



THE TULALIP TRIBES OF WASHINGTON

EMPLOYEE HEALTH CARE PLAN

*Medical * Dental * Vision * Prescription Drugs*

EFFECTIVE: January 1, 2014

NOTICE

Preexisting Condition Exclusion

This plan imposes a preexisting condition exclusion, except for anyone under age 19. This means that if you have a medical condition before coming into the plan, you may have to wait a certain period of time before the plan will begin to provide coverage for that condition. However, you can reduce the length of this exclusion period by the number of days of your prior “creditable coverage.” This, and when the preexisting condition exclusion applies, is explained further in this Summary Plan Description.

Any questions you have about the preexisting condition exclusion or creditable coverage should be directed to:

Customer Service
Healthcare Management Administrators
800-700-7153

Special Enrollment Rights

If you or your dependents lose eligibility for other coverage or if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents in this plan provided you do so within the time required. This is explained further in this Summary Plan Description.

You may also be eligible for a Special Enrollment if you or your dependents gain or lose eligibility for Medicaid or the Children’s Health Insurance Plan (CHIP). This is explained further in this Summary Plan Description.

To request Special Enrollment, including the necessary forms, or to obtain more information, contact your Benefits Administrator.

CREDITABLE COVERAGE - MEDICARE

If you or someone in your family will be covered under either medical plan and Medicare, you should know the coverage for prescription drugs under the plan qualifies as “Creditable Coverage” for purposes of the Medicare prescription drug benefit regulations. If you have not received a Notice of Creditable Coverage, one is available from Tulalip’s Benefits Administrators. The Notice explains the situation further.

MEDICAID – CHILDREN’S HEALTH INSURANCE PLAN

A notice regarding premium assistance which may be available in some states under Medicaid or the Children’s Health Insurance Plan (CHIP) is included at the end of this Summary Plan Description.



TO OUR VALUED EMPLOYEES

Welcome to The Tulalip Tribes of Washington Employee Health Care Plan!

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

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

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

We have contracted with HMA for Health Services to help assure that you are receiving the best and most appropriate treatment when health care is needed. They are your advocates to help improve the quality of your health care and to lower the cost of health care to you and the Plan.

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

We wish you the best of health.

The Tulalip Tribes of Washington Employee Health Care Plan

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This Plan is maintained for the exclusive benefit of the Plan Employees and each Participant's rights under this Plan are legally enforceable.

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

Important Information - Please Read

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

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

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

PRE-AUTHORIZATION OF INPATIENT MEDICAL FACILITY ADMISSIONS AND OUTPATIENT SURGERIES

This plan requires pre-authorization of all inpatient medical facility admissions and all outpatient surgeries. To avoid a penalty, pre-authorization is required for all outpatient surgeries and scheduled admissions. Failure to call for pre-authorization **five days prior** to an outpatient surgery or an admission into a medical facility will result in the following reductions and losses:

- The amount of the payment due will be reduced by a \$250 penalty on the facility charges; and
- The penalty will not apply towards the out-of-pocket maximum.

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

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

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

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

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

CERTIFICATION OF ADDITIONAL DAYS

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

STEPS TO TAKE

When an inpatient admission or surgery is recommended, the patient, the physician or a family member must call HMA's Health Services Department at least five days prior to the admission or surgery to obtain authorization. If an emergency admission or emergency surgery occurs, the patient or a family member should ask the attending physician or the medical facility to contact HMA's Health Services Department within seven days after the admission or surgery, or by the next business day, if later. Please be prepared to give HMA's Health Services Department the following information when you make the call for authorization:

- Name and age of patient.
- Subscriber Identification Number.
- Group Number (4137).
- Medical Facility name and address.
- Name and phone number of admitting physician.
- Admission date.
- Diagnosis.
- Procedure being performed.

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

CASE MANAGEMENT/ALTERNATE TREATMENT

In cases where the covered participant's condition is expected to be or is of a serious nature, case management services from a professional qualified to perform such services may be recommended. The Health Services nurse case manager will work with you, the Plan Administrator, your physician and other health care providers to help assure that the care you receive is provided in the most appropriate and cost effective manner. The case managers are your advocates to help improve the quality of your health care and to lower the cost of health care to you and the Plan. The UR Coordinator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of a patient's care.

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

HOW TO FILE A CLAIM

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

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

CONTINUATION OF COVERAGE PROVISIONS (COBRA)

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

CONTACT FOR QUESTIONS ABOUT THE PLAN BENEFITS

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

**HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
P.O. Box 85008, Bellevue, WA 98015-5008
425/462-1000 - Seattle
800/700-7153 - Other Areas Nationwide
7:00 AM to 5:00 PM, Monday - Friday**

BASE PLAN SCHEDULE OF BENEFITS

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

Idaho/Oregon/Utah/Washington Participants:

HMA Preferred

800/700-7153

OR

www.accesshmacom

Participants in all other States or when traveling:

PHCS Network

800/700-7153

OR

www.accesshmacom

Eligible expenses will be paid at the preferred level when:

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

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

Amounts credited to the deductibles are **not** combined for the Preferred, Participating, and Out-of-Network eligible expenses. Each amount must be satisfied separately.

Amounts credited to the out-of-pocket maximums are combined for Preferred and Participating Network; however, Out-of-Network is **not** combined with the Preferred and Participating eligible expenses. The Out-of-Network out of pocket maximum must be satisfied separately.

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

PRE-AUTHORIZATION FOR MEDICAL FACILITY ADMISSIONS AND OUTPATIENT SURGERIES is required for full benefits. Failure to pre-authorize will result in a \$250 penalty, which will not apply towards the out-of-pocket maximum.

BASE PLAN SCHEDULE OF BENEFITS

MEDICAL BENEFITS

| | Tulalip Health Clinic | Preferred Network | Out Of Network |
|---|--------------------------|----------------------|-------------------|
| INDIVIDUAL DEDUCTIBLE Per calendar year. | No Deductible | \$500 | \$750 |
| FAMILY DEDUCTIBLE Per calendar year. | No Deductible | \$1,500 | \$2,250 |
| INDIVIDUAL OUT-OF-POCKET MAXIMUM Per calendar year. | \$2,000 | \$2,000 | \$4,000 |
| FAMILY OUT-OF-POCKET MAXIMUM Per calendar year. | \$6,000 | \$6,000 | \$12,000 |

If not noted otherwise – these benefits are subject to the deductible.

| | Tulalip Health Clinic | Preferred Network | Out Of Network |
|---|--------------------------|---|-----------------------------|
| ALLERGY INJECTIONS/TESTING | 100% | 90% | 60% |
| ALTERNATIVE SERVICES Limited to 4 visits per calendar year. Includes acupuncture, hypnotherapy, and massage therapy. | 75% | 75% deductible waived | 75% deductible waived |
| AMBULANCE (AIR AND GROUND) | ** | 90% | 90% |
| ANESTHESIOLOGIST Deductible waived for Out-of-Network charges, when both medical facility and primary surgeon are preferred providers. | ** | 80% | 80% |
| ASSISTANT SURGEON Limited to 20% of surgeon's fee. Deductible waived for Out-of-Network charges, when both medical facility and primary surgeon are preferred providers. | ** | 90% | 90% |
| CHEMICAL DEPENDENCY TREATMENT Inpatient (pre-authorization required, except for emergency) | 100% | 90% | 60% |
| Outpatient | 100% | \$20 Copay then 100% deductible waived | 60% |

**BASE PLAN
SCHEDULE OF BENEFITS**

| | Tulalip Health Clinic | Preferred Network | Out Of Network |
|---|----------------------------------|---|---|
| CHIROPRACTIC SERVICES AND X-RAYS Limited to 4 visits per calendar year. | 100% | \$20 Copay then 100% deductible waived | \$20 Copay then 100% deductible waived |
| COCHLEAR IMPLANTS | ** | 90% | 60% |
| CONTRACEPTIVE MANAGEMENT | 100% | 100% deductible waived | 60% |
| DENTAL SERVICES (ACCIDENTAL INJURY) | 100% | 90% | 60% |
| DENTAL TREATMENT – CHILDREN UNDER AGE 5 Dental treatment by a pediatrician or dentist is covered until the child reaches the age of 5. | 100% | 100% deductible waived | 100% deductible waived |
| DIABETIC EDUCATION | 100% | 100% deductible waived | 100% deductible waived |
| DIAGNOSTIC X-RAY AND LABORATORY | 100% | 90% | 60% |
| DIETARY EDUCATION | 100% | 100% deductible waived | 100% deductible waived |
| DURABLE MEDICAL EQUIPMENT Equipment \$500 or less | 80% | 80% deductible waived | 80% deductible waived |
| Equipment more than \$500 | 80% | 80% | 80% |
| EMERGENCY ROOM & SERVICES Copay waived if admitted as an inpatient. | ** | \$350 Copay then 90% | \$350 Copay then 90% |
| FLU SHOTS | 100% | 100% deductible waived | 100% deductible waived |
| HEARING AID BENEFIT | Not Covered | Not Covered | Not Covered |
| HOME HEALTH CARE Limited to 130 visits per calendar year. | ** | 90% | 60% |
| HOSPICE CARE Lifetime maximum six months. | ** | 90% | 60% |
| IMMUNIZATIONS/VACCINES | 100% | 100% deductible waived | 100% deductible waived |
| INFERTILITY DIAGNOSIS | 100% | 90% | 60% |

**BASE PLAN
SCHEDULE OF BENEFITS**

| | Tulalip Health Clinic | Preferred Network | Out Of Network |
|--|--------------------------|---|------------------------------|
| INFUSION THERAPY | 100% | 90% | 60% |
| INPATIENT PHYSICIAN VISIT | ** | 90% | 60% |
| KIDNEY DIALYSIS (OUTPATIENT SERVICES) Limited to 42 treatments per treatment period. | ** | 90% | 60% |
| Supplemental Coverage Payable at 150% of the Medicare allowable. | ** | 100% deductible waived | 100% deductible waived |
| MEDICAL FACILITY SERVICES | | | |
| Inpatient Five day maximum copay per admit. Copay waived if readmitted within 90 days. | ** | \$100 Copay per day then 90% | 60% |
| Outpatient | | | |
| Outpatient Surgical Facility | ** | 90% | 60% |
| Miscellaneous Services | ** | 90% | 60% |
| MEDICAL SUPPLIES | 100% | 90% | 60% |
| MENTAL HEALTH TREATMENT | | | |
| Inpatient (pre-authorization required, except for emergency) Five day maximum copay per admit. | ** | \$100 Copay per day then 90% | 60% |
| Outpatient | 100% | \$20 Copay then 100% deductible waived | 60% |
| NATUROPATHIC SERVICES Limited to 3 visits calendar year. | 75% | 75% deductible waived | 75% deductible waived |
| NEURODEVELOPMENTAL THERAPY Limited to dependent children to age seven. | 100% | 90% | 60% |
| OFFICE VISIT | 100% | \$20 Copay then 100% deductible waived | 60% |
| Prescriptions, Supplies, Surgery, and Miscellaneous services | 100% | 90% | 60% |
| ORTHOTICS | ** | 90% | 60% |
| PRE-ADMISSION TESTING | 100% | 90% | 60% |
| PREVENTIVE CARE (Exam, lab, etc.) | 100% | 100% deductible waived | Not Covered |

BASE PLAN SCHEDULE OF BENEFITS

| | Tulalip Health Clinic | Preferred Network | Out Of Network |
|---|--------------------------|---|--------------------|
| PREVENTIVE COLONOSCOPY/COLON CANCER SCREENING | 100% | 100% deductible waived | 60% |
| PREVENTIVE MAMMOGRAPHY | 100% | 100% deductible waived | Not Covered |
| PROSTHETICS | 100% | 90% | 60% |
| REHABILITATION SERVICES Inpatient Five day maximum copay per admit. | ** | \$100 Copay per day then 90% | 60% |
| Outpatient | ** | 90% | 60% |
| SECOND SURGICAL OPINION | 100% | 90% | 60% |
| SERIOUS MEDICAL CONDITION (Additional benefit) Maximum benefit – \$20,000 per calendar year | ** | 100% | 100% |
| SKILLED NURSING FACILITY CARE Limited to 30 days per calendar year. | ** | 90% | 60% |
| SMOKING CESSATION | 100% | 100% deductible waived | Not Covered |
| STERILIZATION | 100% | 100% deductible waived | 60% |
| SURGEON | ** | 90% | 60% |
| TEMPOROMANDIBULAR JOINT DISORDER | Not Covered | Not Covered | Not Covered |
| TRANSPLANTS | | | |
| Transplants | ** | 90% | 60% |
| Donor Benefits | ** | 90% | 60% |
| Transportation Expenses (Travel, Meals, Lodging) Limited to \$20,000 per transplant. | ** | 90% | 60% |
| URGENT CARE | 100% | \$20 copay then 100% deductible waived | 60% |

BASE PLAN SCHEDULE OF BENEFITS

| | Tulalip Health Clinic | Preferred Network | Out Of Network |
|--|--------------------------|---|-------------------|
| VISION THERAPY (ORTHOPTICS) Lifetime maximum 24 visits. Copay is waived for children to the age of 5. | ** | \$20 Copay then 100% deductible waived | 60% |
| OTHER MISCELLANEOUS ELIGIBLE CHARGES | 100% | 90% | 60% |

**Not all services are available at The Tulalip Health Clinic.

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

CALENDAR YEAR MAXIMUM BENEFITS

| | |
|--------------------------------|------------|
| Alternative Services | 4 visits |
| Chiropractic Services & X-Rays | 4 visits |
| Home Health Care | 130 visits |
| Naturopathic Services | 3 visits |
| Skilled Nursing Facility | 30 days |

LIFETIME MAXIMUM BENEFITS

| | |
|---------------------------------|------------|
| Hospice Care | six months |
| Vision Therapy | 24 visits |
| Major Medical/Prescription Drug | Unlimited |

BASE PLAN SCHEDULE OF BENEFITS

PRESCRIPTION BENEFITS

Caremark - Retail Pharmacies

| | AT TULALIP PHARMACY | AT OTHER RETAIL PHARMACIES |
|--|------------------------|-------------------------------|
| Generic Drugs | \$8 Copay | \$15 Copay |
| Preferred Brand Drugs | \$15 Copay | \$30 Copay |
| Non-Preferred Brand Drugs | \$30 Copay | \$50 Copay |
| | | |
| Dispensing Limit: | | |
| Non-Maintenance Drugs | 34 Days | 34 Days |
| Maintenance Drugs (90 days at 3 copays) | 90 Days | 34 Days |

Note - The Tulalip Pharmacy is open to everyone. You do not have to be a tribal member or Native American to use the pharmacy.

Caremark Mail Service - Mail Order Prescriptions

| | MAIL ORDER COPAYS |
|---------------------------|----------------------|
| Generic Drugs | \$30 Copay |
| Preferred Brand Drugs | \$60 Copay |
| Non-Preferred Brand Drugs | \$100 Copay |

Dispensing limit 90 days.

*This plan requires the pharmacist to fill the prescription with a generic product whenever it is available, unless the prescription is written as "Dispense as Written." If the prescription is not specified as "Dispense as Written" and the prescription is filled with a name brand prescription at the Plan participant's request, then the copay **plus** the difference between the cost of the generic drug and the brand name drug will be charged.*

Creditable Coverage - Medicare

If you or someone in your family will be covered under this plan and Medicare, you should know the coverage for prescription drugs under this plan qualifies as "Creditable Coverage" for purposes of the Medicare prescription drug benefit regulations. If you have not received a Notice of Creditable Coverage, one is available from your Benefits Administrator. The Notice explains the situation further.

Caremark

Customer Service – 866-885-4944
 Website – <http://www.caremark.com>
 Group Number (Base Plan) – 7137
 Carrier Number - 2407

**BASE PLAN
SCHEDULE OF BENEFITS**

VISION BENEFITS

| | Coinsurance |
|---|---------------------------|
| EXAMINATION Copay is waived for children to the age of 5. | \$10 Copay then 100% |
| HARDWARE Limited to \$200 every two calendar years. Maximum does not apply to children under the age of 19. Services utilized prior to turning age 19 will count towards the maximum once the individual turns 19. | \$20 Copay then 100% |
| REFRACTIVE EYE SURGERY | <i>Not Covered</i> |

BASE PLAN SCHEDULE OF BENEFITS

DENTAL BENEFITS

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

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

Eligible expenses will be paid at the preferred level when:

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

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

BASE PLAN SCHEDULE OF BENEFITS

| | Participating & Preferred Network | Out Of Network |
|---|---|-------------------|
| MAXIMUM PAYABLE Per participant, per calendar year. | \$3,000 | \$3,000 |
| Amounts credited to the maximum payable amount is applied to both the Preferred and Out-of-Network eligible expenses. | | |
| TYPE I - PREVENTIVE Oral Exam, Cleaning, X-rays, Fluoride, Sealants. | 100% | 100% |
| TYPE II - BASIC AND RESTORATIVE Fillings, Oral Surgery, Endodontic Treatment, Periodontal Services, Pathology, Anesthesia, Injectables. | 80% | 80% |
| TYPE III - MAJOR AND PROSTHETICS* Bridgework, Relines and Rebases, Crowns, Dentures and their repairs. Subject to a 6-month wait. | 70%* | 70%* |
| Implants* Subject to a 6-month wait. | 50%* | 50%* |
| TYPE IV - ORTHODONTIA | Not Covered | Not Covered |
| TYPE IV – TEMPOROMANDIBULAR JOINT DISORDER Limited to \$1,000 per calendar year. Lifetime maximum \$5,000. | 70% | 70% |

* Important Note – There is a 6-month waiting period for Type III services. You must be enrolled in the plan for 6 months before coverage is provided for Type III services incurred after the end of the waiting period.

BASE PLAN SCHEDULE OF BENEFITS

LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

| | |
|---|----------|
| Employee Basic Term Life | \$25,000 |
| Employee Accidental Death and Dismemberment | \$25,000 |

When you become insured, you will receive a certificate that describes your Life and Accidental Death and Dismemberment insurance in detail. For further information regarding coverage, please refer to this certificate. An employee must be actively-at-work on their effective date to be insured. Life and AD&D insurance is provided through Mutual of Omaha

BUY-UP PLAN SCHEDULE OF BENEFITS

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

Idaho/Oregon/Utah/Washington Participants:

HMA Preferred

800/700-7153

OR

www.accesshma.com

Eligible expenses will be paid at the preferred level when:

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

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

Amounts credited to the out-of-pocket maximums are combined for Preferred and Participating Network; however, Out-of-Network is **not** combined with the Preferred and Participating eligible expenses. The Out-of-Network out of pocket maximum must be satisfied separately.

Once the out-of-pocket is reached, expenses are paid at 100% of allowable charges for the remainder of the calendar year. There are some benefits that are not payable at the 100% coinsurance rate. The following expenses do not apply to the out-of-pocket expense 1) Deductibles; 2) Copays; 3) Penalties; 4) Ineligible charges; 5) Alternative Medicine; 6) Chiropractic Care; 7) Neurodevelopmental Therapy; 8) Rehabilitation; 9) Temporomandibular Joint Disorder treatment 10) Donor benefits 11) Home Health Care; 12) Hospice Care; and 13) Skilled Nursing Facility Benefits. Where a copay is applicable, only one copay is to be taken per day for related outpatient services rendered.

PRE-AUTHORIZATION FOR MEDICAL FACILITY ADMISSIONS AND OUTPATIENT SURGERIES is required for full benefits. Failure to pre-authorize will result in a \$250 penalty, which will not apply towards the out-of-pocket maximum.

BUY-UP PLAN SCHEDULE OF BENEFITS

MEDICAL BENEFITS

| | Tulalip Health Clinic | Preferred Network | Out Of Network |
|---|--------------------------|----------------------|-------------------|
| INDIVIDUAL DEDUCTIBLE Per calendar year. | No Deductible | No Deductible | \$250 |
| FAMILY DEDUCTIBLE Per calendar year. | No Deductible | No Deductible | \$750 |
| INDIVIDUAL OUT-OF-POCKET MAXIMUM Per calendar year. | \$1,500 | \$1,500 | \$2,750 |

If not noted otherwise – these benefits are subject to the deductible.

| | Tulalip Health Clinic | Preferred Network | Out Of Network |
|--|--------------------------|-------------------------|---|
| ALLERGY INJECTIONS/TESTING | 100% | 100% | 70% |
| ALTERNATIVE SERVICES Limited to 25 visits per calendar year. Includes acupuncture, hypnotherapy, and massage therapy. | 75% | 75% | 75% deductible waived |
| AMBULANCE (AIR AND GROUND) | ** | 90% | 90% deductible waived |
| ANESTHESIOLOGIST Deductible waived for Out-of-Network charges, when both medical facility and primary surgeon are preferred providers. | ** | 90% | 90% |
| ASSISTANT SURGEON Limited to 20% of surgeon's fee. | ** | 100% | 100% |
| CHEMICAL DEPENDENCY TREATMENT Inpatient (pre-authorization required, except in emergency) | 100% | 100% | 100% deductible waived |
| Outpatient | 100% | 100% | 100% deductible waived |
| CHIROPRACTIC SERVICES AND X-RAYS Limited to 17 visits per calendar year. | 100% | \$15 Copay then 100% | \$15 Copay then 100% deductible waived |

BUY-UP PLAN SCHEDULE OF BENEFITS

| | Tulalip Health Clinic | Preferred Network | Out Of Network |
|--|--------------------------|----------------------|------------------------|
| COCHLEAR IMPLANTS | ** | 100% | 70% |
| CONTRACEPTIVE MANAGEMENT | 100% | 100% | 70% |
| DENTAL SERVICES (ACCIDENTAL INJURY) | 100% | 100% | 100% |
| DENTAL TREATMENT – CHILDREN UNDER AGE 5 Dental treatment by a pediatrician or dentist is covered until the child reaches the age of 5. | 100% | 100% | 100% deductible waived |
| DIABETIC EDUCATION | 100% | 100% | 100% deductible waived |
| DIAGNOSTIC X-RAY AND LABORATORY | 100% | 100% | 100% |
| DIETARY EDUCATION | 100% | 100% | 100% deductible waived |
| DURABLE MEDICAL EQUIPMENT Equipment \$500 or less | 80% | 80% | 80% deductible waived |
| Equipment more than \$500 | 80% | 80% | 80% |
| EMERGENCY ROOM & SERVICES Copay waived if admitted as an inpatient. | ** | \$75 Copay then 100% | \$75 Copay then 100% |
| FLU SHOTS | 100% | 100% | 100% deductible waived |
| HEARING AID BENEFIT Limited to one pair every 36 months. | 80% | 80% | 80% |
| HOME HEALTH CARE Limited to 130 visits per calendar year. | ** | 100% | 70% |
| HOSPICE CARE Lifetime maximum six months. | ** | 100% | 70% |
| IMMUNIZATIONS/VACCINES | 100% | 100% | 100% deductible waived |
| INFERTILITY DIAGNOSIS | 100% | 100% | 70% |
| INFUSION THERAPY | 100% | 100% | 70% |
| INPATIENT PHYSICIAN VISIT | ** | 100% | 70% |

BUY-UP PLAN SCHEDULE OF BENEFITS

| | Tulalip Health Clinic | Preferred Network | Out Of Network |
|---|--------------------------|-------------------------------------|------------------------------|
| KIDNEY DIALYSIS (OUTPATIENT SERVICES) Limited to 42 treatments per treatment period. | ** | 100% | 70% |
| Supplemental Coverage Payable at 150% of the Medicare allowable. | ** | 100% | 100% deductible waived |
| MEDICAL FACILITY SERVICES | | | |
| Inpatient Five day maximum copay per admit. Copay waived if readmitted within 90 days. | ** | \$100 Copay per day then 100% | 70% |
| Outpatient Outpatient Surgical Facility | ** | 100% | 70% |
| Miscellaneous Services | ** | 100% | 70% |
| MEDICAL SUPPLIES | 100% | 100% | 100% deductible waived |
| MENTAL HEALTH TREATMENT | | | |
| Inpatient (pre-authorization required, except in emergency) Five day maximum copay per admit. | ** | \$100 Copay per day then 100% | 70% |
| Outpatient | 100% | \$15 Copay then 100% | 70% |
| NATUROPATHIC SERVICES Limited to 15 visits per calendar year. | 75% | 75% | 75% |
| NEURODEVELOPMENTAL THERAPY Limited to dependent children to age seven. | 100% | 100% | 70% |
| OFFICE VISIT | 100% | \$15 Copay then 100% | 70% |
| ORTHOTICS | ** | 100% | 70% |
| PRE-ADMISSION TESTING | 100% | 100% | 70% |
| PREVENTIVE CARE (Exam, lab, etc.) | 100% | 100% deductible waived | Not Covered |
| PREVENTIVE COLONOSCOPY/COLON CANCER SCREENING | 100% | 100% | 70% |
| PREVENTIVE MAMMOGRAPHY | 100% | 100% | Not Covered |
| PROSTHETICS | 100% | 100% | 70% |

BUY-UP PLAN SCHEDULE OF BENEFITS

| | Tulalip Health Clinic | Preferred Network | Out Of Network |
|---|--------------------------|-------------------------------------|------------------------------|
| REHABILITATION SERVICES | | | |
| Inpatient Five day maximum copay per admit. | ** | \$100 Copay per day then 100% | 70% |
| Outpatient | ** | 100% | 70% |
| SECOND SURGICAL OPINION | 100% | 100% | 70% |
| SERIOUS MEDICAL CONDITION (Additional benefit) Maximum benefit – \$20,000 per calendar year | ** | 100% | 100% |
| SKILLED NURSING FACILITY CARE Limited to 30 days per calendar year. | ** | 100% | 70%* |
| SMOKING CESSATION | 100% | 100% | Not Covered |
| STERILIZATION | 100% | 100% | 70% |
| SUPPLIES | 100% | 100% | 100% deductible waived |
| SURGEON | ** | 100% | 70% |
| TEMPOROMANDIBULAR JOINT DISORDER | Not Covered | Not Covered | Not Covered |
| TRANSPLANTS | | | |
| Transplants | ** | 100% | 70% |
| Donor Benefits | ** | 100%* | 70%* |
| Transportation Expenses (Travel, Meals, Lodging) Limited to \$20,000 per transplant. | ** | 100% | 100% deductible waived |
| URGENT CARE | 100% | \$15 copay then 100% | 70% |
| VISION THERAPY (ORTHOPTICS) Lifetime maximum 24 visits. Copay waived for children to the age of 5. | ** | \$15 Copay then 100% | 70% |
| OTHER MISCELLANEOUS ELIGIBLE CHARGES | 100% | 100% | 70% |

***Remains at a constant coinsurance level and does not apply to the out-of-pocket maximum.**

**Not all services are available at The Tulalip Health Clinic.

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

BUY-UP PLAN SCHEDULE OF BENEFITS

CALENDAR YEAR MAXIMUM BENEFITS

| | |
|--------------------------------|------------|
| Alternative Services | 25 visits |
| Chiropractic Services & X-Rays | 17 visits |
| Hearing Aids (every 36 months) | 1 pair |
| Home Health Care | 130 visits |
| Naturopathic Services | 15 visits |
| Skilled Nursing Facility | 30 days |

LIFETIME MAXIMUM BENEFITS

| | |
|---------------------------------|------------|
| Hospice Care | six months |
| Vision Therapy | 24 visits |
| Major Medical/Prescription Drug | Unlimited |

BUY-UP PLAN SCHEDULE OF BENEFITS

PRESCRIPTION BENEFITS

Caremark - Retail Pharmacies

| | AT TULALIP PHARMACY | AT OTHER RETAIL PHARMACIES |
|--|------------------------|-------------------------------|
| Generic Drugs | \$8 Copay | \$15 Copay |
| Brand Name Drugs (Preferred or Non-Preferred) | \$15 Copay | \$25 Copay |
| Dispensing Limit: | | |
| Non-Maintenance Drugs | 34 Days | 34 Days |
| Maintenance Drugs (90 days at 3 copays) | 90 Days | 34 Days |

Note - The Tulalip Pharmacy is open to everyone. You do not have to be a tribal member or Native American to use the pharmacy.

Caremark Mail Service - Mail Order Prescriptions

| | MAIL ORDER COPAYS |
|--|----------------------|
| Generic Drugs | \$30 Copay |
| Brand Name Drugs (Preferred or Non-Preferred) | \$50 Copay |

Dispensing limit 90 days.

*This plan requires the pharmacist to fill the prescription with a generic product whenever it is available, unless the prescription is written as "Dispense as Written." If the prescription is not specified as "Dispense as Written" and the prescription is filled with a name brand prescription at the Plan participant's request, then the copay **plus** the difference between the cost of the generic drug and the brand name drug will be charged.*

Creditable Coverage - Medicare

If you or someone in your family will be covered under this plan and Medicare, you should know the coverage for prescription drugs under this plan qualifies as "Creditable Coverage" for purposes of the Medicare prescription drug benefit regulations. If you have not received a Notice of Creditable Coverage, one is available from your Benefits Administrator. The Notice explains the situation further.

Caremark

Customer Service – 866-885-4944
 Website – <http://www.caremark.com>
 Group Number (Buy-Up Plan) – 4137
 Carrier Number - 2407

**BUY-UP PLAN
SCHEDULE OF BENEFITS**

VISION BENEFITS

| | Coinsurance |
|---|-------------------------|
| EXAMINATION Copay is waived for children to the age of 5. | \$10 Copay then 100% |
| HARDWARE Limited to \$600 every two calendar years. Maximum does not apply to children under the age of 19. Services utilized prior to turning age 19 will count towards the maximum once the individual turns 19. | \$20 Copay then 100% |
| REFRACTIVE EYE SURGERY Lifetime maximum \$1,000 (total for both eyes combined) | 100% |

BUY-UP PLAN SCHEDULE OF BENEFITS

DENTAL BENEFITS

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

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

Eligible expenses will be paid at the preferred level when:

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

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

BUY-UP PLAN SCHEDULE OF BENEFITS

| | Participating & Preferred Network | Out Of Network |
|---|---|-------------------|
| MAXIMUM PAYABLE Per participant, per calendar year. | \$4,500 | \$4,500 |
| Amounts credited to the maximum payable amount is applied to both the Preferred and Out-of-Network eligible expenses. | | |
| TYPE I - PREVENTIVE Oral Exam, Cleaning, X-rays, Fluoride, Sealants. | 100% | 100% |
| TYPE II - BASIC AND RESTORATIVE Fillings, Oral Surgery, Endodontic Treatment, Periodontal Services, Pathology, Anesthesia, Injectables. | 80% | 80% |
| TYPE III - MAJOR AND PROSTHETICS* Bridgework, Relines and Rebases, Crowns, Dentures and their repairs. Subject to a 6-month wait. | 70%* | 70%* |
| Implants* Subject to a 6-month wait. | 70%* | 70%* |
| TYPE IV - ORTHODONTIA Lifetime maximum \$2,000. | 50% | 50% |
| TYPE IV – TEMPOROMANDIBULAR JOINT DISORDER Limited to \$1,000 per calendar year. Lifetime maximum \$5,000. | 70% | 70% |

* Important Note – There is a 6-month waiting period for Type III services. You must be enrolled in the plan for 6 months before coverage is provided for Type III services incurred after the end of the waiting period.

BUY-UP PLAN SCHEDULE OF BENEFITS

LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

| | |
|---|----------|
| Employee Basic Term Life | \$35,000 |
| Employee Accidental Death and Dismemberment | \$35,000 |

When you become insured, you will receive a certificate that describes your Life and Accidental Death and Dismemberment insurance in detail. For further information regarding coverage, please refer to this certificate. An employee must be actively-at-work on the effective date of their coverage, or any increase in benefit, in order for the coverage or increase to be effective. Life and AD&D insurance is provided through Mutual of Omaha.

ELIGIBILITY AND ENROLLMENT PROVISIONS

ELIGIBILITY

Employee Eligibility

Employees eligible for coverage under this plan are:

All permanent, regular employees of The Tulalip Tribes of Washington who are regularly scheduled to work 30 hours or more per week are eligible for coverage under this Plan.

Important note for Casino/Bingo Employees: Former temporary employees of The Tulalip Tribes of Washington who become permanent, regular employees of The Tulalip Tribes of Washington (and who work 30 hours or more per week) will be eligible for coverage the first of the month following the date the employee obtains permanent status, provided the employee has been employed 90 days or more. A team member whose status is changed from on-call to part-time or full-time will be eligible on the first day of the month after completing their probation period in the new position.

Ineligible classes of employees, regardless of the number of hours worked, are: (1) part-time employees working less than 30 hours per week; (2) temporary employees; (3) retirees; (4) on-call personnel and (5) emergency personnel.

Dependent Eligibility

Dependents eligible for coverage under this plan are:

- An employee's legally married spouse or qualified domestic partner is eligible for dental benefits only. (Marriage Certificate or Domestic Partner Affidavit is required.) Coverage may continue during a legal separation only if ordered by a court decree. (Copy of the Court Decree is required.)
- An employee's child(ren) under age 26. (See definition below)
- An employee's child(ren) who is incapable of self-support because of mental retardation, mental illness or physical incapacity that began prior to the date on which the child's eligibility would have terminated due to age. Proof of incapacity must be received within 120 days after the date on which the maximum age is attained. Subsequent evidence of disability or dependency may be required as often as is reasonably necessary to verify continued eligibility for benefits.
- An employee's child(ren) whose coverage is required pursuant to a valid court, administrative order or Qualified Medical Child Support Order (QMCSO).
- Adopted children are eligible under the same terms and conditions that apply to natural children of parents covered under this Plan.

Any individual who is covered as an employee can also be covered as a dependent. Dependents can be covered as a dependent of more than one employee. An individual can only add dependents to the Plan during the initial period of eligibility, during the special enrollment period or during the mid-year or annual open enrollment period.

The term "children" means any of the employee's natural children, legally adopted children, or children who have been placed for adoption with the employee prior to the age of 18, or step-children, or children who have been placed under the legal guardianship of the employee or the employee's spouse/domestic partner, including by a court decree or placement by a State agency or children of the employee's domestic partner. Placement for adoption is defined as the assumption and retention of an obligation for total or partial

support of a child in anticipation of adoption irrespective of whether the adoption has become final.

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

A child does not have to be a student, tax dependent or financially dependent upon the employee or parent, or reside with the employee or parent, to be eligible.

ENROLLMENT

Regular Enrollment

To apply for coverage under this plan, the employee must complete and submit an enrollment form within 31 days of the date the individual first becomes eligible for coverage. The completed enrollment form should list all eligible dependents to be covered. Individuals not enrolled during the enrollment eligibility period will be required to wait until the mid-year (5/1) dependent open enrollment or next annual open enrollment period unless they become eligible to enroll as a result of a special enrollment period.

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

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

Newborn: A newborn child is automatically covered under this Plan from birth for a period of 72 hours or until the date of discharge, whichever comes first. In order for coverage to remain in effect, an enrollment form must be completed and submitted to the Plan within 60 days of birth.

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

Important note regarding enrollment for dependents: In order for coverage to be in effect, an enrollment form must be completed and submitted to the Plan within the time frames indicated above. **Dependents are not automatically covered under the Plan.**

Guardianship: A child placed with an employee or spouse/domestic partner as their legal guardian, may be covered from the date the employee or spouse/domestic partner is appointed Guardian, provided the child is enrolled within 60 days of the appointment of the Guardian.

Special Enrollment for Loss of Other Coverage

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

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

- The employee initially declines coverage (or declines coverage for a dependent) even though they did not have other coverage but then later acquires other coverage under a group health plan or other health insurance coverage.

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

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

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

Special Enrollment for Loss of Eligibility Due to Reaching Lifetime Maximum Benefits

A special enrollment period is available for current employees and their dependent, if an individual incurs a claim that causes the individual to meet or exceed a lifetime maximum on all benefits. The current employee or dependent may request the special enrollment within 31 days from the date that the claim putting the individual over the lifetime maximum was denied.

If the other coverage is COBRA continuation coverage, meeting or exceeding a lifetime maximum on all benefits, shall also result in the exhaustion of COBRA continuation coverage. Special enrollment must be requested within 31 days from the date the claim putting the individual over the lifetime maximum was incurred.

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

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

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

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

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

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

Special Enrollment for New Dependents

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

- When an employee marries or enters a domestic partnership, a special enrollment period is available for the employee and newly acquired dependents (i.e. children of the new spouse or domestic partner for medical, the spouse or domestic partner themselves are only eligible for dental benefits). As long as the proper enrollment material is received by the Plan Administrator within the 31 day enrollment period, the effective date of coverage will be the first of the month following the date of marriage or the effective date of the domestic partnership.
- When an employee or spouse/domestic partner acquires a child through birth, adoption, or placement for adoption, a special enrollment period is available for the employee, the spouse/domestic partner (to enroll in dental only), and the dependent. As long as the proper enrollment material is received by the Plan within the 60 day enrollment period, the effective date of coverage will be the date of the birth, adoption, or placement of adoption.

Special Enrollment for New Dependents through Qualified Medical Child Support Order

Section 609(a) of ERISA requires medical benefit plans to honor the terms of a Qualified Medical Child Support Order (QMCSO). The order must be issued as a part of a judgment, order of decree or a divorce settlement agreement related to child support, alimony, or the division of marital property, issued pursuant to state law. Agreements made by the parties, but not formally approved by a court are not acceptable. If the child is enrolled within 31 days of the court or state agency order, the waiting period and pre-existing conditions exclusion period do not apply.

Open Enrollment

An open enrollment period will be held twice every 12 months. The first open enrollment period, which is only to allow eligible employees to enroll or add eligible dependents to the Plan, will be held from April 1st through April 15th, for an effective date of May 1. A second open enrollment period to allow eligible employees to change their participation will be held during the month of October for an effective date of November 1.

The waiting period for coverage of pre-existing conditions for newly enrolled participants will start on the date the coverage becomes effective. The pre-existing conditions limitation for eligible employees enrolling during open enrollment will be six months from the date coverage begins, less any period of creditable coverage.

Dropping A Dependent

A dependent can only be dropped from coverage during the mid-year open enrollment period or the annual open enrollment period, unless there is a qualifying event, such as the person becomes covered under another plan, or loss of employment.

EFFECTIVE DATE OF COVERAGE

Employee Effective Date

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

Casino/Bingo Enrollees: The waiting period is 90 days. Coverage begins for eligible employees on the earlier of: (1) the first of the month coinciding with the end of the 90 day wait; or (2) the first of the month following the end of the 90 day wait; or (3) the first of the month following the date the employee becomes eligible, provided the employee has been employed 90 days or more.

Important note for Casino/Bingo Employees: Former temporary employees of The Tulalip Tribes of Washington who become permanent, regular employees of The Tulalip Tribes of Washington (and who work 30 hours or more per week) will be eligible for coverage the first of the month following the date the employee obtains permanent status, provided the employee has been employed 90 days or more. A team member whose status is changed from on-call to part-time or full-time will be eligible on the first day of the month after completing their probation period in the new position.

All Other Enrollees: The period between the date of hire and first day of the month following the date of hire is the Coverage Waiting period. Coverage is effective the first of the month following the date of hire. If you are hired on the first day of the month, your coverage will be effective the first day of the following month.

Dependent Effective Date

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

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

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

TERMINATION OF COVERAGE

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

Employee

- The date the Employer terminates the Plan and offers no other group health plan.
- The last day of the month in which the employee ceases to meet the eligibility requirements of the Plan.
- The last day of the month in which the employee's employment ends.

- The last day of the month in which the employee begins active service in the armed forces.
- The last day of the month in which the employee fails to make any required contribution when coverage is contributory.
- The last day of the month in which an employee fails to return to work following an approved leave of absence.
- The last day of the month in which the employee retires.

Dependent(s)

- The date the Employer terminates the Plan and offers no other group health plan.
- The date the employee's coverage terminates.
- The last day of the month in which such individual ceases to meet the eligibility requirements of the Plan.
- The last day of the month in which contributions have been made on their behalf.
- The date the dependent becomes an active, full-time member of the armed forces of any country.
- The date the Plan discontinues dependent coverage.

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

CERTIFICATE OF CREDITABLE COVERAGE

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

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

APPROVED FAMILY AND MEDICAL LEAVE

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

An employee must continue to make any premium contribution required under the Plan.

If an employee's leave ends or extends more than 12 weeks, the employee may be eligible to continue coverage under the (COBRA) Continuation of Coverage provisions of the Plan.

Please contact the Group's Human Resources Department or Benefits Administrator for information on how to qualify for a Family/Medical Leave of Absence.

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

The Approved Leave of Absence (Other Than Federal Family and Medical Leave of Absence) provisions of this Plan will comply with the Approved Leave of Absence provisions as described in the Human Resource Ordinance 84 or Tulalip Resort Casino Team Member Handbook, with amendments.

Please contact the Human Resources Department or Benefits Administrator for information on how to qualify for an Approved Leave of Absence.

MILITARY LEAVE OF ABSENCE

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

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

- a. For elections made before December 10, 2004, the 18 month period beginning on the date that Uniformed Service leave commences; or
- b. For elections made on or after December 10, 2004, the 24 month period beginning on the date that Uniformed Service leave commences;
- c. The period beginning on the date that Uniformed Service leave commences and ending on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

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

A preexisting condition exclusion may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, Plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during military service.

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

REINSTATEMENT OF COVERAGE

The Reinstatement of Coverage provisions of this Plan will comply with the Reinstatement of Coverage provisions as described in the Human Resource Ordinance 84 with amendments. With regard to Casino/Bingo employees who terminate employment but return within 31 days, a new Coverage Waiting Period (90 days) will not be required provided the employee is otherwise eligible.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

The Tulalip Tribes of Washington Employee Health Care Plan (the Plan)

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

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

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

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

The Plan Administrator is:

***The Tulalip Tribes of Washington
6406 Marine Drive
Tulalip, WA 98271
360/716-4357***

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

Mailing Address:

***HMA, Inc.
P.O. Box 85016
Bellevue, WA 98015-5016
Attn: COBRA Unit
800/700-7153***

Street Address:

***HMA, Inc.
220 120th Ave NE
Bellevue, WA 98005
Attn: COBRA Unit
800/700-7153***

WHAT IS COBRA COVERAGE?

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

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

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

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

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

WHO IS ENTITLED TO ELECT COBRA?

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

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

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

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

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

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

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

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

WHEN IS COBRA COVERAGE AVAILABLE?

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

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

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

ELECT COBRA. (You may obtain a copy of the Notice of Qualifying Event (Form & Notice Procedures) from the Plan Administrator.)

ELECTING COBRA COVERAGE

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

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

Mailing Address:

***HMA, Inc.
P.O. Box 85016
Bellevue, WA 98015-5016
Attn: COBRA Unit
800/700-7153***

Street Address:

***HMA, Inc.
220 120th Ave NE
Bellevue, WA 98005
Attn: COBRA Unit
800/700-7153***

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

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

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

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

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

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

Qualified beneficiaries may be enrolled in one or more group health components of the Plan at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as the result of a qualifying event, he or she may elect COBRA under any or all of the group health components of the Plan under which he or she was covered on the day before the qualifying event.

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

SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA

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

LENGTH OF COBRA COVERAGE

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

When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months.

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

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

EXTENSION OF MAXIMUM COVERAGE PERIOD

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

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

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

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

Notwithstanding the above 60 day notification of disability period, notice of disability from the Social Security Administration must be delivered to the Plan Administrator during the initial 18 month qualifying event period for consideration of disability as a second qualifying event.

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

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

The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee,

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

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

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

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

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

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

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

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

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary). The Plan Administrator will require repayment to the Plan of all

benefits paid after the termination date, regardless of whether or when you provide notice to the COBRA Administrator of Medicare entitlement or other group health plan coverage.

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

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

COST OF COBRA COVERAGE

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

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

PAYMENT FOR COBRA COVERAGE

All COBRA premiums must be paid by check or money order.

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

Mailing Address:

**HMA, Inc.
P.O. Box 85016
Bellevue, WA 98015-5016
Attn: COBRA Unit
800/700-7153**

Street Address:

**HMA, Inc.
220 120th Ave NE
Bellevue, WA 98005
Attn: COBRA Unit
800/700-7153**

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

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage no later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) See the section above entitled "Electing COBRA Coverage."

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

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

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

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

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

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

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

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

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

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

PLAN CONTACT INFORMATION

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

***Benefits Administrator
The Tulalip Tribes of Washington
6406 Marine Drive
Tulalip, WA 98271
(360) 716-4357***

***Benefits Administrator
Tulalip Resort Casino
10200 Quil Ceda Blvd.
Tulalip, WA 98271
(360) 716-1296***

***Benefits Administrator
Quil Ceda Village
8802 27th Ave NE
Tulalip, WA 98271
(360) 716-5016***

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

NOTICE PROCEDURES

The Tulalip Tribes of Washington Employee Health Care Plan (the Plan)

Notice Procedures for Notice of Qualifying Event

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

You must mail or hand deliver this notice to:

***Benefits Administrator
The Tulalip Tribes of Washington
6406 Marine Drive
Tulalip, WA 98271
(360) 716-4357***

***Benefits Administrator
Tulalip Resort Casino
10200 Quil Ceda Blvd.
Tulalip, WA 98271
(360) 716-1296***

***Benefits Administrator
Quil Ceda Village
8802 27th Ave NE
Tulalip, WA 98271
(360) 716-5016***

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

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

Your notice must contain the following information:

- the name of the Plan (The Tulalip Tribes of Washington Employee Health Care Plan);
- the name and address of the employee or former employee who is or was covered under the Plan;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the qualifying event (divorce, legal separation, or child's loss of dependent status);

- the qualifying event (divorce, legal separation, or child's loss of dependent status);
- the date that the divorce, legal separation, or child's loss of dependent status happened; and
- the signature, name, and contact information of the individual sending the notice.

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

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

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

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

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

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

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

COBRA coverage would have started. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

Notice Procedures for Notice of Disability

The deadline for providing this notice is 60 days after the latest of (1) the date of the Social Security Administration's disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; and (3) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours. Notwithstanding the above 60 day notification of disability period, notice of disability from the Social Security Administration must be delivered to the Plan Administrator during the initial 18 month qualifying event period for consideration of disability as a second qualifying event.

You must mail or hand deliver this notice to:

***Benefits Administrator
The Tulalip Tribes of Washington
6406 Marine Drive
Tulalip, WA 98271
(360) 716-4357***

***Benefits Administrator
Tulalip Resort Casino
10200 Quil Ceda Blvd.
Tulalip, WA 98271
(360) 716-1296***

***Benefits Administrator
Quil Ceda Village
8802 27th Ave NE
Tulalip, WA 98271
(360) 716-5016***

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

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

Your notice must contain the following information:

- the name of the Plan (The Tulalip Tribes of Washington Employee Health Care Plan);
- the name and address of the employee or former employee who is or was covered under the Plan;
- the initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction of hours);
- the date that the covered employee's termination of employment or reduction of hours happened;

- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;
- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary became disabled;
- the date that the Social Security Administration made its determination of disability;
- a statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name, and contact information of the individual sending the notice.

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

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

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

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

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

Notice Procedures for Notice of Second Qualifying Event

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

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

Mailing Address:

*HMA, Inc.
P.O. Box 85016
Bellevue, WA 98015-5016
Attn: COBRA Unit
800/700-7153*

Street Address:

*HMA, Inc.
220 120th Ave NE
Bellevue, WA 98005
Attn: COBRA Unit
800/700-7153*

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

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

Your notice must contain the following information:

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

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

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

- the notice is mailed or hand-delivered to the individual and address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, the COBRA Administrator is able to determine that the notice relates to the Plan;

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

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

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

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

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

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

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

days after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary.

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

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

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

Mailing Address:

HMA, Inc.
P.O. Box 85016
Bellevue, WA 98015-5016
Attn: COBRA Unit
800/700-7153

Street Address:

HMA, Inc.
220 120th Ave NE
Bellevue, WA 98005
Attn: COBRA Unit
800/700-7153

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

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

Your notice should contain the following information:

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

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

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

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

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

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

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

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

PRE-EXISTING CONDITIONS LIMITATIONS

Pre-authorization from the Utilization Review Coordinator does not constitute Plan liability for any pre-existing condition charges during the pre-existing waiting period.

If a claim is paid that was related to a pre-existing condition, the payment will not constitute a waiver of this exclusion for that claim or any subsequent claim if it is later determined that the condition was pre-existing.

PRE-EXISTING CONDITIONS

A pre-existing condition, whether physical or mental, and regardless of the cause of the condition, is a condition for which medical advice, diagnosis, care, or treatment has been recommended or received within the three month period ending on the enrollment date. In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under State law and who operates within the scope of practice authorized by the State law.

PRE-EXISTING CONDITIONS EXCLUSION

The exclusion period for pre-existing conditions commences on your enrollment date and will be no longer than:

Casino/Bingo Enrollees: Six months, less any period of creditable coverage.

All Other Enrollees (except Late Enrollees): Six months, less any period of creditable coverage.

Late Enrollee

A "Late Enrollee" is anyone who enrolls in the plan at some time other than when initially eligible or through a special enrollment period, such as during an open enrollment period.

The exclusion period for a pre-existing condition for a Late Enrollee is six months beginning on the date their coverage is effective, less any period of creditable coverage.

You have the right to demonstrate any *creditable coverage*, and the applicable exclusion period will be reduced by any *creditable coverage* unless it occurred before a *significant break in coverage*.

The term "enrollment date" is defined as the first day of coverage or, if there is a waiting period for coverage to begin under the Plan, the first day of the waiting period. The term "waiting period" refers to, for a person who is otherwise eligible to enroll in the Plan, the period after employment starts and the first day of coverage under the Plan. For a person who is a late enrollee or who enrolls on a special enrollment date, the "enrollment date" will be the first date of actual coverage. If an individual enrolled under one group health plan (Base or Buy Up) changes plans the individual's enrollment date does not change.

The pre-existing conditions exclusion does not apply to pregnancy, genetic information, PKU, chemical dependency treatment, mental health treatment or to any participant (whether covered as an employee or dependent) under the age of 19.

PLAN PAYMENT PROVISIONS

DEDUCTIBLES

Individual

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

Family

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

DEDUCTIBLE CARRYOVER

Although a new medical deductible will apply each calendar year, expenses incurred during October, November and December which are applied against that year's deductible will also be applied toward the deductible for the next year and thus reduce or eliminate the next year's deductible. Any amounts that satisfy an individual deductible will count toward satisfying the family deductible.

AMOUNTS NOT CREDITED TOWARD THE DEDUCTIBLE

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

- Expenses for services or supplies not covered by this Plan.
- Charges in excess of the usual, customary, and reasonable (UCR) charges.
- Copays.
- Expenses incurred for non-compliance with Plan pre-authorization requirements.

COINSURANCE PERCENTAGE

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

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

COPAY

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

OUT-OF-POCKET MAXIMUM

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

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

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

- Expenses not covered under this Plan.
- Expenses incurred as a result of failure to meet the pre-authorization requirements.

NATIVE AMERICAN PLAN PARTICIPANTS

Covered participants under this Plan who are Native American may be eligible for Medicare Like Rates for certain inpatient and outpatient facility claims. If a Tulalip Native, or other Native American Plan participant incurs a claim at a Medicare participating facility, it may be payable at the lesser of "Medicare Like" rates (See Medicare Like Rates under the General Definitions) or any discount negotiated by or on behalf of the Plan. Services received must be medically necessary and be otherwise covered expenses under this Plan. Any deductible, co-payment or co-insurance that is applicable under the terms of this Plan will be included in the payment to the facility for services covered by this provision. This self-funded Tribal Health Plan shall not be considered Alternate Resources for purposes of the Indian Health Services (IHS) payor of last resort rule. (see Alternate Resources under the General Exclusions to the Medical Plan)

Eligibility for this provision is determined by the Tulalip Tribes of Washington.

COMPREHENSIVE MAJOR MEDICAL BENEFITS

ELIGIBLE EXPENSES

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

ALLERGY INJECTIONS/TESTING

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

ALTERNATIVE SERVICES

The alternative medicine benefit consists of services provided by naturopaths, acupuncturists, Chinese Medicine practitioners, massage therapists, and hypnotists. Services are paid as shown in the Schedule of Benefits. Participants who exhaust this benefit may be eligible to receive additional massage therapy benefits under the rehabilitation benefits when medically necessary to restore bodily function lost or impeded due to illness or injury. Hypnotherapy is a covered benefit and includes, but is not limited to, services for the treatment of smoking cessation and weight loss.

AMBULANCE (AIR AND GROUND)

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

BIOFEEDBACK

Biofeedback therapy is an electronic method which allows the patient to monitor the functioning of the body's autonomic systems (e.g. body temperature, heart rate, etc.) and is payable under this Plan.

BLOOD BANK

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

CHEMICAL DEPENDENCY (SUBSTANCE USE DISORDER)

Benefits will be provided for services of a physician and/or an approved chemical dependency treatment facility for medically necessary inpatient and outpatient treatment of chemical dependency, including detoxification and supportive services.

If you receive pre-authorization for services or a referral to a provider from Tulalip Family Services, benefits will be provided for services of a physician and/or an approved chemical dependency treatment facility for medically necessary inpatient and outpatient treatment of chemical dependency, including detoxification and supportive services including ADIS program. Services billed directly by Tulalip Family Services are automatically pre-authorized.

Chemical dependency is defined as physical and/or emotional dependence on drugs, narcotics, alcohol, or other addictive substances to a debilitating degree. Eligible expenses for treatment of chemical dependency shall be paid according to the Schedule of Benefits.

Coverage under this Plan includes treatment in an inpatient medical facility, residential treatment facility, including partial day treatment, and outpatient treatment. Inpatient and residential services are covered when medically necessary and pre-authorized in accordance with this plan's pre-authorization requirements. Outpatient services do not require pre-authorization or review.

Treatment for chemical dependency includes:

- Medical and psychiatric evaluations.
- Inpatient room and board (including detoxification).
- Psychotherapy (individual and group), counseling (individual and group), behavior therapy, family therapy (individual and group) for the covered participants.
- Prescription drugs prescribed by and administered while in an approved treatment facility.
- Supplies prescribed by an approved treatment facility, except for personal items.

Chemical dependency treatment does not include:

- Personal items.
- Items or treatment not necessary to the care or recovery of the patient.
- Custodial care.
- Education or training.
- Wilderness or outdoor treatment programs.
- Coverage for addition to caffeine or nicotine/tobacco.

Inpatient Treatment

When inpatient chemical dependency treatment is recommended, the participant must first contact HMA's Health Services Department at 800/700-7153 to pre-authorize the admission. In addition to pre-authorization the following is required:

- Treatment must be ordered in writing by a physician or certified by HMA's Health Services Department, for the entire length of time the participant is confined.
- Under extenuating circumstances, such as emergency inpatient chemical dependency treatment, you must obtain authorization within 7 days of admission.
- The Plan will cover medically necessary (as determined by Tulalip Family Services) inpatient treatment when ordered or otherwise authorized by Tulalip Family Services for an eligible plan participant. In the event that Tulalip Family Services authorizes care directly for a participant, Tulalip Family Services will be responsible for notifying HMA of the authorization as soon as possible.

Outpatient Treatment

If treatment is provided on an outpatient basis, then treatment must be provided by a physician as defined under this Plan.

No benefits will be provided for information and referral services, information schools, Alcoholics Anonymous and similar chemical dependency programs, long-term care or custodial care and tobacco cessation programs.

CHIROPRACTIC CARE

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

Note: For purposes of this Plan, Participating Chiropractic Providers with Regence BlueShield are considered Preferred Providers. Chiropractic Services rendered by Non-Participating Providers are subject to a deductible.

CLINICAL TRIALS BENEFIT

Expenses incurred as part of a clinical trial may be considered covered under this Plan if the expenses are for patient care services related to a qualified clinical trial.

A qualified clinical trial is defined as a clinical trial that meets all of the following conditions:

1. The clinical trial is intended to treat cancer in a patient who has been so diagnosed; and
2. The clinical trial has been peer reviewed and is approved by at least one of the following:
 - One of the United States National Institutes of Health;
 - A cooperative group or center of the National Institutes of Health;
 - A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;

- The United States Food and Drug Administration pursuant to an investigative new drug exemption;
 - The United States Departments of Defense or Veterans Affairs;
 - Or, with respect to Phase II, III, and IV clinical trials only, a qualified institutional review board; and
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise; and
 4. The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial; and
 5. The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards; and
 6. The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trials; and
 7. The clinical trial does not unjustifiably duplicate existing studies; and
 8. The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.

Phase I clinical trials are not covered.

Patient care services are defined as health care items or services that are furnished to an individual enrolled in a qualified clinical trial, which is consistent with the usual and customary standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the qualified clinical trial.

Patient care services do not include any of the following:

1. An FDA approved drug or device shall be a patient care service only to the extent that the drug or device is not paid for by the manufacturer, the distributor, or the provider of the drug or device; or
2. Non-health care services that a patient may be required to receive as a result of being enrolled in the qualified clinical trial; or
3. Costs associated with managing the research associated with the qualified clinical trial; or
4. Costs that would not be covered for non-investigative treatments; or
5. Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the qualified clinical trial; or
6. The costs of services, which are not provided as part of the qualified clinical trial's stated protocol or other similarly, intended guidelines.

COCHLEAR IMPLANTS

Benefits are available for professional services associated with the pre-operative evaluation, surgery and hospital charges, including the cochlear implant device (device must be FDA approved), and post-operative care and evaluation for a cochlear implant. Prior approval is required.

CONTRACEPTIVE SERVICES

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

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

DENTAL SERVICES

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

- Treatment for accidental injuries to natural teeth provided that the injury occurred while covered under this Plan. Treatment for up to six months from the date of the accident for accidental injuries is provided under this Plan. Injuries caused by biting or chewing are not covered under the medical plan.
- Treatment performed by an oral surgeon to excise and/or biopsy suspected lesions, excised confirmed tumors or malignancies of the oral cavity, tongue, or jaw; whether done in a dental office or hospital.
- Benefits for outpatient hospitalization and anesthesia (anesthesia is covered regardless of place of service) for dental services are covered the same as relevant services listed on your Schedule of Benefits. Services must be prior authorized by the Plan and are only provided for members with complicating medical conditions. Examples of these conditions include, but are not limited to:
 - mental handicaps.
 - physical disabilities.
 - a combination of medical conditions or disabilities that cannot be managed safely and efficiently in a dental office.
 - emotionally unstable, uncooperative, combative patients where treatment is extensive and impossible to accomplish in the office.
- Anesthesia is covered regardless of place of service, when such services would otherwise be covered under this section due to complicating medical conditions. The service must be prior authorized.

All other dental services are excluded.

DIABETIC EDUCATION

Diabetic education is a covered benefit, if provided by a physician/provider as defined under this Plan. Benefit will be provided for diabetic self-management training and education, including nutritional therapy. The Plan will be the final authority on which education programs will meet the criteria of eligibility.

DIAGNOSTIC X-RAY AND LABORATORY

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

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

DIETARY/NUTRITIONAL EDUCATION

Diet/nutrition education is a covered benefit. In order for diet/nutrition education to be considered an eligible charge, the program must be provided by registered dietitians, certified nutritionists, or health care professionals as defined under the definition of physician. The Plan will be the final authority on which education programs will meet the criteria of eligibility.

DURABLE MEDICAL EQUIPMENT

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

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

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

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

EMERGENCY ROOM & SERVICES

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

HEARING AID BENEFIT (Buy Up Plan Only)

The Plan will pay as outlined in the Schedule of Benefits for a hearing aid device.

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

Services will be provided for:

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

HOME HEALTH CARE

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

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

The following services will be considered eligible expenses:

- Part-time or intermittent nursing care by a registered nurse, a licensed vocational nurse or by a licensed practical nurse.
- Physical therapy by a licensed, registered, or certified physical therapist.
- Speech therapy services by a licensed, registered, or certified speech therapist.
- Occupational therapy services by a registered, certified, or licensed occupational therapist.
- Nutritional guidance by a registered dietitian.
- Nutritional supplements such as diet substitutes administered intravenously or by enteral feeding.
- Respiratory therapy services by a certified inhalation therapist.

- Home health aide services by an aide who is providing intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, completing appropriate records.
- Medical supplies, drugs and medicines prescribed by a physician, and laboratory services normally used by a patient in a skilled nursing facility, medical facility or hospital, but only to the extent that they would have been covered under this Plan if the participant had remained in the hospital or medical facility.
- Assessment by a Masters of Social Work (M.S.W.).

Exclusions to Home Health Care

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

HOSPICE CARE

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

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

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

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

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

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

Exclusions to Hospice Care

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

IMMUNIZATIONS/VACCINES

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

INFERTILITY DIAGNOSIS

The Plan covers charges incurred for outpatient services for the diagnosis of infertility for an employee. Services are payable as shown in the Schedule of Benefits. Charges for treatment are a non-covered expense under this Plan.

Diagnosis must be performed on an outpatient basis. The Plan does not cover inpatient or outpatient treatment for infertility.

Services that are not covered include, but are not limited to:

- In-vitro fertilization;
- In-vivo fertilization;
- Gamete inter-fallopian transfer (GIFT);

- Reversal of sterilization (tubal ligation or vasectomy); and
- Any method of artificial insemination, including any and all supplies, services, drugs, and treatments leading up to the procedure of artificial insemination, and until impregnation is confirmed.

INFUSION THERAPY BENEFIT

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

KIDNEY DIALYSIS (OUTPATIENT SERVICES)

Charges for professional treatment, supplies, medications, labs, and facility fees related to outpatient kidney dialysis are covered services under the Plan for up to the 1st 42 treatments, upon the completion of which your Dialysis benefits under this plan have been exhausted, for the remainder of the current treatment period. A Treatment period is defined as the beginning and end of the prescribed dialysis treatment. When kidney dialysis is recommended, the participant must first contact the Plan Supervisor's Health Services Department to pre-authorize the treatment. Eligible services during the 1st 42 treatments received will be covered as shown in the Schedule of Benefits and will be paid in accordance with the applicable provider network agreements.

Eligible services include, but are not limited to, hemodialysis, peritoneal dialysis, and hemofiltration. Eligible expenses include the first forty-two treatments received, starting from the initial kidney dialysis treatment. Treatments received prior to becoming eligible under the Plan, are counted towards the first forty-two treatments; however, they are not covered expenses under the Plan. Benefits are payable as shown in the Schedule of Benefits.

Supplemental Coverage

For any subsequent kidney dialysis treatment (beyond the first forty-two treatments), the Plan will provide additional supplemental coverage for Kidney Dialysis treatment and related services. Charges for professional treatment, supplies, medications, labs, and facility fees related to outpatient kidney dialysis are covered services under this benefit. Eligible services include, but are not limited to, hemodialysis, peritoneal dialysis, and hemofiltration. The Plan's preauthorization requirements apply. This Supplemental Coverage benefit does not access any provider agreements for pricing and applies to any provider the member receives services from.

This Supplemental Coverage benefit for a covered service under this Plan provision will be 150% of the current Medicare reimbursement for the same or similar service. During this subsequent period of treatment, the supplemental coverage will be paid as shown in the Schedule of Benefits. Standard coordination of benefit provisions will apply. In addition, all plan participants with ESRD will be eligible to have their Medicare Part B premiums reimbursed by the Plan as an eligible Plan expense for the duration of their ESRD treatment, as long as they continue to be covered under the Part B coverage and continue to be eligible for coverage under this Plan (proof of payment of the Part B premium will be required prior to reimbursement). Please contact the Plan Supervisor's Customer Service Department for additional information regarding reimbursement of Medicare premiums.

Eligible services received under the Supplemental Coverage provision of this Plan (after the 42nd treatment) will be paid at 150% of the current Medicare allowable for the same or similar service. Deductible Waived.

Notwithstanding the above, in the event that the Provider accepts Medicare Assignment as payment in full, then Eligible Expenses shall mean the lesser of the total amount of charges allowable by Medicare, whether the plan participant is enrolled for Medicare coverage or not, and the total eligible expenses allowable under this Plan exclusive of coinsurance.

MATERNITY SERVICES

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

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

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

Newborns' and Mothers' Health Protection Act

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

MEDICAL FACILITY SERVICES

Inpatient Care

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

- Room and board in a semi-private room.
- Intensive care, cardiac care, isolation or other special care unit.
- Private room accommodations, if medically necessary.
- Nursing care services.
- Prescribed drugs and medications administered in the hospital or the medical facility.
- Anesthesia and its administration.

- Oxygen and its administration.
- Dressings, supplies, casts, and splints.
- Diagnostic services, including but not limited to x-ray, laboratory, and radiological services.
- The use of durable medical equipment.

Outpatient Care

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

Miscellaneous

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

MEDICAL SUPPLIES

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

MENTAL HEALTH TREATMENT

The following mental health conditions or disorders are covered when diagnosed by a physician, psychiatrist, or psychologist:

- Attention Deficit and Disruptive disorder;
- Anxiety, adjustment, mood, and psychotic disorders;
- Depression;
- Bipolar, panic, and cognitive disorders;
- Obsessive-Compulsive disorders;
- Schizophrenia;
- Eating disorders (including Anorexia Nervosa and Bulimia Nervosa);
- Sleep disorders (including insomnia and narcolepsy);
- Impulse control disorders (including Kleptomania and Pyromania);
- Tic disorders;
- Gender identity disorders;
- Personality disorders (including paranoid schizoid and antisocial disorder);
- Delirium and Dementia;
- Somatoform, Factitious, Dissociative, and Parasomnia disorders.
- Stress;
- Anger management;
- Sexual therapy;
- Marriage and family therapy;
- Attention Deficit Hyperactivity Disorder (ADHD);
- Autism spectrum disorder, including Asperger's.

Coverage under this Plan includes treatment in an inpatient medical facility, residential treatment facility, including partial day treatment, and outpatient treatment. Inpatient and residential services are covered when medically necessary and pre-authorized in 01/01/14

accordance with this plan's pre-authorization requirements. Outpatient services do not require pre-authorization or review.

Inpatient Treatment

When inpatient mental health disorder treatment is recommended, the patient must first contact HMA's Health Services Department at 800/700-7153 to pre-authorize admission, unless through Tulalip Family Services (see Below). In addition to pre-authorization the following is required:

- Treatment must be ordered in writing by a physician or certified by HMA's Health Services Department, for the entire length of time the patient is confined.
- Under extenuating circumstances, such as emergency inpatient mental disorder treatment, you must obtain authorization within 7 days of admission, or by the next business day, by HMA's Health Services Department.
- The patient must complete the approved course of treatment in a hospital or medical facility as defined by the Plan.
- The Plan will cover medically necessary (as determined by Tulalip Family Services) inpatient treatment when ordered or otherwise authorized by Tulalip Family Services for an eligible plan participant. In the event that Tulalip Family Services authorizes care directly for a participant, Tulalip Family Services will be responsible for notifying HMA of the authorization as soon as possible.

Outpatient Treatment

If treatment is provided on an outpatient basis, then treatment must be provided by a physician as defined under this Plan.

Mental Health treatment does not include:

- Personal items.
- Items or treatment not necessary to the care or recovery of the patient.
- Custodial care.
- Education or training.
- Wilderness or outdoor treatment programs.

NEURODEVELOPMENTAL THERAPY SERVICES

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

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

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

NEWBORN NURSERY CARE BENEFIT

Medical facility charges incurred by a well newborn during the initial period of confinement will be covered as charges of the baby.

- Medical facility nursery expenses for a healthy newborn, including circumcision.
- Routine pediatric care for a healthy newborn child while confined in a hospital or medical facility immediately following birth.
- Phenylketonuria (PKU) testing within the first seven days of life.

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

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

Circumcision is covered under the surgical benefit performed within 31 days of the birth of the baby whether enrolled in the plan or not.

Important note regarding coverage for newborns: Newborn Dependents are automatically covered under this plan from birth for a period of 72 hours or until the date of discharge, whichever comes first. In order for coverage to remain in effect, an enrollment form must be completed and submitted to the Plan within 60 days of birth.

ORTHOTICS

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

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

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

OUTPATIENT SURGICAL FACILITY

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

PHENYLKETONURIA (PKU) DIETARY FORMULA

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

PHYSICIAN SERVICES

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

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

PRE-ADMISSION TESTING

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

PRESCRIPTION DRUGS

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

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

PREVENTIVE CARE

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

Dental services for children are also covered. Coverage is provided until the first day of the month following the child's 5th birthday.

Services are payable as shown in the Schedule of Benefits. Imaging, except for mammograms, is not covered.

PREVENTIVE COLON CANCER SCREENING/COLONOSCOPY

Preventive colonoscopies and colon cancer screening are covered by the Plan and are paid as shown in the Schedule of Benefits.

PROSTHETIC APPLIANCES

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

RADIATION THERAPY AND CHEMOTHERAPY

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

REHABILITATION BENEFIT

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

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

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

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

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

Physical Therapy - Charges of a registered, certified, or licensed physical therapist are covered when necessary to restore a bodily function lost or impeded due to illness or injury. Covered services include aquatic/swim therapy if medically necessary and included as part of a treatment plan.

Physical therapy prescribed for the prevention of falls for individuals 65 years of age and older will be covered under the Preventive Care benefits of the Plan.

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

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

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

Inpatient Treatment

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

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

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

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

SECOND SURGICAL OPINION

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

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

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

SERIOUS MEDICAL CONDITION – ADDITIONAL BENEFIT

For a serious medical condition which requires a covered person to be hospitalized for 10 days or more, on a continuous or intermittent basis, the plan will cover the reasonable and necessary costs for lodging, transportation and meals, as explained below, up to a maximum benefit of \$20,000 per calendar year.

The expense must be for the covered patient, a caregiver or a companion. All expenses must be incurred while the patient is covered under the plan. The requirement for a caregiver or companion must be medically necessary based on the person's age or condition.

The expense must be ordered or recommended by the patient's physician or directly related to the physician's treatment recommendations.

The expense must be reasonable and necessary and fit the situation with respect to the medical condition, location and patient requirements. The expense must also be the minimum necessary, such as for air travel.

With regard to lodging and transportation, the location of the treatment must be required, rather than optional, for the condition and must be 100 or more miles from the person's home. This benefit is not available when substantially equivalent medical services are available locally. However, when medically necessary alternative lodging is required for a patient, the 100 mile requirement may be waived.

Coverage for meals will be provided only when the expense is required and a result of the medical condition or location and is not the usual expense a person expects to incur daily.

The 10 days of hospitalization must occur within a 12 month period, measured from the first day of hospitalization. This benefit does not cover any hospital or other medical expense. Hospital and other medical expenses may be covered under other parts of this plan.

This benefit is not subject to any deductible, coinsurance or network (preferred provider) requirements of the plan.

The plan will make any final determination with regard to what expenses are eligible.

This benefit does not cover routine visits to see a patient.

SKILLED NURSING FACILITY CARE

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

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

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

SMOKING CESSATION

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

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

STERILIZATION - ELECTIVE

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

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

SURGERY AND RELATED SERVICES

Benefits are provided for the following inpatient or outpatient services:

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

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

TRANSPLANTS

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

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

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

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

- Organ or tissue procurement. These consist of removing, preserving, and transporting the donated part.
- Compatibility testing undertaken prior to procurement is covered if medically necessary. This includes costs related to the search for, typing and testing, and identification of a bone marrow or stem cell donor for allogeneic transplant.

- Medical facility or Hospital room and board and medical supplies.
- Diagnosis, treatment, and surgery by a doctor.
- Private nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).
- The rental of wheelchairs, hospital-type beds, and mechanical equipment required to treat respiratory impairment.
- Local ambulance services, medications, x-rays and other diagnostic services, laboratory tests, and oxygen.
- Rehabilitative therapy consisting of: speech therapy (not for voice training or lisp), audio therapy, visual therapy, occupational therapy, and physiotherapy. Any of these must be in direct respect to rehabilitation from the covered transplant procedure.
- Surgical dressing and supplies.
- Transportation, lodging, and meals, including alternative lodging for the patient when medically necessary.
- Other services approved by the Plan Supervisor's Health Services Department.

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

No benefits will be provided for the following:

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

VISION THERAPY (ORTHOPTICS)

Charges for vision therapy or orthoptic training will be covered as shown in the Schedule of Benefits, for treatment of amblyopia, strabismus, non-strabismic disorder of binocular eye movements, and non-presbyopic accommodative inability.

Services must be ordered by a physician or other provider acting within the scope of their license and include a treatment plan.

Vision therapy charges for eccentric fixation, anomalous retinal correspondence, traumatic brain injury, dyslexia and learning disabilities, or any diagnosis not listed above, will not be covered under the Plan.

GENERAL EXCLUSIONS TO THE MEDICAL PLAN

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

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

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

Alcohol/Drug/Chemical Dependency – Except as provided under the Chemical Dependency Treatment section, any medical treatment required because of the use of narcotics or the use of hallucinogens in any form unless the treatment is prescribed by a physician.

Alternate Resources – This self-funded Tribal Health Plan shall not be considered Alternate Resources for purposes of the Indian Health Services (IHS) payor of last resort rule. This Plan shall not pay for services that are otherwise eligible for payment at Medicare Like Rates under an IHS program.

Alternative Medicine – Services rendered by homeopath, herbalist, and acupressurist. Services for acupressure, rolfing, faith healing services, or reflexology.

Applied Behavioral Analysis – Charges for applied behavioral analysis.

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

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

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

Charges For Lasik Surgery – Charges for Radial Keratotomy, Lasik or laser surgery or similar surgery or services, except as specifically provided under the vision benefit section of the Buy-Up Plan.

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

1. When related to an illness or injury.
2. Except as specifically excluded by this plan, for correction of congenital deformity. To be covered, the surgery must be done within 18 years of the date of birth.
3. A member receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will also receive coverage for:
 - Reconstruction of the breast on which the mastectomy has been performed
 - Surgery and reconstruction of the other breast to produce a symmetrical appearance
 - Prostheses

- Treatment of physical complications of all stages of mastectomy, including lymphedemas

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

Counseling, Education, or Training Services – Counseling, education, or training services, except as stated under the "Diet/Nutritional Education," and "Chemical Dependency Treatment". This includes vocational assistance and outreach; job training such as work hardening programs; smoking cessation programs; family, marital, sexual, social, lifestyle, nutritional, and fitness counseling; and other services or supplies that are primarily educational in nature other than as defined herein.

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

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

Dental – Dental services including treatment of the mouth, gums, teeth, mouth tissues, jawbones or attached muscle, upper or lower jaw augmentation reduction procedures, orthodontic appliances, dentures and any service generally recognized as dental work. Hospital and Physician services rendered in connection with dental procedures are only covered if adequate treatment cannot be rendered without the use of hospital facilities, and if you have a medical condition besides the one requiring dental care that makes hospital care medically necessary. The only exceptions to this exclusion are the services and supplies covered under the Dental Services for Accidental Injuries Benefit and the TMJ Benefit and the dental coverage for children under age 4, or if treatment is necessary due to a malignant tumor.

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

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

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

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

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

Gambling – Charges for treatment of pathological gambling.

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

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

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

Hospice Bereavement – Charges for hospice bereavement treatment.

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

Impotency – Charges associated with impotency and erectile dysfunction, and procedures to restore potency, including but not limited to: corrective or reconstructive surgery; hormone injections; penile implants; or impotency drugs whether or not they are the consequence of illness or injury.

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

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

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

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

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

Mental Health – Services or supplies for any Mental Health condition or disorder not specifically covered under the Mental Health Treatment benefit.

Mental Retardation – Charges for the treatment of mental retardation.

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

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

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

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

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

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

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

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

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

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

Pervasive Developmental Disorders – Pervasive developmental disorders (including Asperger's Syndrome, Rett Syndrome, and Autism).

Pre-existing conditions – Coverage will be provided for covered services and supplies for pre-existing conditions after the pre-existing condition exclusion period ends. This exclusion does not apply to participants under the age of 19.

Preventive Care – Charges for Preventive Care when performed by an Out-of-Network Provider, except as indicated herein.

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

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

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

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

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

Routine Foot Care – Services for routine or palliative foot care, including hygienic care; impression casting for prosthetics or appliances and prescriptions thereof; fallen arches, flat feet, care of corns, bunions (except for bone surgery), calluses, and toenails (except for ingrown toenail surgery), and other asymptomatic complaints of the foot. This includes foot-support supplies, devices, and shoes, except as stated under the "Medical Supplies," or "Orthotics," or "Prosthetic Appliances" benefits of the Plan.

Routine Services – Services or supplies that are not directly related to an illness, injury, or distinct physical symptoms. Examples of routine services include, but not limited to, routine physical exams, diagnostic surgery, premarital exams, insurance exams, routine pap smears, and diagnostic screening. These exclusion do not apply to services and supplies specified under the Preventive Care Benefit, or to routine mammograms.

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

Sexual Dysfunction – Charges for sexual dysfunctions, except therapy.

Temporomandibular Joint Disorder and Myofascial Pain Dysfunction – Medical treatment of Myofascial Pain Dysfunction, Temporomandibular Joint Dysfunction (TMJ) and other jaw disorders and services and/or appliances directly attributable to the TMJ dysfunction will not be covered, except as covered under the dental benefits.

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

Training – Services or supplies for learning disabilities; vocational assistance and outreach; job training or other education or training services.

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

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

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

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

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

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

PRESCRIPTION DRUG CARD PROGRAMS

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

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

GENERIC SUBSTITUTION

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

BRAND NAME PERFORMANCE DRUGS

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

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

PAYMENT SCHEDULE

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

This plan requires the pharmacist to fill the prescription with a generic product whenever it is available, unless the prescription is written as "Dispense as Written." If the prescription is not specified as "Dispense as Written" and the prescription is filled with a name brand prescription at the Plan participant's request, then the copay **plus** the difference between the ingredient cost of the generic drug and the brand name drug will be charged.

DRUGS COVERED

- Legend drugs. Exceptions: See Exclusions below.
- Insulin.
- Disposable needles/syringes.
- Disposable blood/urine glucose/acetone testing agents (e.g. Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Tes-Tape.)
- Tretinoin, all dosage forms (e.g. Retin-A), for individuals through the age of 25 years.
- Compounded medication of which at least one ingredient is a legend drug.
- Legend oral contraceptives.
- Pre-natal vitamins.
- Fluoride preparations (copay does not apply).
- Folic Acid and Iron supplements when prescribed by a physician (copay does not apply).
- Vitamin D supplements when prescribed for fall prevention (copay does not apply).
- Legend contraceptives, all dosage forms, whether medication, device, implant or other (copay does not apply).
- Preventive medications as required by the Patient Protection and Affordable Care Act.
- Any other drug which under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

DRUGS EXCLUDED AND LIMITED

- Contraceptives devices.
- Anorectics (any drug used for the purpose of weight loss).
- Dietary supplements.
- Immunization agents, biological sera, blood, or blood plasma.
- Infertility medications.
- Drugs Used for Cosmetic Purposes (i.e. Botox, Myobloc)
- Growth Hormones (unless pre-authorized).
- Levonorgestrel (Norplant).
- Minoxidil (Rogaine) for the treatment of alopecia.
- Non-legend drugs other than insulin.

- Sildenafil Citrate (Viagra) and other medications for the treatment of impotence.
- Tretinoin, all dosage forms (e.g. Retin-A), for individuals 26 years of age or older.
- Vitamins, singly or in combination (except as required by the Patient Protection and Affordable Care Act).
- Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, except those listed above.
- Charges for the administration or injection of any drug.
- Prescriptions which an eligible individual is entitled to receive without charge from any Worker's Compensation Laws.
- Drugs labeled Caution-limited by federal law to investigational use, or experimental drugs, even though a charge is made to the individual.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed medical facility, rest home, sanitarium, extended care facility, convalescent medical facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order.
- Prescription drugs which may be obtained without charge under local, state, or federal programs.
- Drugs purchased outside the U.S. that are not legal inside the U.S.

PRESCRIPTION DRUG PREAUTHORIZATION

There are certain prescription drugs that need to be preauthorized prior to dispensing for reasons of treating one or more health conditions (some of these conditions may not be covered by the medical plan such as cosmetic procedures for wrinkles). The following drugs are classified as needing preauthorization prior to dispensing.

- ***Growth Hormones:*** Medications used to promote or stimulate growth (e.g. Genotropin, Humatrope, Norditropin, Serostim).

If you should receive a prescription from the physician for any of the drugs listed above, this is the step-by-step process in which to have the prescription drugs preauthorized.

1. The physician can call the Caremark Prior Authorization Department at 866/885-4994
2. The physician must indicate that they would like to start the preauthorization process on the name of the drug to be dispensed.
3. Once received and approved, the information will be entered into the Caremark claim adjudication system to allow the pharmacy to dispense the prescription for you.

SPECIALTY PHARMACY

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

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

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

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

RETAIL PRESCRIPTION DRUG PROGRAM

Caremark

Dispensing Limitations

The amount normally prescribed by a physician, but not to exceed a 34-day supply, or a 90 day supply through the Tulalip Pharmacy for maintenance drugs, except certain maintenance drugs, such as controlled substances, or other drugs as determined by the physician or Tulalip Pharmacy.

Benefit Limitations When Not Using the Drug Card

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

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

Benefits For Employees And Dependents Without A Card

At the option of the Plan Administrator, any employee or dependent of an employee may be required to surrender their prescription card.

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

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

MAIL ORDER PRESCRIPTION DRUG PROGRAM

Caremark Mail Service

When to Use Your Mail Order Prescription Drug Card Program

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

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

Dispensing Limitations

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

Ordering Information

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

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

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

DENTAL BENEFITS

For participants covered under this section, the Plan will pay the dental benefits listed herein. Benefits are subject to the limitations shown in the Schedule of Benefits in addition to limitations shown in this section. Charges in excess of the usual, customary, and reasonable fees in the geographic area where treatment is rendered are not eligible under this Plan.

OPTIONAL PREDETERMINATION OF BENEFITS

Before beginning a course of treatment for which dentist's charges are expected to be \$250 or more, you are encouraged to send a description of the proposed course of treatment and charges to the Plan Supervisor. This information may be transmitted on a standard dental claim form available from the dentist. The Plan Supervisor will then determine the estimated benefits payable for the proposed treatment and advise the participant and the dentist before treatment begins.

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

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

DESCRIPTION OF BENEFITS

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

COVERED DENTAL EXPENSES

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

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

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

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

ALTERNATE TREATMENT

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

TYPE I - PREVENTIVE

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

- Preventive oral examinations and consultations during regular business hours limited to two treatments per calendar year.
- Prophylaxis (preventive teeth cleaning) limited to two treatments per calendar year.
- Topical application of fluoride limited to two treatments per calendar year to age 15. Fluoride will be covered twice per calendar year for individuals over the age of 15 who are receiving chemotherapy or radiation therapy which causes a weakening of enamel. (Individuals receiving chemotherapy or radiation therapy should contact HMA's Customer Service Department for assistance with claim submission and processing.)
- Dental x-rays:
 - Full mouth series limited to once in any 60 consecutive month period.
 - Charges for bitewing x-rays are covered once per calendar year.
- Sealants for permanent molars to prevent crevice decay, to age 15.

TYPE II - BASIC AND RESTORATIVE

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

- Fillings of silver amalgam, composite, plastic, porcelain, silicate, and synthetic restoration.
- Repairs of dentures and bridges; including recementing of crowns, inlays, onlays, and bridgework.
- Palliative (alleviation of pain) emergency treatment.
- Extractions (removal of teeth).
- Endodontics (treatment of disease of the tooth pulp) including pulpotomy, pulp capping and root canal treatment.
- Oral surgery, including surgical extractions and general anesthetic (when necessary).
- Apicoectomy (including retrograde filling).
- Periodontic services (treatment of the supporting tooth structures).
 - Periodontal maintenance, limited to twice per calendar year.
 - Periodontal Scaling and Root Planning or Subgingival Curettage are limited to a combined maximum of four quadrants per calendar year
 - For women who are pregnant, a periodontal exam and 2 additional cleanings, including periodontal scaling, is covered during the 12 month period beginning with the estimated date they became pregnant.
 - For a person who has an underlying medical condition, such as heart disease or diabetes which can be affected by periodontal disease, a periodontal exam and two (2) additional cleanings, including periodontal scaling, is covered per calendar year. Prior authorization is required.
- Denture adjustments.
- Addition of teeth to partial denture or bridgework to replace extracted natural teeth.
- Denture tissue conditioning.
- Harmful habit appliances limited to initial appliance to age 15.
- Occlusal adjustments, limited to four quadrants per calendar year.
- Space maintainers limited to initial appliance only. Allowance includes all adjustments in the first six months after installation: fixed, unilateral, band or stainless steel crown type or removal bilateral type.
- Alveoplasty.
- Emergency examinations.
- Frenectomy.

TYPE III - MAJOR AND PROSTHETICS

Type III benefits are only available to individuals who have been continuously enrolled on the plan for 6 consecutive months.

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

- Crowns and crown build up.
- Stainless steel crowns, limited to once per tooth every 24 months.
- Post and core.
- Inlays and onlays.
- Bridges, fixed and removable.
 - Precision attachments limited to the allowance for a bridge
- Rebasing or Relining (but not both) of dentures, limited to once per calendar year.
- Dentures, full and partial.
- Implants.
- Night Guards (Occlusal Guard) – Limited to once every 3 years. (a mouthpiece for sports or other activities is not covered)
- Pin retention, when related to a Type III service.

PROSTHESIS REPLACEMENT RULE

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

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

TYPE IV – ORTHODONTIA (Buy-Up Plan Only)

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

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

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

Covered expenses include the following:

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

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

TYPE IV – TEMPOROMANDIBULAR JOINT DISORDER

This Plan covers medically necessary treatment of Temporomandibular Joint Disorders (TMJ) when provided by a licensed dentist, approved medical facilities, licensed physical therapist or licensed oral surgeon. Oral surgeons will be covered only for the surgical treatment of TMJ disorders under this benefit. TMJ benefits will be paid as outlined in the Schedule of Benefits.

EXCLUSIONS AND LIMITATIONS TO THE DENTAL PLAN

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

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

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

Bonded Fillings, Laments, or Veneers – Charges for bonded fillings, laments, or veneers.

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

Congenital Malformation – Charges for congenital malformation.

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

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

Diagnostic Casts and Study Models – Charges for diagnostic casts and study models.

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

Habit Breaking Appliances – Charges for habit breaking appliances (except Night Guards).

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

Nitrous oxide – Charges for Nitrous oxide.

Oral Hygiene Instruction – Charges related to oral hygiene instruction.

Periodontal Appliance – Charges for periodontal appliances.

Prescriptions – Prescriptions are not covered under the Dental Plan. Dental prescriptions are paid under your Prescription Drug Care Program.

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

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

Provisional Splinting – Charges for provisional splinting.

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

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

1. An appliance, or modification of an appliance, for which an impression was made before such person became covered.
2. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered.
3. Root canal therapy, for which the pulp chamber was opened before such person became covered.

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

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

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

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

VISION BENEFITS

COVERED SERVICES

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

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

Covered vision hardware includes:

- Single, bifocal and trifocal lenses, including no-line lenses
- Anti-reflective and anti-scratch coatings for lenses
- Transition lenses
- Contact lenses
- Frames

Refractive Eye Surgery (Buy-Up Plan Only): Benefits include laser eye surgery, radial keratotomy, and other corrective eye laser or surgical treatments. Benefits will be payable as shown in the Schedule of Benefits.

EXCLUSIONS TO THE VISION PLAN

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

1. Charges for special procedures, such as orthoptics (see medical section) or vision training, or for special supplies, such as non-prescription sunglasses and subnormal vision aids.
2. Drugs or medications of any kind.
3. Charges for services or supplies which are received while the participant is not covered.
4. Charges for any vision care services or supplies which are included as covered expenses under any other benefit section included in this Plan.
5. Charges for vision care services or supplies for which benefits are provided under any worker's compensation law or any other law of similar purpose, whether benefits are payable as to all or only part of the charges.
6. Charges for any eye examination required by an employer as a condition of employment, or which an employer is required to provide under a labor agreement, or which is required by any law or government.
7. Charges for refractive eye surgery including radial keratotomy or lasik surgery (Base Plan only).

GENERAL DEFINITIONS

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

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

APPROVED CHEMICAL DEPENDENCY TREATMENT FACILITY – For the purpose of treatment of chemical dependency, the definition of the term facility includes any public or private treatment facility providing services for the treatment of chemical dependency that has been licensed or approved as a chemical dependency treatment facility by the State in which it is located.

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

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

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

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

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

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

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

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

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

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

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

- Employee - their inability to engage, as a result of accident or illness, in their normal occupation on a full time basis;
- Dependent - their inability to perform the usual and customary duties or activities of a dependent in good health and of the same age.

DOMESTIC PARTNER – A person who, with the employee, meets the requirements as indicated on the Employer's Domestic Partner Affidavit.

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

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

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

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

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

EMERGENCY ADMISSION – An admission will be deemed emergent if, in the opinion of a physician with knowledge of the participant's medical condition(s), delay would seriously jeopardize the life or health of the participant, hinder the ability of the participant to regain maximum function, or would otherwise subject the participant to severe pain that cannot be adequately managed on an outpatient basis.

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

ERISA – The Employee Retirement Income Security Act of 1974 and its amendments.

EXPERIMENTAL OR INVESTIGATIVE – This Plan does not consider eligible for benefits (other than off-label drug use, see definition of “Off-Label Drug Use.”) any treatment, procedure, facility, equipment, drug, drug usage, device or supply which, at the time rendered, does not meet the criteria listed below:

- Approval has been granted by the Federal Food and Drug Administration (FDA), or by another United States governmental agency, for general public use for treatment of a condition.
- It has been scientifically demonstrated by the medical profession to have efficacy in terms of:
 - When the prognosis for the patient's condition is terminal, that the treatment substantially extends the probabilities of the participant's survival.
 - When deterioration of a body system is progressive and reasonably certain to (or has) disabled or incapacitated the patient, that the treatment can be substantially expected to improve the probabilities of arresting the condition's progress.
 - When the body function has been lost by the patient, that the treatment has been shown to restore the body function to usefulness at least sixty percent of the time treatment has been utilized.
- Treatment must be ordered by an institution or provider within the United States that has scientifically demonstrated proficiency in such treatment. All services directly connected with a non-approved experimental or investigational procedure are not covered.
- It is not specifically excluded as Experimental and Investigative.
- A qualified clinical trial, as described under the “Clinical Trials Benefit” of this plan is not considered “Experimental Or Investigative” for the purposes of this plan.

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

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

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

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

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

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

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

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

INJURY – See Accident/Accidental Injury.

INPATIENT – Anyone admitted to an inpatient status in a medical facility or other institutional facility.

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

LIFETIME – While covered under this Plan. Wherever this word appears in this document in reference to benefit maximums and limitations. Under no circumstances does lifetime mean during the lifetime of the covered person.

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

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

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

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

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

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

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

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

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

MEDICALLY NECESSARY – A procedure, treatment, service, equipment, drug, or medicine that is:

1. Deemed appropriate, essential and is recommended for the diagnosis or treatment of the Cover Person's symptoms by a licensed physician, dentist or other medical practitioner who is practicing within the scope of his or her license and specialty or primary area of practice, and
2. Within the scope, duration and intensity of that level of care which is required to provide safe, adequate and appropriate diagnosis or treatment, and
3. Prescribed in accordance with the generally accepted, current professional medical practice and is not considered Experimental or Investigative.
4. Not solely for the convenience of the participant, family members or a provider of services or supplies.
5. The least costly of the alternative supplies or levels of service which can be safely provided. When specifically applied to a medical facility inpatient, it further means that the service or supplies cannot be safely provided in other than a medical facility inpatient setting without adversely affecting the person's condition or the quality of medical care rendered.

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

MEDICARE LIKE RATES – The rate that Medicare would normally pay as determined by an independent third party with applicable patient co-payments, co-insurance and deductible amounts also included in the payment to the provider.

NON-EMERGENCY MEDICAL FACILITY ADMISSIONS – A medical facility admission (including normal childbirth) which may be scheduled at the convenience of a participant

without endangering such participant's life or without causing serious impairment to that participant's bodily functions.

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

1. Medically necessary off-label drug use will be accepted if the drug is otherwise covered by the Plan and if one of the following criteria are met:
 - A. Drug Compendia: One of the following drug compendia indicates that the drug is recognized as effective for the indication:
 - The American Hospital Formulary Service Drug Information;
 - Drug Facts and Comparison;
 - The U.S. Pharmacopoeia Dispensing Information;
 - American Medical Association Drug Evaluation;
 - National Cancer Care Network;
 - National Cancer Institute; or
 - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services.
 - B. Scientific Evidence/Substantially Accepted Peer-Reviewed Medical Literature: The majority of the scientific evidence indicates that the drug is effective for the off-label indication. The evidence must:
 1. Consist of an adequate number of well-designed studies with sufficient numbers of patients in relation to the incidence of the disease;
 2. Be published in peer reviewed journals. The studies must be printed in journals or other publications that publish original manuscripts only after the manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy, validity, and reliability;
 3. There must be enough information in the peer-reviewed literature to allow judgment of the safety and efficacy;
 4. Demonstrate consistent results throughout all studies; and
 5. Document positive health outcomes and demonstrate:
 - i. That the drug is as effective as or more effective than established alternatives; and
 - ii. Improvements that are attainable outside the investigational setting.
 - C. Recognized as effective for treatment of such indication by the Federal Secretary of Health and Human Services.

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

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

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

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

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

PHYSICIAN/PROVIDER – The following individuals who are legally qualified and appropriately licensed, and providing service within their lawful scope of practice are considered physicians and/or providers when acting within the scope of their license for services covered by this Plan:

- Advanced Registered Nurse Practitioner (A.R.N.P.)
- Certified Diabetes Educator
- Certified Nurse Midwife (C.N.M.) and Licensed Midwife
- Certified Nutritionist
- Chiropractor (D.C.)
- Denturist
- Doctor of Dental Surgery (D.D.S.)
- Doctor of Medical Dentistry (D.M.D.)
- Doctor of Medicine (M.D.)
- Doctor of Optometry (O.D.)
- Doctor of Osteopathy (D.O.)
- Licensed Acupuncturist (L.Ac.)
- Licensed Clinical Social Worker (L.C.S.W.)
- Licensed Masters in Social Work (M.S.W.)
- Licensed Masters of Education (M. Ed.)
- Licensed Practical Nurse (L.P.N.)
- Licensed Professional Counselor
- Licensed Speech Therapist
- Licensed Speech Language Pathologist (S.L.P.)
- Licensed Vocational Nurse (L.V.N.)
- Master of Arts (M.A.)
- Occupational Therapist (O.T.L./O.T.R.)
- Physician's Assistant (P.A.)
- Psychiatrist (M.D.)
- Registered Clinical Social Worker (R.C.S.W.)
- Registered Dental Assistant (R.D.A.)
- Registered Dental Hygienist (R.D.H.)
- Registered Dietitian (R.D.C.)
- Registered Nurse (R.N.)
- Registered Physical Therapist (R.P.T.)
- Registered Psychologist
- Registered Respiratory Therapist (R.R.P.)
- Audiologist
- Certified Mental Health Counselor (C.M.H.C.)
- Certified Psychiatric/Mental Health Clinical Nurse
- Doctor of Podiatry (D.P.M.)
- Licensed Massage Therapist (L.M.P.)
- Licensed Masters of Counseling (M.C.)
- Licensed Naturopathic Physicians (N.D.)

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

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

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

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

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

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

PROTECTED HEALTH INFORMATION (PHI) – Individually Identifiable Health Information, as defined in HIPAA §164.501 (see §164.514(2)(b)(i) for individual identifiers), whether it is in electronic, paper or oral form that is created or received by or on behalf of the Plan Sponsor or the Plan Supervisor.

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

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

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

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

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

- The amount negotiated with in-network providers for the same emergency service provided (excluding any in-network copayment or coinsurance amount applied). If multiple rates with in-network providers are negotiated, the amount used will be the median of all negotiated rates;
- The amount for the emergency service calculated using the normal method used for calculating other out of network reimbursements (such as the usual, customary, and reasonable amount) excluding any in-network copayment or coinsurance imposed;
- The amount that would be paid under Medicare for the emergency service, excluding any in-network copayment or coinsurance imposed.

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

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

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

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

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

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

- It is licensed to provide and is engaged in providing, on an inpatient basis, for participants convalescing from injury or disease, professional nursing services rendered by a Registered Graduate Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Graduate Nurse, physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
- Its services are provided for compensation from its patients and patients are under the full-time supervision of a physician or Registered Graduate Nurse (R.N.).
- It provides 24 hours per day nursing services by a licensed nurse, under the direction of a full-time Registered Graduate Nurse (R.N.).
- It maintains a complete medical record on each patient.

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

SPOUSE – The employee's lawfully wed spouse, which is legally recognized in the jurisdiction in which the employee has his/her principle residence, not including a common-law marriage.

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

SUMMARY PLAN DESCRIPTION – The document required by ERISA containing a summary of the benefits provided under the Plan. In the event of a discrepancy between the summary and the Plan Document, the provisions stated in the Plan Document will supersede.

SURGICAL PROCEDURE – A surgical procedure is defined as:

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

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

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

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

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

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

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

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

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

GENERAL PROVISIONS

ADMINISTRATION OF THE GROUP MEDICAL PLAN

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

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

AMENDMENT OF PLAN DOCUMENT

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

APPLICABLE LAW

It is the intent of the parties to this Plan that the provisions herein shall be subject to and interpreted by the Employee Retirement Income Security Act as amended (ERISA) and not the insurance laws of the individual states. This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations.

APPLICATION AND IDENTIFICATION CARD

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

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

ASSIGNMENT OF PAYMENT

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

AUDIT AND REVIEW FEES

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

AUDIT INCENTIVES

If a covered employee or a dependent discovers an error in the provider's medical billing which is subsequently recovered or if the benefits payable are reduced due to the identification of the error, the medical plan will reimburse the participant 50% of the recovered or reduced amount up to \$100 per incident. No benefit is payable for any errors made by the Plan Supervisor in processing the claim.

CANCELLATION

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

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

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

The Plan may be canceled or terminated at any time without advance notice by the Plan Administrator.

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

CLAIMS FOR BENEFITS AND APPEALING A CLAIM

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

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

A call from a provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits**

is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a clean claim (a claim which includes all the information necessary to make a decision) must be filed with the Plan (which will be considered a “Post-Service Claim”). At that time, a determination will be made as to what benefits are payable under the Plan.

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

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

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

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

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

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

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

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

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

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

When Health Claims Must Be Filed

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

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

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

Timing of Claim Decisions

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

- Pre-service Urgent Care Claims:
 - If the participant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
 - If the participant has not provided all of the information needed to process the claim, then the participant will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
 - The participant will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:
 - The Plan's receipt of the specified information; or
 - The end of the period afforded the participant to provide the information.
 - If there is an adverse benefit determination, a request for an expedited appeal may be submitted orally or in writing by the participant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the participant by telephone, facsimile, or other similarly expeditious method. Alternatively, the participant may request an expedited review under the external review process.
- Pre-service Non-urgent Care Claims:
 - If the participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
 - If the participant has not provided all of the information needed to process the claim, then the participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of

the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the participant (if additional information was requested during the extension period).

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

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

Notification of an Adverse Benefit Determination

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

- Information sufficient to allow the participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- A reference to the specific portion(s) of the plan provisions upon which a denial is based;
- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- A description of any additional information necessary for the participant to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the participant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final review;
- A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the participant's claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the participant, free of charge, upon request;
- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the participant, free of charge, upon request; and

- Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes.
- In a claim involving urgent care, a description of the Plan's expedited review process.

Appeal of Adverse Benefit Determination

Full and Fair Review of All Claims

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

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

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

Requirements for First Appeal

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

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

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

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

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

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

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

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

Timing of Notification of Benefit Determination on First Review

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

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

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

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

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

- Information sufficient to allow the participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- A reference to the specific portion(s) of the plan provisions upon which a denial is based;
- Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
- A description of any additional information necessary for the participant to perfect the claim and an explanation of why such information is necessary;
- A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the participant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final review;
- A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the participant's claim for benefits;
- The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
- Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar

criterion was relied upon in making the determination and a copy will be provided to the participant, free of charge, upon request;

- In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the participant, free of charge, upon request; and
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Requirements for Second Appeal

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

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

Timing of Notification of Benefit Determination on Second Review

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

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

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

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

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

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

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

Furnishing Documents in the Event of an Adverse Determination

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

Decision on Review

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

External Review Process

A. Standard external review

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

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

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

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

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

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

- (a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- (b) The adverse benefit determination or the final adverse benefit determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
- (c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and
- (d) The claimant has provided all the information and forms required to process an external review.

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

- 3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Plan Supervisor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.
- 4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

B. Expedited external review

- 1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
 - (a) An adverse benefit determination if the adverse benefit determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
 - (b) A final internal adverse benefit determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of

care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

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

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

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

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

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

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.
3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the adverse benefit determination or final internal adverse benefit determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

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

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

CONDITIONS PRECEDENT TO THE PAYMENT OF BENEFITS

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

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

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

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

COORDINATION OF BENEFITS

Definitions

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

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

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

Application

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

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

6. When a dependent child is covered under more than one plan, the following rules apply. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
 - (a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - (i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
 - (ii) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
 - (b) For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
 - (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;
 - (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;
 - (iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits; or
 - (iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - I. The plan covering the custodial parent;
 - II. The plan covering the custodial parent's spouse;
 - III. The plan covering the non-custodial parent; and then
 - IV. The plan covering the non-custodial parent's spouse.

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

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

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

Coordination of Benefits with Medicaid

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

FACILITY OF PAYMENT

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

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

FIDUCIARY OPERATION

Each fiduciary shall discharge their duties with respect to the Plan solely in the interest of the employees and beneficiaries and: (1) for the exclusive purposes of providing benefits to employees and their beneficiaries and defraying reasonable expenses of administering the Plan, (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a like character and with like aims, and (3) in accordance with the documents and instruments governing the Plan to the extent that they are consistent with the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

FREE CHOICE OF PHYSICIAN

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

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

HIPAA - 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 describes the legal obligations of Tulalip's group medical and dental plans (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out payment of claims, or medical or dental plan operations, or treatment, or for any other purposes that are permitted or required by law.

The Plan is required to provide this Notice of Privacy Practices (the "Notice") to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "protected health information." Generally, protected health information is individually identifiable health information, including demographic information, collected from you or created or received by a health care provider, a health care clearinghouse, a health Plan, or your employer on behalf of a group health Plan, that relates to:

- (1) your past, present or future physical or mental health or condition;
- (2) the provision of health care to you; or
- (3) the past, present or future payment for the provision of health care to you.

The terms "medical" or "health", "health care", "health plan", "health care provider" and "health information" are intended to encompass prescription drug, vision and dental within their meaning, as well as medical.

If you have any questions about this Notice or about the Plan privacy practices, please contact the Privacy Administrator for Tulalip's benefit plans (360-716-5001).

Effective Date

This Notice is effective November 1, 2012.

Plan Responsibilities

The Plan is required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to your protected health information;
- provide you with a copy of this Notice of the Plan's legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

The Plan reserves the right to change the terms of this Notice and to make new provisions regarding your protected health information that the Plan maintains, as allowed or required by law. If the Plan makes any material change to this Notice, the Plan will provide you with a copy of the revised Notice of Privacy Practices by hand, email or mail.

How The Plan May Use and Disclose Your Protected Health Information

Under the law, the Plan may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that

the Plan may use and disclose your protected health information. For each category of uses or disclosures the Plan will explain what the Plan means and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

For Treatment. The Plan may use or disclose your protected health information to facilitate medical or dental treatment or services by providers. The Plan may disclose medical or dental information about you to providers, including doctors, dentists, nurses, technicians, medical students, or other personnel who are involved in taking care of you. For example, the Plan might disclose information about your prior medical history to another health care provider. Usually, you would know about this and it would be at your request.

For Payment. The Plan may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from physicians or other health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, the Plan may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. The Plan may also share your protected health information with a utilization review or precertification service provider. Likewise, the Plan may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health Plan to coordinate benefit payments.

For Health Care Operations. The Plan may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, the Plan may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; conducting or arranging for medical review, legal services, audit services, and fraud & abuse detection programs; business Planning and development such as cost management; and business management and general Plan administrative activities.

To Business Associates. The Plan may contract with individuals or entities known as Business Associates to perform various functions on the Plan's behalf or to provide certain types of services. In order to perform these functions or to provide these services, Business Associates will receive, create, maintain, use and/or disclose your protected health information, but only after they agree in writing with the Plan to implement appropriate safeguards regarding your protected health information. For example, the Plan may disclose your protected health information to a Business Associate to administer claims or to provide support services, such as utilization management or subrogation, but only after the Business Associate enters into a Business Associate Agreement with the Plan. However, Business Associates are included under the Health Insurance Portability and Accountability Act even without such an agreement.

As Required by Law. The Plan will disclose your protected health information when required to do so by federal, state or local law. For example, the Plan may disclose your protected health information when required by national security laws or public health disclosure laws.

To Avert a Serious Threat to Health or Safety. The Plan may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, the Plan may disclose your protected health information in a proceeding regarding the licensure of a physician.

To Plan Sponsors. For the purpose of administering the Plan, including claim appeals, the Plan may disclose to certain employees of Tulalip protected health information. However, those employees will only use or disclose that information as necessary to perform Plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

Special Situations

In addition to the above, the following categories describe other possible ways that the Plan may use and disclose your protected health information. For each category of uses or disclosures, the

Plan will explain what the Plan means and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways the Plan is permitted to use and disclose information will fall within one of the categories.

Organ and Tissue Donation. If you are an organ donor, the Plan may release your protected health information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, the Plan may release your protected health information as required by military command authorities. The Plan may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plan may release your protected health information for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks. The Plan may disclose your protected health information for public health actions. These actions generally include the following:

- to prevent or control disease, injury, or disability;
- to report births and deaths;
- to report child abuse or neglect;
- to report reactions to medications or problems with products;
- to notify people of recalls of products they may be using;
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- to notify the appropriate government authority if the Plan believes that a patient has been the victim of abuse, neglect, or domestic violence. The Plan will only make this disclosure if you agree, or when required or authorized by law.

Health Oversight Activities. The Plan may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, the Plan may disclose your protected health information in response to a court or administrative order. The Plan may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. The Plan may disclose your protected health information if asked to do so by a law enforcement official –

- in response to a court order, subpoena, warrant, summons or similar process;
- to identify or locate a suspect, fugitive, material witness, or missing person;
- about the victim of a crime if, under certain limited circumstances, the Plan is unable to obtain the victim's agreement;
- about a death that the Plan believes may be the result of criminal conduct; and
- about criminal conduct.

Coroners, Medical Examiners and Funeral Directors. The Plan may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities. The Plan may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or are in the custody of a law enforcement official, the Plan may disclose your protected health information to the correctional institution or law enforcement official if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Research. The Plan may disclose your protected health information to researchers when:

- (1) the individual identifiers have been removed; or
- (2) when an institutional review board or privacy board has (a) reviewed the research proposal; and (b) established protocols to ensure the privacy of the requested information, and approves the research.

Required Disclosures

The following is a description of disclosures of your protected health information the Plan is required to make.

Government Audits. The Plan is required to disclose your protected health information to the Secretary of the United States Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA privacy rule.

Disclosures to You. When you request, the Plan is required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. The Plan is also required, when requested, to provide you with an accounting of most disclosures of your protected health information if the disclosure was for reasons other than for payment, treatment, or medical plan or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

Other Disclosures

Personal Representatives. The Plan will disclose your protected health information to individuals authorized by you, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide the Plan with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, the Plan does not have to disclose information to a personal representative if the Plan has a reasonable belief that:

- (1) you have been, or may be, subjected to domestic violence, abuse or neglect by such person; or
- (2) treating such person as your personal representative could endanger you; and
- (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

Spouses and Other Family Members. With only limited exceptions, the Plan will send all mail to the employee. This includes mail relating to the employee's spouse and other family members who are covered under the Plan, and includes mail with information on the use of Plan benefits by the employee's spouse and other family members and information on the denial of any Plan benefits to the employee's spouse and other family members. If a person covered under the Plan has requested Restrictions or Confidential Communications (see below under "Your Rights"), and if the Plan has agreed to the request, the Plan will send mail as provided by the request for Restrictions or Confidential Communications.

Authorizations. Other uses or disclosures of your protected health information not described above will only be made with your written authorization. You may revoke written authorization at any time, so long as the revocation is in writing. Once the Plan receives your written revocation, it will only be effective for future uses and disclosures. It will not be effective for any information that

may have been used or disclosed in reliance upon the written authorization and prior to receiving your written revocation.

Your Rights

You have the following rights with respect to your protected health information:

Right to Inspect and Copy. You have the right to inspect and copy certain protected health information that may be used to make decisions about your health care benefits. To inspect and copy your protected health information, you must submit your request in writing to Tulalip's Privacy Administrator. If you request a copy of the information, the Plan may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

The Plan may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to Tulalip's Privacy Administrator.

Right to Amend. If you feel that the protected health information the Plan has about you is incorrect or incomplete, you may ask the Plan to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to Tulalip's Privacy Administrator. In addition, you must provide a reason that supports your request.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, the Plan may deny your request if you ask to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by the Plan, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If the Plan denies your request, you have the right to file a statement of disagreement with the Plan and any future disclosures of the disputed information will include your statement.

Right to an Accounting of Disclosures. You have the right to request an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposes of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to Tulalip's Privacy Administrator. Your request must state a time period of not longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, the Plan may charge you for the costs of providing the list. The Plan will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on your protected health information that the Plan uses or discloses for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that the Plan discloses to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that the Plan not use or disclose information about a surgery that you had.

The Plan is not required to agree to your request. However, if the Plan does agree to the request, the Plan will honor the restriction until you revoke it or the Plan notifies you.

To request restrictions, you must make your request in writing to Tulalip's Privacy Administrator. In your request, you must indicate (1) what information you want to limit; (2) whether you want to limit the Plan's use, disclosure, or both; and (3) to whom you want the limits to apply-for example, disclosures to your spouse.

Right to Request Confidential Communications. You have the right to request that the Plan communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that the Plan only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Tulalip's Privacy Administrator. The Plan will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. The Plan will accommodate all reasonable requests if you clearly provide information that the disclosure of all or part of your protected information could endanger you.

Right to be Notified of a Breach. You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this notice. You may ask the Plan to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice. To obtain a paper copy of this notice, contact Tulalip's Privacy Administrator.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services (www.hhs.gov/ocr/office/index.html). To file a complaint with the Plan, contact:

Privacy Administrator
Tulalip Tribes of Washington
8802 – 27th Ave NE
Tulalip, WA 98271
(360) 716-5001

All complaints must be submitted in writing. You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office of Civil Right

INADVERTENT ERROR

Inadvertent error by the Plan Administrator in the keeping of records or in the transmission of employee's applications shall not deprive any employee or dependent of benefits otherwise due, provided that such inadvertent error is corrected by the Plan Administrator.

MEDICARE

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

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

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

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

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

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

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

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

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

Disabled Employees with End-Stage Renal Disease (ESRD)

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

MISREPRESENTATION

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

NOTICE

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

PHOTOCOPIES

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

PLAN ADMINISTRATION

The Plan Administrator shall be responsible for compliance by the Plan with all requirements of Part 1, Subtitle B of Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA).

PLAN IS NOT A CONTRACT OF EMPLOYMENT

The Plan shall not be deemed to constitute a contract of employment between the Plan Administrator and any employee or to be a consideration for, or an inducement to or condition of the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Plan Administrator or to interfere with the right of the Plan Administrator to discharge any employee at any time.

PLAN SUPERVISOR NOT A FIDUCIARY

The Plan Supervisor is not a fiduciary with respect to this engagement and shall not exercise any discretionary authority or control over the management or administration of the Plan, or the management or disposition of any funds. The Plan Supervisor shall limit its activities to carrying out ministerial acts of notifying Plan Participants and making benefit payments as required by the Plan. Any matters for which discretion is required shall be referred by Plan Supervisor to the Plan Administrator, and Plan Supervisor shall take direction from Plan Administrator in all such matters. The Plan Supervisor shall not be responsible for advising the Plan Administrator with respect to their fiduciary responsibilities under the Plan. The Plan Supervisor may rely on all information provided to it by Plan Administrators well as the Plan's other vendors. The Plan Supervisor shall not be responsible for determining the existence of Plan Assets, if any.

PRIVILEGES AS TO DEPENDENTS

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

RIGHT OF RECOVERY

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

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

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

Benefits Conditional Upon Cooperation

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

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

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

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

You and your eligible dependents are also required to:

- Notify the Plan Supervisor at 800/700-7153 as soon as possible, that the Plan may have a right to obtain restitution of any and all benefits paid by the Plan. You will later be contacted by HMA, and you must provide the information requested. If you retain legal counsel, your counsel must also contact HMA;
- Inform HMA in advance of any settlement proposals advanced or agreed to by another party or another party's insurer;

- Provide the Plan Administrator all information requested by the Plan Administrator regarding an action against another party, including an insurance carrier; this includes responding to letters from the Plan Supervisor (and other parties designated by Plan Administrator acting on behalf of the Plan) on a timely basis;
- Not settle, without the prior written consent of the Plan Administrator, or its designee, any claim that you or your eligible dependents may have against another party, including an insurance carrier; and
- Take all other action as may be necessary to protect the interests of the Plan.

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

Right of Full Restitution

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

- Any full or partial payment which an insurance carrier makes (or is obligated or liable to make) to you or your eligible dependents; and
- You or your eligible dependents, if any full or partial payments are made to you or your eligible dependents by any party, including an insurance carrier, in connection with, but not limited to, your or another party's:
 - Uninsured motorist coverage;
 - Under-insured motorist coverage;
 - Other medical coverage;
 - No fault coverage;
 - Workers' compensation coverage;
 - Personal injury coverage;
 - Homeowner's coverage;
 - Any other insurance coverage available; or
 - Any other personal asset or payment source.

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

Surrogacy Arrangement or Agreement

If you enter into a surrogacy arrangement or agreement and you receive compensation or reimbursement for medical expenses, you must reimburse the Plan for covered services you receive related to conception, pregnancy, or delivery in connection with that arrangement

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

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

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

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

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

Payment Recovery to be Held in Trust

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

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

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

SUMMARY PLAN DESCRIPTION

This document is the Summary Plan Description.

The Tulalip Tribes of Washington, of Marysville, Washington hereby establishes this Health Care Plan for the payment of certain expenses for the benefit of its eligible employees.

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

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

TAXES

Charges for surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) and other state imposed surcharges (as applicable to the Plan), will be considered covered expenses by this Plan. Local, State and Federal taxes, associated with supplies or services covered under this Plan, will also be considered covered expenses by this Plan.

STATEMENT OF ERISA RIGHTS

As a participant in The Tulalip Tribes of Washington Employee Health Care Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan 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 Employee Benefits Security Administration [*note: previously called the Pension and Welfare Benefits Administration*].

Obtain, on written request to the plan administrator, copies of documents governing the operation of the plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report [*note: this means the Form 5500*]. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse/domestic partner, or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents will have to pay for such coverage. Review this summary plan description for the rules governing your COBRA continuation coverage rights.

Creditable Coverage

You shall be entitled to a reduction or elimination of exclusionary periods of coverage for your pre-existing conditions under your group health plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under a plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for up to 6 months after your enrollment date in your coverage. Please refer to the "open enrollment" and "pre-existing conditions limitations" sections and other sections of this SPD.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the plan, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration [*note: previously called the Pension and Welfare Benefits Administration*], U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

The location and public phone numbers for the EBSA offices and departments can be found on their web site at: www.dol.gov/ebsa.

PLAN SPECIFICATIONS

This document is the Summary Plan Description for the purposes of ERISA.

| | |
|--|---|
| NAME OF PLAN | The Tulalip Tribes of Washington Employee Benefit Plan |
| NAME & ADDRESS OF EMPLOYER/ PARTICIPATING GROUP | The Tulalip Tribes of Washington 6406 Marine Drive Tulalip, WA 98271 360/716-4357 |
| EMPLOYER IDENTIFICATION NUMBER | 91-0557816 |
| PLAN NUMBER | 501 |
| TYPE OF PLAN | Employee Welfare Plan (Health Care: Medical, Dental, Prescription Drug and Vision; and Group Life and AD&D, which is explained in a separate booklet.) |
| TYPE OF PLAN ADMINISTRATION | Healthcare Management Administrators, Inc. provides ministerial administrative services on behalf of The Tulalip Tribes of Washington. The Health Care Plan is a self-funded plan which uses the HMA Preferred provider network. The Group Life and AD&D is an insured plan with contract administration. |
| ORIGINAL PLAN EFFECTIVE DATE | November 1, 1998 |
| LAST AMENDED DATE | January 1, 2014 |
| PLAN YEAR | November 1 st through October 31 st |
| PLAN ADMINISTRATOR/SPONSOR & NAMED FIDUCIARY & DESIGNATED LEGAL AGENT | The Tulalip Tribes of Washington 6406 Marine Drive Tulalip, WA 98271 |
| EMPLOYEES | Eligible Employees of The Tulalip Tribes of Washington, when they meet the eligibility requirements described herein. |
| GROUP NUMBER | 4137 |
| SOURCE OF CONTRIBUTIONS | The employer and employee share the cost of health care coverage. |
| PLAN SUPERVISOR | Healthcare Management Administrators, Inc. PO Box 85008 Bellevue, Washington 98015-5008 425/462-1000 Seattle Area 800/700-7153 All Other Areas |

FUNDING MEDIUM

Health Care Benefits are paid through general assets of the employer. The employer purchases insurance to provide the Group Life and AD&D benefits.

The Tulalip Tribes of Washington, of Tulalip, Washington hereby establishes this Plan for the payment of certain expenses for the benefit of its eligible employees to be known as The Tulalip Tribes of Washington Employee Benefit Plan.

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

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

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

Notice

Medicaid Children's Health Insurance Program (CHIP) Premium Assistance

This section includes a Notice from the Department of Labor regarding premium assistance under the state Medicaid and CHIP programs. If you have any questions about the program, you should contact the Medicaid office shown in the notice.

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for these programs, but also have access to health insurance through their employer. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free 1-866-444-EBSA (3272).

If you live in one of the following States, you may be eligible for assistance paying your employer health plan premiums. The following list of States is current as of July 31, 2012. You should contact your State for further information on eligibility –

| ALABAMA – Medicaid | COLORADO – Medicaid |
|--|---|
| Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447 | Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 |
| ALASKA – Medicaid | |
| Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529 | |
| ARIZONA – CHIP | FLORIDA – Medicaid |
| Website: http://www.azahcccs.gov/applicants Phone (Outside of Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437 | Website: https://www.flmedicaidtprecovery.com/ Phone: 1-877-357-3268 |
| | GEORGIA – Medicaid |
| | Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health |

| | |
|---|---|
| | Insurance Premium Payment (HIPP) Phone: 1-800-869-1150 |
| IDAHO – Medicaid and CHIP | MONTANA – Medicaid |
| Medicaid Website: www.accesstohealthinsurance.idaho.gov Medicaid Phone: 1-800-926-2588 CHIP Website: www.medicaid.idaho.gov CHIP Phone: 1-800-926-2588 | Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084 |
| INDIANA – Medicaid | NEBRASKA – Medicaid |
| Website: http://www.in.gov/fssa Phone: 1-800-889-9949 | Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278 |
| IOWA – Medicaid | NEVADA – Medicaid |
| Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562 | Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900 |
| KANSAS – Medicaid | |
| Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884 | |
| KENTUCKY – Medicaid | NEW HAMPSHIRE – Medicaid |
| Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570 | Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218 |
| LOUISIANA – Medicaid | NEW JERSEY – Medicaid and CHIP |
| Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447 | Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 1-800-356-1561 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710 |
| MAINE – Medicaid | |
| Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741 | |
| MASSACHUSETTS – Medicaid and CHIP | NEW YORK – Medicaid |
| Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120 | Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831 |
| MINNESOTA – Medicaid | NORTH CAROLINA – Medicaid |
| Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629 | Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100 |
| MISSOURI – Medicaid | NORTH DAKOTA – Medicaid |

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| <p>Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005</p> | <p>Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604</p> |
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| OKLAHOMA – Medicaid and CHIP | UTAH – Medicaid and CHIP |
| Website: http://www.insureoklahoma.org Phone: 1-888-365-3742 | Website: http://health.utah.gov/upp Phone: 1-866-435-7414 |
| OREGON – Medicaid and CHIP | VERMONT– Medicaid |
| Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-877-314-5678 | Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427 |
| PENNSYLVANIA – Medicaid | VIRGINIA – Medicaid and CHIP |
| Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462 | Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647 |
| RHODE ISLAND – Medicaid | WASHINGTON – Medicaid |
| Website: www.ohhs.ri.gov Phone: 401-462-5300 | Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm Phone: 1-800-562-3022 ext. 15473 |
| SOUTH CAROLINA – Medicaid | WEST VIRGINIA – Medicaid |
| Website: http://www.scdhhs.gov Phone: 1-888-549-0820 | Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability |
| SOUTH DAKOTA - Medicaid | WISCONSIN – Medicaid |
| Website: http://dss.sd.gov Phone: 1-888-828-0059 | Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002 |
| TEXAS – Medicaid | WYOMING – Medicaid |
| Website: https://www.gethiptexas.com/ Phone: 1-800-440-0493 | Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531 |

To see if any more States have added a premium assistance program since July 31, 2012, or for more information on special enrollment rights, you can contact either:

**U.S. Department of Labor
Services**

**Employee Benefits Security Administration Centers for Medicare & Medicaid
Services**

www.dol.gov/ebsa

1-866-444-EBSA (3272)

U.S. Department of Health and Human

www.cms.hhs.gov

1-877-267-2323, Ext. 61565

Plan Effective November 1, 1998

Plan Restated and Amended January 1, 2014

Plan Arranged By:

**Brown & Brown of Washington, Inc.
1501 Fourth Ave Suite 2400
Seattle, WA 98101**

(206) 956-1600

Claim Administration By:

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

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