January – December

Community Connections, Inc.
721 Stedman Street
Ketchikan AK 99901

HSA Plan
Medical & Pharmacy

Restated January 1, 2022

SUMMARY PLAN DESCRIPTION

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CONTACT INFORMATION

How to Reach Your Claims Administrator
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Office Hours:
8:00 a.m. to 5:00 p.m. Monday through Thursday 8:00 a.m. to 4:00 p.m. Friday *All times are Pacific Standard Time* *Messages may be left on voice mail after hours*
How to Reach Your Pharmacy Benefit Manager
Elixir 2181 East Aurora Road Suite 201 Twinsburg, OH 44087 Customer Service: (800) 361-4542 Website: www.elixirsolutions.com
How to Reach Your Preauthorization / Utilization Management Consultant
Medical Rehabilitation Consultants 111 West Cataldo, Suite 200 Spokane, WA 99201-3203 Telephone: (509) 328-9700 Toll Free: (800) 827-5058 Fax: (509) 328-9777 Email: info@medrehabconsultants.com Website: www.medrehabconsultants.com

MONEY SAVING TIPS FOR PARTIALLY SELF-INSURED HEALTH PLANS

- **Carry Your Card** with you and show it to all health care providers and pharmacies. Your card has important information your doctor, dentist, pharmacist or provider needs in order to file your claim.
- It's important to understand that this Plan offers higher benefits – saving you money – when you use preferred (PPO) providers (doctors, hospitals, labs, etc.) in the **First Choice Health PPO Network,** First Choice Health PPO Network affiliate or the Multiplan Wrap Network and purchase your prescription drugs through the Envision Rx pharmacy network.
- Please note this plan does have exclusions, limitations and benefits that require preauthorization. Make yourself familiar with these benefits in order to utilize your plan effectively.
- Cut the cost of your prescriptions. If possible, get your doctor to prescribe you **generic drugs.**
- Take advantage of the **preventive care benefits** your plan offers.
- **Practice healthy living.** One of the easiest ways to lower your medical expenses over the long term is to establish and maintain a healthy lifestyle.
- **Never assume** anything about your health insurance. Get your information up front and BEFORE you need it.

ABOUT THIS BOOKLET

This booklet describes Community Connections, Inc. HSA Health Care Plan as of January 1st, for eligible Plan participants.

The Community Connections, Inc. HSA Health Care Plan was established January 1, 2016, to provide health coverage for members and their families.

We encourage you to become familiar with your benefits and the valuable protection they offer. This booklet will also help you understand what services are and are not covered and any special steps you need to take to get the highest level of coverage.

It's important for all Plan participants to use these benefits wisely, which starts with understanding them. Carefully read and keep this booklet for future reference, so you understand how to make the Plan work best for you.

If you have questions about your coverage or eligibility, please contact your Claim's Administrator, Rehn & Associates, Inc.

INTRODUCTION

This Summary Plan Description has been prepared for the Employees and their Dependents of Community Connections, Inc., (Employer) effective January 1, 2018.

This document provides a general summary of Plan benefits. This document, Community Connections, Inc. HSA Health Care Plan, contains the Plan document for the medical and pharmacy benefits program required by ERISA §102. This document does not constitute an employment contract or guarantee to continue employment for any period of time. In addition, medical benefits are not vested. Community Connections, Inc. may delegate some or all of its responsibilities to other entities such as insurance companies and claims payers. Community Connections, Inc. reserves the right to amend or delete any of the Plans or Plan provisions described herein at any time.

Please review this benefit booklet carefully. It contains a schedule of benefits and all the general provisions of the Plan. To receive the maximum benefits of this Plan, a Preferred Provider must provide health care services. Affiliate Networks have contracted with physicians, specialists, hospitals, and other health care professionals in your service area in order to offer you a network of Providers from which you may choose to receive your health care services.

This document is a description of the Community Connections, Inc. HSA Health Care Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. Coverage under the Plan will take effect for an eligible employee and designated dependents when the employee and such dependents satisfy all of the eligibility requirements of the Plan, including any applicable waiting periods. Members are responsible for any copay, deductible and coinsurance amounts, as well as any non-covered services and amounts in excess of the allowed charge when a Non-Preferred Provider provides services. Amounts in excess of the member's copay, deductible, coinsurance, and the payment by Claims Administrator for covered services rendered by a Preferred Provider shall be considered to be contractual adjustments and shall not be billed to the member.

Rehn & Associates, Inc. will act as the third party administrator and claims processing fiduciary for this partially self-funded plan. Community Connections, Inc., as a partially self-funded employer, is the Plan Administrator with discretionary authority to determine eligibility for benefits, and to construe and interpret the terms of the Plan, except as delegated to Rehn & Associates, Inc. under Plan Processes.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason, with or without notice. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, coinsurance, maximums, copayments, exclusions, limitations, definitions, eligibility and the like at any time with or without notice.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections and payment, utilization review or other cost management requirements, lack of medical necessity, lack of timely filing of claims or lack of coverage. Failure to provide Coordination of Benefits information may result in delay of coverage or temporary termination of coverage until information is received. Fraudulent use of Coordination of Benefits rules will result in automatic termination of eligibility.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage is terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for service or supply is incurred on the date it is furnished. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to covered charges incurred before termination, amendment or elimination.

MEDICAL OVERVIEW

AFFILIATE NETWORKS

Preferred Provider Network	First Choice Health Network
Wrap National Network	Multiplan
Outpatient Surgery Network	BridgeHealth Network
Transplant Network	Interlink Health Services

Affiliate Networks *are provider networks with whom Rehn & Associates has contracted to ensure that Members have access to Preferred Providers. Please see member identification card(s) for list of Affiliate Networks. These Networks are also referred to as Preferred Provider Organizations (PPO).*

BridgeHealth Network *provides Plan Members and their Covered Dependents access to the BridgeHealth Network when their treating physicians recommend certain covered medical procedures and they elect to receive treatment from medical providers participating in the BridgeHealth Network.*

Interlink Health Services *includes a Centers of Excellence transplant benefit and offers transplant benefits to eligible candidates through the Interlink Health Services TransplantCOE EPO network. To view the current list of eligible TransplantCOE transplant providers, please visit www.interlinkhealth.com/TransplantCOE.*

DEDUCTIBLE

Annual Deductible – Individual	$2,800
Annual Deductible – Family	$5,600

Deductible *is the amount of charges, up to the Allowed Charge, for Covered Services payable by a Member to a Provider who is recognized for payment under this Plan before the Plan will assume any liability for all or part of the remaining Covered Services. Benefits, except as otherwise specified, shall apply only after the deductible has been met. Charges for services payable by the Member due to a reduction in benefits, denial of benefits, or amounts charged in excess of Allowed Charge are the financial responsibility of the Member and shall not be considered as an eligible expense for application towards the deductible amount.*

COINSURANCE MAXIMUM

Preferred Provider	n/a
Non-Preferred Provider	Unlimited

Coinsurance maximum *refers to the maximum out-of-pocket amount that a covered employee will have to pay for expenses covered under the plan. Coinsurance maximum includes coinsurance only.*

PRE-AUTHORIZATION

Some medical services may require that a Pre-Authorization be obtained.

Pre-Authorization *is the process a Provider of service must follow when required by plan design. When the Provider contacts Medical Rehabilitation Consultants (MRC) to initiate the process, MRC will review the treatment plan for, among other things, appropriateness of care, place of service, and medical necessity.*

USUAL, CUSTOMARY & REASONABLE (UCR)

Some medical services may be paid at Usual, Customary & Reasonable (UCR) charges.

UCR *charges represent the average or most common amount charged by providers for a particular service, treatment, or supply in the same geographic area. Information on rates for procedures is compiled into a national data bank and updated twice per year. When a claim is submitted for payment that hits the UCR benefit, before making the claim payment, rates are reviewed and double checked to make sure that hospitals and doctors are not billing excessively for the particular service or procedure. The term "Usual, Customary and Reasonable" is not intended to be the same as the term "Usual and Reasonable" as that term is defined in the Outpatient Dialysis Provision.*

MEDICAL BENEFITS

Acupuncturist
Acupuncture is the practice of inserting very fine needles into the skin to stimulate specific anatomic points in the body for therapeutic purposes. Maximum benefit of 12 visit(s) per calendar year.

Preferred Provider: Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: Deductible, covered at 60% of the UCR

Allergy Injections
Immunotherapy ("allergy shots") is a form of preventive and anti-inflammatory treatment of allergies to substances such as pollens, house dust mites, fungi, and stinging insect venom.

Preferred Provider: Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: Deductible, covered at 60% of the UCR

Allergy Testing
Allergy tests provide specific information about what you are and are not allergic to.

Preferred Provider: Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: Deductible, covered at 60% of the UCR

Ambulance, Air and Ground
A vehicle such as an airplane, helicopter or a designated ground vehicle which transports a sick or injured person to a care facility and is equipped and staffed to provide medical care during transit. An air ambulance is used when ground ambulance is not available or would cause life threatening delays in treatment.

Preferred Provider: Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: Deductible, covered at 60% of Billed Charges

Anesthesiologist, Inpatient and Outpatient
Anesthesia is the use of drugs or other agents that cause insensibility to pain during a surgery or other procedure. The different types of anesthesia include, but are not limited to: general anesthesia, epidural anesthesia, spinal anesthesia, topical anesthesia, regional anesthesia, and local anesthesia.

Preferred Provider: Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: Deductible, covered at 60% of Billed Charges

Blood; Product or Transfusion
Blood is made up of plasma, red blood cells, white blood cells, cryoprecipitate and platelets; blood circulates through the body to carry away waste matter and carbon dioxide and brings nourishment to the tissues. Transfusion constitutes the drawing and processing of autologous blood.

Preferred Provider: Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: Deductible, covered at 60% of the UCR

Blood; Storage & Transportation
Storage and transportation of blood products.

Preferred Provider: Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: Deductible, covered at 60% of the UCR

Chemical Dependency, Inpatient
Inpatient Chemical Dependency Services are provided at an inpatient facility whose function is to provide a structured program for the treatment, rehabilitation and prevention of chemical dependency. These services are special clinical services that are available only in an inpatient hospital setting. Specific criteria must be met by the member in order for inpatient chemical dependency to be approved.

Preferred Provider: **Pre-authorization is required for these services.**
Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: **Pre-authorization is required for these services.**
Deductible, covered at 60% of the UCR

Chemical Dependency, Outpatient Family Counseling
Counseling provided to the family of a Plan Member undergoing Chemical Dependency treatment not in an inpatient setting.

Preferred Provider: Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: Deductible, covered at 60% of the UCR

Chemical Dependency, Outpatient, Other
All other services provided in conjunction with necessary Chemical Dependency treatment not in an inpatient facility.

Preferred Provider: Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: Deductible, covered at 60% of the UCR

Chemical Dependency, Outpatient, Visit
A visit with a provider regarding Chemical Dependency services not in an inpatient setting.

Preferred Provider: Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: Deductible, covered at 60% of the UCR

Chemotherapy Services
Treatment where drugs flow through the bloodstream usually for the treatment of cancer.

Preferred Provider: **Pre-authorization is required for these services.**
Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: **Pre-authorization is required for these services.**
Deductible, covered at 60% of the UCR

Chiropractor, Adult, Extremity Manipulation, Other
Extremity manipulation is a corrective procedure, performed by a chiropractor, applied to a joint of an appendage or appendages performed on Plan Members age thirteen (13) and over. Maximum benefit of 12 visit(s) per calendar year.

Preferred Provider: Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: Deductible, covered at 60% of the UCR

Chiropractor, Child, Extremity Manipulation, Other
Extremity manipulation is a corrective procedure, performed by a chiropractor, applied to a joint of an appendage or appendages performed on Plan Members through the age of twelve (12). Maximum benefit of 12 visit(s) per calendar year.

Preferred Provider: Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: Deductible, covered at 60% of the UCR

Contraception, Devices
Contraceptive processes, implantable, injectable, insertable devices, Oral/Topical that prevent conception, received from a medical provider in their place of service.

Preferred Provider: Covered at 100% of the Allowed Charges
Non-Preferred Provider: Covered at 100% of the UCR

Contraception, Office Visit
Office visit related to contraception management. Maximum benefit limit of 2 visit(s) every 12 months.

Preferred Provider: Covered at 100% of the Allowed Charges
Non-Preferred Provider: Covered at 100% of the UCR

Dialysis Services
Procedure that is a substitute for the function of the kidneys, which are responsible for filtering waste products from the blood. Alternate Names: Artificial Kidneys, Hemodialysis, Peritoneal Dialysis, Renal Replacement Therapy. Please refer to Dialysis Treatment Outpatient Description (Page 26).

Preferred Provider: **Pre-authorization is required for these services.**
Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: **Pre-authorization is required for these services.**
Deductible, covered at 60% of the UCR

Dietician and Nutritionist, Diabetic Only
Providing diabetic related nutritional assessment, education and medical nutritional therapy.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Durable Medical Equipment (DME), Diabetic Supplies
Includes but are not limited to: glucose meters, test strips, syringes and lancets.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Durable Medical Equipment (DME), Major Equipment
Includes, but is not limited to, infusion pumps, insulin pumps, hospital beds, wheelchairs, apnea monitors, c-pap machines, one (1) wig per calendar year for members receiving cancer treatment that leads to hair loss or have been diagnosed with Alopecia, and enteral/parenteral formula. Items shall be limited to the standard model of such medical equipment. Repairs and replacement costs will only be covered if the equipment was used by the Member in the manner and for the purpose for which the equipment was intended and the replacement costs are necessarily incurred due to normal wear and tear of the equipment. Durable medical equipment may be rented or purchased. When equipment is rented, the rental charges shall not exceed the purchase price.

Preferred Provider:	**Pre-authorization is required for services over $2,500.** Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	**Pre-authorization is required for services over $2,500.** Deductible, covered at 60% of the UCR

Durable Medical Equipment (DME), Other /Supplies
Includes, but are not limited to, minor equipment such as bandages, wraps, crutches, canes, and ostomy supplies.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Emergency Services, Facility
Health care services required to treat an emergency medical condition. A medical emergency is an accidental bodily injury or the sudden onset not sudden discovery of a medical condition manifesting itself with severe symptoms of sufficient seriousness that the absence of immediate medical care would result in placing member's life in jeopardy or persons or permanent impairment or dysfunction of any body parts, organs or bodily functions. Copay Waived if admitted inpatient.

Preferred Provider:	$350 Copay, Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	$350 Copay, Deductible, covered at 100% of Billed Charges

Emergency Services, Other
Other charges associated with a visit to an emergency room.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Health Education, Diabetic Education
Services may be accessed to gain understanding of a Member's current Diabetic Illness, Injury, physical disability, or condition. Provides diabetic counseling and instruction programs, also classes such as childbirth education programs and Smoking Cessation.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Home Health Care
Care is provided in the home by a home health agency that must be Medicare-certified or licensed/certified by the state in which it operates. To be eligible for this benefit the Member must be confined to the home or receiving therapy which the Plan determines to be best provided in the home. These services will no longer be available when there is a failure to progress with said therapy. Benefit maximum of 130 visit(s) per calendar year.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Hospice Care
Healthcare option for members who are faced with a terminal illness and not expected to live more than 6 months. Services must be provided by an agency that is Medicare-certified or licensed/certified by the state in which it operates. Benefit maximum of 6 months per lifetime. (Maximum includes up to 10 days inpatient and 240 hours of respite care).

Preferred Provider:	**Pre-authorization is required for these services.**
	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	**Pre-authorization is required for these services.**
	Deductible, covered at 60% of the UCR

Hospital Services, Inpatient, Facility, Newborn
Inpatient facility services rendered to a newborn. Hospital services are provided for injured or ill persons. A hospital is a facility that provides diagnosis, treatment, and care of persons who need acute care under the supervision of physicians. Certain procedures may be considered cosmetic and subject to review.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Hospital Services, Inpatient, Facility, Other
Inpatient facility services rendered to hospital patients other than newborns.

Preferred Provider:	**Pre-authorization is required for these services.**
	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	**Pre-authorization is required for these services.**
	Deductible, covered at 60% of the UCR

Hospital Services, Inpatient, Surgeon
Professional surgical services provided in an inpatient setting.

Preferred Provider:	**Pre-authorization is required for these services.**
	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	**Pre-authorization is required for these services.**
	Deductible, covered at 60% of the UCR

Hospital Services, Inpatient, Visit
A patient encounter with a health care provider in an inpatient setting.

Preferred Provider:	**Pre-authorization is required for these services.**
	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	**Pre-authorization is required for these services.**
	Deductible, covered at 60% of the UCR

Hospital Services, Outpatient, Facility, Surgery
Professional surgical services provided in an outpatient setting. Surgical services include services of a surgeon and an assistant surgeon or co-surgeon.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Hospital Services, Outpatient, Facility, Other
Services other than a surgery or visit received in an outpatient setting.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Hospital Services, Outpatient, Surgeon
Professional surgical services provided in an outpatient setting.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Hospital Services, Outpatient, Visit
A patient encounter with a health care provider in an outpatient setting.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Immunizations
Immunizations are the administration, usually by injection, of immunogens in order to protect individuals from developing specific diseases. Immunizations include but are not limited to: Chicken Pox (Varicella), Diphtheria, Tetanus and Pertussis (DTaP), Haemophilus Influenza B (HIB), Hepatitis B (HBV), Inactive Polio Vaccine (IPV), Measles, Mumps and Rubella (MMR), Pneumococcal pneumonia, Meningitis, influenza, and Human Papillomavirus (HPV).

Immunizations, Adult
Immunizations for Plan Members age 19 or over.

Preferred Provider:	Covered at 100% of Allowed Charges
Non-Preferred Provider:	Covered at 100% of the UCR

Immunizations, Adult, Shingles over age 59
Immunization to prevent Shingles performed in an office setting, if performed at a pharmacy, please see pharmacy benefit.

Preferred Provider:	Covered at 100% of Allowed Charges
Non-Preferred Provider:	Covered at 100% of the UCR

Immunizations, Child
Immunizations for Plan Members through the age of 18.

Preferred Provider:	Covered at 100% of Allowed Charges
Non-Preferred Provider:	Covered at 100% of the UCR

Injectable Medications, Other
All other injectable medications.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Injectable Medications, Pre-Auth List, Growth Hormone
Human Growth Hormone delivered via intravenous injection in a provider's office or outpatient setting.

Preferred Provider:	**Pre-authorization is required for these services.**
	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	**Pre-authorization is required for these services.**
	Deductible, covered at 60% of the UCR

Injectable Medications, Pre-Auth List, Other

The following Injectable Medications require Prior-Authorization: Amevive, Avonex, Botox, Carticel, Depo-Lupron, Enbrel, Forteo, Humira, Hyalgan, Inerferon, IVIG medications, Kineret, Orencia, Prolastin, Remicade, Remodulin, Rituxan, Supartz, Synagis, Synvisc, Thyrogen, Visudyne, and Xolair. This list is subject to change.

Preferred Provider:	**Pre-authorization is required for these services.** Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	**Pre-authorization is required for these services.** Deductible, covered at 60% of the UCR

Injectable Medications, Spinal Steroid

Injection of a steroid for diagnostic or therapeutic purposes to relieve pain and/or inflammation.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Injectable Medications, Vitamin B, Pernicious Anemia and Vitamin B Deficiency

Receiving a Vitamin B shot for the condition of pernicious anemia or Vitamin B deficiency.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Injury to Sound Natural Teeth

The initial repair, not replacement, to Sound Natural Teeth, which are without disease, fillings, or crowns; including the services of a licensed Dentist or Oral Surgeon for the prompt, initial repair of Injury to Sound Natural Teeth within 6 months from the date of injury. An injury or accident is caused from an outside force or trauma to the teeth and mouth. This does not include biting or chewing accidents.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Massage Therapy

Massage therapy is a health care service involving the external manipulation or pressure of soft tissue for therapeutic purposes. Services are based on medical necessity and must be prescribed by a physician. Maximum benefit of 45 combined visits per calendar year (PT, OT, ST, Massage, Cardiac and pulmonary rehab and chronic pain combined).

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Maternity

Any service, treatment, or procedure rendered during the antepartum and postpartum periods as a result of conception. Maternity benefits shall include, but not be limited to, care required for vaginal delivery, cesarean section, and/or complications related to a pregnancy. Maternity admission for vaginal delivery does not require pre-authorization. If the Hospital stay extends beyond forty eight (48) hours post-admission notification will be required. Maternity admission for cesarean section delivery does not require pre-authorization. If the Hospital stay extends beyond ninety six (96) hours post-admission notification will be required.

Maternity services, as described, for a dependent child (not Subscriber or Subscriber's Spouse) are not a covered benefit.

Home Births and charges related to a home birth are not a covered benefit.

The midwife is covered as any other provider only in a hospital setting.

Maternity, Genetic Counseling and Testing

Analysis of DNA, RNA, chromosomes, proteins, and metabolites to detect genotypes, mutations or chromosomal changes to see if an unborn child may be at risk of inheriting or developing a disease or genetic abnormality.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Maternity, Inpatient, Anesthesiologist
Services provided by an anesthesiologist in an inpatient hospital setting for maternity care.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of Billed Charges

Maternity, Inpatient, Facility
Inpatient facility services for maternity care. Follows 48/96 hour rule stated above.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Maternity, Inpatient, Surgeon
Professional surgical services provided in an inpatient setting for maternity care.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Maternity, Inpatient, Visit
A patient encounter with a health care provider in an inpatient setting for maternity care.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Maternity, Office Visit
A patient encounter with a health care provider in an office or clinic for maternity care.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Maternity, Other
Other services, treatment, or procedures required for vaginal delivery, cesarean section, ectopic pregnancy, and spontaneous abortion and miscarriage.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Maternity, Outpatient, Anesthesiologist
Maternity outpatient refers to non-emergency services or treatment received in a Hospital when the Member is not admitted. Services provided by an anesthesiologist in an outpatient hospital or office setting for maternity care.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of Billed Charges

Maternity, Outpatient, Facility, Other
Services other than a surgery or visit received in an outpatient setting for maternity care.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Maternity, Outpatient, Facility, Surgery
Outpatient facility services for maternity care.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Maternity, Outpatient, Surgeon
Professional surgical services provided in an outpatient setting for maternity care.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Maternity, Outpatient, Visit
A patient encounter with a health care provider in an outpatient setting for maternity care.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Maternity, Pathology / Diagnostic Testing
Maternity pathology and diagnostic testing services.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Maternity, Radiology, Other
Maternity Radiology services.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Maternity, Radiology, Ultrasound
Maternity ultrasounds which use high-frequency sound waves to produce images during maternity. Benefit Maximum of 2 ultrasounds per pregnancy, should more be required a pre-authorization must be obtained.

Preferred Provider:	**Pre-authorization is required for these services after 2 services** Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	**Pre-authorization is required for these services after 2 services** Deductible, covered at 60% of the UCR

Mental or Neuropsychiatric Conditions, Inpatient Services
Acute Inpatient Hospitalization is provided specifically for those members who, as a result of a psychiatric disorder, are an acute and significant danger to themselves or others, or are acutely and significantly disabled, or whose activities of daily living are significantly impaired. This level of care involves the highest level of skilled psychiatric services. It is rendered in a freestanding psychiatric hospital or the psychiatric unit of a general hospital.

Preferred Provider:	**Pre-authorization is required for these services** Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	**Pre-authorization is required for these services** Deductible, covered at 60% of the UCR

Mental or Neuropsychiatric Conditions, Outpatient Services
Outpatient and/or Professional Services include individual treatment, including monitoring, evaluating, and testing.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Mental or Neuropsychiatric Conditions, Outpatient Services, Group Therapy
Group Therapy in an Outpatient or Professional setting.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Mental or Neuropsychiatric Conditions, Outpatient Services, Medication Management
Medication management with a Provider for Mental or Neuropsychiatric services.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Mental or Neuropsychiatric Conditions, Outpatient Services, Testing
Testing for Mental or Neuropsychiatric conditions.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Mental or Neuropsychiatric Conditions, Outpatient Services, Visit

Visit for a Mental or Neuropsychiatric condition.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Naturopath

Naturopathic doctors are trained specialists in a separate and distinct healing art which uses non-invasive natural medicine. They are not medical doctors (M.D.s). Maximum benefit of 12 visit(s) per calendar year.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Neurodevelopmental Therapy - Inpatient

Inpatient Facility Services for Neurodevelopmental Therapy. Hands-on treatment approach used by physical therapists, occupational therapists, and speech-language pathologists. NDT was developed to enhance the function of adults and children who have difficulty controlling movement as a result of neurological challenges, such as cerebral palsy, stroke, and head injury.

Preferred Provider:	**Pre-authorization is required for these services** Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	**Pre-authorization is required for these services** Deductible, covered at 60% of the UCR

Neurodevelopmental Therapy - Outpatient

Outpatient Services for Neurodevelopmental Therapy. Hands-on treatment approach used by physical therapists, occupational therapists, and speech-language pathologists. NDT was developed to enhance the function of adults and children who have difficulty controlling movement as a result of neurological challenges, such as cerebral palsy, stroke, and head injury.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Office Visits, Physician

A Physician is a general medical practitioner who will see adults of all ages or a pediatrician who will see children through adolescents for uncomplicated and common medical problems. A Physician can be a general practitioner, general internist, family practitioner, general pediatrician and/or an obstetrician/gynecologist (OB/GYN).

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Office Visits, Specialist

A Specialist is a physician whose practice concentrates on certain body systems, specific age groups, or complex scientific techniques developed to diagnose or treat certain types of disorders. Types of Specialists; Allergy, Immunology, Cardiology, Dermatology, Gastroenterology, Neurology, Orthopedic, Otolaryngology, Pulmonologist, Rheumatology, Surgeons, Urology and All Other.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Orthopedic Appliances

Orthopedic appliances are appliances, braces and splints required for normal daily activities or treatment of any illness or injury.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Orthotics
Custom-made orthotics are medical devices that support and gently reposition the heel, arch, muscles, ligaments, tendons, and bones in the feet, enabling these structures to work together to make each step you take pain-free. Unlike shoe inserts bought over the counter, custom-made orthotics are built from molds of your feet to meet your unique needs. Maximum benefit of one (1) pair per calendar year.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Osteopathic Manipulation
Osteopathic Manipulation is a system of hands-on techniques meant to help alleviate pain, restore motion, support the body's natural functions and influence the body's structure to help it function more efficiently.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Pathology and Diagnostic Testing
Laboratory tests are provided for inpatient, outpatient and professional services. Pathology is the science of interpreting microscopic views of body tissues.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Phototherapy
Phototherapy is exposure to non-ionizing radiation for therapeutic benefit. It may involve exposure to ultraviolet B (UVB), ultraviolet A (UVA) or various combinations of UVB and UVA.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Preventive Care, Annual Gynecological Examinations
Preventive Care examinations are for the evaluation and management of a healthy individual without complaints or symptoms associated with Illness or Injury, including routine diagnostic examinations and tests. Routine gynecological examinations, including pelvic examination and breast examination.

Preferred Provider:	Covered at 100% of Allowed Charges
Non-Preferred Provider:	Covered at 100% of the UCR

Preventive Care, Colonoscopy, Facility, Other
The procedure enables the physician to see things such as inflamed tissue, abnormal growths, and ulcers. It is most often used to look for early signs of cancer in the colon and rectum. Colonoscopies are considered diagnostic if they are being used to look for causes of unexplained changes in bowel habits or to evaluate symptoms like abdominal pain, rectal bleeding, and weight loss. Any other charges related with a preventive colonoscopy. Maximum benefit of 1 every 10 years starting at age 50.

Preferred Provider:	Covered at 100% of Allowed Charges
Non-Preferred Provider:	Covered at 100% of the UCR

Preventive Care, Pathology and Diagnostic Testing
Laboratory and diagnostic testing billed along with the well examination.

Preferred Provider:	Covered at 100% of Allowed Charges
Non-Preferred Provider:	Covered at 100% of the UCR

Preventive Care, Pathology and Diagnostic Testing, Annual Gynecological
Laboratory and diagnostic testing billed along with the Annual Gynecological examination.

Preferred Provider:	Covered at 100% of Allowed Charges
Non-Preferred Provider:	Covered at 100% of the UCR

Preventive Care, Radiology, Other
Radiology billed along with the well examination.

Preferred Provider:	Covered at 100% of Allowed Charges
Non-Preferred Provider:	Covered at 100% of the UCR

Preventive Care, Radiology, Screening Mammogram
A screening mammogram is performed for women who have no symptoms that would be of medical concern. It usually involves two X-rays of each breast. Maximum benefit of one (1) service per calendar year.

Preferred Provider:	Covered at 100% of Allowed Charges
Non-Preferred Provider:	Covered at 100% of the UCR

Preventive Care, Well Examination, Well Adult
Well physical examinations are provided for healthy individuals, age 19 or over (adult). This includes routine prostate examinations, including digital rectal examination (DRE) exam for adult men or Washington State Department of Transportation (DOT) annual exam.

Preferred Provider:	Covered at 100% of Allowed Charges
Non-Preferred Provider:	Covered at 100% of the UCR

Preventive Care, Well Examination, Well Child
Well physical examinations are provided for healthy children two (2) years through eighteen (18) years of age (child).

Preferred Provider:	Covered at 100% of Allowed Charges
Non-Preferred Provider:	Covered at 100% of the UCR

Preventive Care, Well Examination, Well Baby
Well-baby care, for infants and babies newborn through twenty-four (24) months of age.

Preferred Provider:	Covered at 100% of Allowed Charges
Non-Preferred Provider:	Covered at 100% of the UCR

Prosthetics
A prosthesis is a device used to replace an absent body part with an artificial substitute. Prosthetics include, but are not limited to, the purchase, fitting, necessary adjustments, repairs and replacements of prosthetic devices and supplies which replace all or part of an absent body organ including contiguous tissue.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Radiation Therapy
Radiation therapy shall consist of the use of high energy penetrating rays, or natural or artificial radioactive substances to treat disease.

Preferred Provider:	**Pre-authorization is required for these services** Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	**Pre-authorization is required for these services** Deductible, covered at 60% of the UCR

Radiology
Radiology refers to a variety of non-invasive methods for identifying and monitoring diseases or injuries via the generation of images representing internal anatomic structures and organs of the patient's body. Radiology is provided for inpatient, outpatient and professional services.

Radiology, Bone Density
Bone Density Testing measures the strength and density of bone and the mineral concentration in the skeleton. A bone density test assists physicians to understand what treatments, if any, are needed to arrest further bone loss and perhaps reverse the effects of osteoporosis.

Preferred Provider:	**Pre-authorization is required for these services** Deductible, covered at 100% of Allowed Charges

Non-Preferred Provider: **Pre-authorization is required for these services**
Deductible, covered at 60% of the UCR

Radiology, CT Scan

A CT scan is used to define normal and abnormal structures in the body and/or assist in procedures by helping to accurately guide the placement of instruments or treatments.

Preferred Provider: **Pre-authorization is required for these services**
Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: **Pre-authorization is required for these services**
Deductible, covered at 60% of the UCR

Radiology, Diagnostic Mammography

Diagnostic mammograms are done to evaluate abnormalities that have been seen or suspected on a prior screening mammogram; subjective or objective abnormalities in the breast; or an inexplicable change in breast size or shape. Diagnostic mammography typically takes longer and involves correspondingly more radiation exposure than a screening mammogram.

Preferred Provider: Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: Deductible, covered at 60% of the UCR

Radiology, Echocardiogram

Echocardiograms are ultrasound images that help identify abnormalities in the heart muscle and valves, and find any fluid that may surround the heart.

Preferred Provider: Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: Deductible, covered at 60% of the UCR

Radiology, MRI / MRA

MRI (magnetic resonance imaging) or MRA (magnetic resonance angiography) scans are radiology techniques which use magnetism, radio waves, and a computer to produce images of body structures.

Preferred Provider: **Pre-authorization is required for these services**
Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: **Pre-authorization is required for these services**
Deductible, covered at 60% of the UCR

Radiology, Other Imaging

Includes but is not limited to X-ray. Radiologists and technologists record X-ray images of bones, blood vessels, tissues and various internal organs so that an accurate diagnosis can be made.

Preferred Provider: Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: Deductible, covered at 60% of the UCR

Radiology, PET Scan

PET (positron emission tomography) scans, and similar SPECT (single photon emission computed tomography) scans, forms of nuclear imaging, use low doses of radioactive substances to diagnose or treat a variety of diseases, including many types of cancers, heart disease and certain other abnormalities within the body.

Preferred Provider: **Pre-authorization is required for these services**
Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: **Pre-authorization is required for these services**
Deductible, covered at 60% of the UCR

Radiology, Ultrasound

Ultrasound or "sonography" is a radiology technique, which uses high-frequency sound waves to produce images of the organs and structures of the body.

Preferred Provider: Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider: Deductible, covered at 60% of the UCR

Rehabilitation Therapy

Rehabilitation Services are a specialty of medicine concerned with the evaluation, treatment and management of disability and disabling conditions. Physical therapy (PT) is rehabilitation concerned with restoration of function and prevention of disability following disease, injury, or loss of body part. Occupational therapy (OT) facilitates learning of the skills and functions essential for adaptation and productivity to achieve ones maximum potential with regards to their activities of daily living. Speech therapy (ST) is the treatment of communication disabilities and swallowing disorders.

Rehabilitation Therapy, Cardiac Rehabilitation, Facility

Cardiac Rehabilitation involves treatment and education that lead the cardiac patient to attain maximum physical and psychological function. Forty-five (45) combined visits per calendar year (PT, OT, ST, Massage, Cardiac and pulmonary rehab and chronic pain combined)

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Rehabilitation Therapy, Inpatient, Facility

Inpatient Rehabilitation is to restore a Member who was disabled as the result of a covered acute Illness, Injury, condition, or disease to a level of function which allows that Member to live as independently as possible. Conditions for Inpatient Rehabilitation services covered under this Plan must be acute in nature. The applicable requirements set forth in the paragraphs below must be met to qualify for this benefit.

Covered benefits are limited to: Extensive intracranial injury, cerebral laceration and contusions, subarachnoid subdural extradural hemorrhage following injury, intracranial bleeding following injury, and other intracranial injury. Extensive spinal cord injury. extensive crushing injury involving multiple fractures, lower extremity amputation due to trauma or new amputation due to illness. Inflammatory diseases of the central nervous system resulting in marked neurological neuromuscular deficiency limited to encephalitis, intracranial and intraspinal abscess. Disorders of the central nervous system are limited to hemiplegia and paraplegia. Strokes of all etiologies are covered if the patient is able to actively participate in rehabilitation. Neoplasms resulting in marked neurological and or neuromuscular deficit are limited to spinal cord compression due to neoplasm and intracranial neoplasm.

Diagnosis alone does not justify benefit application for Inpatient Rehabilitation. The medical condition of the Member must meet the following criteria for benefit consideration and must be documented in writing: Severe physical neuromuscular neurological impairment necessitating the need for twenty-four (24) hour nursing care must be present; The Member must be responsive to verbal and visual stimuli; No other medical, surgical, or psychological impairing condition shall be present which may limit rehabilitation progress; The Member must show potential for rehabilitation.

Maximum benefit of thirty (30) days per calendar year.

Preferred Provider:	**Pre-authorization is required for these services** Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	**Pre-authorization is required for these services** Deductible, covered at 60% of the UCR

Rehabilitation Therapy, Outpatient Rehabilitation, Facility

Outpatient Rehabilitation includes services and supplies required to improve or restore lost bodily function that was previously normal. Forty-five (45) combined visits per calendar year (PT, OT, ST, Massage, Cardiac and pulmonary rehab and chronic pain combined)

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Skilled Nursing Facility

Facility providing skilled nursing care on a 24-hour basis as well as rehabilitative services at an inpatient level. A hospital inpatient level of care would be required if a SNF were not available. SNF care is necessary when alternative levels of care, such as office, outpatient, home, or an intermediate care facility or rest home are unable to provide the frequency and/or intensity of services needed. Covered services include room and board and ancillary services.

To be eligible for this benefit all of the following conditions must be satisfied: (1) The Member's admittance must be subsequent to hospitalization in an acute care hospital for at least three days and must be within fourteen days following discharge from the acute care hospital (2) The Illness or Injury must require skilled nursing care on a continuing basis (3) Confinement must be for circumstances reflecting the need for convalescence from an Illness, treatment of a terminal

condition, or a long term Illness. Maximum benefit of sixty (60) days per calendar year and must be subsequent to hospital stay in an acute care hospital for at least three (3) days.

Preferred Provider:	**Pre-authorization is required for these services** Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	**Pre-authorization is required for these services** Deductible, covered at 60% of the UCR

Sleep Studies

Studies conducted while the member sleeps to diagnose sleep disorders and/or sleep apnea.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Smoking Cessation, Classes

Health education programs which address the member's dependency on tobacco and treatment for addiction to nicotine. Although referred to as "smoking" cessation, includes treatment for dependence on other forms of tobacco and/or nicotine such as chewing tobacco.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Sterilization, Female

Female Sterilization is a surgical procedure which renders an individual incapable of reproduction.

Preferred Provider:	Covered at 100% of the Allowed
Non-Preferred Provider:	Covered at 100% of the UCR

Sterilization, Male

Male Sterilization is a surgical procedure which renders an individual incapable of reproduction.

Preferred Provider:	Covered at 100% of the Allowed
Non-Preferred Provider:	Covered at 100% of the UCR

Surgical Services, ASC

See the BridgeHealth Network section of this Summary Plan Description for further details and coverage savings.

Surgical Services, ASC, Facility

Ambulatory Surgery Center (ASC) is a distinct entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization. Facility charges related to surgery provided at an ASC.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Surgical Services, ASC, Surgeon

Professional surgical services provided in an ASC setting.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Surgical Services, Office Visit

Professional surgical services provided in an office setting.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Surgical Services, Second Opinion

A second opinion may be obtained prior to a surgical service.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Urgent Care Services

Urgent Care/Minor Emergency Services are minor medical emergency services for minor injury or illness that is non-life threatening. Minor injuries or illnesses include, but are not limited to, sprains and minor broken bones, earaches, severe sore throat or cough, minor infections, and cuts requiring stitches.

Preferred Provider:	Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	Deductible, covered at 60% of the UCR

Transplants

A transplant is the transferring of a healthy tissue or organ to replace a damaged tissue or organ; also refers to the tissue or organ transplanted. Benefits are paid when the Plan Member is receiving or donating organs or tissue.

No benefits will be provided unless the Member obtains written pre-authorization from Medical Rehabilitation Consultants prior to Inpatient admission for a transplant. Medical Rehabilitation Consultants reserves the right to review all requests for prior approval based on the Member's medical condition, the Physician who will perform the transplant procedure, and the Facility in which the transplant procedure will be performed. Medical Rehabilitation Consultants reserves the right, at its sole option, to contract with specific facilities to perform these transplant services and to base benefit payments upon the terms and conditions of such third party contract. Experimental and investigational services are not covered.

Preferred Provider:	**Pre-authorization is required for these services** Deductible, covered at 100% of Allowed Charges
Non-Preferred Provider:	**Pre-authorization is required for these services** Deductible, covered at 60% of the UCR

Organ Transplant

Organ transplants include: Kidney, Pancreas w/ Kidney, Liver, Heart, Heart w/ pair of lungs, Single lung, Double lung and Bone marrow.

Bone marrow transplant is defined as stem cell (includes peripheral) rescue and/or support, or transplantation/reinfusion of bone marrow. Bone marrow from a different person is covered for these diagnoses only: Accutelymphocytic or acute non-lymphocytic leukemia; Aplastic or chronic myelogenous leukemia; Hodgkin's lymphoma, limited to stage 3 or 4; Non-Hodgkin's lymphoma, limited to stage 3 or 4 of intermediate or high grade; Severe combined immunodeficiency (not HIV or AIDS); Wiskott-Aldrich syndrome; Infantile malignant osteoporosis; Neuroblastoma, limited to stage 3 or 4 in children over age one; and Homozygous beta thalassemia. Bone marrow from the beneficiary (self-donated) is covered for these diagnoses only: Acute lymphocytic or acute non-lymphocytic leukemia; Hodgkin's lymphoma, limited to stage 3 or 4; Non-Hodgkin's lymphoma, limited to stage 3 or 4 of intermediate or high grade; Neuroblastoma, limited to stage 3 or 4; and Germ cell.

Organ Transplants, Donor

When only the donor is a Member of this Plan, benefits for the donor's expenses are limited to payment of organ procurement services and costs incurred when the Plan Member is donating organs or tissue to another. No donor expenses shall be paid unless the donor's organ is actually used in the transplant. Medical complications and unforeseen medical effects of the donation will be covered as any other Illness regardless of whether the organ is actually used in the transplant. Should services be provided by a Non-Preferred Provider, maximum benefit limit of $75,000 applies.

Organ Transplants, Recipient

Costs incurred when the Plan Member is receiving donated organs or tissue. No benefits whatsoever are available to a Non-Member recipient.

Organ Transplants, Procurement Costs

Organ procurement services means those diagnostic or medical services to evaluate, select, store, identify, or test the organ that is actually used in a transplant. It also means the donor's surgical and Hospital services directly related to the removal of an organ or tissue that is actually used in a transplant. Organ procurement costs also include those expenses incurred by recipients in the medical process to locate a compatible donor. Transportation of the donor or for the donated organ or tissue is not an organ procurement service. Organ procurement service benefits will only be paid if the donor organ is actually used for a transplant.

Organ Transplants, Transportation

Travel and lodging expenses will be covered under the Plan subject to the conditions described below.

(1) Distance requirement. The Center of Excellence (COE) facility must be more than 100 miles away from the patient's residence.

(2) Travel allowances. Travel is reimbursed between the patient's home and the facility for round trip (air, train or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll cost will be reimbursed per IRS guidelines.

(3) Lodging allowances. Reimbursement of expenses Incurred by the patient and any companion for hotel lodging away from home is reimbursed at a rate of $50 per night per person, to a maximum of $100 per night.

(4) Overall maximum. Travel and lodging reimbursement is limited to $7,500 for any one transplant or procedure type, including tandem transplants. This is a combined maximum for the patient, companion and donor.

(5) Companions. One companion is permitted per adult and 2 parents or guardians are permitted per Child.

Organ Transplants, Network

INTERLINK Exclusive Provider Organization (EPO) Network

The plan includes a Centers of Excellence transplant benefit and offers transplant benefits to eligible candidates through the INTERLINK Health Services ("INTERLINK") TransplantCOE EPO network. Coverage for transplant services rendered at an INTERLINK credentialed TransplantCOE program will be paid at 100% of eligible hospital, professional and organ/marrow charges. Co-payments, deductibles and other member responsibilities still apply. To view the current list of eligible TransplantCOE transplant providers, please visit www.interlinkhealth.com/TransplantCOE.

COVERED TRANSPLANTS include solid organs (heart, lung, liver, pancreas, kidney, multi- visceral/small bowel, or any combination thereof as a multi-organ transplant), bone marrow, stem cell and islet transplants.

EMERGENCY TRANSPLANT CARE AT NON-INTERLINK TransplantCOE Providers

Coverage for unplanned and unscheduled emergency transplantation ("Emergency Transplant") is a benefit included in the plan, to be paid according to the contract terms negotiated by INTERLINK and agreed to by Plan, or Plan's agent, and Provider; however, if payment terms cannot be agreed upon within 10 days of the emergency transplant, then the transplant shall be paid at 110% of Medicare allowable and be considered payment in full. The transplanting hospital must provide the following documents to INTERLINK, who will then forward them onto the Plan, within 24 hours of the Emergency Transplant:

(1) A letter from the transplanting hospital's Surgical Director detailing the medical conditions leading to the Emergency Transplant

(2) A copy of the United Network For Organ Sharing ("UNOS") Status 1 Listing Request and Status 1A confirmation Notice From UNOS; and,

(3) A detailed contract proposal for the Emergency Transplant.

MEDICAL HARDSHIP PROPOSED TRANSLANT CARE: NON-EPO TRANSPLANT EXCEPTION PROCESS

The Plan may approve non-TransplantCOE transplant care for documented Medical Hardship cases, to be paid according to the contract terms negotiated by INTERLINK and agreed to by Plan, or Plan's agent, and Provider; however, if payment terms cannot be agreed upon within 10 days of Provider's billing proposal to Plan, then payment shall be paid at 110% of Medicare allowable. Medical Hardship, as used here, could include such instances where the patient may be too medically frail to travel, re-transplantation following a successful transplant by the same transplant team, or a living donor hardship. For consideration, Medical Hardship forms must be submitted to INTERLINK within 3 business days of the plan being contacted for transplant benefits or approval for evaluation. All information will be forwarded to the plan for consideration. For Medical Hardship transplant benefit consideration, the transplant center must complete and submit the following forms:

(1) A letter from the Surgical Director to the plan detailing the medical conditions supporting the Medical Hardship;

(2) A completed Medical Hardship Form: *Key Outcome Indicators Worksheet;*

(3) A completed Medical Hardship Form: *Transplant Billing Report Table* for the prior three years of transplant billing history; and,

(4) A detailed contract proposal for the proposed Medical Hardship transplant.

Medical Hardship Forms can be downloaded from: www.interlinkhealth.com/medicalhardship

Pre-Authorization Requirement for Organ Transplant*

Covered Expenses incurred in connection with any organ or tissue transplant listed in this provision will be covered subject to referral to and pre-authorization by the Plan Administrator's authorized review specialist. Transplant coverage is offered under this plan through an EPO network of credentialed and volume monitored transplant professionals and facilities. Coverage is also provided for transplant services obtained outside the EPO for Emergency Transplants, and for certain transplant cases involving a Plan approved Medical Hardship condition.

As soon as reasonably possible, but in no event more than ten (10) days after a Covered Person's attending physician has indicated that the Covered Person is a potential candidate for a transplant, the Covered Person or Covered Person's physician should contact the Plan Administrator for referral to the network's medical review specialist for evaluation and pre-authorization. A comprehensive treatment plan must be developed for this plan's medical review, and must include such information as diagnosis, the nature of the transplant, the setting of the procedure, (i.e., name and address of the hospital), any secondary medical complications, a five year prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment. (One or both confirming second opinions may be waived by the plan's medical review specialist.) Additional attending physician's statements may also be required. A non-network hospital may provide a comprehensive treatment plan independent of the EPO, but this will be subject to a Medical Hardship review and may result in no benefit coverage for the transplant at that center.

All potential transplant cases will be assessed for their appropriateness for Large Case Management.

*Failure to pre-authorize a transplant procedure will result in the application of a $5,000 deductible to all Covered Expenses incurred as a result of the transplant. This deductible is in addition to any other plan deductible and co-payment requirements, which would normally be applicable to the transplant procedure.

Organ Transplant Network

As a result of the pre-authorization review, the Covered Person will be asked if they wish for assistance gathering information about participating transplant programs. The term "participating transplant program" means "a licensed healthcare facility and transplant program that has met INTERLINK's Quality Assurance Program standards for participation, and been declared a TransplantCOE program by INTERLINK Health Services' Quality Assurance Committee. The transplant network's goal is to perform necessary transplants in the most appropriate setting for the procedure using some of the nation's most experienced and qualified transplant teams.

Transplant Benefit Period

Covered Expenses will accumulate during a Transplant Benefit Period. The term "Transplant Benefit Period" means the period that begins on the date of the initial evaluation and ends on the date, which is twelve (12) consecutive months following the date of the transplant. (If the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant).

Covered Transplant Expenses

The term "Covered Expenses" with respect to transplants includes the reasonable and customary expenses for services and supplies which are covered under this plan (or which are specifically identified as covered only under this provision) and which are medically necessary and appropriate to the transplant, including:

(1) Charges incurred in the evaluation, screening, and candidacy determination process;

(2) Charges incurred for organ transplantation;

(3) Charges for organ procurement, including donor expenses not covered under the donor's plan of benefits.

   a) Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ;

   b) Charges for organ procurement for a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow up care;

   c) If the transplant procedure is a hematopoetic stem cell transplant, coverage will be provided for the cost of the acquisition of stem cells. This may be either peripherally or via bone marrow aspiration as clinically indicated, and is applicable to both the patient as the source (autologous) and related or unrelated donor as the source (allogeneic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the

stem cells, up to the time of reinfusion. (The harvesting of the stem cells need not be performed within the transplant benefit period);

(4) Charges incurred for follow up care, including immuno-suppressant therapy; and

(5) Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two (2) other individuals. In addition, all reasonable and necessary lodging and meal expenses incurred during the transplant benefit period will be covered up to a maximum of $10,000 per transplant period.

Re-Transplantation
Re-transplantation will be covered up to two re-transplants, for a total of three transplants per person.

Donor Expenses
Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this plan or any other benefit plan covering the donor. In addition, medical expense benefits for a donor who is not a participant under this plan are limited to a maximum of $10,000 per transplant benefit period when the transplant services are provided out of network. This does not include the donor's transportation and lodging expenses.

Extended Benefits in the Event of Termination
In the event of termination of the plan, or of the recipient's termination of membership in an eligible class, if a transplant treatment program had commenced while coverage was in force and benefits had not been exhausted, then benefits will be paid for Covered Expenses related to the same organ transplant which are incurred during the lesser of: (a) the remainder of that transplant benefit period or (b) one month after termination of the plan or membership, as though coverage had not ended.

TRAVEL & LODGING (NON-EMERGENCY)

Travel Expenses for non-emergency commercial coach air transportation and appropriate lodging costs are covered for coverable medical expenses and upon approval by the Plan administrator. The plan will cover round trip coach airfare and housing if it is certified by a case manager at Medical Rehab Consultants that adequate treatment cannot be provided locally. The Plan will also cover the round-trip coach air fare for an accompanying adult if the patient is a minor (under 19) or is a spouse to the patient. Other accompanying adults are covered for patients that are incapacitated. Incapacitated will be defined when an individual cannot attend to any one of the following:

- Unable to board the aircraft; or
- Deplaning; or
- Arranging ground transportation to the facility where treatment is to be rendered; or
- Process through admission at the facility where treatment is to be rendered.

Benefits are subject to the calendar year deductible and applicable coinsurance and limited to the nearest location where adequate treatment can be provided. Members are responsible for expenses beyond the nearest location where treatment can be obtained. Services that are not reimbursable by the Plan are related food charges, tips, taxi fare, bus fare, ferry fare, train fare, gas fees, other service fees, travel agencies, and first-class air fare.

BRIDGEHEALTH NETWORK

The Health Plan provides Plan Members and their Covered Dependents ("Covered Persons") access to the BridgeHealth Network when their treating physicians recommend certain covered medical procedures ("Covered Services") and they elect to receive treatment from medical providers participating in the BridgeHealth Network ("Providers").

Pre-authorization is required for these services.

Covered Services include the Medical Costs for the procedure as well as:

Transportation and lodging benefits apply to members accessing providers more than 100 miles from their home. Arrangements must be reserved, scheduled and approved through BridgeHealth Medical.

- Transportation: Round trip transportation between the member's home and the provider for member and one companion.
- Lodging: One-room accommodation at a BridgeHealth approved hotel.

- No Deductible applied to the Medical Costs incurred under the BridgeHealth program.
- Meals and Incidentals for Member and Companion: Meals and incidental amount paid by Employer to member prior to procedure unless otherwise noted. Member portion paid for out-patient days only. This benefit applies to members accessing providers more than 100 miles from their home.
    - $50.00 per person per day or,
    - $125.00 per week for stays of 15+ days

Certain examinations, tests, treatments or other medical services may be required prior to or following travel within the BridgeHealth Network. Any medical services performed by anyone not a Provider participating in the BridgeHealth Network, including such pre and post care, shall be subject to the coverage limits and other terms of the Health Plan.

The Health Plan shall remain responsible for costs for changes required once travel and other accommodations have been made, as well as any emergency or life-saving health services required as a result of any medical procedures or services received by the Covered Person.

Limitations and Disclosures:

BridgeHealth Medical, Inc. is a Delaware corporation that communicates the availability of medical and surgical diagnostic, treatment and care services and coordinates the delivery of such services with travel, communication and other non-medical aspects of the interaction with the service providers to institutional healthcare purchasers and their Covered Persons. BridgeHealth Medical, Inc. does not provide any medical care or medical advice and does not evaluate or recommend any medical Providers or procedure.

The non-medical benefits provided may be subject to taxation as income to the Covered Person; particularly any Recovery Benefit paid to a Covered Person. BridgeHealth will provide appropriate documentation for benefits paid.

DIALYSIS TREATMENT - OUTPATIENT

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

Pre-authorization is required for these services.

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

1) the concentration of dialysis providers in the market in which Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services,

2) the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,

3) evidence of (i) significant inflation of the prices charged to Plan members by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan members to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers, and

4) the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Plan members' interests, such as subsidies for other plans and discriminatory profit-taking.

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

1) Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis- related claims").

2) Claims Affected. The Dialysis Program shall apply to all dialysis- related claims received by the Plan on or after January 1, 2016, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.

3) Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator shall consider factors including:

   i) Market concentration: The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

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

4) In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Plan member, to the following payment limitations, under the following conditions:

   i) Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Plan member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

   ii) Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Plan Administrator's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.

   iii) Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

   iv) Usual and Reasonable Charge. With respect to dialysis- related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

   v) Additional Information related to Value of Dialysis-Related Services and Supplies. The Plan member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

   vi) All charges must be billed by a provider in accordance with generally accepted industry standards.

5) Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

6) Discretion. The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law.

C. The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan member's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

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

PRE-AUTHORIZATION REQUIREMENTS

Pre-Authorization Access

Pre-authorizations can be initiated by contacting Medical Rehabilitation Consultants. See contact information at the beginning of this booklet.

Pre-Admission Authorization

Medical Rehabilitation Consultants (MRC) will review proposed admissions, other than for emergency or urgent care (see Post-Admission Authorization). Medically Necessary hospitalization will be pre-certified and written notice will be provided to the Member and the referring Physician. Maternity admission does not require pre-authorization. If the admission is determined to be medically unnecessary, Medical Rehabilitation Consultants may propose alternatives to the Inpatient admission after discussing the case with the attending Physician. The Member and the Member's Physician may wish to consider alternatives suggested by the physician reviewer.

If pre-admission authorization is not obtained services may be denied. Such reduced benefit may not be considered an eligible expense for application to the Member's Coinsurance maximum provision of this Plan.

Pre-admission authorization does not guarantee benefit payment will be made. Benefit payments will be made based upon Plan provisions and eligibility criteria.

Post-Admission Authorization

Emergency and urgent admissions require post-admission authorization, to substantiate medical necessity of continued Inpatient care. These admissions are subject to post-admission review on the first working day following the admission.

Post-admission authorization does not guarantee benefit payment will be made. Benefit payment shall be made based upon Plan provisions and eligibility criteria.

CASE MANAGEMENT

The Case Management program is strictly confidential. The Plan has contracted with Medical Rehabilitation Consultants (MRC) to provide case management services in certain health care treatment situations. The Case Management program provides professional intervention to help participants who have catastrophic or significant ongoing health conditions. Case Managers (registered nurses) will evaluate patients for inclusion in the Case Management program based on diagnosis, hospital stays, or at the request of the Plan or participant. The Case Manager will work with the patient, doctors and family members to coordinate care. The purpose of the program is to help the patient navigate the complex health care system and ensure that proper and cost-effective care is being received.

Discharge Planning

Discharge planning provides assistance by a discharge planner in coordinating discharge from an acute care provider when a less acute level of care is appropriate as prescribed by the Member's Physician or attending Physician, if other than the Member's Physician. The discharge planner will assist the Member in transfer to the next appropriate level of care.

Continued Stay Review

Inpatient admission shall be subject to continued review as to medical necessity. If, at any time, a Member's continued Inpatient hospitalization is determined to be medically unnecessary, the Member, the Member's Physician, and the admitting Physician, if other than the Member's Physician, will be notified by telephone and in writing that a recommendation for denial of benefits will be issued.

Individual Case Management Benefits

Medical Rehabilitation Consultants may authorize benefits in an individual case for specific services that would not ordinarily be covered services if it appears to Medical Rehabilitation Consultants that use of such services will reduce costs and not compromise the quality of care. Medical Rehabilitation Consultants shall advise Rehn & Associates who will follow through and inform the member and the Providers in writing when, and to what extent, such benefits will be provided. Providing such benefits shall not constitute an amendment to this Plan.

PHARMACY OVERVIEW

Pharmacy Benefit Manager: Elixir
2181 East Aurora Road Suite 201
Twinsburg, OH 44087
Customer Service: (800) 361-4542
Website: www.elixirsolutions.com

PHARMACY BENEFITS

Retail

Maximum days supply allowed: 30 day supply
90 day supply (for 3 Copays)

Generic Drugs:	$10 Copay, covered at 100% of Allowed charges
Preferred Brand:	$30 Copay, covered at 100% of Allowed charges
Non-Preferred Brand:	$50 Copay, covered at 100% of Allowed charges

Mail Order

Maximum days supply allowed: 90 day supply

Generic Drugs:	$25 Copay, covered at 100% of Allowed charges
Preferred Brand:	$75 Copay, covered at 100% of Allowed charges
Non-Preferred Brand:	$125 Copay, covered at 100% of Allowed charges

PRESCRIPTION DRUG PLAN PARAMETERS

Dispense as Written

Coverage for preventive contraceptives and contraceptive devices is limited to contraceptives that are considered Generic Drugs unless no equivalent Generic Drug is available and the Preferred or Non-Preferred Drug is otherwise covered under the Prescription Drug Card Program. If the Covered Person chooses a Preferred or Non-Preferred Drug rather than the Generic equivalent when there is a Generic equivalent available and the Physician has allowed a Generic Drug to be dispensed, the Covered Person will be responsible for the cost difference between the Generic Drug and the Preferred or Non-Preferred Drug. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Generic Incentive

The program incentivizes the member to fill with generic equivalent medications when available. If the member fills for a brand name prescription when there is a generic equivalent available, the member is responsible for the brand copay plus the difference in cost between the brand and generic medications.

FDA Recommendations

Prescription drugs are available to be used in accordance with FDA dosing recommendations. Quantities greater than FDA standards must require prior-authorization. Quantity limits may apply to certain prescriptions.

Coordination of Benefits

There is no Coordination of Benefits (COB) for prescription benefits.

Medication Coverage

This Plan covers medications on a formulary of preferred medications within selected therapeutic categories. The formulary is developed by a committee of pharmacists and physicians from various medical specialties. The medications in all therapeutic categories are reviewed based on safety, effectiveness, and cost and the most cost-effective drugs in each class are selected as preferred medications. The committee reviews new and current medications regularly. The formulary is updated periodically and is subject to change.

Contraceptive Coverage

Over-the-Counter is covered.
Contraception coverage is restricted to generic products only.
IUD and Implantable devices are covered.

Coverage for preventive contraceptives and contraceptive devices is only available for women of child bearing age.

Prescription Vitamins
Fluoride is covered.

Diabetic Supplies
Supplies including test strips, syringes, insulin and lancets.

Prescription Compounding
Any prescription being compounded must be submitted directly to the Pharmacy Benefits Manager using a direct computer billing system. If a prescription cannot be submitted via the direct computer billing system and must be submitted using a paper claim, a pre-authorization will be required for the prescription to be covered. Standard copays and/or coinsurance will apply to each individual product or drug utilized within the compound.

PRESCRIPTION DRUG PRIOR-AUTHORIZATION PROGRAM
Drugs that require prior approval, if covered by the Plan, include, but are not limited to: Actiq, Accutane, Aralast, Avonex, Botox, Copaxone, Depo-Lupron, Enbrel, Forteo, Fuzeon Kit, Growth Hormone, Hyalgan, Humira, Immune globulins, Interferon, IVIG medications, Kineret, Lotronex, Lupron, Oral Anti-fungal medications, Orencia, Orthovisc, Prolastin, Remicade, Remodulin, Rituxan, Supartz, Synagis, Synvisc, Thyrogen injections, Tysabri, Tretinoin, Xolair.

Injectable medications purchased at the pharmacy will require pre-authorization.

PHARMACY PLAN EXCLUSIONS

Aspirin: Tablets / Chews

Anabolic steroids

Antabuse

Cosmetic: Drugs prescribed for cosmetic purposes, including but not limited to hair loss/growth, wrinkles or other dermatological agents, including Tretinoin, in all dosage forms.

Electrolyte Replacement

Experimental/Investigational: Drugs labeled for investigational use or experimental drugs, even though a charge is made to the Member.

Folic Acid Supplements: Multivitamin with folic acid, including prenatals.

Hematinics

Immunizations/Blood Products: Immunization agents, biological sera, blood, or blood plasma.

Impotence: Medications or hormones for the treatment of impotence.

Infant Formulas

Inpatient Drugs: Medication received as an Inpatient in a licensed Hospital or other provider.

Iron Supplements: Iron suspension, Ferrous sulfate.

Lost/Stolen: Replacement of lost or stolen medication.

Mineral and nutrient supplements.

Non-legend prescription drugs: Regardless of the strength or dosage required, other than insulin.

Not Covered Services: prescription medications related to health care services which are not covered under this Plan.

Over-the-Counter Drugs and Supplies: Except as specified elsewhere in the Summary Plan Description and not including insulin or diabetic testing supplies, any prescription medications that are available over-the-counter regardless of the dosage or strength and those not requiring a prescription order are excluded, including, but not limited to aspirin, antacids, benzoyl peroxide preparations, cosmetics, medicated soaps, food supplements, bandages, and home pregnancy tests.

Oral Fluoride Supplements: Sodium fluoride products only, not in combination.

Pigmenting/depigmenting agents.

Refills/Old Orders: Any prescription refilled more than the number specified by the Physician, or any refill dispensed after one

year from the Physician's original order.

Sexual Dysfunction: Drugs to treat sexual dysfunction.

Stimulants

Testosterone (for women)

Vitamins: Vitamins except those specified herein, and requiring a written prescription.

Weight Loss: Anorectics (any drug used for the purpose of weight loss, obesity or weight management).

MEDICAL PLAN EXCLUSIONS

Act of War: any Injury, Illness, or physical disability resulting from any act of war or from explosion of atomic or similar fissionable materials in war (declared or undeclared), armed invasion, or aggression, national disaster, or from any Illness or Injury contracted or incurred during military service, including any complications or recurrences thereof.

Administrative Fees: for telephone consultations, missed appointments, claim form completion, interest charges, legal services, obtaining and/or copying medical records, or Provider travel and/or lodging expenses.

Abortion: Expenses related to elective abortions will not be considered eligible, except as specified under the Maternity benefit under Eligible Medical Expenses.

Adoption: Neither expenses relating in any way to the natural mother, nor expenses relating to the adopted child prior to the date upon which the child becomes a covered dependent under the Plan.

Air Filtration: humidifiers, vaporizers, air conditioners, or any other air filtration, purification unit or system.

Armed Services: any condition for which the Veterans Administration or any of the armed services is responsible or to the extent benefits are provided or covered by any governmental agency, except as otherwise provided by law. Condition caused by or arising from service in the armed forces of any country, including the Air Force, Army, Coast Guard, Marines, National Guard, Navy, or civilian forces or units auxiliary thereto.

Automobile Coverage: services and supplies to the extent that benefits are payable under the terms of an automobile medical, automobile no-fault, automobile uninsured motorist and/or underinsured motorist, personal injury protection (PIP), commercial liability, or homeowner's policy, or similar contract or insurance when such contract or insurance is issued to or provides benefits for any Member. Any benefits paid by the Employer contrary to this exclusion are provided solely to assist the Member. By providing such benefits, the Employer is not waiving any right to reimbursement or to subrogation as provided in this Plan.

Blood - Storage and Transportation: The storage and transportation of blood products.

Biofeedback – General Anxiety Disorder: Biofeedback for the treatment of generalized anxiety disorder.

Biofeedback - Other Conditions: Biofeedback for the treatment of any condition other than generalized anxiety disorder.

Complication for Non-Covered Services: no benefits shall be provided for services, supplies, or charges which result from the treatment of any direct or indirect complication of any Injury, Illness, physical disability, or condition for which coverage is not or was not provided.

Conduct Disorders: including but not limited to, under socialized and socialized conduct disorders; impulse control disorders such as pathological gambling, kleptomania and pyromania; explosive or aggressive outburst disorder; oppositional disorders in childhood or adolescence; and hyperkinetic conduct disorder (this exclusion does not include Attention Deficit Disorder, with and without hyperactivity, which is covered under the Mental or Neuropsychiatric section of this plan).

Convenience Items: including, but not limited to items such as telephones, television, guest trays or meals, clothing, personal hygiene items or services; food services such as Meals on Wheels, ramps, handrails, air conditioners, communication devices or other supportive environmental equipment; housing, homemaker or housekeeping services, except by home health aides or as ordered in a hospice treatment plan.

Cosmetic: cosmetic appliances (including non-prescription color contact lenses) or re-constructive procedures and attendant hospitalization, except for Newborn Children, done for aesthetic purposes and not to restore an impaired function of the

body. Cosmetic procedures will not be covered regardless of the fact that the lack of correction causes emotional or psychological effects. Cosmetic procedures include sclerotherapy regardless of reason. Services for re-constructive surgery incidental to or following covered surgery resulting from trauma, infection, or other diseases of the involved part, or re-constructive breast surgery resulting from a mastectomy shall not be excluded as Cosmetic.

Counseling: benefits for counseling in the absence of Illness or Injury, except as specifically set forth in the Plan, including, but not limited to, educational, social skills, or bereavement counseling; marital; sex or interpersonal relationship counseling, lifestyle, or fitness counseling, financial, legal, spiritual or pastoral counseling; or counseling with the Member's friends, employer, school counselor, or school teacher.

Court-Ordered Treatment: services or supplies for treatment ordered by any court.

Criminal or Illegal Act: charges for services received as a result of Injury or Illness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior or by participating in a riot or public disturbance.

Custodial Care: regardless of where such care is rendered, convalescent care when the need for definitive medical treatment no longer exists, or for any portion of confinement that becomes convalescent or Custodial Care. This includes care principally for senile deterioration, mental retardation, mental deficiency or mental illness.

Dentistry: whether resulting from disease, dental treatment, or Injury, except for treatment of a fractured jaw or injury to Sound Natural Teeth. Dental services and supplies, including, but not limited to extractions, prosthetics, fillings, crowns, treatment of dental caries or gingivitis, braces, banding, retainers, splinting, dental implants, removal or replacement of teeth, dental surgery, malocclusion including development abnormalities or any other procedures or appliances for tooth movement provided for, or in conjunction with, dental and/or orthodontic care, are specifically excluded under the medical benefits Plan.

Developmental Delays: evaluation, habilitative treatment, education, or training services or supplies for dyslexia.

Educational or Vocational Testing: services for educational or vocational testing or training, including driver's education.

Excess Charges: the part of an expense for care and treatment of an Injury or Illness that is in excess of the allowed amount. Additionally, "boutique" charges, subscription or retainer fees, concierge fees or any related fees, membership fees, or charges related to the completion of forms, even if required, are not covered.

Experimental/Investigational: any service or supply which is determined by Medical Rehabilitation Consultants to be Experimental or Investigational on the date furnished. Experimental/Investigational services include, but are not limited to: cloning, gene therapy and other similar services.

Foot Care: routine foot care procedures including, but not limited to the trimming of nails (except in the case of a Diabetic patient), corns, calluses, or routine hygienic care, arch supports, corrective shoes, and other services and supplies for fallen arches, or other symptomatic complaints of the feet.

Foreign Travel: care, treatment, or supplies received outside of the United States if travel is for the sole purpose of obtaining medical services or care. If medical emergency while traveling please see Other Plan Provisions section 4.

Fraudulent or Misrepresented Charges: expenses related in any way to billings or statements containing fraudulent information or misrepresentations.

Hair Loss: care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

Hearing - Aids and Devices: Hearing aides are instruments to help in hearing, including Behind-the-ear (BTE) hearing aids, In-the-ear (ITE) hearing aids, In-the-canal (ITC) hearing aids, and Completely-in-the-canal (CIC) hearing aids.

Hearing - Testing

Heating pads, contour chairs, or therapeutic beds.

Hypnosis: expenses for hypnosis, regardless of purpose or application.

Illegal Drugs: services, supplies, care or treatment to a Plan Member for Injury or Illness that is a direct or indirect consequence of that Member’s voluntary taking of or being under the influence of any controlled substance, drug,

hallucinogen or narcotic not administered on the advice of a Physician. This exclusion includes recreational or medicinal use of marijuana, or any other substance considered illegal, even if prescribed by a Physician.

Immunizations, Adult, Shingles under age 59: Immunization to prevent Shingles.

Infertility: Testing, diagnosis and treatment of infertility, including procedures, supplies and drugs. Assisted Reproductive Technology (ART) is any combination of chemical and/or mechanical means of obtaining gametes and placing them into a medium (whether internal or external to the human body) to enhance the chance that reproduction will occur. Examples of ART include, but are not limited to, donor sperm utilized for artificial insemination or procedures to induce fertilization with professional or technical assistance, in-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), peritoneal oocyte and sperm transfer (POST), tubal ovum transfer (TOT), and pronuclear stage tubal transfer. This includes services, supplies, drugs, and procedures for reproductive disorders, defects, and/or inadequacies, whether or not the consequence of Illness, disease, or Injury. Disorders, defects, and/or inadequacies shall include, but not be limited to: impotency, frigidity, infertility, sterility, reversal of surgical sterilization.

Insurance Coverage: any and all services, supplies and benefits that result from or arise out of an accident, occurrence or incident for which there exists any first party medical payment coverage or first party medical reimbursement coverage or any third party liability coverage, to include but not limited to, medical payment coverage, automobile medical, automobile no-fault coverage, automobile uninsured motorist and/or underinsured motorist coverage, personal injury protection (PIP), automobile bodily injury coverage, automobile liability insurance policy, third-party automobile liability coverage, commercial liability coverage, homeowner's liability coverage, a personal liability umbrella policy or any other similar contract, coverage or insurance policy when such contract or insurance is issued to or provides benefits for any Member. Any benefits which may be paid by the Employer contrary to this exclusion are provided solely to assist the Member in the form of an "advance." By providing such benefits, the Employer is not waiving any right to reimbursement or to subrogation as provided in this Plan.

Intracellular Vitamin Analysis: any services and supplies related to Intracellular Vitamin Analysis, including, but not limited to the patented blood test called Functional Intracellular Analysis (FIA).

Late Fees

Maternity - dependent child: Maternity expenses incurred by a Dependent.

Maternity – Home Births: Home Births and charges related to a home birth.

Mental or Neuropsychiatric Conditions - Family Counseling

Missed Appointments: expenses for missed appointments, regardless of reason.

Non-Medically Necessary Services: services and supplies to the extent that they are not Medically Necessary for treatment of an Illness, Injury, physical disability, or condition, or are not recommended and approved by the attending Physician. This includes care and treatment billed by a hospital for non-emergency admissions and autopsy services.

Obesity -Other: Non-surgical services for the treatment of obesity. This provision does not include professional surgical services.

Obesity -Surgery: Bariatric surgery of any type for the purposes of addressing obesity.

Orthognathic Surgery/Splint: Orthognathic surgery is surgery performed on the bones of the jaws to change their positions.

Out-of-contract Services by Provider: services received by a Preferred Provider which are outside the contract between the PPO and said Provider.

Physical/Fitness Equipment: physical fitness or physical therapy equipment, including, but not limited to whirlpools, spas, hot tubs, weight lifting equipment, charges in or by health spas, or weight loss/exercise programs.

Recreational Therapy: provides treatment services and recreation activities to individuals with disabilities or illnesses, including but not limited to: arts and crafts, animals, sports, games, dance and movement, drama, music, and community outings, meant to treat and maintain physical, mental, and emotional well-being by reducing depression, stress, and anxiety; to recover basic motor functioning and reasoning abilities; to build confidence; and to socialize effectively so that patients can enjoy greater independence, as well as reduce or eliminate the effects of their illness or disability.

Services and Supplies: (1) for which a Member is not required to make payment, (2) that are made only because benefits are available under this Plan, or (3) for which a Member would have no legal obligation to pay in the absence of this or any similar

coverage.

Services by Relation: services and supplies furnished by a person who is related by blood, marriage, adoption, or who lives in the Member's home.

Services related to Employment: any Injury or Illness which arises out of and/or in the course of employment for which the Member is covered under the provisions of State or self-insured Industrial Insurance, Worker's Compensation, or any federal act or similar law. Additionally, DOT licensing fees, pre-employment screenings and evaluations, or vision exams in connection with employment, etc, are not covered.

Sex Transformation: Expenses in connection with sex transformation will not be considered eligible.

Sexual Disorders: services, supplies, drugs and procedures for sexual disorders, defects, and/or inadequacies, whether or not the consequence of Illness, disease or injury. Disorders, defects, and/or inadequacies shall include, but not be limited to impotency, frigidity, sterility, reversal of surgical sterilization, or gender transformations.

Special Nutritional Supplements: special foods or diets, vitamins, minerals, dietary and nutritional supplements, and nutritional therapy.

Surrogate Pregnancy: services or supplies related to surrogate pregnancy.

Temporomandibular Joint Dysfunction (TMJ): Expenses for treatment or services due to Temporomandibular Joint Dysfunction (TMJ).

Thermography: a procedure in which a heat-sensing infrared camera is used to record the surface heat produced by different parts of the body. Abnormal tissue growth can cause temperature changes, which may show up on the thermogram.

Third Party Liability: services and supplies to the extent that benefits are payable by a liable third party. Any benefits paid by the Employer contrary to this exclusion are provided solely to assist the Member in the form of an "advance." By providing such benefits, the Employer is not waiving any right to reimbursement or to subrogation as provided in this Plan.

Transplants (non-human): services and supplies in conjunction with non-human organ and/or tissue transplants, zenographs or artificial, manufactured organs (whether of permanent or temporary use). No benefits shall be paid for the purchase of any organ or body part. No benefits shall be paid for donor or organ procurement services and costs incurred outside the United States.

Vision: vision analysis, therapy or training related to muscular imbalance of the eye (orthoptics), or pleoptics. Services and supplies for the purpose of surgically altering the refractive error of the cornea and their results both direct and indirect, including, but not limited to, radial keratotomy, corneal modulation, keratomileusis, or refractive keratoplasty.

DEFINITIONS

Affiliate Networks are provider networks with whom Rehn & Associates has contracted to ensure that Members have access to Preferred Providers. Please see your member identification card(s) for a list of Affiliate Networks. These Networks are also referred to as Preferred Provider Organizations (PPO).

Allowed Charge is the maximum allowance for specific services or supplies. This allowance is based upon many factors, including: a Provider’s fee schedule with an Affiliate Network; the allowable for Non-Preferred Providers as determined by your employer; or a negotiated payment amount. If the services rendered are a plan exclusion, or if the Provider is Non-Preferred, the Provider may not be obligated to accept the allowed charge as payment in full and you may, therefore, be billed the full amount.

The term “Allowed Charge” is not intended to be the same as the term “Usual and Reasonable” as that term is defined in the Outpatient Dialysis Provision.

Claims Processing Fiduciary means Rehn & Associates, but only to the extent described under Plan Processes; otherwise, the Plan Administrator is the fiduciary under the plan.

Clean Claim is a claim which is payable under applicable claims processing guidelines and which does not require special handling, additional information or further review and which was submitted utilizing approved forms and procedures and within twelve (12) months of the date of service.

Coinsurance is the percentage share payable by you on claims for which the self-insured employer provides benefits at less than 100% of the allowed charge.

Coinsurance maximum refers to the maximum out-of-pocket amount that a covered employee will have to pay for expenses covered under the plan. Coinsurance maximum includes coinsurance only.

Copay is a specified dollar amount that a member must pay out-of-pocket for a specified service at the time the service is rendered. Copays are taken before coinsurance. One (1) copay applies per day per provider.

Covered Service is a medically necessary service or supply which is specifically set forth in the schedule of benefits section of this plan, provided by a licensed health care Provider, practicing within the scope of such Provider's license, and is recognized for payment under this Plan, and not otherwise excluded under this plan. Rehn & Associates, through utilization of its resources and agents, has the sole discretion to determine if a health care service or supply is a covered service.

Custodial Care is care provided primarily for maintenance of a patient or which is designed essentially to assist a patient in meeting his or her activities for daily living and which is not primarily provided for its therapeutic value in the treatment of an Illness, disease, bodily Injury, or condition. Custodial Care includes, but is not limited to help in walking, bathing, dressing, feeding, preparation of special diets, and supervision over self-administration of medications not requiring constant attention of trained medical personnel.

Deductible is the amount of charges, up to the Allowed Charge, for Covered Services payable by a Member to a Provider who is recognized for payment under this Plan before the Plan will assume any liability for all or part of the remaining Covered Services. Benefits, except as otherwise specified, shall apply only after the deductible has been met. Charges for services payable by the Member due to a reduction in benefits, denial of benefits, or amounts charged in excess of Allowed Charge are the financial responsibility of the Member and shall not be considered as an eligible expense for application towards the deductible amount.

Deductible Carryover includes any medical expense incurred to satisfy the deductible in whole or in part during the last ninety (90) days of the prior calendar year. This amount would be applied toward the current calendar year deductible, provided enrollment has been continuous.

Dental Charges are the charges, as determined by Rehn & Associates, made by a Dentist or other Physician for necessary care, appliances or other dental materials listed as a covered dental service. A dental charge is incurred on the date the service or supply for which it is made, is performed, or is furnished. However, there are times when one overall charge is made for all or part of a course of treatment. In this case, Rehn & Associates will apportion that overall charge to each of the separate visits or treatments. The charge will be considered to be incurred as each visit or treatment is completed.

Dentist is a person who has received a degree in Dentistry and is duly licensed to practice Dentistry by governmental authority having jurisdiction over the licensing and practice of Dentistry.

Dentistry refers to the treatment or repair of teeth, bones, tissues of the mouth and defects of the human jaw and associated structures. Dentistry shall include, but not be limited to, surgical procedures involving the mandible and maxilla where performed for the purpose, at least in part, of preparing such boney structure for dentures or the attachment of teeth, artificial or natural. Dentistry shall also include the administration of anesthetic in connection with any treatments listed above.

Experimental and/or Investigational Treatment refers to the use of any treatment, procedure, provider, equipment, drug, device, or commodity, regardless of its medical necessity, deemed by Rehn & Associates to be either investigative, experimental, or in the early development stage of medical technology. The determination by Rehn & Associates will be based on objective data and information obtained by Rehn & Associates, reviewed by competent medical personnel, and available on request.

Family is two (2) or more persons related by blood, marriage, or law who are enrolled under the same identification number.

Health Care Plan Administrator is the Employer.

Health Care Plan describes any medical plan offered by an employer or its affiliates to employees, dependents, and/or for those individuals electing COBRA continuation coverage.

Illness refers to a bodily disorder, disease, or condition other than an Injury. All such bodily disorders existing concurrently, which are due to the same cause or pathologically related causes, shall be considered to be one Illness. Successive Illnesses from the same cause, or from treatment or complications thereof, shall be considered as the same Illness.

Injury refers to a physical Injury caused by an unexpected or unintended occurrence, independent of disease or bodily

infirmity, or caused by unintended ingestion of toxic substances. All bodily disorders sustained in the same mishap or accident or from treatment or complications thereof or pathologically related thereto shall be considered as one Injury. Self-inflicted bodily injury resulting from a mental or physical health condition shall be considered an Injury. Bodily disorders resulting from allergies shall not be considered an Injury.

Medically Necessary refers to those services or supplies provided by a Physician or Provider that are required to identify or treat a Member's Illness or Injury and which, as determined by Rehn & Associates are:

- consistent with the symptoms, diagnosis, and/or treatment of the Member's condition, disease, ailment, or Injury and likely to stabilize or improve the Member's condition;
- appropriate with regard to the standards of good medical practice recognized and approved at the time employed by Physicians practicing within the state of Washington as accepted medical practice;
- not primarily for convenience of a Member, Physician, or Provider; and
- the most appropriate supply or level of service that can safely be provided to the Member.

When applied to the care of an Inpatient, it further means that the Member's medical symptoms or condition requires that the services cannot safely be provided to the Member as an Outpatient. The fact that a Physician or Provider may prescribe, order, recommend, or approve a service or supply does not, of itself, render such service or supply Medically Necessary or covered under this Plan.

Member is any person who satisfies the eligibility and enrollment qualifications and is enrolled for coverage under this Plan. The term Member shall include eligible employees, dependents, and individuals qualified for continued coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272 (COBRA).

Non-Preferred Provider is defined as a Provider which does not have a current contract with a Preferred Provider Organization (PPO) with whom Rehn & Associates is contracted to provide healthcare services. Services provided by a Non-Preferred Provider shall be reimbursed according to the plan's Non-Preferred Provider benefit level. Any balance remaining after a Rehn & Associates payment shall be the responsibility of the Member.

Orthodontic Services are defined as the movement of one or more teeth by the use of active appliances. It includes:

- treatment plan and records, including initial, interim and final records;
- periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances;
- orthodontic retention, including any and all necessary fixed and removable appliances and related visits.

Physician is an individual who is licensed to practice medicine or osteopathy in the state in which he or she practices, has training and experience in the field in which he or she practices and is board certified or has completed an approved specialty training program.

Plan describes the written agreement identifying the terms and conditions of such agreement including general provisions, exclusions, limitations, schedule of benefits, any endorsements thereto, and application form(s). No oral statements or representations by any person, including employers, agents, or representatives of Rehn & Associates, can change, alter, delete, add, or otherwise modify the expressed written terms of this Plan or a validly executed endorsement to this Plan. The plan may be modified or terminated at any time at the sole discretion of the Employer.

Pre-Authorization is the process a Provider of service must follow when required by a plan design. When the Provider contacts Medical Rehabilitation Consultants (MRC) to initiate the process, MRC will review the treatment plan for, among other things, appropriateness of care, place of service, and medical necessity.

Preferred Provider is a Physician, Hospital, or other Provider, as herein defined, who or which has contracted with a PPO to provide covered services to Members and to accept the Member's deductible, copay, and coinsurance, plus Rehn & Associates benefit payment as payment in full.

Prescribed means your provider orders the use of a medicine or other treatment.

Subscriber describes an eligible person who has applied for coverage, satisfied the enrollment qualifications, is accepted and enrolled for coverage, and in whose name the identification card is issued.

Terminal Illness refers to an Illness or condition, in which it is medically probable that the patient has less than six (6) months

to live, provided such Illness or condition continues its normal course. His or her physician must certify the patient's condition as terminal.

Utilization Management is the evaluation of the treatment plan to determine whether recommended medical services and place of treatment are necessary, appropriate, and at or above quality standards for a Member's Illness, Injury, physical disability, or condition.

ELIGIBILITY REQUIREMENTS

1. The Plan Administrator has the discretionary authority to determine eligibility for benefits, to construe the terms used in this Plan and to interpret the terms of the benefit Plan, except as provided under Plan Processes. Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all.
2. In order for an applicant to become entitled to or a member to continue the benefits of this Plan, the following qualifications must be met:

   2.1 An enrolled employee hereunder is any employee as to whom each and all of the following qualification exists:

   - The employee must be in a benefit eligible position working one hundred thirty (130) or more hours per month and;
   - The employee must have completed the one (1) month orientation period as well as the sixty (60) day waiting period.
   - The employee must be a U.S. citizen or legally authorized to work in the United States;
   - The employee must be actively at work or on an approved benefit eligible leave or receiving salary continuation; and
   - The employee must submit all enrollment paperwork completed and on schedule. Newly eligible employees must submit their paperwork to the Benefits Office in Human Resources within 60 days from date of hire.

   2.2 An enrolled dependent hereunder is any dependent as to whom the following qualifications exist:

   - The legal spouse of the Subscriber; or
   - Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll. Individuals may request enrollment for such children for 30 days from the date of notice. Enrollment will be effective retroactively to January 1st. For more information contact your Human Resources Department.
   - Enrolled dependent children through eighteen (18) years of age.
   - Overage dependent if they are between the ages of nineteen (19) through age twenty-five (25); further a dependent child must be one of the following:
     - A natural, step, or adopted child of the Subscriber, a child placed for adoption;
     - A legally placed ward in the Subscriber's home;
     - A child of a divorced Subscriber if the child is not self-supporting; or
     - A foster child is not eligible.
     - Dependent child(ren) whose coverage must continue pursuant to a state court's medical child support order (Qualified Medical Child Support Order, (QMCSO)).
3. Subscribers and their dependents may, without special or late enrollment status, apply for coverage when they initially become eligible. Annually thereafter, members must participate in the Employer Group open enrollment process. All rules regarding mid-year changes are according to IRS regulations.
4. If a family status change occurs such as marriage, divorce, legal separation, birth, death, change in spouse's employment that affects health care coverage, the Subscriber must contact the Human Resource office within sixty (60) days of the event. Newborn Children or children placed for the purpose of adoption may be added within sixty (60) days of the event, coverage will be effective the date of the birth/adoption. New enrollment due to marriage will be effective the first of the month following the date of marriage. Premiums may apply from the effective date of eligibility.

5. Prior to legal finalization of an adoption, the coverage provided herein shall continue until the first of the following events occurs: (1) the date the child is removed permanently from placement, or (2) the date the Subscriber rescinds, in writing, the agreement of adoption and the agreement assuming financial responsibility. If one of the foregoing events occurs, coverage shall terminate on the last day of the month in accordance with the Plan rules and practices.
6. Any unmarried child enrolled who is, or becomes incapable of self-sustaining employment by reason of developmental disability or physical handicap prior to reaching his or her twenty-sixth (26th) birthday and who is primarily dependent upon the Subscriber for support and maintenance, shall not be terminated so long as this Plan remains in force and the dependent remains in such condition, provided the Subscriber maintains coverage under this Plan, if the Subscriber has, within thirty-one (31) days of such dependent's reaching age twenty-six (26), submitted proof of such dependent's incapacity as herein described. The Plan will require subsequent proof of the dependent's disability and dependency.
7. In the absence of fraud, all statements made by applicants or Members shall be deemed representations and not warranties. No statement made for the purpose of effecting coverage shall void such coverage or reduce benefits unless such statement is contained in a written instrument signed by the Subscriber.

Leave of Absence

Coverage for Subscribers and enrolled Dependents may be continued during an employer approved leave of absence, provided the Subscriber submits the appropriate monthly contribution amount. Refer to the companies Personnel Policies for information concerning the employee's Leave of Absence or Family Medical Leave Act. To continue dependent coverage during a benefit eligible leave, the Subscriber must make monthly premium contributions directly to your Employer.

Termination

Your eligibility for Plan benefits terminates on the date of termination in which employment is terminated. Coverage may also terminate if you fail to pay your share of the premium, if your hours drop below the required eligibility threshold, if you or your dependents submit false claims, or fail to submit Coordination of Benefits information in a timely manner after enrollment, etc. Coverage for your spouse and dependents terminates when your coverage terminates. Their coverage will also cease for other reasons, such as divorce, the dependent child attaining the overage limit, etc. Benefits will also cease for employees, spouses and dependents on the termination date of the Plan. Depending on the reason why coverage was terminated, you and your covered spouse and dependents might have the right to continue coverage temporarily under COBRA. See the "Continuation of Coverage - COBRA" section of this booklet.

ENROLLMENT

Annual Enrollment

Each year during annual enrollment, the member may choose the benefit options the member wants by completing a new enrollment form. The member may change options or add coverage for the member's family during the annual enrollment period. Most selections the member makes are in effect for one calendar year. However, the employer reserves the right to amend, delete or terminate any of the plans or plan provisions described at any time, with or without notice. The time period for enrolling is limited.

Special Enrollment

Special enrollment rules apply to the member's medical benefits. Under these rules, if the member declined medical coverage for themselves or eligible family members because the member had other coverage, the member may be able to enroll themselves and the member's dependents in the Health Care Plan within a thirty (30) day special enrollment period after other coverage ends.

To be eligible for special enrollment, the loss of coverage must have been due to loss of eligibility (for example, resulting from divorce, death, termination of employment or reduction of hours of employment) or termination of employer contributions toward the coverage.

Children's Health Insurance Program Reauthorization Act (CHIPRA)

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), effective 4/1/09, amends the Internal Revenue Code to require a group health plan to permit an employee who is eligible, but not enrolled, for coverage under the plan to enroll if either of the following conditions are met: (1) the employee or dependent covered under Medicaid or CHIP has coverage terminated as a result of loss of eligibility, and the employee requests coverage under the group health plan within 60 days after such termination; or (2) the employee or dependent becomes eligible for Medicaid or CHIP assistance if the employee requests coverage within 60 days after the eligibility determination date.

Change in Status

Except for special enrollment, you may only change your medical coverage elections once per year during the annual open enrollment. Elections made during that time apply for the entire calendar year. Please refer to above Eligibility section regarding time frames for status changes.

A change in status includes:

- Marriage, divorce, or legal separation
- Death of your spouse or dependent
- Birth, adoption, or placement for adoption of a child
- Employment status, such as the beginning or ending of employment.
- Work schedule, such as a switch between part-time and full-time or a strike or lockout, or commencement or return from an unpaid leave of absence that results in a gain or loss of coverage eligibility.
- Changes in your member's dependent's age status or other factor affecting his or her eligibility.
- Open Enrollment of spouse's employer.

Any changes made in elections must be consistent with the change in status.

STANDARD PLAN PROVISIONS

Information You Need To Know

1. Rehn & Associates has contracted with Preferred Provider Organizations (PPO) nationwide to offer Providers from which you may access your health care services. To receive the maximum benefits of this Plan, a PPO Provider must provide such services.
2. Rehn & Associates will act as third party administrator and claims processing fiduciary for this self-funded plan. Community Connections, Inc., as a self-funded employer, is the Plan Administrator with discretionary authority to determine eligibility for benefits, and to construe and interpret the terms of the Plan, except as delegated to Rehn & Associates under Plan Processes.
3. The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason, with or without notice. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility, etc.
4. No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses. Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan. Members are responsible for any copay, coinsurance and deductible amounts as defined in this Plan, as well as Non-Covered Services and amounts in excess of Rehn & Associates allowed charge when services are provided by a Non-Preferred Provider. Amounts in excess of the Member's copay, coinsurance, deductible and the payment by Rehn & Associates for covered services rendered by a Preferred Provider shall be considered to be contractual adjustments and shall not be billed to the Member.
5. The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage begins or after coverage is terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force, except as outlined in the current Employer Payer Agreement. An expense for a service or supply is incurred on the date the service or supply is furnished. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to covered charges incurred before termination, amendment or elimination.

Other Plan Provisions

1. Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections and payment, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. Failure to provide Coordination of Benefits information may result in delay of coverage or temporary termination of

coverage until information is received. Fraudulent use of Coordination of Benefits rules will result in automatic termination of eligibility. See the "Coordination of Benefits" section of this booklet.

2. If there is not a Preferred Provider within twenty-five (25) miles of your home, benefits for services will be reimbursed as if a Preferred Provider provided the services.
3. Non-emergency care at an emergency room will not be covered.
4. If you are traveling outside of the United States of America and require treatment for an injury or medical emergency, any payments you make for medical treatment may be reimbursed, provided the following guidelines are met:
    - The Plan must have authorized Rehn & Associates to reimburse Plan Members for emergency treatment incurred outside of the United States. If authorization has not been given, the following procedures do not apply.
    - Members must pay for medical services at the time of service.
    - Upon returning to the United States, submit an itemized statement of charges that includes diagnosis, and all charges paid. The exchange rate for foreign currency must also be noted on submitted forms.
    - Charges submitted must be for a serious injury medical emergency.
    - Claims in a foreign language must be submitted in English.
    - Claims will not be reimbursed for non-covered services or for services that are determined to be not medically necessary.

Preferred and Non-Preferred Providers

A Preferred Provider is a Physician, Hospital, or other Provider, as herein defined, who or which has contracted with a PPO to provide covered services to Members and to accept the Member's Deductible, Copay, and Coinsurance, plus the benefit payment as payment in full.

A Non-Preferred Provider is defined as a Provider which does not have a current contract with a Preferred Provider Organization (PPO). Services provided by a Non-Preferred Provider shall be reimbursed according to the plan's Non-Preferred Provider benefit level. Any balance remaining after the admistrator's payment shall be the responsibility of the Member.

Plan Processes

Rehn & Associates as the claims processing fiduciary is responsible for evaluating all benefit claims and is vested with full discretionary authority to approve or deny claims and appeals, and to interpret the Plan as necessary to do so, including for example determining whether treatment is "medically necessary" or "experimental." Rehn & Associates may delegate certain administrative or claims processing tasks to subcontractors for review.

Claims Filing

Claims for services of Preferred Providers will be submitted for you. For office visits and prescriptions, you will pay either a copay or coinsurance at the time of service. For other types of services, you will typically receive a bill from your provider for the balance you owe after the Plan has paid its portion of your claim.

Occasionally, you may need to file a claim directly to Rehn & Associates. Here's how to file a claim:

1. Obtain a Rehn & Associates claim form from your Human Resources office or download one at the Community Connections, Inc. website.
2. Complete and sign the form.
3. Attach the itemized doctor, hospital or other health care provider bill to your completed claim form. Rehn & Associates will accept any form that contains all of the itemized information necessary to process and pay benefits.
4. Submit the completed Statement of Claim form and attached bills within 90 days after the date of service to:

Community Connections, Inc.
Health Care Plan
PO Box 5433
Spokane, WA 99205

If all coverage and eligibility requirements are met, the benefit payment will be sent directly to the patient, or to the Assigned Provider of Services (your hospital, doctor, clinic, etc.) The deadline for submitting benefit claims is one year from the date of service: Claims submitted more than 12 months after the date of service will not be paid.

Clean Claim Submission

No benefits shall be provided for any claim submitted more than twelve (12) months from the date services were rendered. If your claim is denied, you may appeal to Rehn & Associates for a review of the denied claim. Your appeal will be decided in accordance with reasonable claims procedures, as required by ERISA. See the "Appeal Process" section of this booklet.

APPEAL PROCESS

Procedure for Disputed Claims

In the event that a claim for benefits is denied, the following is the procedure for you to appeal a claim;

If your claim is denied in whole or in part, the third-party administrator (TPA) shall notify you of the denial and will include the specific reasons for the denial and specific plan provisions or IRS rules or regulations upon which the denial is based and a description of any material necessary for your claim to be processed. Within 15 days from the date your request for claim was received, the TPA may extend the period by which it expects to render its decision on your claim to a period not to exceed 60 days and shall notify you in writing of the extension.

If your claim is denied, you or your authorized representative may appeal the denial in writing to the Plan Sponsor. You have 180 days from the date you receive the written notification of your denial to make your appeal. You will have the right to review pertinent documents and submit written issues and comments concerning your claim request to the Plan Sponsor.

After the Plan Sponsor receives your request of an appeal by you or your authorized representative, the Plan Sponsor shall consider your appeal within 60 days from the time that your request for review was received.

In special circumstances, the Plan Sponsor may request a 60-day extension to review the decision. The Plan Sponsor's decision shall be furnished to you and shall include specific reasons for their decision and specific references to pertinent plan provisions or IRS rules or regulations on which the decision was based.

The Plan Sponsor may determine that a hearing is required to properly consider a claim that has been requested for review. In that event, if the Plan Sponsor determines such a hearing is required, such determination shall constitute special circumstances permitting an extension of time in which to consider the claim that is requested for review.

COORDINATION OF BENEFITS

All of the benefits under this Plan are subject to these provisions:

1. Your "Certificate of Continuing Coverage" or "HIPAA Certificate" is required when coverage under the Plan other than your Employer Plan begins or ends. Failure to provide Coordination of Benefits information may result in delay of coverage or temporary termination of coverage until information is received.
2. Benefits shall be provided under this Plan to the extent that the Member could not have received benefits for the same services under any other Plan had a claim been made. If the other Plan has a coordination of benefits provision and if the benefits provided under this Plan and all other Plans under which the Member is covered would exceed the Allowed expense for the claim being processed, then this coordination of benefits provision will apply. This means that the benefits under this Plan and all other Plans under which the Member is covered will be reduced so that the sum of the benefits of all Plans shall not exceed the lesser of the other Plan Allowed Charge or Rehn & Associates Allowed Charge for that claim. If the benefits of this Plan are reduced because of this coordination of benefits provision, each claim during that Calendar Year will be processed as it is received by Rehn & Associates and previous benefit reductions during that Calendar Year will be taken into consideration in determining the amount to be paid. The benefits of the other Plan shall include all benefits that would have been payable had the claim been duly made therefore.
3. If both this Plan and the other Plan provide that the benefits of this Plan must first be exhausted, the other Plan may be ignored in determining benefits under this Plan; but otherwise the following rules shall establish the order of benefit payment under this Plan and the other Plan:
    - 3.1 The benefits of a Plan that cover the Member other than as a dependent shall be exhausted first.
    - 3.2 The benefits of a Plan that cover the Member as the Dependent of the parent whose birthday (day and month only) falls earlier in a year are determined before those of the parent whose birthday falls later in that year. If the other Plan does not have this rule and the two Plans do not agree on the order of benefits, the rule in this Plan will

be administered as if the other plan contained this rule. If such Member is a Dependent child whose parents are separated or divorced, the following rules shall apply:

3.2.1 If the parent with custody has not remarried, the benefits of the Plan of the parent with custody will be exhausted before the Plan of the parent without custody.

3.2.2 If the parent with custody has remarried, the benefits of the Plan that cover the child will be exhausted in the following order:

3.2.2.1 Plan of the parent with custody

3.2.2.2 Plan of the spouse of the parent with custody

3.2.2.3 Plan of the parent without custody

3.2.2.4 Plan of the spouse of the parent without custody

3.2.3 Notwithstanding, if there is a court decree that established financial responsibility for the health care of the child, the benefits of the Plan that covers the child as the dependent of the parent with such financial responsibility shall be exhausted first.

3.2.4 When rules 1 and 2 above do not establish an order of benefit determination, the benefits of a Plan that has covered the individual receiving services for the longer period of time shall be applied before the benefits of a Plan that has covered such individual the shorter period of time. In the event the individual receiving services has been covered for the same period of time under both Plans, the benefits of the Plan which has covered the Subscriber for the longer period of time shall be applied before the benefits of the Plan which has covered the Subscriber for the shorter period of time, provided that:

3.2.4.1 The benefits of a Plan covering the person on whose expenses claim is based as a laid off or retired employee, or Dependent of such person, shall be determined after the benefits of any other Plan covering such person as an employee, other than a laid off or retired employee, or Dependent of such person; and

3.2.4.1 If either Plan does not have a provision regarding laid off or retired employees, which results in each Plan determining its benefits after the other, then the provisions of (1) of this subsection shall not apply.

Eligibility and Plan Verification

Rehn & Associates shall provide a contact person, available during normal business hours, for Providers to further verify the eligibility, plan benefits, and obtain billing information for Members. Providers shall be entitled to rely on Rehn & Associates verification of a Member's eligibility under the Plan.

APPLICABLE FEDERAL LAW

Compliance with Law and Court Orders

Rehn & Associates processes claims in compliance with applicable Washington State and Federal law. In the event a court of competent jurisdiction enters a Qualified Medical Child Support Order (QMCSO) or other order regarding enrollment of or payment of medical expenses for a dependent child or alternate recipient, a copy of such order must be provided to the member's employer. Rehn & Associates shall comply, as directed, with any such order to the extent required by law. For more information see the "Qualified Medical Child Support Orders" section of this booklet.

Family Medical Leave Act

This Plan shall be administered to accommodate the specific requirements of the Family and Medical Leave Act of 1993 (Public Law 103-3), the Act. Any term or provision of this Plan relating to eligibility for coverage that contradicts or conflicts with the express terms of the Act is hereby declared invalid. The Policyholder shall keep Rehn & Associates advised regarding the eligibility for coverage of any employee who may be entitled to the benefits extended by the Act.

Women's Health and Cancer Rights Act of 1998

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours (or ninety-six (96) hours).

Mental Health Parity Act

The Mental Health Parity Act (MHPA), signed into law on September 26, 1996, requires that annual dollar limits on mental health benefits be no lower than any such dollar limits for medical and surgical benefits offered by a group health plan or health insurance issuer offering coverage in connection with a group health plan.

MHPA applies to group health plans for plan years beginning on or after January 1, 1998. The original sunset provision (providing that the parity requirements would not apply to benefits for services furnished on or after September 30, 2001) has been extended several times. If you have questions about the sunset provision, contact the EBSA office nearest you.

The law:

- Generally requires parity of mental health benefits with medical/surgical benefits with respect to the application of aggregate annual dollar limits under a group health plan
- Provides that employers retain discretion regarding the extent and scope of mental health benefits offered to workers and their families (including cost sharing, limits on numbers of visits or days of coverage, and requirements relating to medical necessity)

The law, however, does not apply to benefits for substance abuse or chemical dependency.

The law also contains the following two exemptions:

- Small employer exemption. MHPA does not apply to any group health plan or coverage of any employer who employed an average of between 2 and 50 employees on business days during the preceding calendar year, and who employs at least 2 employees on the first day of the plan year
- Increased cost exemption. MHPA does not apply to a group health plan or group health insurance coverage if the application of the parity provisions results in an increase in the cost under the plan or coverage of at least one percent

Qualified Medical Child Support Orders

The Employee Retirement Income Security Act of 1974 (ERISA) and the Child Support Performance and Incentive Act of 1998 (CSPIA) require the Employer to take certain actions to help enforce state administrative and court orders for medical child support.

The Employer adopts the following procedures under ERISA to determine whether medical child support orders qualify with ERISA's requirements and thus are to be carried out. The Employer may modify or terminate these procedures to satisfy legal requirements.

A qualified medical child support order (QMCSO) establishes a child's right to receive benefits for which a plan participant or qualified beneficiary for continuation of coverage is eligible, and which the Plan has determined meets the requirements to be a qualified medical child support order.

A medical child support order must:

- Specify the name and last known mailing address of the participant and the name and mailing address of each child covered by the order; and,
- Include a reasonable description of the type of coverage to be provided by the Plan to each child, or the manner in which such type of coverage is to be determined; and,
- Specify each period to which such order applies; and,
- Specify each plan to which such order applies.

A QMCSO must not require the Plan to provide any type or form of benefit or any option not otherwise provided under the Plan, except to meet requirements of Section 1908 of the Social Security Act (relating to enforcement of state laws regarding child support and reimbursement of Medicaid).

Upon receiving a medical child support order from a court of law, Rehn & Associates shall:

- Promptly notify in writing the Participant, each child covered by the order, and each representative for these parties of the receipt of the medical child support order. The notice shall include a copy of the order and these QMCSO procedures for determining if the order is qualified;
- Permit the child to designate a representative to receive copies of notices sent to the alternate recipient regarding the medical child support order;
- Within a reasonable time after receiving a medical child support order, determine if it is qualified and notify the participant and child(ren) subject of the order; and

Once the order is determined to be qualified, ensure the child is enrolled according to plan terms and the order and is otherwise treated by the Plan as a covered beneficiary for ERISA reporting and disclosure purposes. As such, the plan will distribute to the child a copy of the Summary Plan Description (SPD) and any subsequent material modifications adopted by the plan sponsor.

In the event the Plan receives a state administrative or court medical child support order under CSPIA requiring the Employer to withhold employee contributions for group health coverage for a child, the Employer will determine whether the employee is covered or eligible under the plan, and whether the child may be eligible under the plan.

After the Employer determines the employee is subject to income withholding to pay for the child's coverage, the Employer and/or Rehn & Associates, shall notify the employee, the child and the child's custodial parent (when that is not the employee) that coverage is or will become available. The Employer and/or Rehn & Associates will furnish the custodial parent a description of the coverage available, the effective date of the coverage and any forms, documents or other information needed to put such coverage into effect, as well as information needed to submit claims for benefits.

The Employer will determine whether employee contributions are available to pay for the child(ren)'s coverage. If such funds are available, the Employer will withhold such contributions from the employee's income and notify the employee to that effect.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are on voluntary or involuntary duty with certain uniformed services (e.g. the U.S. Armed Forces, National Guard, or commissioned members of the Public Health Service), coverage under your medical plan remains in effect for you and your enrolled dependents for the lesser of the period of your leave or twenty-four (24) months, as long as you pay your portion of the premium. Active duty includes: active duty, active duty for training, inactive duty training, full-time National Guard duty, and an absence for the purpose of determining your fitness to perform any of these types of duties.

If your leave is thirty (30) days or less, you are required to pay the same amount to maintain coverage as an active employee. If your leave is for thirty-one (31) days or longer, you are required to pay 102% of the full cost of coverage (employer and employee contributions) as described in the COBRA section of this document.

STATEMENT OF YOUR RIGHTS UNDER ERISA

As a participant in this 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 may be entitled to:

- Examine, without charge, at the Trust Administrative Office and at all local union offices upon 10 days written request, all Plan documents including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon 10 days written request to the Employer. The Employer may impose a reasonable charge for the copies. Participants and beneficiaries may wish to inquire as to the amount of the charges before requesting copies.
- Receive a summary of the Plan's annual financial report. The Employer is required by law to furnish each participant with a copy of this summary annual report. This requirement is applicable to groups of one hundred (100) members or more.

- File suit in a federal court if any materials requested are not received within 30 days of a participant's request, unless the materials were not sent because of matters beyond the control of the administrator. The court may require the Employer to pay up to $110 for each day's delay until the materials are received.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the people who are responsible for the operation of the employee benefits plan. These persons are referred to as “fiduciaries” of the Plan. Fiduciaries must act solely in the interest of the Plan participants and they must exercise prudence in the performance of their Plan duties.

In the event Plan fiduciaries misuse the assets of the Plan, you may request assistance from the U.S. Department of Labor or sue in federal court, which may award you costs of suit, including your attorney fees if you are successful. If you are not successful, the court may award you with the Trust attorney fees.

If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security 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 NW, Washington, D. C. 20210.

All questions with respect to Plan participation, eligibility for benefits or the nature and amount of benefits, or with respect to any matter of Plan administration, should be referred to the office of:

Rehn & Associates
PO Box 5433
Spokane, WA 99205
(509) 534-0600 / (800) 872-8979

IMPORTANT STATEMENTS

Access to Service

Failure to satisfy Plan requirements or meet criteria does not deny access to service. It does, however, result in reduced payment or denial of payment for non-authorized services. Charges for those services will be the financial responsibility of the member.

Authorization as to Medical Information

Members, for themselves, their heirs, executors, administrators, and assigns, do hereby expressly authorize any Provider to fully impart to Rehn & Associates any and all medical information or knowledge acquired by such Provider with reference to such member, by means of examination or otherwise, either prior to or subsequent to the effective date of this Plan, and further authorize Rehn & Associates to examine all professional and institutional records pertaining to such member's physical and/or mental condition.

Hold Harmless

Members are responsible for applicable Deductibles, Copays and Coinsurance amounts for Covered Services, as identified in this Plan under the schedule of benefits. Any balances remaining after such amounts, and Rehn & Associates benefit payment for Covered Services, shall be treated as contractual adjustments by PPO Providers and shall not be billed to the Member. Any balances after Rehn & Associates payment to Non-Preferred Providers shall be the responsibility of the Member. The Member is one hundred percent (100%) responsible for non-covered services as billed by any provider.

Limitations of Liability

Providers rendering services to Members are as to Rehn & Associates solely independent contractors and are not agents of Rehn & Associates for any purpose hereunder. Rehn & Associates shall have no liability whatsoever for any negligence, act, failure to act, or omission on the part of any such Provider, employees of such Provider or any other person. Rehn & Associates shall not be liable to any person or entity for the inability or failure to procure or provide the benefits of this Plan by reason of epidemic, disaster, provider terminations, or other cause or condition beyond the control of Rehn & Associates.

Member Rights and Responsibilities

Failure to satisfy plan requirements or meet criteria does NOT deny access to service. It does, however, result in reduced payment or denial of payment for non-authorized services or services not rendered by a specific provider. Charges for those services will be your responsibility.

By taking part in the responsibility for your care you are entitled to certain rights:

- You have the right to be informed. Be sure you understand the features and requirements of this Plan. This booklet

is designed to provide you with details of your coverage including covered services as well as exclusions, limitations, and other terms and conditions.

- You have a right to expect considerate courteous treatment with respect to your privacy and dignity. Information regarding your health care will be kept confidential, unless you have given written permission to release information or if information is required by law.
- You have a right to ask questions and participate in making decisions involving your health and medical care. You have the right to refuse treatment and be informed of the possible consequences for refusing treatment.
- You have the right to receive information about your medical conditions, health status, the recommended course of treatment, choices, and risks involved. You have the right to a second opinion.
- It is your responsibility to present your identification (ID) card to Providers at the time service is performed.

It is your responsibility to give accurate and complete medical information to all Providers, follow medical advice and ask questions if you do not understand or need an explanation.

Non-Assignability

The benefits hereunder shall not, by the Member or any person entitled thereto, be pledged, hypothecated, encumbered, or assigned.

Vesting of Policies

Under no circumstances does a Member acquire a vested interest in continued receipt of a particular benefit or level of benefits. If benefits for a service or supply are eliminated or modified for a new Plan Year, or during the Plan Year, benefits shall not be provided for those services or supplies rendered after the effective date of the elimination or modification. There will be no grandfathering of benefits. No oral or written statements or representations given in good faith by any person, including employers, agents, or representatives of Rehn & Associates or the self-funded employer, can change, alter, delete, add, or otherwise modify the expressed written terms of this Plan or a validly executed endorsement to this Plan, even if the statements or representations are misleading or incorrect.

Wrongful Payment

Should Rehn & Associates make any incorrect payments or overpayments for services or supplies provided to a Member or ineligible person, the Plan shall be fully reimbursed by the reprocessing of those incorrectly processed claims.

SUBROGATION

If a Member (Subscriber or Dependent) receives benefits under this Plan for treatment of Injuries resulting from the act or omission of another person, firm, or corporation (or, "third party"), the Plan shall be subrogated to all of the rights of the Member or the personal representative of a deceased Member to recover compensation or damages to the extent of all payments made by the Plan.

The Member or his or her personal representative shall notify Rehn & Associates in writing of the facts of the accident or occurrence and the name and address of the party who may be responsible. The Member shall do nothing to prejudice the Plan's subrogation rights and shall cooperate fully with Rehn & Associates including providing advice as to the status of the Member's claim and prior notification of any proposed litigation or settlement.

Expenses that are the responsibility of a third party are excluded under this Plan. Rehn & Associates and the self-funded employer shall have no liability for claims paid by any third party. Please see the Exclusions "Automobile Coverage" and "Third Party Liability." The Plan may "advance" benefits pending a recovery sum which will reimburse the self-funded employer for claims paid. The Member or personal representative of the Member will be asked to sign a reimbursement agreement before benefits are advanced on behalf of the Member. There is no waiver of rights by the employer if an "advance" of benefits is made without a signed agreement.

If reasonable collection costs and reasonable legal expenses have been incurred by the Member or his or her personal representative in recovering medical expenses which have been previously paid by the Plan, whether by an action for damages or otherwise, the amount of the subrogation claim of the Plan shall be proportionately reduced to no less than two-thirds (2/3) of the total amount paid by the Plan in connection with Injuries related to such accident. However, the Plan does not pay for, nor is it responsible for the payment of participants' attorney's fees. Attorney's fees are to be paid solely by the participant.

The Plan is entitled to recovery:

- As a first priority claim.
- Regardless of the characterization of the settlement or judgment.
- Even if the participant is not "made whole." As medical expenses are considered damages, when a third party is liable. This agreement requires the good faith cooperation of all parties involved.

The Member shall cooperate by reimbursing the Plan from any recovery received.

The Member shall not interfere with the Plan's right to recover. Neither will the Plan interfere with the Member's right to receive a settlement.

The Member shall consult with the Plan before taking any steps to recover. If a third-party recovery is being considered, please call Rehn & Associates and ask to speak to the Claims Coordinator concerning third-party liability.

The Member shall keep the Plan informed of all developments in their recovery efforts.

Motor Vehicle Coverage

Most motor vehicle insurance policies provide medical expense coverage and uninsured and/or underinsured motorist insurance. The term motor vehicle insurance includes medical expense coverage, personal injury protection coverage, uninsured motorist coverage, underinsured motorist coverage, or any coverage similar to any of the coverages listed prior. Benefits for health care expenses are excluded under this Plan to the extent that you or your enrolled dependent receives payments from medical expense coverage, personal injury protection coverage, uninsured motorist coverage, or underinsured motorist coverage.

Here are some rules which apply with regard to motor vehicle insurance coverage:

1. If a claim for health care expenses arising out of a motor vehicle accident is filed with the Plan and motor vehicle insurance has not yet paid, benefits for covered expenses under the Plan may be advanced as long as you or your enrolled dependent agrees in writing:
    - To give Rehn & Associates information about any motor vehicle insurance coverage which may be available to you or your enrolled dependents; and
    - To otherwise secure the Plan's rights and you or your enrolled dependent's rights.
2. If the Plan has paid benefits before motor vehicle insurance has paid, the Plan is entitled to reimbursement of the benefits it has paid out of any subsequent motor vehicle insurance recovery or payment made to or on behalf of you or your enrolled dependent.
3. If you or your enrolled dependent incurs health care expenses for treatment of the illness or injury arising out of a motor vehicle accident after receiving a recovery from uninsured or underinsured motor vehicle coverage, benefits for otherwise covered expenses under the Plan will be excluded until the total amount of health care expenses incurred after the recovery exceeds the net recovery amount (as defined in the "Third Party Liability" section of this booklet).
4. You or your enrolled dependent who was involved in a motor vehicle accident may have rights both under motor vehicle insurance coverage and against a third party who may be responsible for the accident. In that case, both this provision and the "Third Party Liability" provision in this booklet apply. However, double reimbursement will not be sought.

Third Party Liability

This provision applies when you or an enrolled dependent incurs health care expenses in connection with an illness or injury for which one or more third parties may be responsible. In that situation, benefits for otherwise covered expenses are excluded under this Plan to the extent you or your enrolled dependent receives a recovery from or on behalf of the responsible third party regardless of whether you or your enrolled dependent is made whole by recovery from the third party.

Here are some rules which apply in these third party liability situations:

1. If a claim for health care expense is filed under the Plan and you have not yet received recovery from the responsible person, benefits under the Plan may be advanced for covered expenses if you or your enrolled dependent agrees in writing to hold any recovery in trust for the Plan up to the amount of benefits paid under the Plan. You or your enrolled dependent may be required to sign an agreement guaranteeing the plan's rights to full reimbursement before any benefits under the Plan are advanced.
2. If benefits under the Plan have already been paid, the Plan will be entitled to full reimbursement of the benefits it has

paid from the proceeds of any recovery you or your enrolled dependent receives from or on behalf of the third party regardless of whether you or your enrolled dependents are made whole by recovery from the third party.

3. The Plan is entitled to full reimbursement of the benefits it has paid as explained previously regardless of whether:

   3.1 the recovery is the result of a court judgment, arbitration award, compromise settlement, or any other arrangement;

   3.2 the third party or the third party's insurer admits liability; or

   3.3 the health care expenses are itemized or expressly excluded in the third-party recovery.

The Plan will not pay any fees or costs associated with a claim/lawsuit by you or your enrolled dependent against the third party.

If you or your enrolled dependent incurs health care expenses for treatment of the illness or injury after receiving a recovery exceeding full compensation for the loss, benefits under the Plan for otherwise covered expenses will be excluded until the total amount of health care expenses incurred after the recovery exceeds the net recovery amount.

The net recovery amount is:

- The amount of the recovery; plus
- The amount you or your enrolled dependent recovered from any other source such as other insurance as a result of the illness or injury; minus
- The difference between the total amount of related third-party health expenses incurred prior to the recovery and the benefits paid under the Plan before the recovery toward such expense; minus
- The amount you or your enrolled dependent reimbursed to the Plan or other insurers or lien holders out of the recovery for benefits paid under the Plan before the recovery; minus
- The total costs paid by you or your enrolled dependent or on your or your enrolled dependent's behalf in obtaining the recovery such as reasonable attorney fees and court costs.

Workers' Compensation

This provision applies if you or your enrolled dependent has filed or is entitled to file a claim for workers' compensation. Benefits for treatment of an illness or injury arising out of or in the course of employment or self-employment for wages or profit are excluded under this Plan. The only exception would be if you or your enrolled dependent is exempt from state or federal workers' compensation law.

Here are some rules which apply in situations where a workers' compensation claim has been filed:

1. You must notify Rehn & Associates in writing within ten days of filing a workers' compensation claim.
2. If the entity providing workers' compensation coverage has denied you or your enrolled dependent's claims and you have filed an appeal, benefits under the Plan for covered expenses may be advanced if you or your enrolled dependent agrees in writing to hold any recovery you or your enrolled dependent obtains from the entity providing workers' compensation coverage in trust for the Plan up to the amount of the benefits it has paid. You or your enrolled dependent may be required to sign an agreement guaranteeing the Plan's rights to reimbursement before any benefits are advanced.
3. If the benefits under the Plan have already been paid, the Plan will be entitled to reimbursement of the benefits it has paid from the proceeds of any recovery you or your enrolled dependent receives from or on behalf of the entity providing workers compensation coverage.
4. The Plan is entitled to full reimbursement of the benefits it has paid from the proceeds of any recovery you or your enrolled dependent received from or on behalf of the entity providing workers' compensation coverage. This is so regardless of whether:

   4.1 The recovery is the result of an arbitration award, compromise settlement, or any other arrangement;

   4.2 The entity providing workers' compensation coverage admits liability; or

   4.3 The health care expenses are itemized or expressly excluded in the recovery.

5. A deduction of a proportionate share the reasonable expenses of obtaining a recovery such as attorney fees and court costs will be allowed from the amount reimbursed to the plan.

6. If you or your enrolled dependent incurs health care expenses for treatment of the illness or injury after receiving a recovery, benefits under the plan for otherwise covered expenses will be excluded until the total amount of health care expenses incurred after the recovery exceeds the net recovery amount, as defined in the "Third Party Liability" section of this booklet.

CONTINUATION OF COVERAGE - COBRA

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This outline is intended only to summarize your rights and obligations under the law. The Plan offers no greater COBRA rights than what the COBRA statute requires and this Notice should be construed accordingly.

The Consolidated Omnibus Budget Reconciliation Act of 1985, Public Law 99-272 (COBRA) is a federal law that applies to employers of twenty (20) or more employees. This law gives enrolled Members the right, in certain circumstances, to continue coverage under their employer's health plan for a limited time beyond the date coverage would otherwise have been terminated. Continued coverage is not automatic. Under COBRA, a qualified individual must apply for continued coverage within a certain time period and may also have to pay the full cost for the coverage plus 2%.

References below to the "Plan Administrator" generally refer to your employer and references to the COBRA Administrator refer to Rehn & Associates.

Conditions for Continuation of Coverage under COBRA

1. For COBRA continuation coverage to become effective, all of the following requirements must be satisfied:
   - The qualified individual(s) must elect continued coverage no more than thirty (30) days after either the date coverage was to end because of a "qualifying event", or the date he or she is notified of the right to continue coverage, whichever is later.
   - The qualified individual(s) must send the initial required premium payment to the COBRA Administrator, not more than forty-five (45) days after the date he, she, or they have elected continued coverage.
   - Subsequent required premiums must be paid monthly to the COBRA Administrator.
2. A qualified individual must be notified of his or her rights under COBRA within forty-four (44) days of the date the Plan Administrator receives notice of the qualifying event.
3. The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan or COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment or death of the employee, the employer must notify the Plan Administrator of the qualifying event within sixty (60) days of any of these events.
4. For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan or COBRA Administrator. The Plan requires you to notify the Plan or COBRA Administrator within sixty (60) days after the qualifying event occurs.

Qualifying Events:

1. COBRA may be elected for up to eighteen (18) consecutive calendar months for an employee and his or her covered dependents if the "qualifying event" is that:
2. The employee's work hours are reduced resulting in a loss of eligibility for medical benefits; or,
3. The employee's employment terminates (voluntary or involuntary) for reasons other than gross misconduct.
4. If the individual continuing coverage is determined to be disabled (under Title II (OASDI), within sixty (60) days of the "qualifying event," or Title XVI (SSI) of the Social Security Act) on the date of the "qualifying event" identified above, he or she may elect COBRA for up to a total of twenty-nine (29) consecutive calendar months from the date of the "qualifying event." To be eligible for the extended continuation period, the individual must present a copy of the disability determination to the COBRA Plan Administrator, during the initial eighteen (18) month period and no later than sixty (60) days after the individual receives the disability determination.
5. COBRA may be elected for up to thirty-six (36) consecutive calendar months for the covered spouse or dependent children if the qualifying event resulting in loss of medical coverage is:
6. The death of the employee;

7. The employee and spouse legally separate or divorce;
8. A child loses eligibility for dependent coverage (for example: age limitation or marriage)
9. In addition, the occurrence of one of these events during the initial eighteen (18) month period described above can extend that period for a continuing dependent up to 36 months.

COBRA Election Period

1. Once the Plan or COBRA Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.
2. You (the employee) or your qualified beneficiaries must elect continuation coverage within sixty (60) days after Plan coverage ends, or, if later, 60 days after the Plan or COBRA Administrator sends you notice of the right to elect continuation coverage. If you or your family-member does not elect continuation coverage within this sixty (60) day election period, you will lose your right to elect continuation coverage. Your (or your qualified beneficiaries) election, if mailed, is effective on the day the election is sent (post-marked) to the COBRA Administrator.
3. Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only.
4. In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a sixty-three (63) day gap in health coverage, and election of continuation coverage 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 pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within thirty (30) days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Notices Required

1. The Plans provide that your spouse’s coverage terminates as of the last day of the month in which a divorce or legal separation occurs. A dependent child’s coverage terminates the last day of the month in which he or she ceases to be an eligible dependent under the Plans (for example, after attainment of a certain age). You (the employee) or a qualified beneficiary have the responsibility to notify the Plan or COBRA Administrator upon a divorce or legal separation, or a child losing dependent status within sixty (60) days after the later of the qualifying event or the date coverage is lost. If the qualifying event is a divorce or legal separation, you must present a copy of the divorce decree or proof of legal separation during the sixty (60) day notice period. If you or a family member fails to notify the Plan or COBRA Administrator during the sixty (60) day notice period, any family member who loses coverage will NOT be offered the option to elect continuation coverage. Further, if you or a family member fail to notify the Plan or COBRA Administrator, and contrary to Plan terms any claims are paid mistakenly for expenses incurred after the last day of the month of the divorce or legal separation or child losing dependent status, then you and your qualifying family members will be required to reimburse the Plans for any claims paid.
2. You (the employee) or your qualified beneficiaries must also notify the COBRA Administrator within thirty (30) days if, after electing COBRA coverage you or a qualified beneficiary becomes covered under another group health plan. Further, if you or a qualified beneficiary fails to notify the COBRA Administrator, and contrary to Plan terms any claims are paid mistakenly for expenses incurred, then you and your qualified beneficiaries will be required to reimburse the Plans for any claims paid.
3. Once the Plan or COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, and pays the required premium, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost.

4. COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, or dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

5. When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

COBRA Payment Procedures

1. Once your COBRA Administrator, has received your correctly completed COBRA election (or enrollment) form, the selections chosen will confirm that you wish to continue coverage under the COBRA plan. Coverage is not activated until payment is received even if the election form is received within the election deadline. As stated above, COBRA payments are due within the first forty-five (45) days after your sixty (60) day election period.

2. Rehn & Associates is your COBRA Administrator, so the following procedures apply: Your COBRA payment is due (in full) the first (1st) of each month to the COBRA Administrator. Premium payments will have a thirty-one (31) day grace period. On the first (1st) day of each month, your eligibility status will be set as Terminated until your premium payment for that month is received. Once received, your eligibility status will be set as Effective retroactively back to the first (1st) day of that month and extending until the last day of that month. If your premium payment is not delivered or postmarked within the grace period, your coverage will be terminated back to the last day of the month for which we received a full premium payment. Payments by bounced checks indicating non-sufficient funds do not constitute payment. If funds are not made available by the end of the grace period, coverage will be terminated back to the last day of the month for which full payment was received.

3. COBRA premiums and benefits are subject to change at any time during the plan year. In the event of a premium or benefit change, you will be notified with new premiums and benefits. Upon yearly plan renewal, you will receive a letter listing updated premiums.

Premium Payments

1. Each qualified beneficiary will be required to pay the entire cost of continuation coverage. The premium you will be charged will not be more than 102% of the total cost of providing coverage. The premium for an extension of continuation coverage due to a disability can be as much as 150% of the cost of coverage for the 19th through 29th months of coverage.

2. If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage to the COBRA Administrator, within forty-five (45) days after the date of your election. (This is the date the Election Notice is post-marked, if mailed). If you do not make your first payment for continuation coverage within those forty-five (45) days, you will lose all continuation coverage rights under the Plan.

3. Your first payment for continuation coverage must cover the cost of continuation coverage from the time your coverage under the Plans would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period.

4. All other premiums are due (in full) the first (1st) of each month. Premium payments will have a thirty-one (31) day grace period, which will not be extended for holidays or weekends. A premium payment is made on the date it is sent (post-marked). The Plans will not send periodic notices of payments due for these coverage periods.

The Trade Act

1. The Trade Act of 2002 amended ERISA. This amendment created a new tax credit for certain individuals who became eligible for trade adjustment assistance (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualifying health insurance, including continuation coverage. If you have questions about these tax provisions, you may call the Health Care Tax Credit Customer Contact Service Center toll-free at (866) 626-4282. More information about the Trade Act is also available at http://www.doleta.gov/tradeact/2002act_index.cfm.

2. The new second COBRA election period is intended to assist individuals who become TAA-eligible in taking advantage of a new tax credit, also created by the Trade Act of 2002. Under the new tax provisions, individuals who become eligible for TAA assistance can take a tax credit of premiums paid for qualified health insurance. The Trade Act of 2002 provides for advance payment of the tax credit to health insurers, beginning in 2003. COBRA continuation coverage is one of the types

of health insurance that qualifies for the tax credit.

Maximum Length of COBRA Coverage

1. Thirty-six (36) Months: When the qualifying event is the death of the employee, your divorce or legal separation, or a dependent child ceasing to be a dependent under the terms of the plan, COBRA continuation coverage lasts for up to thirty-six (36) months.

2. Eighteen (18) Months: If you or your qualified beneficiaries lose group health coverage due to termination of employment (other than for gross misconduct) or reduction in hours of employment, coverage may be continued for up to eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability extension of eighteen (18) month period of continuation coverage

If you or your qualified beneficiaries covered under the Plans is determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage, you and your family can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The Social Security Administration must formally determine under Title IX (Old Age, Survivors, and Disability Insurance) or Title XVI (Supplemental Security Income) of the Social Security Act that the disability exists and when it began. For the twenty-nine (29) month continuation coverage period to apply, the qualified beneficiary must present the COBRA Administrator with a copy of the Social Security Determination of Disability within sixty (60) days of the date of the determination and before the end of the original eighteen (18) month period that applies to the qualifying event. If these procedures are not followed or if the notice is not provided to the Plan Administrator within the required period, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA CONTINUATION COVERAGE. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the COBRA Administrator of that fact within thirty (30) days of SSA's determination. Further, if you or a family member fails to notify the COBRA Administrator, and contrary to Plan terms any claims are paid mistakenly for expenses incurred, then you and your qualified beneficiaries will be required to reimburse the Plans for any claims paid.

Second qualifying event extension of eighteen (18) month period of continuation coverage

1. Eighteen (18) month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first eighteen (18) months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is thirty-six (36) months from the date of the initial termination of employment or reduction in hours. Such second qualifying events 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 Plans. You must notify the COBRA Administrator of the second qualifying event within sixty (60) days of the second qualifying event (see Notices Required). If these procedures are not followed or if the notice is not presented to the Plan Administrator within the required sixty (60) day period, THEN THERE WILL BE NO EXTENSION OF COBRA CONTINUATION COVERAGE DUE TO A SECOND QUALIFYING EVENT.

2. An event cannot be a 2nd qualifying event entitling a qualified beneficiary to extended COBRA coverage unless the event would have caused a loss of coverage under the plans.

3. In no event will continuation coverage last beyond thirty-six (36) months from the date of the original qualifying event. The thirty-six (36) months is counted from the date of the first qualifying event.

Children Born or Placed for Adoption after the Qualifying Event

If, during the period of continuation coverage, a child is born to the covered employee or is placed for adoption with the covered employee and the covered employee has elected continuation coverage for himself or herself, the child is considered a qualified beneficiary. The covered employee or other guardian has the right to elect continuation coverage for the child, provided the child satisfies the otherwise applicable plan eligibility requirements (for example, age). The covered employee or a family member must notify the Plan Administrator within sixty (60) days of the birth, adoption or placement to enroll the child on COBRA and COBRA coverage will last as long as it lasts for other family members of the employee. (The thirty (30) day period is the Plans normal enrollment window for newborn or adopted children.) If the covered employee or family member fails to notify the Plan Administrator in a timely fashion, the covered employee will NOT be offered the option to elect COBRA coverage for the newborn or adopted child.

Open Enrollment Rights and HIPAA Special Enrollment Rights

Qualified beneficiaries who have elected COBRA will be given the same opportunity to change their coverage option or add or drop dependents at open enrollment as similarly situated active employees. In addition, HIPAA's special enrollment rights will apply to those who have elected COBRA. HIPAA, a federal law, gives a person already on COBRA certain rights to add

dependents if such person acquires a new dependent (through marriage, birth, adoption or placement for adoption), or if an eligible dependent declines coverage because of other coverage and then later loses such coverage due to certain qualifying reasons. Except for children described above under Children Born or Placed for Adoption after the Qualifying Event, dependents that are added under HIPAA's special enrollment rights do not become qualified beneficiaries -their coverage will end at the same time coverage ends for the person who elected COBRA and later added them.

Termination of Continued Coverage (COBRA)

1. You and your qualified beneficiaries have the obligation to notify the COBRA Administrator within thirty (30) days after becoming covered under another group health plan. The Plan reserves the right to retroactively cancel COBRA coverage and to seek reimbursement of all benefits paid after that point in the event that you or any qualified beneficiary fails to notify the COBRA Administrator of the new coverage.
2. Continued coverage will end on the last day for which required contributions have been paid in the monthly period in which the first of the following occurs:
    - The applicable continuation period expires.
    - The next monthly required contribution is not paid when due or within the grace period.
    - For an individual whose coverage has been extended from eighteen (18) months to twenty-nine (29) months due to disability, continued coverage beyond eighteen (18) months ends if there is a final determination that the individual is no longer disabled under the Social Security Act. However, coverage will not end on the date indicated above, but on the last day for which required contributions have been paid in the first month that begins more than thirty (30) days after the date of the determination.
    - The individual subsequently becomes covered under another group health care program. Note that under HIPAA, a federal law, exclusion or limitation of the other group health plan might not apply at all to the qualified beneficiary, depending on the length of his or her creditable health plan coverage prior to enrolling in the other plan.
    - The employer no longer offers health coverage to any employee.
    - Occurrences of any event (e.g., submission of fraudulent benefit claims) that permits termination of coverage for cause with respect to covered employees or their spouses for a reason other than the COBRA coverage requirements of federal law.

Deadlines to Remember

1. You must notify the Plan or COBRA Administrator of a newborn child, or child placed for adoption in your home within thirty (30) days of the birth/placement or the child will not be offered the option to elect COBRA coverage.
2. You or your dependents must notify the Plan or COBRA Administrator of a divorce, legal separation, or a child's loss of dependent status within thirty-one (31) days of the event.
3. Upon termination of health plan coverage, immediately advise your Plan or COBRA Administrator if you desire continued coverage under COBRA. Complete instructions on how to elect continuation coverage will be given to you within fourteen (14) days of the date you provide the Plan or COBRA Administrator with timely notice of the "qualifying event." The person(s) eligible to continue coverage then has sixty (60) days in which to elect continuation.
4. After you elect COBRA continuation for you or your dependents, you have forty-five (45) days from the date of the election in which to pay the premium owed for continuous coverage during the period preceding the election (for example: back to the time of the "qualifying event"). Premium payments should be paid to the COBRA Administrator.

Keep Your Plan Informed of Address Changes

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

HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA), Pub. L. 104-191 was enacted on August 21, 1996. HIPAA amended the Public Health Service Act (PHS Act), the Employee Retirement Income Security Act of 1974 (ERISA), and the Internal Revenue Code of 1986 (CODE) to provide for, among other things, improved portability and continuity of health insurance coverage in the group and individual insurance markets, and group health plan coverage provided in connection with employment. Sections 102(c)(4), 101(g)(4) and 401 (c)(4) of HIPAA require the Secretaries of Health and Human Services,

Labor and the Treasury each to issue regulations necessary to carry out these provisions.

The Law

- provides credit for prior health coverage and a process for providing certificates concerning prior coverage to a new group health plan or issuer;
- provides new rights that allow individuals to enroll for health coverage when they lose other health coverage or add a new dependent;
- prohibits discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors;
- guarantees availability of health insurance coverage for small employers and renewability of health insurance coverage in both the small and large group markets; and,
- preserves the states' role in regulating health insurance, including the states' authority to provide greater protections.

HIPAA Rules

The Health Insurance Portability and Accountability Act (HIPAA) offers protection for millions of American workers that improve portability and continuity of health insurance coverage.

HIPAA Protects Workers and Their Families By

- Providing new rights that allow individuals to enroll for health coverage when they lose other health coverage, get married or add a new dependent.
- Prohibiting discrimination in enrollment and in premiums charged to employees and their dependents based on health status-related factors.
- Guaranteeing availability of health insurance coverage for small employers and renewability of health insurance coverage for both small and large employers.
- Preserving the states' role in regulating health insurance, including the states' authority to provide greater protections than those available under federal law.

Rules published by the Departments of Labor, Health and Human Services, and the Treasury provide guidance to both employees and employers with respect to these HIPAA provisions in the following areas:

Creditable Coverage

- Includes prior coverage under another group health plan, an individual health insurance policy, COBRA, Medicaid, Medicare, CHAMPUS, the Indian Health Service, a state health benefits risk pool, FEHBP, the Peace Corps Act, or a public health plan.

Certificates of Creditable Coverage

- Certificates of creditable coverage must be provided automatically and free of charge by the plan or issuer when an individual loses coverage under the plan, becomes entitled to elect COBRA continuation coverage or exhausts COBRA continuation coverage. A certificate must also be provided free of charge upon request while you have health coverage or anytime within 24 months after your coverage ends.
- Certificates of creditable coverage should contain information about the length of time you or your dependents had coverage as well as the length of any waiting period for coverage that applied to you or your dependents.
- For plan years beginning on or after July 1, 2005, certificates of creditable coverage should also include an educational statement that describes individuals' HIPAA portability rights. A new model certificate is available on EBSAs Web site.
- If a certificate is not received, or the information on the certificate is wrong, you should contact your prior plan or issuer. You have a right to show prior creditable coverage with other evidence — like pay stubs, explanation of benefits, letters from a doctor — if you cannot get a certificate.

Special Enrollment Rights

- Are provided for individuals who lose their coverage in certain situations, including on separation, divorce, death, termination of employment and reduction in hours. Special enrollment rights also are provided if employer contributions toward the other coverage terminates.
- Are provided for employees, their spouses and new dependents upon marriage, birth, adoption or placement for adoption.

Discrimination Prohibitions

- Ensure that individuals are not excluded from coverage, denied benefits, or charged more for coverage offered by a plan or issuer, based on health status-related factors.

HIPAA PRIVACY NOTICE

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.

The Plan commitment to privacy:
The privacy of your personal health information is important to the Plan. To effectively manage your health benefits, the Plan must collect and share personal health information (PHI). PHI shall have the same definition as set forth in the Privacy Standards (45 CFR Part 164), but generally shall mean individually identifiable health information about the past, present or future physical or mental health condition of an individual, including information about treatment or payment for treatment. The Plan considers PHI private, and the Plan has policies and procedures in place to make sure that only the minimum amount of information necessary is shared with those parties who have a legitimate business need for the information. This notice provides you with important information about the Plan privacy policies including what types of PHI we collect, what types of PHI we may disclose and to whom we may disclose PHI.

What information does the Plan collect?

The Plan must collect personal health information about you and your dependents in order to provide health care services to you. This information may come to us in writing, in person, by telephone or electronically. This information may include:

1. Application information including items such as your name, address, social security number, birth date, and employment status. We may receive this information directly from you or through your health plan's sponsor.
2. Information regarding transactions that occur during your relationship with us, including medical claims information, clinical case management information, payment information, service inquiries and appeals information.
3. Health information about you relating to treatment, needed to obtain payment for treatment or for administrative purposes, or necessary to evaluate the quality of the care that you receive.

How does the Plan protect information?

Rehn & Associates is your health plan's third party administrator. The Plan restricts access to PHI to those employees of Rehn & Associates who need the information to provide health plan services to you and your family. The Plan maintains the highest physical and electronic security safeguards to protect your information against unauthorized access. The Plan takes privacy very seriously. The Plan has a Privacy Committee whose responsibility is to develop procedures to support this endeavor, to educate the Plan staff and to test and enforce these mechanisms to protect privacy.

The Plan is required by law to maintain the privacy of protected health information and to provide affected individuals with notice of its legal duties and privacy practices with respect to PHI. The Plan does not disclose PHI, except as permitted by law. The Plan will disclose information during normal health plan operations to help ensure that you receive the care that you need, or as required to secure payments for the services or benefits you receive. When the Plan is required to disclose information, specific policies and practices are followed to ensure that the party the Plan releases information to be whom they say they are and that they have a legitimate need for that information. Then only the minimum amount of information required is released. Any party with whom the Plan shares your information is required to keep this information confidential as required by law. Information that is publicly available or that is reported in aggregate (a summary across a population that cannot identify individuals) is not considered PHI.

To whom is PHI disclosed, and why?

The Plan is permitted to use and disclose protected health information without your authorization for treatment, payment and health care operations. Examples of when the Plan is permitted to use and disclose PHI and the data shared with a third party include:

For Treatment, Payment and Health Care Operations, the Plan may use and disclose protected health information for treatment, payment and health care operation activities. The Plan may disclose protected health information for the treatment activities of any health care provider, payment activities of any health care provider, or the health care operations of a health care provider if both health care Providers have or had a relationship with you and the protected health information pertains to the relationship.

1. For Treatment. Treatment is the provision, coordination or management of health care and related services for an individual by one or more health care Providers. The Plan may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, pharmacist or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care Providers to determine what treatment you should receive. Health care Providers will also record actions taken by them in the course of your treatment and note how you respond to the actions.
2. For Payment. The Plan may use and disclose your health information to others for purposes of processing payment for treatment and services that you receive. “Payment” generally shall mean activities taken to determine or fulfill Plan responsibilities with respect to eligibility, coverage, provision of benefits, or reimbursement for healthcare. The information on a bill may contain information that identifies you, your diagnosis and treatment or supplies used in the course of treatment. This includes the management of your health benefits and the authorization of payments for health care may require that the Plan release information to Providers, provider network organizations, or an excess loss insurance company. This exchange usually includes benefit information and / or PHI history that the Plan has on file. The Plan will always work to ensure that the information released is limited to what is needed for the current inquiry, that it facilitates your care or your benefits and that it is not used for any other purpose.
3. For Health Care Operations. The Plan may use and disclose health information about you for operational purposes. For example, your health information may be disclosed for:
    - Quality assessment and improvement activities, including case management and care coordination.
    - Competency assurance activities, including provider or health plan performance evaluation, credentialing and accreditation
    - Conducting or arranging for medical reviews, audits or legal services, including fraud and abuse detection and compliance programs
    - Specified insurance functions, such as underwriting, risk rating and reinsuring risk
    - Business planning, development, management and administration
    - Performing utilization review or for structuring wellness and disease management programs. Educational materials and screening reminders may be sent to Plan members. The Plan may also perform risk assessments and identify and contact those who may benefit from disease management programs.
    - Licensing, auditing and / or quality assurance programs may require the release of randomly selected records to an audit or accreditation organization or a federal or state agency.
    - For Public Interest and Benefit Activities. The Privacy rule permits use and disclosure of protected health information, without an individual's authorization or permission, for 12 national priority purposes. These disclosures are permitted, although not required, by the Rule in recognition of the important uses made of health information outside the health care context. Specific conditions or limitations apply to each public interest purpose, striking the balance between the individual privacy interest and the public interest need for this information.
    - As Required by Law. The Plan may use and disclose information about you as required by law.
    - Cadaveric Organ, Eye or Tissue Donation. The Plan may use or disclose protected health information to facilitate the donation and transplantation of cadaveric organs, eyes and tissue.
    - Decedents. The Plan may disclose protected health information to funeral directors as needed, and to coroners or medical examiners to identify a deceased person, determine the cause of death, and perform other functions authorized by law.
    - Essential Government Functions. Your health information may be disclosed for specialized government functions such a protection of public officials or reporting to various branches of the armed services.

- For a Serious Threat to Health or Safety. The Plan may disclose protected health information that they believe is necessary to prevent or lessen a serious and imminent threat to a person or the public, when such disclose is made to someone they believe can prevent or lessen the threat (including the target of the threat). Covered entities may also disclose the law enforcement if the information is needed to identify or apprehend an escapee or violent criminal.
- For judicial and administrative proceedings pursuant to legal authority;
- Health oversight activities. To report to health oversight agencies for purposes or legally authorized audits and investigations necessary for oversight of the health care system.
- Law Enforcement Purposes. The Plan may disclose protected health information to law enforcement officials for law enforcement purposes under the following six circumstances, and subject to specified conditions: (1) as required by law (including court orders, court-ordered warrants, subpoenas) and administrative requests; (2) to identify or locate a suspect, fugitive, material witness, or missing person; (3) in response to a law enforcement official's request for information about a victim or suspected victim of a crime; (4) to alert law enforcement of a person's death, of the covered entity suspects that criminal activity caused the death; (5) when a covered entity believes that protected health information is evidence of a crime that occurred on its premises; and (6) by a covered health care provider in a medical emergency not occurring on its premises, when necessary to inform law enforcement about the commission and nature of a crime, the location of the crime or crime victims, and the perpetrator of the crime.
- Public Health Activities. The Plan may disclose protected health information to: (1) public health authorities authorized by law to collect or receive such information for preventing or controlling disease, injury, or disability and to public health or other government authorities authorized to receive reports of child abuse and neglect; (2) entities subject to FDA regulation regarding FDA regulated products or actives for purposes such as adverse event reporting, tracking of products, product recalls, and post-marketing surveillance; (3) individuals who may have contracted or been exposed to a communicable disease when notification is authorized by law; and (4) employers, regarding employees, when requested by employers for information concerning a work-related illness or injury or workplace related medical surveillance, because such information is needed by the employer to comply with the Occupational Safety and Health Administration (OSHA), the Mine Safety and Health Administration (MHSA) or similar state law.
- Research. The Plan may use your health information for research purposes when an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your health information has approved the research.
- Victims of abuse, neglect or domestic violence. In certain circumstances, the Plan may disclose protected health information to appropriate government authorities regarding victims of abuse, neglect, or domestic violence.
- Workers' Compensation. Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.
- Other uses:
    - Enrollment information; such as your name, address, plan name and coverage dates may be released to your pharmacy benefits carrier or other organizations responsible for delivering or administering a portion of your health care.
    - The Plan may also share information to facilitate the change over or acquisition of your health plan to another insurer or Third Party Administrator (TPA).
    - If the Plan uses or discloses your PHI for any reason other than treatment, payment or healthcare operation, as defined in the Privacy Standard, it must first obtain your written authorization. Once you provide the authorization, you may revoke it at any time.

What does this mean to me?

Every effort is made to protect your PHI and the trust you have placed in the Plan. You should be aware, however, that in the course of administering your health benefits, PHI must be disclosed. Disclosure is permitted only when required or allowed by law. The Plan considers the activities described in the previous section key for the management of your health plan. The Plan also recognizes that many people do not want to receive marketing materials based upon their health plan participation or health history. The Plan does not participate in this type of activity and would seek your special consent before disclosing your information.

HEALTH INFORMATION RIGHTS

You have the right to:

1. Request a restriction on certain uses and disclosures of your PHI. However, the Plan is not required to agree to a requested restriction.
2. Inspect and copy your PHI that is held by the Plan.
3. Amend your PHI, if appropriate.
4. Obtain a paper copy of the notice of information practices upon request.
5. Request an accounting of the disclosures of their protected health information by the Plan. The maximum disclosure accounting period is the six years immediately preceding the accounting request. The Privacy Rule does not require accounting for disclosures:

   For treatment, payment, or health care operations. This includes

   - To the individual or the individual's personal representative
   - For notification or of to persons involved in an individual's health care or payment for health care
   - For national security or intelligence purposes
   - To correctional institutions or law enforcement officials for certain purposes regarding inmates or individuals in lawful custody, or
   - Incident to an otherwise permitted or required uses or disclosures.

6. Disclosure of information regarding members who are no longer enrolled in the health plan;
   - The Plan policies, for the protection of PHI, remain in effect even after you terminate from the Plan. The Plan will retain your records and administer your benefits retroactively for as long as required by law.

What if I believe this Privacy Policy is violated?

Your privacy is important to the Plan. The Plan has systems and policies in place to prevent the unlawful or accidental disclosure of your information. If you believe that this policy has been violated or if you believe there has been an inappropriate or unauthorized disclosure of your PHI, please let the Plan know. You will not be retaliated against for filing a complaint. Please submit your complaint in writing to the Plan. You may also call in, or call to request additional information. Complaints can also be submitted to the Secretary of Health and Human Services. Please direct any concerns or complaints to the Plan Privacy Officer. Please see the General Information section located at the end of this document.

Changes or Updates to this Privacy Notice

This notice reflects our current privacy policies and practices. The Plan is required to abide by the terms of the notice currently in affect. However, the Plan reserves the right to amend this notice and make the new policy provisions effective for all protected health information that it maintains. Any material change in the information collected or disclosed will result in a revised notice. As a member, you will receive an updated notice regarding our privacy policies annually or at the time of any significant change. The original effective date of this Notice was December 1, 2008. If you have any questions or wish to receive any additional information regarding the Privacy Policy, please contact the Plan Privacy Officer.

GENERAL PLAN INFORMATION

The Employee Retirement Income Security Act of 1974 (ERISA) requires that the following information be furnished to you.

Name of Plan
Community Connections, Inc. HSA Health Care Plan.

Employer Identification Number "EIN":
92-0112719

Original Effective Date:
January 1, 2016

Type of Plan
This Plan can be described as a health care plan that provides medical, surgical, hospital and pharmacy benefits for a health plan document.

Type of Administrator
Administered by the Plan sponsor in accordance with the summary plan description, administrative agreement and business associate agreements. Claims to be processed for benefits are sent to Rehn & Associates, Inc. The Plan sponsor (not Rehn & Associates, Inc.) is responsible for paying claims.

Source of Contribution
The plan is funded through employer and employee contributions.

Funding Medium
This Plan is partially self-funded. Partially Self-funded medical claims for employees and their dependents are paid in part by the employer's general assets and in part by employees' payroll deductions.

Calendar Year
The Calendar Year for this plan ends December 31st each year. Each twelve (12) month period commencing on January 1st, consists of an entire Calendar Year for the purposes of accounting and all reports to the United States Department of Labor and other regulatory bodies.

Contact Information of Plan Administrator/Sponsor/Fiduciary
Community Connections Inc.
721 Stedman Street
Ketchikan, AK 99901

Name and Address of Plan Excess Loss Reinsurer
HCC Life Insurance Company
11100 Wayzata Blvd Suite 350
Minnetonka MN 55305

Agent for Services of Legal Process
The Health Care Plan Administrator may be served with process. Please serve legal process (e.g., subpoena) to:

Community Connections Inc.
721 Stedman Street
Ketchikan, AK 99901

Cobra Administrator
Community Connections Inc.
721 Stedman Street
Ketchikan, AK 99901

Third Party Administrator
Rehn & Associates, Inc.
1322 N Post
Spokane. WA 99201
Phone (509) 534-0600
Toll Free (800) 872-8979
Website: www.rehnonline.com

Hours of operation (Pacific Standard Time):
Monday through Thursday from 8:00 a.m. to 5:00 p.m.
Friday 8:00 a.m. to 4:00 p.m.

Utilization Management / Case Management
Medical Rehabilitation Consultants
111 W Cataldo Ave # 200
Spokane, WA 99201
Phone (509) 328-9700
Fax (509) 328-9777
Hours of operation (Pacific Standard Time):
Monday through Friday from 8:00 a.m. to 5:00 p.m.

Appeals Department
Rehn & Associates, Inc.
1322 N Post
Spokane. WA 99201
Phone (509) 534-0600
Toll Free (800) 872-8979
Website: www.rehnonline.com
Hours of operation (Pacific Standard Time):
Monday through Thursday from 8:00 a.m. to 5:00 p.m.
Friday 8:00 a.m. to 4:00 p.m.

The Plan Privacy Officer
Rehn & Associates, Inc.
1322 N Post
Spokane. WA 99201
Phone (509) 534-0600
Toll Free (800) 872-8979
Website: www.rehnonline.com
Hours of operation (Pacific Standard Time):
Monday through Thursday from 8:00 a.m. to 5:00 p.m.
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