury – Accidental physical injury caused by unexpected external means requiring treatment by a physician.

Intensive Care Unit – A separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill and or injured. This also includes what is referred to as a "coronary care unit" or an "acute care unit". It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Intensive Outpatient Services – A program that have the capacity for planned, structured, service provision of at least two hours per day and three days per week. The range of services offered could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and medical monitoring. These services would include multiple or extended treatment / rehabilitation / counseling visits or professional supervision and support. Program models include structured "crisis intervention programs," "psychiatric or psychosocial rehabilitation," and some "day treatment."

Late Enrollee – A Covered Person who enrolls under the Plan other than during the earliest date on which coverage can become effective under the terms of the plan; or during a special enrollment period.

Lifetime – Refers to benefit maximums and limitations while covered under this Plan.

Medical Care Facility – A Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency – Accidental injury or sudden onset of a medical condition for which failure to get immediate medical care could be life threatening, cause serious harm to bodily functions, or seriously damage a body organ or part with acute symptoms requiring immediate medical care, including, but not limited to, conditions such as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary (Medical Necessity) – Care and treatment recommended or approved by a physician, which is consistent with the patient's condition and accepted standards of medical practice, medically proven to be effective treatment of the condition, not performed solely for the convenience of the patient or provider, not conducted for investigative, educational, experimental or research purposes, and is the most appropriate level of service that can be safely provided to the patient. The fact that a physician may prescribe, order, recommend, or approve a service does not, of itself, make it medically necessary or make the charge a covered expense, even though it is not specifically listed as an exclusion under this Plan.

Off-label Drug use is considered Medically Necessary when all of the following conditions are met:

1. The Drug is approved by the Food and Drug Administration (FDA).
2. The prescribed Drug use is supported by one of the following standard reference sources:
   a. Micromedex® DRUGDEX®.
   b. The American Hospital Formulary Service Drug Information.
   c. Medicare approved Compendia.
   d. Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the Drug is safe and effective for the specific condition.
3. The Drug is Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

Medicare – The program established by Title 1 of Public Law 89.97 (79 Stat. 291) as amended, entitled Health Insurance for the Aged Act, and which includes: Part A - Hospital Insurance Benefits for the Aged; Part B - Supplementary Medical Insurance Benefits for the Aged.

Medicare Entitlement – Receiving coverage from Medicare. Normally this is accomplished when an individual who is age 65 signs up for Social Security benefits, which automatically enrolls the individual in the Medicare Program. Medicare coverage also is possible for individuals with kidney (end-stage renal) disease, or for individuals younger than age 65 who Social Security deems disabled, effective on the first day of the 25th month after the date the individual's Social Security disability began. Social Security disability benefits do not begin until the sixth full month of disability.

Mental Disorder – Any disease or condition that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity – A diagnosed medical condition in which a Covered Person has: (a) a body mass index of 40 or greater; or (b) a body mass index of 35 or greater with co-morbidity or co-existing conditions such as: (i) hypertension; (ii) heart disease; (iii) sleep apnea: or (iv) diabetes.

No-Fault Auto Insurance – The basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Orthotic – A custom-made brace or external device made for a weak, diseased, or injured body part. An Orthotic can increase, decrease, or eliminate motion or support the weak, diseased, or injured body part.

Outpatient Care – Treatment including services, supplies and medicines provided and used at a Hospital under the direction of a physician to a person not admitted as a registered bed patient; or services rendered in a physician's office, laboratory or X-ray facility, an ambulatory surgical center, or the patient's home.

Partial Hospitalization – A medically necessary alternative to Inpatient Hospitalization with continuous treatment for at least four hours, but not more than 12 hours, in any consecutive 24 hour period in a Hospital or Treatment Center.

Pharmacy – A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician – A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Occupational Therapist, Physiotherapist, Speech Language Pathologist, psychiatrist, midwife, and any other practitioner of the healing arts who is licensed and regulated by a State or Federal agency, acting within the scope of that license.

A **Provider** shall include an entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "Provider" as defined herein if that entity is not deemed to be a "Provider" by the Centers for Medicare and Medicaid Services (CMS) for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's

status as a Provider. All facilities must meet the standards as set forth within the applicable definitions of the Plan as it relates to the relevant provider type.

All medical services provided must be within the scope of his or her license or certificate.

Plan – Vancouver Firefighters Union Health & Trust Health Care Plan Employee Benefits Plan, which is a benefits plan for certain employees of Vancouver Firefighters Union Health & Trust and is described in this document.

Plan Sponsor – Distinguished from Health Plan for privacy purposes. Defined at section 3(16)(B) of ERISA, 29 U.S.C. 1002 (16)(B).

Plan Year – The 12-month period beginning on either the effective date of the Plan or on the day following the end of the first plan year, which is a short plan year.

Preferred Provider Organization (PPO) – A company that contracts with a selected group of Hospitals and physicians (preferred providers) offering quality care. Utilization management techniques are applied to covered services. The Plan pays network providers on a fee-for-service basis, usually at discounted rates. The Plan is designed to provide financial incentives in the form of increased benefits to members utilizing preferred providers.

Pregnancy – Childbirth and conditions associated with pregnancy, including complications.

Prescription Drug – Any of the following: a drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed physician. Such drug must be medically necessary in the treatment of a sickness or injury.

Preventive/Wellness Care – This includes services and supplies for screening procedures used to establish a baseline and regularly scheduled exams performed for the purpose of promoting good health and early detection of disease.

Protected Health Information – Information that is created or received by the Plan, or a Business Associate of the Plan, whether oral, written, or in electronic form, and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Individually Identifiable Health Information includes information of persons living or deceased.

Qualified Medical Child Support Order – An issued order, judgment, decree or settlement agreement by a court of competent jurisdiction that requires a non-custodial parent to provide medical coverage for his or her child who might not otherwise be eligible for coverage. A qualified order includes information regarding: 1) The Covered Person's name and address; 2) The name and last known mailing address of the alternate recipient (i.e., the child); 3) The name of the Plan the child will be covered by; 4) A reasonable description of the type and scope of health coverage provided under the Plan; 5) The period of time to which the order applies; and 6) The order must be signed by the Judge, Commissioner or Magistrate who is presiding over the divorce. The enacted Omnibus Budget Reconciliation Act of 1993 (OBRA 93) provides for the recognition of qualified medical child support orders (QMCSO) by group health plans.

Reasonable – Reasonable and/or Reasonableness shall mean in the Plan Administrator's discretion, services or supplies, or fees for services or supplies, which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider's error or mistake. 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 evidence-based guidelines, and the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; (b) CMS and (c) The Food and Drug Administration. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

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

The Plan Administrator 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 – Monies paid to the Covered Person by way of judgment, settlement or otherwise to compensate for all losses caused by the injuries or sickness whether or not said losses reflect medical, dental or other charges covered by the Plan.

Recovery from another plan under which the Covered Person is covered. This right of refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

Rehabilitation Hospital – An appropriately licensed Institution, which is established in accordance with all relevant Federal, State and other applicable laws, to provide therapeutic and restorative services to individuals seeking to maintain, reestablish, or improve motor-skills and other functioning deemed Medically Necessary for daily living, that have been lost or impaired due to Sickness and/or Injury. To be deemed a "Rehabilitation Hospital," the Institution must be legally constituted, operated, and accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities, as well as approved for its stated purpose by the Centers for Medicare and Medicaid Services (CMS) for Medicare purposes.

To be deemed a "Rehabilitation Hospital," the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

Residential Treatment Facility – A facility licensed or certified as such by the jurisdiction in which it is located to operate a program for the treatment and care of Participants diagnosed with alcohol, drug or Substance Abuse disorders or mental illness.

Reimbursement – Repayment to the Plan for medical or dental benefits that it has advanced toward care and treatment of the injury or sickness.

Routine Care – The medical treatment or services neither directly related nor medically necessary for the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition, which is known or reasonably suspected.

Sick Leave – Time away from work due to an Injury or Illness. When an Employee is on an unpaid leave with a non-occupational Injury, the underlying medical condition determines how long the Employee remains an active Employee with the City. Employees that are Injured use Sick Leave first or FMLA then they may exhaust their vacation. They are still on the books with the City as an active Employee and the City will continue to make contributions on the Employee's behalf even if the Employee is not getting paid. An Employee on unpaid leave who has not had a termination of employment (typically, because of a pending fit for duty assessment following a non-occupational

Injury) and who retains rights to City contributions as an active member of the collective bargaining unit, remains eligible for coverage under the Plan.

Sickness/Illness – Disease or medical condition or pregnancy diagnosed and requiring treatment by a physician.

Specified Benefit Amount – The charges for services and supplies, listed and included as Covered Charges under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees do not exceed the Specified Benefit Amount. The determination that a charge does not exceed the Specified Benefit Amount include, but are not limited to, the following guidelines:

- 1.4 times the Medicare allowed amount for a Hospital facility, facility which is owned and operated by a Hospital, or an Ambulatory Surgery Centers;
- 1.2 times the Medicare allowed amount for Physician and other eligible providers;
- 100% of the Organ Procurement Organization's invoice cost; and,
- 100% of the National Marrow Donor Program's invoice cost.

Substance Abuse and/or Substance Use Disorder – Any use of alcohol, any drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as outlined below.

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more of the following, occurring within a 12 month period:

1. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household).
2. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use).
3. Craving or a strong desire or urge to use a substance.

Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights).

Temporomandibular Joint (TMJ) Syndrome – The treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Third Party Administrator – The claims administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims.

Third Party Administrative Functions – Activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Plan administration functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans – such as vision and dental. Protected Health Information for these purposes may not be used by or

between Covered Entities or Business Associates of a Covered Entity in a manner inconsistent with HIPAA's Privacy Regulation, absent an authorization from the individual. Plan administration specifically does not include any employment-related functions.

Total Disability – Employee's complete inability to perform any and every duty of his or her regular or customary occupation or similar occupation for which the employee is reasonably capable due to education and training, as a result of illness or injury, or a dependent's inability to perform the normal activities of a person of like age and sex who is in good health.

Treatment Center – A facility licensed as a psychiatric, alcohol or substance abuse treatment facility by the state in which it is located that provides a planned program of treatment for mental and nervous disorders, or alcohol or substance abuse based on a written plan established and supervised by a physician.

Urgent Care – Medical treatment which if the regular time periods observed for claims were adhered to: (a) could seriously jeopardize the life or health of the plan participant or their ability to regain maximum function; or (b) would in the opinion of a physician with knowledge of the plan participant's medical condition, subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Usual and Customary – Usual and Customary (U&C) shall mean Covered Expenses which are identified by the Plan Administrator, taking into consideration any or all of the following: 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 Providers of similar training and experience for the service or supply, and/or the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made 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 and Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Covered Person 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 and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

GENERAL PROVISIONS

Administration – This plan of benefits is administered through the Human Resources Department / Benefits Personnel of Vancouver Firefighters Union Health & Trust. The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Covered Person's rights; and to determine all questions of fact and law arising under the Plan. The Loomis Company has been retained to provide independent services in the area of claims processing.

The Plan is administered by the Plan Administrator within the purview of ERISA, and in accordance with these provisions. An individual, committee, or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the appointed Plan Administrator or a committee member 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 shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. 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 all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the claims appeal procedures of the Plan.

Duties of the Plan Administrator

The duties of the Plan Administrator include 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 Participant's rights and/or availability of benefits.
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 ERISA.
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.
12. To perform each and every function necessary for or related to the Plan's administration.

Assignment of Benefits – In the event a Plan participant has executed an Assignment of Benefits, the Plan shall direct amounts payable under the terms of this Plan to the provider of service. If the Plan receives notification from a provider that the provider has the Plan participant's authorization to assign benefits on file, then that shall be acceptable notice to the Plan that an Assignment of Benefits has been executed. Benefits may not, however, be assigned to anyone other than the provider of service without the approval of Vancouver Firefighters Union Health & Trust.

All benefits payable by the Plan may be assigned to the provider of services or supplies at the Plan Participant's option and at the Plan's discretion unless evidence of previous payment is submitted. Payments made in accordance with an assignment are made in good faith and release the Plan's obligation to the extent of the payment

Plan Amendment or Termination – Vancouver Firefighters Union Health & Trust reserves the full, absolute and discretionary right to amend, modify, suspend, withdraw, discontinue or terminate the Plan in whole or in part at any time for any and all participants of the Plan by formal action taken by the Board of Directors, or by the execution of a written amendment by the Plan Sponsor. If the Plan is amended, modified, suspended, withdrawn, discontinued or terminated, covered employees and covered dependents will be entitled to benefits for claims incurred prior to the date of such action. Such changes may include, but are not limited to, the right to (1) change or eliminate benefits, (2) increase or decrease participant contributions, (3) increase or decrease deductibles and/or co-payments, and (4) change the class of employees or dependents covered by the Plan.

Medical Care Decision – The benefits under the Plan provide solely for the payment of certain health care expenses. All decisions regarding health care are solely the responsibility of each Covered Person in consultation with the health care providers selected. The Plan contains rules for determining the percentage of allowable health care expenses that will be reimbursed, and whether particular treatments or health care expenses are eligible for reimbursement. The Covered Person in accordance with the Plan's appeal procedures may dispute any decision with respect to the level of health care reimbursements, or the coverage of a particular health care expense. Each Covered Person may use any source of care for health treatment and health coverage as selected, and neither the Plan nor the employer shall have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a Covered Person not to seek or obtain such care, other than the liability of the Plan for the payments of benefits as outlined herein.

Fraud - Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Covered Person acts fraudulently or intentionally makes material misrepresentations of fact. It is a Covered Person's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age,

relationships, etc. It is also a Covered Person's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Covered Persons being canceled, and such cancellation may be retroactive.

If a Covered Person, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Covered Person of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Covered Person is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Covered Person and their entire Family Unit of which the Covered Person is a member.

A determination by the Plan that a rescission is warranted will be considered an adverse benefit determination for purposes of review and appeal. A Covered Person whose coverage is being rescinded will be provided a 30 day notice period as described under the Affordable Care Act (ACA) and regulatory guidance. Claims incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

Protection Against Creditors - To the extent this provision does not conflict with any applicable law, 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 Covered Person, the Plan Administrator in its sole discretion may terminate the interest of such Covered Person or former Covered Person in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Covered Person or former Covered Person, his or her spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a dependent of such Covered Person or former Covered Person, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

Binding Arbitration - ***NOTE****: The Employee is enrolled in a plan provided by the Employer that is subject to ERISA, any dispute involving an adverse benefit determination must be resolved under ERISA's claims procedure rules, and is not subject to mandatory binding arbitration. The individual may pursue voluntary binding arbitration after he or she has completed an appeal under ERISA.*

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this Binding Arbitration provision. To the extent that the Federal Arbitration Act is

inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Covered Person and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Covered Person and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Covered Person waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Covered Person.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Covered Person making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Covered Person and the Plan Administrator, or by order of the court, if the Covered Person and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

Unclaimed Self-Insured Plan Funds - In the event a benefits check issued by the Third Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Covered Person subsequently requests payment with respect to the voided check, the Third Party Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA, and any other applicable State law(s).

No Waiver or Estoppel - All parts, portions, provisions, conditions, and/or other items addressed by this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the narrowest fashion possible.

RIGHTS AND PROTECTIONS

As a Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Pension and Welfare Benefit Administration.

- Obtain copies of all plan documents such as the Form 5500, insurance contracts, collective bargaining agreements, updated summary plan descriptions, and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.

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

- Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this document and the documents governing the plan or the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of this plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and the other Covered Persons and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If a claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Covered Person can take to enforce the above rights. For instance, if a Covered Person requests information from the Plan and does not receive it within 30 days, they may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until the Covered Person receives the materials, unless the materials were not sent because of reasons beyond the control of the Administrators. If anyone has a claim for benefits, which is denied or ignored, in whole or in part, they may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if anyone is discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or file suit in a federal court. The court will decide who should pay court costs and legal fees. If the individual is successful, the court may order the persons sued to pay these costs and fees. If the individual loses, the court may order that person to pay these costs and fees, for example if it finds the claim is frivolous.

If there are any questions about the Plan, contact the Plan Administrator. If there are any questions about this statement or about ERISA rights, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Area Office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Pension and Welfare Benefits Administration.

LEGISLATIVE COMPLIANCE

All provisions of the Plan shall at all times be in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), ERISA and other applicable governmental laws, statutes, regulations, or rules promulgated by any governing unit having appropriate jurisdiction. The Plan Administrator shall administer the Plan accordingly, as well as complying with any changes to such statutes, regulations or rules affecting these provisions.

Pursuant to HIPAA, the Plan will at no time take into consideration any health status related factors, (physical or mental illnesses, prior receipt of health care, prior medical history, genetic information, evidence of insurability, conditions arising out of acts of domestic violence, or disability) which exist in relation to a person who is eligible for coverage under the Plan for purposes of determining the initial or continued eligibility of coverage under the Plan, for determining the level of contribution to Plan funding, or to determine the level of benefits which will be made available to a person. All Plan participants will be given written notice of any material reduction in benefits provided by the plan within 60 days of the adoption of such material reduction.

No provision contained in this booklet nor any portion of the Plan shall give a Plan participant or entity acting on their behalf any right or cause of action, either at law or in equity against the Plan Administrator, the Third Party Administrator, the Plan Sponsor, or the Utilization Review Administrator for the acts of any Hospital where care is received, for the acts of any physician, or other provider from whom services are received and benefits are provided under this Plan.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how protected health information (or "PHI") may be used or disclosed by us (or your Group Health Plan) to carry out payment, health care operations, and for other purposes that are permitted or required by law. This Notice also sets out our legal obligations concerning your PHI, and describes your rights to access, amend and manage your PHI.

PHI is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health plan, your employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (i) your past, present, or future physical or mental health or condition; (ii) the provision of health care to you; or (iii) the past, present, or future payment for the provision of health care to you.

This Notice of Privacy Practices had been drafted to be consistent with what is known as the "HIPAA Privacy Rule," and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact: The Loomis Company at the customer service number listed on your ID card.

Effective Date: This Notice of Privacy Practices became effective on September 23, 2013.

OUR RESPONSIBILITIES

We are required by law to maintain the privacy of your PHI. We are obligated to: provide you with a copy of this Notice of our legal duties and of our privacy practices related to your PHI; abide by the terms of the Notice that is currently in effect; and notify you in the event of a breach of your unsecured PHI. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI that we maintain. If we make a material change to our Notice, we will make the revised Notice available by posting on the group website.

PERMISSIBLE USES AND DISCLOSURES OF PHI

Payment and Health Care Operations

We have the right to use and disclose your PHI for all activities that are included within the definitions of "payment" and "health care operations" as set out in 45 C.F.R. § 164.501 (this provision is a part of the HIPAA Privacy Rule). We have not listed in this Notice all of the activities included within these definitions, so please refer to 45 C.F.R. § 164.501 for a complete list.

- ***Payment:*** We will use or disclose your PHI to pay claims for services provided to you and to obtain stop-loss reimbursements or to otherwise fulfill our responsibilities for coverage and providing benefits. For example, we may disclose your PHI when a provider requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

- ***Health Care Operations:*** We will use or disclose your PHI to support our business functions. These functions include, but are not limited to: quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning, and business development. For example, we may use or disclose your PHI: (i) to provide you with

information about a disease management program; (ii) to respond to a customer service inquiry from you; or (iii) in connection with fraud and abuse detection and compliance programs.

OTHER PERMISSIBLE USES AND DISCLOSURES OF PHI

The following is a description of other possible ways in which we may (and are permitted to) use and/or disclose your PHI.

- *Required by Law:* We may use or disclose your PHI to the extent the law requires the use or disclosure. When used in this Notice, "required by law" is defined as it is in the HIPAA Privacy Rule. For example, we may disclose your PHI when required by national security laws or public health disclosure laws.

- *Public Health Activities*: We may use or disclose your PHI for public health activities that are permitted or required by law. For example, we may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or we may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. We also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

- *Health Oversight Activities:* We may disclose your PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (i) the health care system; (ii) government benefit programs; (iii) other government regulatory programs; and (iv) compliance with civil rights laws.

- *Abuse or Neglect:* We may disclose your PHI to a government authority that is authorized by law to receive reports of abuse, neglect, or domestic violence. Additionally, as required by law, we may disclose to a governmental entity authorized to receive such information your PHI if we believe that you have been a victim of abuse, neglect, or domestic violence.

- *Legal Proceedings:* We may disclose your PHI: (i) in the course of any judicial or administrative proceeding; (ii) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized); and (iii) in response to a subpoena, a discovery request, or other lawful process, once we have met all administrative requirements of the HIPAA Privacy Rule. For example, we may disclose your PHI in response to a subpoena for such information, but only after we first meet certain conditions required by the HIPAA Privacy Rule.

- *Law Enforcement:* Under certain conditions, we also may disclose your PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (i) it is required by law or some other legal process; (ii) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person; and (iii) it is necessary to provide evidence of a crime that occurred on our premises.

- *Coroners, Medical Examiners, Funeral Directors; Organ Donation Organizations:* We may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death, or for the coroner or medical examiner to perform other duties authorized by law. We also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, we may disclose PHI to organizations that handle organ, eye, or tissue donation and transplantation.

- *Research:* We may disclose your PHI to researchers when an institutional review board or privacy board has: (i) reviewed the research proposal and established protocols to ensure the privacy of the information; and (ii) approved the research.
- *To Prevent a Serious Threat to Health or Safety:* Consistent with applicable federal and state laws, we may disclose your PHI if we believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.
- *Military Activity and National Security, Protective Services:* Under certain conditions, we may disclose your PHI if you are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If you are a member of foreign military service, we may disclose, in certain circumstances, your information to the foreign military authority. We also may disclose your PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons, or heads of state.
- *Inmates:* If you are an inmate of a correctional institution, we may disclose your PHI to the correctional institution or to a law enforcement official for: (i) the institution to provide health care to you; (ii) your health and safety and the health and safety of others; or (iii) the safety and security of the correctional institution.
- *Workers' Compensation:* We may disclose your PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.
- *Emergency Situations:* We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interest. If the disclosure is in your best interest, we will disclose only the PHI that is directly relevant to the person's involvement in your care.
- *Fundraising Activities:* We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.
- *Group Health Plan Disclosures:* We may disclose your PHI to a sponsor of the group health plan – such as an employer or other entity – that is providing a health care program to you. We can disclose your PHI to that entity if that entity has contracted with us to administer your health care program on its behalf.
- *Underwriting Purposes:* We may use or disclose your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing in the underwriting process your PHI that is genetic information.
- *Others Involved in Your Health Care:* Using our best judgment, we may make your PHI known to a family member, other relative, close personal friend or other personal representative that you identify. Such a use will be based on how involved the person is in your care, or payment that relates to your care. We may release information to parents or guardians, if allowed by law.

If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

USES AND DISCLOSURES OF YOUR PHI THAT REQUIRE YOUR AUTHORIZATION

- *Sale of PHI:* We will request your written authorization before we make any disclosure that is deemed a sale of your PHI, meaning that we are receiving compensation for disclosing the PHI in this manner.
- *Marketing:* We will request your written authorization to use or disclose your PHI for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.
- *Psychotherapy Notes:* We will request your written authorization to use or disclose any of your psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.

Other uses and disclosures of your PHI that are not described above will be made only with your written authorization. If you provide us with such an authorization, you may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that we already have used or disclosed, relying on the authorization.

REQUIRED DISCLOSURES OF YOUR PHI

The following is a description of disclosures that we are required by law to make.

- *Disclosures to the Secretary of the U.S. Department of Health and Human Services:* We are required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.
- *Disclosures to You:* We are required to disclose to you most of your PHI in a "designated record set" when you request access to this information. Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your PHI that are for reasons other than payment and health care operations and are not disclosed through a signed authorization.

  We will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant state law. However, before we will disclose PHI to such a person, you must submit a written notice of his/her designation, along with the documentation that supports his/her qualification (such as a power of attorney).
- *Even if you designate a personal representative*, the HIPAA Privacy Rule permits us to elect not to treat the person as your personal representative if we have a reasonable belief that: (i) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; (ii) treating such person as your personal representative could endanger you; or (iii) we determine, in the exercise of our professional judgment, that it is not in your best interest to treat the person as your personal representative.
- *Business Associates:* We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide the services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract

terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide member service support, utilization management, subrogation, or pharmacy benefit management.

- *Other Covered Entities:* We may use or disclose your 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, we may disclose your PHI to a health care provider when needed by the provider to render treatment to you, and we may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing or credentialing. This also means that we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.
- *Plan Sponsor:* We may disclose your PHI to the plan sponsor of the Group Health Plan for purposes of plan administration or pursuant to an authorization request signed by you.

POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Rule regulations generally do not "preempt" (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule regulations, might impose a privacy standard under which we will be required to operate. For example, where such laws have been enacted, we will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

YOUR RIGHTS

The following is a description of your rights with respect to your PHI.

- *Right to Request a Restriction:* You have the right to request a restriction on the PHI we use or disclose about you for payment or health care operations. *We are not required to agree to any restriction that you may request.* If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you. You may request a restriction by contacting the Plan Administrator. It is important that you direct your request for restriction to the Plan Administrator so that we can begin to process your request. Requests sent to persons or offices other than the Plan Administrator might delay processing the request.

  We will want to receive this information in writing and will instruct you where to send your request when you call. In your request, please tell us: (1) the information whose disclosure you want to limit; and (2) how you want to limit our use and/or disclosure of the information.

- *Right to Request Confidential Communications*: If you believe that a disclosure of all or part of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

  You may request a restriction by contacting the Plan Administrator. It is important that you direct your request for confidential communications to the Plan Administrator so that we can begin to process your request. Requests sent to persons or offices other than the one indicated might delay processing the request.

We will want to receive this information in writing and will instruct you where to send your written request when you call. In your request, please tell us: (1) that you want us to communicate your PHI with you in an alternative manner or at an alternative location; and (2) that the disclosure of all or part of the PHI in a manner inconsistent with your instructions would put you in danger.

We will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of your PHI could endanger you. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting your request, you will be required to provide us information concerning how payment will be handled. For example, if you submit a claim for payment, state or federal law (or our own contractual obligations) may require that we disclose certain financial claim information to the plan participant (*e.g.*, an Explanation of Benefits, or "EOB"). *Unless* you have made other payment arrangements, the EOB (in which your PHI might be included) will be released to the plan participant.

Once we receive all of the information for such a request (along with the instructions for handling future communications), the request will be processed usually within two business days.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI might be disclosed (such as through an EOB). Therefore, it is extremely important that you contact the Plan Sponsor as soon as you determine that you need to restrict disclosures of your PHI.

If you terminate your request for confidential communications, the restriction will be removed for all your PHI that we hold, including PHI that was previously protected. Therefore, you should not terminate a request for confidential communications if you remain concerned that disclosure of your PHI will endanger you.

- *Right to Inspect and Copy*: You have the right to inspect and copy your PHI that is contained in a "designated record set." Generally, a "designated record set" contains medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

  To inspect and copy your PHI that is contained in a designated record set, you must submit your request to the Plan Administrator. It is important that you contact the Plan Administrator to request an inspection and copying so that we can begin to process your request. Requests sent to persons or offices other than the Plan Administrator might delay processing the request. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies associated with your request.

  We may deny your request to inspect and copy your PHI in certain limited circumstances. If you are denied access to your information, you may request that the denial be reviewed. To request a review, you must contact the Plan Administrator. A licensed health care professional chosen by us will review your request and the denial. The person performing this review will not be the same one who denied your initial request. Under certain conditions, our denial will not be reviewable. If this event occurs, we will inform you in our denial that the decision is not reviewable.

- *Right to Amend*: If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. You may request that we amend your information by contacting

the Plan Administrator. Additionally, your request should include the reason the amendment is necessary. It is important that you direct your request for amendment to the Plan Administrator so that we can begin to process your request. Requests sent to persons or offices other than the Plan Administrator might delay processing the request.

In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity. If we deny your request, you have the right to file a statement of disagreement with us. Your statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include your statement.

- *Right of an Accounting*: You have a right to an accounting of certain disclosures of your PHI that are for reasons other than treatment, payment, or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by you or your personal representative. You should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to your right to an accounting. There also are other exceptions to this right.

  An accounting will include the date(s) of the disclosure, to whom we made the disclosure, a brief description of the information disclosed, and the purpose for the disclosure.

  You may request an accounting by submitting your request in writing to the Plan Administrator. It is important that you direct your request for an accounting to the Plan Administrator so that we can begin to process your request. Requests sent to persons or offices other than the Plan Administrator might delay processing the request.

  Your request may be for disclosures made up to 6 years before the date of your request, but not for disclosures made before April 14, 2003. The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

- *Right to a Copy of This Notice*: You have the right to request a copy of this Notice at any time by contacting the Plan Administrator. If you receive this Notice on our Website or by electronic mail, you also are entitled to request a paper copy of this Notice.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by calling us at the customer service number listed on your ID card. A copy of a complaint form is available from this contact office.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems; and (4) be filed within 180 days of the time you became or should have become aware of the problem.

We will not penalize you or in any other way retaliate against you for filing a complaint with the Secretary or with us.

HIPAA SECURITY REGULATIONS

We are required to:

- Implement administrative, physical, and technical standards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;
- Ensure that the firewall required by the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;
- Ensure that any agent or subcontractor to whom the Plan Administrator provides electronic PHI agrees to implement reasonable and appropriate security measures; and
- Report to the Plan any security incident of which the Plan Administrator becomes aware.

NO VERBAL MODIFICATIONS

The Covered Person shall not rely on any oral statement from any employee of The Loomis Company which modifies or otherwise affects the benefits, general limitations and exclusions, or other provisions of this Plan and increases, reduces, waives or voids any coverage or benefits under this Plan.

In addition, such oral statement shall not be used in the prosecution or defense of a claim under this Plan.

Any written or oral verification received from Vancouver Firefighters Union Health & Trust is based upon eligibility information and Plan benefits, which are subject to change. Therefore, any verification should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to a participant.

MISSTATEMENTS

In the event of any misstatement of any fact(s) affecting coverage under the Plan, the true facts will be used to determine the proper coverage. Coverage means eligibility as well as the amount of any benefits herein.

This booklet is not a contract. It explains in non-technical language the essential features of your Employee Benefit Program. Contact the Human Resources Department / Benefits Personnel if there are any questions concerning coverage.

ESTABLISHMENT OF THE PLAN

Adoption of the Plan Document and Summary Plan Description
This Plan Document and Summary Plan Description ("Document"), made by Vancouver Firefighters Union Health & Trust (the "Company" or the "Plan Sponsor") as of October 1, 2024, hereby sets forth the provisions of the Vancouver Firefighters Union Health & Trust Health and Welfare Benefit Plan (the "Plan"), which was originally adopted by the Company, effective October 1, 2024. Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

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

Adoption of the Document
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Document as the written description of the Plan. This Document represents both the Plan Document and the Summary Plan Description, which is required by sections 402 and 102 of the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

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

Vancouver Firefighters Union Health & Trust

By: _____

Name: _____

Date: _____ Title: _____

Version 2024.2