CITY OF BELLEVUE

HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

January 1, 2018

This document is not intended to provide legal advice and should not be relied upon in that regard. Accordingly, you should consult with your own legal advisers regarding compliance with applicable laws.

CITY OF BELLEVUE
HEALTH AND WELFARE PLAN
SUMMARY PLAN DESCRIPTION

TABLE OF CONTENTS

INTRODUCTION ... 1

ADMINISTRATIVE INFORMATION ... 1

ELIGIBILITY ... 2

DETERMINATION OF FULL-TIME EMPLOYEES ... 2

PAYMENTS FROM THIRD PARTIES ... 2

CONTINUATION RIGHTS/COBRA NOTICE ... 3
- Qualifying Events ... 4
- Continuing Coverage ... 4
- Notice ... 4
- Election Procedures and Deadlines ... 5
- Cost of COBRA Continuation Coverage ... 5
- When Continuation Coverage Ends ... 5

AMENDMENT AND TERMINATION ... 5

INCLUDED BENEFIT DOCUMENTS INCORPORATED BY REFERENCE ... 5

CLAIMS PROCEDURES ... 6
- In General ... 6
- Timing of Notice of Claim ... 6
- Group Health Plan Claims ... 6
- Content of Notice of Adverse Benefit Determination ... 8
- Appeal of Adverse Benefit Determination ... 9
- Denial of Appeal ... 12
- External Claims Process ... 13

REFUNDS/INDEMNIFICATION ... 13

MILITARY SERVICE ... 13

FMLA ... 13

QUALIFIED MEDICAL CHILD SUPPORT ORDERS ... 13

WOMEN'S HEALTH AND CANCER RIGHTS ACT ... 14

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT ... 14

LOSS OF BENEFIT ... 14

NON-ALIENATION ... 14

PLAN ADMINISTRATION DISCRETION ... 14

GRANDFATHERED HEALTH PLAN ... 15

WELFARE BENEFIT PLAN CHART ADDENDUM ... 16

APPENDIX: DETERMINATION OF FULL-TIME EMPLOYEES ... 18

INTRODUCTION

City of Bellevue (the "Employer") established the City of Bellevue Health and Welfare Plan (the "Plan") effective since 1985 and the Plan has been amended and restated effective January 01, 2018. This summary describes the Plan and together with the incorporated documents, describes the benefits offered under the Plan (the "Included Benefits").

This Summary Plan Description supersedes any and all previous Summary Plan Descriptions. Although the purpose of this document is to summarize the more significant provisions of the Plan, the Plan document and Included Benefit Documents will prevail in the event of any inconsistency.

ADMINISTRATIVE INFORMATION

1. The Plan's name is City of Bellevue Health and Welfare Plan
   The Plan Year End is the 12 month period ending on December 31

   This Plan is not intended to comply with the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

2. The Plan Sponsor is City of Bellevue
   450 110th Avenue NE
   Bellevue, Washington, 98004
   Email: mrobinson@bellevuewa.gov
   Human Resources Department: 425-452-6838
   Employer Identification Number: 91-6007020
3. The Plan Administrator is the Employer
   450 110th Avenue NE
   Bellevue, Washington, 98004
   Human Resources Department: 425-452-6838
   Email: mrobinson@bellevuewa.gov
4. The Claims Administrator for each benefit will be the respective insurance provider or third-party administrator of the benefit. Contact information for the insurance provider or third-party administrator can be found in the Welfare Benefit Plan Chart Addendum.
5. The agent for legal service is City Attorney
   450 110th Avenue NE
   Bellevue, Washington, 98004

   Service of legal process may also be made upon the Plan Administrator.
6. The Plan is not funded by a trust.
7. Funding
   The cost of benefits offered under the Plan is either covered by contributions from the Employer, contributions

by you, or will be shared by you and the Employer. Where you and the Employer share the cost of coverage, the Employer will contribute the difference between your premium and the amount required to pay benefits under the Plan.

Any dividends, retroactive rate adjustments, rebates, or other refunds of any type that may become payable under any Included Benefit or in connection with an Included Benefit do not become assets of the Plan but are the property of, and will be retained by, the Employer unless otherwise mandated by law.

8. The COBRA contact is: Navia Benefit Solutions
   P.O. BOX 3961 Seattle, WA 98124
   Phone: 425-452-3490

ELIGIBILITY

Your eligibility for participation and for benefits under the Plan is described in the documents summarizing the Included Benefits. These documents are available from the Plan Administrator. See the addendum to this Plan document for the list of the eligibility requirements.

DETERMINATION OF FULL-TIME EMPLOYEES

See Appendix: Determination of Full-Time Employees to determine individual eligibility for health benefits under the group health and welfare benefits plan for purposes of the Patient Protection and Affordable Care Act ("PPACA").

PAYMENTS FROM THIRD PARTIES

The Plan has a specific and first right of reimbursement from any payment, amount, or recovery you receive from a third party relating to expenses covered by the Plan. By accepting the benefits of the Plan, you agree to these rights of the Plan, which are described in the Plan document. Below is a summary of these rights. If the reimbursement provisions in this "Payments from Third Parties" provisions conflict with subrogation, right of recovery, or reimbursement provisions in an insurance contract or other document governing the Included Benefit at issue, the provisions in the other document will govern.

The Plan's share of the recovery will not be reduced because the full damages or expenses claimed have not been reimbursed unless the Plan agrees in writing to the reduction. Further, the Plan's right to reimbursement will not be affected or reduced by any equitable defenses that may affect the Plan's right to reimbursement.

The Plan may enforce its rights by requiring you to assert a claim to any of the benefits to which you may be entitled. The Plan will not pay your attorneys' fees or costs associated with the claim or lawsuit without express written authorization from the Employer.

If the Plan should become aware that a Participant has received a third party payment, amount or recovery and not reported such amount, the Plan, in its sole discretion, may suspend all further benefits payments related to the Participant and any covered dependents until the reimbursable portion is returned to the Plan or offset against

amounts that would otherwise be paid to or on behalf of the Participant.

By participating in the Plan, you consent and agree:

- that a constructive trust, lien or an equitable lien by agreement in favor of the Plan exists with regard to any settlement or recovery from a third person or party.
- to cooperate with the Plan in reimbursing the Plan for costs and expenses.
- to notify the Plan if you have any reason to believe that the Plan may be entitled to recovery from any third party and to sign an agreement that confirms the prior acceptance of the Plan's subrogation rights and the Plan's right to be reimbursed for expenses arising from circumstances that entitle you payment, amount or recovery from a third party.
- to not assign your rights to settlement or recovery against a third person or party to any other party, including your attorney(s), without the Plan's consent.

If you fail or refuse to execute the required agreement, the Plan may deny payment of any benefits until the agreement is signed. Alternatively, if you fail or refuse to execute the required agreement and the Plan nevertheless pays benefits to you, your acceptance of such benefits shall constitute agreement to the Plan's right to subrogation or reimbursement.

The Plan's reimbursement will not be reduced by attorneys' fees and expenses without express written authorization from the Plan.

These rights apply even after you are no longer a Participant in the Plan. The Plan Administrator has the authority and discretion to resolve all disputes regarding the Plan's subrogation and reimbursement rights and to make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

CONTINUATION RIGHTS/COBRA NOTICE

The right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan, was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review, the documents describing the Included Benefits, this Summary Plan Description, or contact the Plan Administrator.

If you are participating in an Included Benefit subject to COBRA and the Employer is not a small employer, then COBRA applies. A "small employer" is generally an employer that employs at least 20 employees, but you should contact the Plan Administrator who can inform you if the Employer is a small employer not subject to COBRA and is not required to comply with these rules.

Should you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage. You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and

lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

Except as set forth in an Included Benefit document, the following shall apply only to the Included Benefits subject to COBRA:

Qualifying Events

You have the right to continue your coverage under the Plan if any of the following events results in your loss of coverage under the Plan:

- termination of employment for any reason other than gross misconduct
- reduction in your hours of employment

Your spouse and dependent children (including children born to you or placed for adoption with you) have the right to continue coverage under the Plan if any of the following events results in their loss of coverage under the Plan:

- termination of your employment for any reason other than gross misconduct
- reduction in your hours of employment
- you become enrolled in Medicare
- you and your spouse divorce or are legally separated
- your death
- your dependent ceases to be a "dependent child" for purposes of COBRA

Persons entitled to continue coverage under COBRA are "Qualified Beneficiaries."

If the cost of COBRA continuation coverage for the remainder of the Plan Year equals or exceeds the amount of reimbursement you have available under the Plan for the remainder of the Plan Year, you, your spouse, and/or your dependent child(ren) generally do not have the right to elect COBRA continuation coverage. You will be provided notice of your right to elect COBRA continuation coverage.

Continuing Coverage

You may continue the level of coverage you had in effect immediately preceding the Qualifying Event. However, if Plan benefits are modified for similarly situated active employees, then they will be modified for you and other Qualified Beneficiaries as well. You will be eligible to make a change in your benefit election with respect to the Plan upon the occurrence of any event that permits a similarly situated active employee to make a benefit election change during a Plan Year.

Notice

You, your spouse, or your dependent child(ren) must notify the Plan Administrator or its delegate in writing of a divorce, legal separation, or a child losing dependent status under the Plan within 60 days after the later of (1) the date of the Qualifying Event or (2) the date on which coverage is lost under the Plan because of the event. After

receiving notice of a Qualifying Event, the Plan Administrator will provide Qualifying Beneficiaries with an election notice, which describes the right to COBRA continuation coverage and how to make an election. Notice to your spouse is deemed notice to your covered dependents that reside with the spouse.

You or your dependent(s) are responsible for notifying the Plan Administrator or its delegate if you or your dependent(s) become covered under another group health plan or entitled to Medicare.

Election Procedures and Deadlines

A Qualified Beneficiary may make an election for COBRA continuation coverage if he or she is not covered under the Plan as a result of another Qualified Beneficiary's COBRA continuation election. To elect COBRA continuation coverage, you must complete the applicable election form within 60 days from the later of (1) the date the election notice was provided to you or (2) the date that the Qualified Beneficiary would otherwise lose coverage under the Plan due to the Qualifying Event and submit it to the Plan Administrator or its delegate. If the Qualified Beneficiary does not return the election form within the 60-day period, it will be considered a waiver of his or her COBRA continuation coverage rights.

Cost of COBRA Continuation Coverage

The cost of COBRA continuation coverage will not exceed 102% of the applicable premium for the period of continuation coverage.

When Continuation Coverage Ends

You may be able to continue coverage under the Plan until the end of the Plan Year (or 18 months, please contact the COBRA contact for further information on the length of COBRA coverage) in which the Qualifying Event occurs. However, COBRA continuation coverage may end earlier for any of the following reasons:

- You fail to make a required COBRA continuation coverage contribution;
- The date that you first become covered under another Plan;
- The date that you first become entitled to Medicare; or
- The date the Employer no longer provides a Plan to any of its employees.

AMENDMENT AND TERMINATION

The Employer intends to continue the Plan indefinitely, but reserves the right to amend or terminate the Plan or an Included Benefit, in whole or in part, at any time and for any reason. No participant or beneficiary has a vested right in or to any future Plan benefits.

INCLUDED BENEFIT DOCUMENTS INCORPORATED BY REFERENCE

This Plan incorporates the terms of all welfare benefit plans sponsored by Employer and any affiliate who has adopted the Plan ("Included Benefits"). See the addendum to this Plan document for a list of these plans. Certain documents describing these Included Benefits include information about eligibility, benefits, and

employee/employer contributions for each of the separate Included Benefits, which are incorporated by reference into this summary plan description. These documents may include summary plan descriptions for the Included Benefits, as well as summary benefit booklets, certificates of coverage, enrollment materials, etc. These documents, together with this document, constitute the entire summary plan description for the Plan.

CLAIMS PROCEDURES

In General

Unless the applicable Included Benefit specifies group health plan claims procedures that are compliant with section 2719 of the Patient Protection and Affordable Care Act and associated regulations, the following procedures will apply. An Included Benefit that that has a group health plan claims procedure that is in compliance with the aforementioned Act and associated regulations will apply. For non-group health plan claims, the Included Benefit procedures will apply.

You must submit your claim for benefits in accordance with the applicable Claims Administrator's guidelines. Claims may also be submitted to the applicable Claims Administrator at the address specified at the beginning of this document.

Before you can file a lawsuit for benefits under the Plan, you must exhaust the Plan's internal remedies. A lawsuit for benefits under the Plan must be brought within one year after the date of a final decision on the claim in accordance with the claims procedure described above.

A request for benefits is a "claim" subject to these procedures only if you or your authorized representative file the claim in accordance with these procedures. A request for prior approval of a benefit or service where prior approval is not required under the Plan is not a "claim" under this section. Similarly, a casual inquiry about benefits or the circumstances under which benefits might be paid under the Plan is not a "claim" for purposes of this section, unless the applicable Claims Administrator determines that the inquiry is an attempt to file a claim. If the applicable Claims Administrator or its delegate receives a claim, but there is not enough information to process the claim, you will be given an opportunity to provide the missing information.

You may designate an authorized representative by providing the applicable Claims Administrator with written notice of the designation. In the case of a claim for medical benefits involving urgent care, your health care professional with knowledge of your medical condition may act as your authorized representative.

Timing of Notice of Claim

The applicable Claims Administrator will notify you of a claim denial within a reasonable period of time, but not later than the time frames below. The time frames will vary depending on the type of Included Benefit and may be extended for any period of time necessary for you to respond to a request for additional information.

Group Health Plan Claims

The following procedures apply to the Included Benefits that are "group health plans."

A. Urgent Care Claims

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

If you fail to follow the Plan's procedures for filing an urgent care claim, the applicable Claims Administrator will notify you of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than 24 hours following the failure. Notification may be oral, unless you request written notification. This paragraph applies only to a communication from you that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific individual, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The applicable Claims Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, but not later than 72 hours after receipt of the claim by the Plan. If you fail to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan, the applicable Claims Administrator will notify you as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The applicable Claims Administrator will notify you of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified information, or (2) the end of the period given to you to provide the specified additional information.

B. Pre-Service Claims

A "pre-service" claim is any claim where the Plan conditions receipt of the benefit on approval in advance of obtaining medical care. If you fail to follow the Plan's procedures for filing a pre-service claim, the applicable Claims Administrator will notify you of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than 5 days following the failure. Notification may be oral, unless you request written notification. This paragraph applies only to a communication by you that is received by a person or organizational unit customarily responsible for handling benefit matters; and that names a specific individual, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

The applicable Claims Administrator will notify you if its determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but no later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the applicable Claims Administrator for up to an additional 15 days. The applicable Claims Administrator may only extend the deadline if they determine both that such an extension is necessary due to matters beyond the control of

the Plan and they notify you, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

C. Post-Service Claims

A post-service claim is any claim for a benefit under the Plan that is not a pre-service claim. In the case of a post-service claim, the applicable Claims Administrator will notify you of the Plan's adverse benefit determination within a reasonable period of time, but no later than 30 days after receipt of the claim. This period may be extended one time by the applicable Claims Administrator for up to an additional 15 days. The applicable Claims Administrator may only extend the deadline if they determine both that such an extension is necessary due to matters beyond the control of the Plan and they notify you, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and you will have at least 45 days from receipt of the notice within which to provide the specified information.

D. Concurrent Care Claims

If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments will constitute claim denial. The applicable Claims Administrator will notify you of the denial at a time sufficiently in advance of the reduction or termination to allow you to appeal and obtain a review of that denial before the benefit is reduced or terminated.

Any request by you to extend the course of treatment beyond the period of time or number of treatments that is an urgent care claim will be decided as soon as possible, taking into account the medical exigencies, and the applicable Claims Administrator will you of the denial, whether adverse or not, within 24 hours after the Plan receives the claim, provided that the claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

Content of Notice of Adverse Benefit Determination

If your claim is denied, the applicable Claims Administrator will provide you with a written notice identifying:

1. the reason(s) for the denial;
2. the Plan provisions on which the denial is based;
3. any material or information needed to grant the claim and an explanation of why the additional information is necessary; and
4. an explanation of the steps that you must take if you wish to appeal the denial, including, as necessary, a statement that you may bring a civil action under ERISA.

In addition, the following information will also be included in the written notice for a group health plan claim:

1. the specific rule, guideline, protocol, or other similar criterion, if any, that was relied upon in the denial; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in the denial and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; or
2. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that the explanation will be provided free of charge to you upon request.

A denied claim for a group health plan benefit under the Plan will include the following information in the written notice:

1. Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
2. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal.
3. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist you with the internal claims and appeals and external review processes.
4. The Plan must also:
    a. Ensure that the reason or reasons for any adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim; and
    b. Provide to you, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination. The Plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review.

In the case of a denied urgent care claim where the Included Benefit is a group health plan, the notice will include a description of the expedited review process applicable to such claims.

This information may be provided orally provided that a written or electronic notification is furnished to you not later than 3 days after the oral notification.

<u>Appeal of Adverse Benefit Determination</u>

You may appeal the denial of a claim (including a rescission of coverage) by filing a written appeal with the applicable Claims Administrator on or before the 180th day after you receive the applicable Claims Administrator's written notice that the claim has been denied.
Your written appeal must identify both the grounds and specific Plan provisions upon which the appeal is based.

You will lose the right to appeal if your appeal is not timely made.

The Plan will provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefit. You may submit written comments, documents, records, and other information relating to the claim for benefits. The Plan will take into account all comments, documents, records, and other information you submit relating to the claim, without regard to whether such information was submitted or considered in the initial claim. The applicable Claims Administrator will consider the merits of your written presentations, the merits of any facts or evidence in support of the denial of benefits, and such other facts and circumstances as the applicable Claims Administrator may deem relevant.

If the claim is for group health plan benefits the following will apply.

1. The review will not afford deference to the initial claim denial. The appeal will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the denial that is the subject of the appeal, nor the subordinate of that individual.
2. In deciding an appeal of any denial that is based on a medical judgment, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of a consultation will be an individual who is neither an individual who was consulted in connection with the claim denial that is the subject of the appeal, nor the subordinate of any such individual.
3. The Plan will identify, upon the request of the claimant, the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with your claim denial, without regard to whether the advice was relied upon in the denial.
4. In the case of an urgent care claim, the Plan will expedite review of the claim and you may submit a request for an expedited appeal of a denial orally or in writing. All necessary information, including the Plan's benefit determination on review, will be transmitted between you and the Plan by telephone, facsimile, or other available similarly expeditious method.
5. Before the Plan issues any adverse benefit determination, the applicable Claims Administrator will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan, insurer, or other person making the benefit determination (or at the direction of the Plan) in connection with the claim, and any new or additional rationale must be provided to you as soon as possible and sufficiently in advance of the date on which the Plan must provide you with the notice of final adverse benefit determination so that you have a reasonable opportunity to respond prior to that date.
6. If the determination is based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the date on which the notice of final adverse benefit determination is required to be provided to give you a reasonable opportunity to respond prior to that date. If the new or additional evidence is received so late that it would be impossible to provide it in time for you to have a reasonable opportunity to respond, the Plan's deadline for providing a notice of final adverse benefit determination will be delayed until you have had reasonable opportunity to respond. After you respond, or had a reasonable opportunity to respond but failed to do so, the applicable Claims Administrator will notify you of the Plan's benefit determination as soon as a Plan acting in a reasonable and prompt fashion can provide the notice, taking into account the medical exigencies.

The applicable Claims Administrator will ordinarily rule on an appeal of a claim denial within 60 days following receipt of the claim. The time frame will begin at the time your appeal is filed in accordance with the reasonable procedures of the Plan, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. However, if special circumstances require an extension and the applicable Claims Administrator furnishes you with a written extension notice during the initial period, the applicable Claims Administrator may extend this period of time by 60 days if written notice of the extension is furnished to you prior to the termination of the initial 60-day period. In the event that the extension is due to your failure to submit information necessary to decide a claim, the period for making the benefit determination on review will start on the date that you respond to the request for additional information.

If the claim is for group health plan benefits, the applicable Claims Administrator will notify you of the Plan's benefit determination on review as follows.

1. Urgent Care Claims The applicable Claims Administrator will notify you of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of your request for review of an adverse benefit determination by the Plan.
2. Pre-Service Claims The applicable Claims Administrator will notify you of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but no later than 30 days after receipt by the Plan of your request for review of an adverse benefit determination.
3. Post-Service Claims The applicable Claims Administrator will notify you of the Plan's benefit determination on review within a reasonable period of time, but no later than 60 days after receipt by the Plan of your request for review of an adverse benefit determination.

All claims and appeals involving group health plan benefits will be adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. No decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will be made based upon the likelihood that the individual will support the denial of benefits.

The following applies to any claim for group health plan benefits (or appeal of a claim for group health plan benefits):

1. The Plan must ensure that any notice of adverse benefit determination includes information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. The Plan must provide to you, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination. The Plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review;
3. The Plan must ensure that the reason or reasons for any adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim. In the case of a notice of final adverse benefit determination, this description must

include a discussion of the decision;

4. The Plan must provide a description of available internal appeals and external review processes, including information regarding how to initiate an appeal; and
5. The Plan must disclose the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist you with the internal claims and appeals and external review processes.

Denial of Appeal

If an appeal is wholly or partially denied, the applicable Claims Administrator will provide you with a notice identifying:

1. the reason or reasons for such denial;
2. the Plan provisions on which the denial is based;
3. a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits; and
4. a statement describing your right to bring an action under section 502(a) of ERISA if determined to be necessary under CMS Technical Guidance released on August 17, 2012. The determination rendered by the applicable Claims Administrator will be binding upon all parties.

If the denied claim is for a group health plan benefit under the Plan, the following information will also be included in the written notice:

1. Information sufficient to identify the claim involved (including the date of service, the health care provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
3. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793 to assist you with the internal claims and appeals and external review processes; and
4. The Plan must also:
   a. Ensure that the reason or reasons for any adverse benefit determination includes the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim and a discussion of the decision if the notice is a final adverse benefit determination; and
   b. Provide to you, as soon as practicable, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, associated with any adverse benefit determination. The Plan must not consider a request for such diagnosis and treatment information, in itself, to be a request for an internal appeal or external review;

In the case of a group health plan, the notice will also include:

1. if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that

such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to you upon request;

2. if the adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
3. the following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

External Claims Process

State Process To the extent the Plan is required pursuant to 45 CFR 147.136(c)(1) to comply with a State external claims process that includes at a minimum the consumer protections in the NAIC Uniform Model Act, then the Plan will comply with the state external claims process of 45 CFR 147.136(c).

Federal Process To the extent the Plan is not required pursuant to 45 CFR 147.136(c)(1) to comply with the State external claims process, then the Plan will comply with the Federal external claims process of 45 CFR 147.136(d).

REFUNDS/INDEMNIFICATION

You must immediately repay any excess payments/reimbursements. You must reimburse the Employer for any liability the Employer may incur for making such payments, including but not limited to, failure to withhold or pay payroll or withholding taxes from such payments or reimbursements. If you fail to timely repay an excess amount and/or make adequate indemnification, the Plan Administrator may: (i) to the extent permitted by applicable law, offset your salary or wages, and/or (ii) offset other benefits payable under this Plan.

MILITARY SERVICE

If you serve in the United States Armed Forces and must miss work as a result of such service, you may be eligible to continue to receive benefits with respect to any qualified military service.

FMLA

If you go on unpaid leave that qualifies as family leave under the Family and Medical Leave Act you may be able to continue receiving benefits. Please see the FMLA policy in our Employee Handbook for more information, copies of which may be obtained through Human Resources or through our internal website.

NATIONAL MEDICAL SUPPORT NOTICE

In certain circumstances you may be able to enroll a child in the Plan if the Plan receives a National Medical Support Notice (NMSN).

WOMEN'S HEALTH AND CANCER RIGHTS ACT

To the extent required by the Women's Health and Cancer Rights Act (WHCRA) of 1998, this Plan provides coverage for all stages of reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the Plan or coverage. Written notice of the availability of such coverage shall be delivered to Participants upon enrollment and annually thereafter. Contact the Plan Administrator for more information.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

LOSS OF BENEFIT

You may lose all or part of any payment due to you if we cannot locate you when your benefit becomes payable to you.

NON-ALIENATION

You may not alienate, anticipate, commute, pledge, encumber, or assign any of the benefits or payments which you may expect to receive, contingently or otherwise, under the Plan, except that you may designate a Beneficiary.

PLAN ADMINISTRATOR DISCRETION

The Plan Administrator has the authority to make factual determinations, to construe and interpret the provisions of the Plan, to correct defects and resolve ambiguities in the Plan and to supply omissions to the Plan. Any construction, interpretation, or application of the Plan by the Plan Administrator is final, conclusive, and binding on all parties.

GRANDFATHERED HEALTH PLAN

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

WELFARE BENEFIT PLAN CHART ADDENDUM

If there is a conflict in the information provided by this addendum and the applicable contract, policy, or benefit booklet, the applicable contract, policy or benefit booklet will control, except with regard to the benefit, funding and contributions information. For terms and definitions used in this addendum, please see the applicable contract, policy, or benefit booklet.

Benefit	Contact Information (Questions, Claims & Appeals)	Eligibility	Funding & Contributions
Medical	Premera Blue Cross Attn: Appeals Coordinator P.O. Box 91102 Seattle, WA 98111-9202 Fax: (425) 918-5592	Full-Time Employees, Spouses/Domestic Partners and Eligible Dependents.	Self-funded.
Medical	Kaiser Foundation Health Plan WA Attn: Member Appeal Department or Medical Director PO BOX 34593 Seattle, WA 98124-1593	Full-Time Employees, Spouses/Domestic Partners and Eligible Dependents.	Fully-Insured.
Dental	Delta Dental of Washington P.O. BOX 75983 Seattle, WA 98175-0983	Fully-Benefited Employees, Spouses/Domestic Partners and Eligible Dependents. Fully-Benefited Employees are non-variable hour, non-part-time, and non-seasonal employees.	Fully-Insured.
Dental	Willamette Dental of Washington, Inc. Attn: Member Services 6950 NE Campus Way Hillsboro, OR 97124-5611	Fully-Benefited Employees, Spouses/Domestic Partners and Eligible Dependents. Fully-Benefited Employees are non-variable hour, non-part-time, and non-seasonal employees.	Fully-Insured.
Vision	VSP 333 Quality Drive Rancho Cordova, CA 95670-7985	Fully-Benefited Employees, Spouses/Domestic Partners and Eligible Dependents. Fully-Benefited Employees are non-variable hour, non-part-time, and non-seasonal employees.	Fully-Insured.
FSA	Navia Benefit Solutions claims@naviabenefits.com P.O. BOX 53250 Bellevue, WA 98015 Fax: 425-451-7002 or 866-535-9227	Fully-Benefited Employees, Spouses and Eligible Dependents. Fully-Benefited Employees are non-variable hour, non-part-time, and non-seasonal employees.	Fully-Insured.

Benefit	Contact Information (Questions, Claims & Appeals)	Eligibility	Funding & Contributions
EAP	Wellspring Family Services 1900 Rainier Avenue South Seattle, WA 98144	Fully-Benefited Employees, Spouses/Domestic Partners and Eligible Dependents. Fully-Benefited Employees are non-variable hour, non-part-time, and non-seasonal employees.	Fully-Insured.

APPENDIX: DETERMINATION OF FULL-TIME EMPLOYEES

City of Bellevue Determination of Full-Time Employees under the City of Bellevue Health and Welfare Plan (the "Plan")

The following procedures apply for determining eligibility for group health benefits under the Plan.

All Full-Time Employees and their dependents must be offered participation in the group health benefits offered under the Plan.

1. Full-Time Employees

   Full-Time Employee and FTE are defined as:

   A. An Employees scheduled or otherwise expected to work at least 30 hours per week or 130 hours per calendar month.
   B. A variable-hour, seasonal, and part-time Employee who works at least 30 hours per week during the Initial Measurement Period.
      a. A variable-hour Employee is an Employee whose status as a FTE cannot be determined at the Employee's start date because the Employee's hours are variable or otherwise uncertain.
      b. A seasonal Employee is an Employee who is hired into a position for which the customary annual employment period is six months or less and which begins at approximately the same time of each calendar year.
      c. A part-time Employee is an Employee reasonably expected to be employed on average less than 30 hours of service per week during the Initial Measurement Period.

   An Employee will remain a "variable-hour Employee," "seasonal Employee," or "part-time" Employee, as applicable, during the Initial Measurement Period unless the Employee experiences a change in employment status in which the Employee is expected to work at least 30 hours per week or 130 hours per calendar month.

2. Initial Eligibility Determination

   A. FTE
   An Employee who is scheduled to work at least 30 hours per week upon their date of hire is an FTE for purposes of the group health benefits under the Plan.
   B. All Other Employees (Variable-Hour, Seasonal, Part-Time)
   An Employee who, upon their date of hire, is not expected to work at least 30 hours per week on average is an FTE only if they work at least 30 hours per week on average during their Initial Measurement Period. The Initial Measurement Period is 12 months. An Employee's Initial Measurement Period will begin on the first day of the month following the Employee's date of hire.

   If the Employee works at least on average 30 hours per week during their Initial Measurement Period, the Employee will be an FTE for their Initial Stability Period. The Initial Stability Period is 12 months.

3. Ongoing Eligibility Determination

A. Monthly Measurement Method
An Employee's status as an FTE will be determined by counting their hours of service for each calendar month. If the hours worked in the month exceed 130, or exceed 30 hours per week on average, the Employee is an FTE.

The Monthly Measurement Method will be used for
- Non-variable, non-part time, and non-seasonal employees

B. Look-Back Measurement Method
An Employee's status as an FTE will be determined by counting the Employee's hours of service during the Standard Measurement Period. The Standard Measurement Period is 12 months beginning on 10/16 and ending on 10/15.

If the Employee works 30 hours per week on average during the Standard Measurement Period, the Employee is an FTE for the duration of the Standard Stability Period. The Standard Stability Period is 12 months, beginning on 01/01 and ending on 12/31.

If an Employee is an FTE during the Standard Measurement Period, they will be eligible for group health benefits under the Plan during the entire Standard Stability Period. The Employee will remain eligible for group health benefits during the entire Standard Stability Period, regardless of the Employee's actual number of hours of service during the Stability Period, as long as he or she remains an Employee of the Employer. Similarly, if an Employee is not an FTE during the Standard Measurement Period, he will not be eligible for group health benefits during the entire Standard Stability Period.

The Look-Back Measurement Method will be used for
- Variable, seasonal, part-time hourly employees

4. Re-Hired Employees

An Employee is treated as a new Employee for purposes of this policy if they incur a Break in Service. If the Employee is treated as a new Employee (has incurred a Break in Service), they will begin a new Standard Measurement Period beginning on their start date. If the Employee is not treated as a new Employee (has not incurred a Break in Service), their Standard Measurement Period will continue uninterrupted.

A Break in Service is a period of 13 or more consecutive weeks during which the Employee is not credited with an hour of service. If an Employee is employed for less than 13 weeks before ceasing hours of service, the Employee will be deemed to have incurred a Break in Service if the number of weeks during which the Employee is credited with hours of service is fewer than the number of weeks that they are not credited with an hour of service. An Employee who does not work any hours of service for a period of four consecutive weeks or fewer will not be treated as a new Employee.

An Employee who was enrolled in group health benefits coverage under the Plan on the date of their termination of employment may resume participation in the group health benefits under the Plan on first day of the month following the date of rehire if the Employee has not had a Break in Service, provided that the Stability Period on the date of reemployment is the same as the Stability Period in effect on the date of the individual's prior termination of employment. If reemployment begins during a new Stability Period, participation in the group health benefits under the Plan will begin first day of the month following the date of rehire if, based on the applicable Measurement Period, the individual is an FTE on the date of reemployment.

If the Employee is reemployed after a Break in Service, eligibility to become a participant in the group health benefits under the Plan will be based on the individual's status on the date of rehire.

If the Employee had not satisfied any applicable waiting period prior to his termination of employment, upon rehire, the waiting period will be reduced by the period of prior employment.