PeaceHealth Medical Plan

Employee Participant Handbook

Washington/Alaska/Oregon

Effective: January 1, 2012
Welcome to the PeaceHealth Employee Health Care Plan!

We are pleased to provide this comprehensive program of medical and prescription drug coverage.

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

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

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

For questions regarding the Plan’s benefits or the procedures necessary to receive these benefits, please call Healthcare Management Administrators, Inc. (HMA) at 425/974-3886. When calling from outside of Seattle, call HMA toll free at 866/206-7786.

We wish you the best of health.

PeaceHealth Employee Health Care Plan
# TABLE OF CONTENTS

**IMPORTANT INFORMATION - PLEASE READ**  ................................................................. 7  
PRE-AUTHORIZATION ........................................................................................................ 7  
CERTIFICATION OF ADDITIONAL DAYS ........................................................................ 9  
STEPS TO TAKE ................................................................................................................ 9  
CASE MANAGEMENT/ALTERNATE TREATMENT ................................................................. 9  
HOW TO FILE A CLAIM ...................................................................................................... 10  
CONTINUATION OF COVERAGE PROVISIONS ................................................................. 10  
CONTACT FOR QUESTIONS ABOUT THE PLAN BENEFITS ............................................ 10

**SUMMARY OF BENEFITS** ............................................................................................ 11  
USING THE PLAN’S IN-NETWORK BENEFITS ................................................................ 12  
ENROLLED OUT-OF-AREA PARTICIPANT BENEFITS .................................................... 13  
USING THE PLAN’S OUT-OF-NETWORK BENEFIT ......................................................... 14  
USING NON-NETWORK PROVIDERS ............................................................................. 15

**ELIGIBILITY AND ENROLLMENT PROVISIONS** ........................................................... 16  
ELIGIBILITY ......................................................................................................................... 16  
EMPLOYEE ELIGIBILITY .................................................................................................... 16  
DEPENDENT ELIGIBILITY ................................................................................................. 16  
ENROLLMENT ....................................................................................................................... 19  
REGULAR ENROLLMENT ..................................................................................................... 19  
SPECIAL ENROLLMENT FOR LOSS OF OTHER COVERAGE ............................................ 20  
SPECIAL ENROLLMENT FOR LOSS OF ELIGIBILITY DUE TO REACHING LIFETIME MAXIMUM BENEFITS 21  
SPECIAL ENROLLMENT FOR LOSS OF STATE CHILDREN’S HEALTH INSURANCE PROGRAM (SCHIP) OR MEDICAID ........................................................................................................ 21  
SPECIAL ENROLLMENT FOR NEW DEPENDENTS .......................................................... 21  
SPECIAL ENROLLMENT FOR NEW DEPENDENTS THROUGH QUALIFIED MEDICAL CHILD SUPPORT ORDER ........................................................................................................ 22  
OPEN ENROLLMENT ........................................................................................................... 22  
CERTIFICATE OF CREDITABLE COVERAGE .................................................................... 22  
EFFECTIVE DATE OF COVERAGE .................................................................................... 22  
EMPLOYEE EFFECTIVE DATE ............................................................................................ 22  
DEPENDENT EFFECTIVE DATE ......................................................................................... 23  
TERMINATION OF COVERAGE ........................................................................................ 24  
EMPLOYEE ........................................................................................................................ 24  
DEPENDENT(S) ................................................................................................................... 24  
APPROVED FAMILY AND MEDICAL LEAVE ..................................................................... 24  
MILITARY LEAVE OF ABSENCE ......................................................................................... 25  
REINSTATEMENT OF COVERAGE ...................................................................................... 25

**CONTINUATION COVERAGE** .......................................................................................... 26  
INTRODUCTION .................................................................................................................. 26  
WHAT IS CONTINUATION COVERAGE? ........................................................................ 27  
WHO IS ENTITLED TO ELECT CONTINUATION COVERAGE? .................................... 28  
WHEN IS CONTINUATION COVERAGE AVAILABLE? ..................................................... 29  
ELECTING CONTINUATION COVERAGE ....................................................................... 30  
SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT CONTINUATION COVERAGE ............................................................... 31  
LENGTH OF CONTINUATION COVERAGE ..................................................................... 31  
EXTENSION OF MAXIMUM COVERAGE PERIOD .......................................................... 32  
TERMINATION OF CONTINUATION COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD ................................................................. 33
The Plan Administrator has the right to amend this Plan at any time. The Plan Administrator will make a good faith effort to communicate to the Plan participants all Plan amendments on a timely basis. For further information, see the section titled Amendment of Plan Document located in the General Provisions section of this Plan.
Important Information - Please Read

Plan Supervisor: HEALTHCARE MANAGEMENT ADMINISTRATORS, INC. (HMA)
425/974-3886 - SEATTLE
866/206-7786 - NATIONWIDE

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

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

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

This group health plan’s fiduciaries believe this plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the PPACA). As permitted by the PPACA, 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 PPACA 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 PPACA, 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 to non-grandfathered health plan status can be directed to the Plan Administrator at 425/747-1711.

PRE-AUTHORIZATION

This plan requires pre-authorization of all inpatient medical facility admissions and all outpatient surgeries, as well as the following services:

- All inpatient admissions, including admission to a hospital, skilled nursing facility, or rehabilitation facility. For emergency hospitalizations, the participant, or a relative, need to notify HMA within 48 hours, or as soon as reasonably possible.
- All outpatient surgical procedures (unless the surgical procedure is performed in the doctor’s own office).
- All non-emergency inpatient mental health and inpatient chemical dependency services must be pre-authorized by:
  - Mental Health Match at 1-800-457-3798 (System Office - Bellevue, Oregon Region, Siuslaw Region, Oregon Medical Laboratory, Southeast Alaska Region, Lower Columbia Region, and System Services and PeaceHealth

01/01/12 7 020183
Laboratories employees located in Southeast Alaska, Oregon, Siuslaw and Lower Columbia Regions).

- **Health Promotion Network at 1-800-244-6142 or 360-715-6575** (for Whatcom Region employees, and PeaceHealth Laboratories and System Services employees located in Whatcom Region).

- All human organ/tissue transplant related services.
- All hospice services.
- Medical supplies, durable medical equipment, appliances, and prosthetic devices in excess of $500.
- Temporomandibular Joint (TMJ) syndrome services (surgical procedures only).
- All outpatient hospitalizations and anesthesia for covered dental services.
- Some Prescriptions Drugs (see a more detailed list in the Prescription Drug Card Program section of this booklet).
- Services related to Bariatric surgery.

Pre-authorization is required for all outpatient surgeries and scheduled admissions. Failure to call for pre-authorization **five days prior** to an outpatient surgery or an admission into a medical facility or, in the case of an emergency admission, failure to obtain authorization either within 48 hours after the emergency admission or on the next business day, if later, may result in the denial of the participant’s claim.

At the time that the participant’s doctor recommends surgery or an inpatient admission, the participant or the participant’s doctor should contact HMA’s Health Services Department to request the pre-authorization. All inpatient and outpatient non-emergency surgeries and all non-emergency admissions (excluding normal vaginal deliveries where the length of stay is 48 hours or less and cesarean section deliveries where the length of stay is 96 hours or less) must be pre-authorized in advance. The participant must call no later than five days prior to the medical facility admission or surgery. Surgeries performed in the doctor’s own office do not need to be pre-authorized. Emergency medical facility admissions and emergency surgeries must be authorized within 48 hours after the medical facility admission or surgery, or by the next business day, if later.

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

**Pre-authorization does not guarantee payment of benefits.**

**The Health Services Department should be contacted at the following numbers:**

**HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.**
425/974-3886 - SEATTLE AREA
866/206-7786 - NATIONWIDE
CERTIFICATION OF ADDITIONAL DAYS

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

STEPS TO TAKE

When an inpatient admission or surgery is recommended, the patient, the physician or a family member must call HMA’s Health Services Department at least five days prior to the admission or surgery to obtain authorization. If an emergency admission or emergency surgery occurs, the patient or a family member should ask the attending physician or the medical facility to contact HMA’s Health Services Department within 48 hours of admission or surgery, or by the next business day, if later. Please be prepared to give HMA’s Health Services Department the following information when calling for authorization:

- Name and age of patient.
- Subscriber Identification Number.
- Group Number (020183).
- Medical Facility name and address.
- Name and phone number of admitting physician.
- Admission date.
- Diagnosis.
- Procedure being performed.

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

CASE MANAGEMENT/ALTERNATE TREATMENT

In cases where the covered participant's condition is expected to be or is of a serious nature, case management services from a professional qualified to perform such services may be recommended. The Health Services nurse case manager will work with the participant, the Plan Administrator, the participant’s physician and other health care providers to help assure that the care the participant receives is provided in the most appropriate and cost effective manner. The case managers are the participant’s advocates to help improve the quality of health care and to lower the cost of health care to the participant and the Plan.

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

- All providers should send bills to the address listed on the participant’s medical identification card.

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

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

CONTINUATION OF COVERAGE PROVISIONS

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

CONTACT FOR QUESTIONS ABOUT THE PLAN BENEFITS

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

HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
P.O. Box 85008, Bellevue, WA 98015-5008
425/974-3886 - Seattle
866/206-7786 - Other Areas Nationwide
SUMMARY OF BENEFITS

The level of benefits received is based upon the participant’s decision at the time treatment is needed to access care through either network or non-network providers. Benefits are payable at the network level by accessing care through a Network Provider, Network Medical Facility or from a Network Hospital. Out-of-network charges will be paid at the out-of-network level of benefits if the participant is enrolled in the Open Network PPO Plan, Open Network Plus PPO Plan, or High Deductible Health Plan (HDHP). To find the online listing of the HMA Provider Networks, access the websites listed below:

<table>
<thead>
<tr>
<th>State</th>
<th>Provider Network / Panel</th>
<th>Provider Directory</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington</td>
<td>Preferred</td>
<td><a href="http://www.regence.com">www.regence.com</a></td>
</tr>
<tr>
<td>Oregon</td>
<td>Participating &amp; Preferred</td>
<td><a href="http://www.regence.com">www.regence.com</a></td>
</tr>
<tr>
<td>Alaska (Ketchikan)</td>
<td>All Ketchikan Providers</td>
<td>866/206-7786</td>
</tr>
</tbody>
</table>

Provider Network Information for Mental Health & Chemical Dependency Benefits ONLY

Please review the chart below to determine what Provider network is available for your selected benefit plan, based on where you live. To maximize your benefit dollars available, make sure to utilize a provider that is considered in network for you.

<table>
<thead>
<tr>
<th>State</th>
<th>Plan</th>
<th>Network</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon</td>
<td>In-Network</td>
<td>Mental Health Match (MHM)</td>
<td>PPO</td>
</tr>
<tr>
<td>Oregon</td>
<td>In-Network</td>
<td>Regence of Oregon</td>
<td>None</td>
</tr>
<tr>
<td>Oregon</td>
<td>In-Network</td>
<td>All other providers</td>
<td>None</td>
</tr>
<tr>
<td>Oregon</td>
<td>Open-Network, Open-Network Plus, HDHP</td>
<td>Mental Health Match (MHM)</td>
<td>PPO</td>
</tr>
<tr>
<td>Oregon</td>
<td>Open-Network, Open-Network Plus, HDHP</td>
<td>Regence of Oregon</td>
<td>Non PPO</td>
</tr>
<tr>
<td>Oregon</td>
<td>Open-Network, Open-Network Plus, HDHP</td>
<td>All other providers</td>
<td>Non PPO</td>
</tr>
<tr>
<td>Washington</td>
<td>In-Network</td>
<td>Regence of Washington</td>
<td>PPO</td>
</tr>
<tr>
<td>Washington</td>
<td>In-Network</td>
<td>All other providers</td>
<td>None</td>
</tr>
<tr>
<td>Washington</td>
<td>Open-Network, Open-Network Plus, HDHP</td>
<td>Regence of Washington</td>
<td>PPO</td>
</tr>
<tr>
<td>Washington</td>
<td>Open-Network, Open-Network Plus, HDHP</td>
<td>All other providers</td>
<td>Non PPO</td>
</tr>
</tbody>
</table>

Note: The Mental Health Match network is located in Lane County.
USING THE PLAN’S IN-NETWORK BENEFITS

This section summarizes basic information participants need to know to take advantage of the benefits offered by the PeaceHealth health plans.

Network Providers
PeaceHealth has contracted for arrangements with certain physicians/providers. These providers are called “network providers.” The agreements with these providers enable participants to receive quality health care for a reasonable cost. For in-network benefits to be covered, participants must receive health care services from network providers. The participant’s network provider will work with HMA to arrange for any Plan pre-authorization requirements that may be required for certain covered services.

Open Network PPO Plan, Open Network Plus PPO Plan, and HDHP participants have an additional out-of-network benefit that gives them access to non-network providers, see the “Using The Plan’s Out-of-Network Benefit” section.

In-Network PPO Plan, Open Network PPO Plan, Open Network Plus PPO Plan participants, designated as Out-of-Area Participants have a special Out-of-Area benefit allowing them to use non-network providers. For further information, see the “Enrolled Out-of-Area Participant Benefits” section.

To encourage optimum health, we promote wellness and preventive care. We also believe wellness and overall health is enhanced by working closely with one physician or provider – the participant’s personal physician/provider. He or she can provide most of the participant’s care and can track all of the participant’s medical care to avoid unneeded or conflicting treatment. To encourage this relationship, out-of-pocket costs for office visits with a network personal physician/provider are generally lower. Participants can, however, see any network provider they want for covered medical services. When participants do this, their out-of-pocket costs will generally be higher. The choice is up to the participant.

Charges will be paid at the in-network level when:

- The services are billed by a network provider, hospital, or medical facility.
- The services are for a non-network assistant surgeon or anesthesiologist where the medical facility and the primary surgeon are both in-network providers.
- If a covered participant is traveling and receives emergency services inside or outside the network area.
- For Southeast Alaska, services for all providers in Ketchikan (billing with a Ketchikan address).
- Ambulance services in the case of emergency.
- The plan participant is enrolled on the In-Network PPO plan and medically necessary services are not available from an In-Network provider within 30 miles of the individual’s place of residence.

If the covered participant lives outside the area serviced by the network provider organization, the participant may elect Out-of-Area participant status, and eligible expenses will be reimbursed at the Out-of-Area level of benefits.

If the participant is unsure about a provider's, hospital's or other facility’s participation in the PeaceHealth Plan, visit the Online Regence Provider Directory at www.regence.com before making an appointment. Participants can also call the HMA
Customer Service Team to get information about a provider's participation with the PeaceHealth Plan.

We encourage our participants to use the Online Provider Directory for network provider and hospital information. The online directory is updated on a frequent basis and includes additional information on each provider.

For a more complete listing of covered services, please see the Summary of Benefits.

**ENROLLED OUT-OF-AREA PARTICIPANT BENEFITS**

**Introduction**
Participants who live outside the Regence Network Provider service area (including dependents who are away at school) are eligible to become an Out-of-Area Participant. See the “Definitions” section for the Plan's definition of “Dependent” and “Out-of-Area Participant.”

This section discusses how enrolled Out-of-Area Participants can obtain covered services through the Plan’s Out-of-Area benefit.

**Enrollment – Out of Area Participants**
To apply for Out-of-Area Participant benefits, complete an Out-of-Area Participant Enrollment form, available on My HR. If an Out-of-Area Participant Enrollment form is not completed, an Out-of-Area participant will not be covered for Out-of-Area participant benefits.

**Coverage**
A participant with Out-of-Area benefits may see any provider, in or out of the service area. The Plan will pay up to 80 percent of covered charges, with no deductible for eligible benefit services. The Plan’s payment is based on usual, customary, and reasonable charges (UCR). Charges which exceed UCR are the participants responsibility and are not applied to the participant’s annual out-of-pocket maximum.

The plan does not provide Out-of-Area benefits for participants on Continuation Coverage, with the exception of dependents residing outside the service area.

**Additional Information:**

- See the “Approved Non-network Provider Categories” section below for information regarding Plan-approved non-network providers.
- See “How to File a Claim” in the Important Information section for information on payment of non-network provider claims.
- See the Out-of-Area Summary of Benefits for specific coverage information.

**Pre-authorization**
Out-of-area participants are responsible for obtaining pre-authorization from the Plan prior to receiving certain services from non-network providers. For a list of these services and how to obtain pre-authorization, see “Pre-authorization” in the Important Information section.

**Change of status -- Enrolled Out-of-Area Participants**
These participants may change to the subscriber’s In-Area plan benefits when they return to the service area. If they do so, they will receive In-Area benefits. They also must follow Plan
procedures for the In-Area plan. Participants must contact the Caregiver Resource Center (CRC)/My HR to change back to In-Area coverage.

Participants who change their status must wait at least 30 days before switching again. For example, if a dependent child returned to the service area for summer vacation, the employee must contact the Caregiver Resource Center (CRC)/My HR to change the child back to In-Area coverage. Then, to be eligible for Out-of-Area coverage again, the child would need to have been covered under the In-Area benefit plan for at least 30 days.

If a dependent comes home for a short visit that is less than 30 days (for example, during Christmas vacation), coverage will remain at the 80 percent Out-of-Area benefit level. Please contact the Caregiver Resource Center (CRC)/My HR with any questions regarding change of status for dependents.

USING THE PLAN’S OUT-OF-NETWORK BENEFIT

This section summarizes basic information participants need to know for taking advantage of the non-network provider or out-of-network benefits offered by the Open Network PPO Plan, Open Network Plus PPO Plan, and the HDHP.

Out-of-Network Benefits
Open Network Plus PPO Plan, Open Network PPO Plan, or HDHP participants may choose to seek care through network providers using the in-network benefit or seek care through non-network providers by using the out-of-network benefit. (Some services are covered only when the participant uses the in-network benefit; see the Summary of Benefits for details.) Generally, when a participant uses the out-of-network benefits the participant’s coinsurance payments will be higher than when using in-network benefits. It is usually to the participant’s advantage to use the in-network benefits whenever possible. Out-of-network benefits are described in the “Out-of-Network” column on the Summary of Benefits.

After a participant meets the Plan’s annual deductible, out-of-network benefits are paid according to usual, customary, and reasonable (UCR) charges. Amounts charged by a non-network provider in excess of UCR are the participant’s responsibility and do not apply to their out-of-pocket maximums or deductibles.

Additional Information:

- See the “Approved Non-network Provider Categories” section for information regarding Plan-approved non-network providers.
- See “How to File a Claim” in the Important Information section for information on payment of non-network provider claims.

The following services are not covered under the out-of-network benefit. These services are only covered under the in-network benefit:

- Bariatric surgery and related services
- Diabetic education and counseling
- Infertility/fertility services
- Alternative Care (Open Network Plus Plan only)
- Chiropractic (In-Network PPO Plan, Open Network Plus PPO Plan, and HDHP only; no benefits available to Open Network PPO Plan participants)
USING NON-NETWORK PROVIDERS

This section summarizes basic information for In-Network PPO Plan, Open Network Plus PPO Plan, Open Network PPO Plan enrolled Out-of-Area Participants, Open Network PPO Plan, and HDHP participants using the out-of-network benefit when obtaining covered services from non-network providers. (Generally, except for emergency or urgent situations outside the Plan’s service area, In-Network PPO Plan participants cannot obtain covered services from non-network providers unless they are enrolled Out-of-Area Participants.)

Pre-authorization

Pre-authorization is required for inpatient admissions and outpatient surgeries received from a non-network provider. Please see the “Pre-authorization” section (under General Information) for specific information on requirements and penalties.

Approved Non-Network Provider Categories

When a participant uses non-network providers, the Plan provides benefits for covered medically necessary care only when it is received from providers or facilities in approved categories, and when the provider is practicing within the scope of his or her license.

The Plan has approved and may provide reimbursement for non-network qualified practitioners and facilities. Qualified practitioners are defined as a physician, women’s health care provider, nurse practitioner, clinical social worker, physician assistant, psychologist, dentist, or other practitioner who is professionally licensed by the appropriate state agency to diagnose or treat a bodily injury or illness and who provides services covered by the Plan within the scope of that license. A qualified facility is defined as a facility, institution, or clinic duly licensed by the appropriate state agency, which is primarily established and operating within the lawful scope of its license.

Important Note:

While the Plan will provide reimbursement for covered services received by any of the Plan approved providers listed above, for benefits to be paid the participant must receive medically necessary covered services as listed in this handbook. All treatment, supplies, and medications excluded by the Plan are not covered no matter what type of approved category of provider the participant sees.
ELIGIBILITY AND ENROLLMENT PROVISIONS

ELIGIBILITY

Employee Eligibility

Employees eligible for coverage under this plan are:

All active employees of PeaceHealth who are regularly scheduled to work 20 hours or more per week are eligible for coverage under this Plan.

Ineligible classes of employees, regardless of the number of hours worked, are: (1) temporary employees, (2) individuals providing services to the Employer under contracts that designate the individuals as independent contractors regardless of whether such individuals are treated as employees for federal withholding and employment tax purposes, (3) leased employees, and (4) individuals regularly scheduled to work less than 20 hours per week.

Special Provision for Siuslaw Region Employees

Employees on an approved partial educational leave of absence (policy SR.52.42) may work less than 20 hours per week with a minimum of 8 hours per week. A partial educational leave of absence may be granted for up to two years.

Individuals Enrolling on the High Deductible Health Plan Option:

The PeaceHealth HDHP is a qualified HDHP. This means that in addition to the above criteria, an individual who is enrolled in this plan cannot be covered under any plan other than a qualified HDHP (including a spouse’s FSA) or coverage that is otherwise considered permitted coverage or permitted insurance under the Internal Revenue Code (Code), cannot be enrolled in Medicare and cannot be claimed as a dependent on another person’s tax return.

Dependent Eligibility

Dependents eligible for coverage under this plan are:

- An employee’s legally married spouse as defined in the definition section. Coverage may continue during a legal separation only if ordered by a court decree.

- Legally Domiciled Adults (LDAs), provided they meet the following requirements:

  1. Is over age 18, and
  2. During the Plan Year and for a minimum of 12 months prior to enrollment has as his or her principal residence the covered employee’s home, and
  3. Is a member of the covered employee’s household*, and
  4. Is not the covered employee’s employee (e.g. nanny), and
  5. Is not an eligible dependent child, and
  6. Does not have access to other medical coverage (group or Medicare)

* A member of the covered employee’s household is a person who is part of the core family unit and intends to remain so for the foreseeable future; someone with whom the covered employee has a close personal relationship, provides financial support, and is committed to a relationship of mutual caring. This would not include a renter, or other person living in the home on a casual basis.
There may be tax implications depending on whether or not the LDA is the employee’s tax dependent. Federal law requires that the value of employer-provided coverage for LDAs who are not tax dependents be imputed and reported as taxable income to the employee. The amount reported as taxable income for LDA coverage under the PeaceHealth Employee Health Care Plan is determined each year. It is recommended that employees who are considering enrolling an LDA to consult with an attorney about the tax and other legal implications of electing LDA coverage.

- PeaceHealth will cover a maximum of two (2) adults in the household. If both the employee and their spouse have coverage through PeaceHealth, the employee cannot add an LDA.

- Domestic Partners, provided they meet the following requirements:

  1. Both persons share a common residence;
  2. Both persons are at least eighteen years of age;
  3. Neither person is married to someone other than the party to the domestic partnership and neither person is in a state registered domestic partnership with another person;
  4. Both persons are capable of consenting to the domestic partnership;
  5. Both of the following are true:
     a. The persons are not nearer of kin to each other than second cousins, whether of the whole or half blood computing by the rules of the civil law; and
     b. Neither person is a sibling, child, grandchild, aunt, uncle, niece, or nephew to the other person; and
  6. Either (a) both persons are members of the same sex; or (b) at least one of the persons is sixty-two years of age or older.

Or

Persons are in a Domestic Partnership registered with the Washington Secretary of State.

Coverage is available to the dependent children of one or both domestic partners provided that the children otherwise meet the dependent child eligibility requirements of the Plan.

Upon termination of a domestic partner relationship, an employee must notify the Plan Administrator, acknowledging that the relationship has ended. Coverage for domestic partners and their dependent children will cease on the last day of the month the domestic partner relationship has ended. Domestic partners will be eligible for the Continuation of Coverage provisions of the Plan to the same extent as a spouse.

There may be tax implications depending on whether or not the domestic partner is the employee's tax dependent. Federal law requires that the value of employer-provided coverage for domestic partners who are not tax dependents be imputed and reported as taxable income to the employee. The amount reported as taxable income for domestic partner coverage under the PeaceHealth Employee Health Care Plan is determined each year. It is recommended that employees who are considering enrolling a domestic partner consult with an attorney about the tax and other legal implications of electing domestic partner coverage.
Please contact the Caregiver Resource Center (CRC)/My HR for more information on how to qualify for coverage under this provision.

- An Eligible Employee’s child:

  1. who is married or unmarried, under the age of 26, regardless of whether or not the child is eligible for employer sponsored coverage through their own employer, whether or not a full-time student, whether or not claimed as a dependent on the employee’s federal income taxes, and whether or not dependent upon the employee for support.

     A special enrollment period will be held from October 1, 2011 through October 30, 2011 to allow dependent children whose coverage previously ended or were not previously eligible for coverage due to the attainment of age, to now enroll for coverage under the Plan. The dependent (and covered employee) will be eligible to enroll in any benefit package available to other similarly situated individuals. Coverage for eligible dependents that are enrolled during this special enrollment period, will become effective January 1, 2012.

  2. who is under age 26 in circumstances where the Eligible Employee is divorced or legally separated, or a party to a support arrangement under which no person contributes one-half of the child’s support for the calendar year, and all persons other than the Eligible Employee disclaim the child as a dependent for federal income tax purposes; or

  3. who is determined by the Plan Administrator or its agent to be disabled (within the meaning of Code Section 22(e)(3)), and who may be claimed by the Eligible Employee as a dependent on his federal income tax return, if the child is:

     a. Unmarried,

     b. Determined Social Security Disabled, and

     c. Incapable of self-support because of mental retardation, mental illness, or physical incapacity that began prior to the date on which the child’s eligibility would have terminated due to age.

     Proof of incapacity must be received no later than 120 days after the date on which the maximum age is attained. Subsequent evidence of disability or dependency may be required as often as is reasonably necessary to verify continued eligibility for benefits. The disabled child does not have to live with the Eligible Employee to be eligible for coverage.

  4. whose coverage is required pursuant to a valid court, administrative order, or Qualified Medical Child Support Order (QMCSO).

  5. Adopted children are eligible under the same terms and conditions that apply to dependent, natural children of parents covered under this Plan.

  6. Any individual who is covered as an employee can also be covered as a dependent. Dependents can be covered as a dependent of more than one employee. See the “Coordination of Benefits” section for information on how claims will be paid.

The term “child” includes a biological child, a legally adopted child when placed in custody or a child placed for adoption, a stepchild, a foster child, and a child related to an Eligible Employee by blood or marriage for whom the Eligible Employee, domestic partner or spouse have legal guardianship, or children who have been placed under the legal guardianship of
the employee or the employee’s spouse or domestic partner by a court decree or placement by a State agency. Placement for adoption is defined as the assumption and retention of an obligation for total or partial support of a child in anticipation of adoption irrespective of whether the adoption has become final. The child's eligibility terminates upon termination of the legal obligation. The term “child” does not include a child who otherwise satisfies the definition of Dependent but who is in active military service.

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

ENROLLMENT

Regular Enrollment

To apply for coverage under this plan, the employee must complete the online enrollment application within 30 days of the date the individual first becomes eligible for coverage. The completed enrollment should list all eligible dependents to be covered. Individuals not enrolled during the enrollment eligibility period will be required to wait until the next open enrollment period unless they become eligible to enroll as a result of a special enrollment period.

When the employee acquires a new dependent (birth, marriage, affirmation of domestic partnership, adoption, etc.), the dependents must be enrolled within the enrollment eligibility periods specified below. The special enrollment provisions below apply to domestic partners to the same extent as a spouse.

Newly acquired dependent: A newly acquired dependent (except a newborn child or a child placed for adoption) must be enrolled within 30 days of the date of acquisition.

Newborn: A newborn child may be covered from birth provided the child is enrolled within 60 days of the date of birth.

A newborn child of an enrolled employee, spouse or domestic partner will be covered for 21 days following the child’s birth. The Caregiver Resource Center (CRC)/My HR must be notified of the birth. To continue the newborn child’s coverage beyond 21 days, the child must be eligible under the terms of the Plan and a completed enrollment application, listing the child as a dependent, must be received by the Caregiver Resource Center (CRC)/My HR within 60 days from the date of birth. Newborn children of an enrolled dependent child are not eligible for coverage under the plan unless they meet the definition of an eligible dependent.

Adopted Child: A child placed for adoption may be covered from the date of placement provided the child is enrolled within 60 days of the date of placement.
Special Enrollment for Individuals Who Previously Reached the Lifetime Maximum Benefits

A special enrollment period will be held from October 1, 2011 through October 30, 2011 to allow individuals whose coverage previously ended due to reaching the lifetime limit for all benefits under the plan to re-enroll for coverage under the Plan. The individual (and employee) will be eligible to enroll in any benefit package available to other similarly situated individuals. Coverage for individuals that are enrolled during this special enrollment period will become effective January 1, 2012.

Special Enrollment for Loss of Other Coverage

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

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

The current employee or dependent may request the special enrollment within 30 days of the loss of other health coverage under the following circumstances.

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

Effective date of coverage will be the first of the month following the date of the qualifying event, as long as the request is received by the Plan Administrator within 30 days of the qualifying event.
**Special Enrollment for Loss of Eligibility Due to Reaching Lifetime Maximum Benefits**

A special enrollment period is available for current employees and their dependent, if an individual incurs a claim that causes the individual to meet or exceed a lifetime maximum on all benefits under a non-PeaceHealth medical plan. The current employee or dependent may request the special enrollment within 30 days from the date that the claim putting the individual over the lifetime maximum was denied.

If the other coverage is COBRA continuation coverage, meeting or exceeding a lifetime maximum on all benefits, shall also result in the exhaustion of COBRA continuation coverage. Special enrollment must be requested within 30 days from the date the claim putting the individual over the lifetime maximum was incurred.

Effective date of coverage will be the first of the month following the date of the qualifying event, as long as the request is received by the Plan Administrator within 30 days of the qualifying event.

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

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

- The employee’s or dependent’s SCHIP coverage or Medicaid coverage is terminated due to a loss of eligibility.

- The employee or dependent becomes eligible for SCHIP or Medicaid premium assistance.

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

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

**Special Enrollment for New Dependents**

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

- When an employee marries or begins a domestic partnership, a special enrollment period is available for the employee and newly acquired dependents. As long as the proper enrollment form is received by the Caregiver Resource Center (CRC)/My HR within the 30 day enrollment period, the effective date of coverage will be the first of the month following the date of marriage.

- When an employee, domestic partner or spouse acquires a child through birth, adoption, or placement for adoption, a special enrollment period is available for the employee and the dependent child. As long as the proper enrollment form is received by the Plan within the 60 day enrollment period, the effective date of coverage will be the date of the birth, adoption, or placement of adoption.
Special Enrollment for New Dependents through Qualified Medical Child Support Order

The Plan will honor the terms of a Qualified Medical Child Support Order (QMCSO). The order must be issued as a part of a judgment, order of decree or a divorce settlement agreement related to a child support, alimony, or the division of marital property, issued pursuant to state law. Agreements made by the parties, but not formally approved by a court, are not acceptable. If the child is enrolled within 60 days of the court or state agency order, the waiting period and pre-existing conditions exclusion period do not apply.

Open Enrollment

An open enrollment period is held once every 12 months to allow eligible employees to change their participation. The open enrollment period will be held the last quarter of the year for an effective date of January 1.

The waiting period for coverage of pre-existing conditions for newly enrolled participants will start on the date the coverage becomes effective. The pre-existing conditions limitation for eligible employees enrolling during open enrollment will be six (6) months from the date coverage begins, less any period of creditable coverage.

CERTIFICATE OF CREDITABLE COVERAGE

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

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

EFFECTIVE DATE OF COVERAGE

Employee Effective Date

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

Coverage Waiting Period

System Services Employees, Siuslaw Region Employees, and Lower Columbia Region Physicians: Coverage begins for eligible employees on the first of the month following the date they become benefit eligible.

PeaceHealth Oregon Region: The waiting period is 30 days from the date the employee becomes benefit eligible. Coverage begins for eligible employees on the first of the month following the waiting period.
Southeast Alaska Region, and PeaceHealth Laboratories Employees: The waiting period is 60 days from the date the employee becomes benefit eligible. Coverage begins for eligible employees on the first of the month following the waiting period.

Whatcom Region Employees: The waiting period is 90 days from the date the employee becomes benefit eligible. Coverage begins for eligible employees on the first of the month following the waiting period.

Lower Columbia Region Non-Physician Employees: The waiting period is 60 days from the date the employee becomes benefit eligible. Coverage begins for eligible caregivers on the first of the month following the waiting period. For WSNA and Teamster employees, the waiting period is 90 days from the date the caregiver becomes benefit eligible. Coverage begins for eligible caregivers on the first of the month following the waiting period.

Past Service Credit policy: If an otherwise eligible employee worked for an organization that is acquired by PeaceHealth, the pre-existing condition exclusion is waived if the employee’s prior service with the organization is sufficient to satisfy requirements under this Plan.

Dependent Effective Date

If the employee elects coverage for dependents during the first 30 days of eligibility, the dependents’ effective date will be the same as the employee’s effective date.

If the covered employee marries, the employee must add the newly acquired dependents within 30 days of the date of marriage and the effective date of coverage is the first of the month following the date of marriage.

If the covered employee enters into a domestic partnership, the employee must add the newly acquired dependents within 30 days of the affirmation of domestic partnership and the effective date of coverage is the first of the month following the date the affirmation is submitted to the Caregiver Resource Center (CRC)/My HR.

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

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

Employee

- The date the Employer terminates the Plan and offers no other group health plan.
- The last day of the month in which the employee ceases to meet the eligibility requirements of the Plan.
- The last day of the month in which the employee's employment ends.
- The last day of the month in which the employee begins active service in the armed forces.
- The last day of the month in which an employee fails to return to work following an approved leave of absence.
- The last day of the month in which the employee retires.

Dependent(s)

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

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

APPROVED FAMILY AND MEDICAL LEAVE

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

Please contact the Caregiver Resource Center (CRC)/My HR for information on how to qualify for a Family/Medical Leave of Absence.
MILITARY LEAVE OF ABSENCE

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

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

a. For elections made before December 10, 2004, the 18 month period beginning on the date that Uniformed Service leave commences; or

b. For elections made on or after December 10, 2004, the 24 month period beginning on the date that Uniformed Service leave commences;

c. The period beginning on the date that Uniformed Service leave commences and ending on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

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

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

Please contact the Caregiver Resource Center (CRC)/My HR for information concerning eligibility for USERRA and any requirements of the Plan.

REINSTATEMENT OF COVERAGE

If an employee or dependent who was covered under this Plan terminates employment or loses eligibility for coverage and is rehired or again becomes eligible for coverage, all waiting periods, deductibles and out-of-pockets must be re-satisfied.
INTRODUCTION

This Plan is a church plan and as such is exempt from the requirements of federal law which require Continuation Coverage to qualified beneficiaries upon a qualifying event. Notwithstanding that fact, this Plan is administered in a manner consistent with the requirements of federal law but with certain exceptions. For example, Continuation Coverage is not made available under this Plan if a qualified beneficiary is covered under another group health plan as of the date of a qualifying event. Contact the Plan Administrator with questions concerning a participants right to Continuation Coverage.

PeaceHealth Employee Health Care Plan (the Plan)

The following information about a qualified beneficiary's right to continue health care coverage in the Plan is important. Please read it very carefully.

Continuation Coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. Continuation Coverage can become available to an employee when he/she would otherwise lose group health coverage under the Plan. It can also become available to an employee’s spouse, LDA or domestic partner and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. The following paragraphs generally explain continuation coverage, when it may become available to an employee and their family, and what a qualified beneficiary needs to do to protect the right to receive it.

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

The Plan has multiple group health components, and a participant may be enrolled in one or more of these components. Continuation Coverage (and the description of Continuation Coverage contained in this SPD) applies only to the group health plan benefits offered under the Plan and not to any other benefits offered under the Plan or by PeaceHealth (such as life insurance, disability, or accidental death or dismemberment benefits).

The Plan Administrator is:

PeaceHealth
14432 SE Eastgate Way, Suite 300
Bellevue, WA 98007-6412
425/747-1711
The party responsible for administering Continuation Coverage ("Plan Administrator") is:

PeaceHealth Caregiver Resource Center (CRC)
P.O. Box 873910
Vancouver, WA 98687
CRC@peacehealth.org
855-333-MYHR (6947)

WHAT IS CONTINUATION COVERAGE?

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

After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, Continuation Coverage must be offered to each person losing Plan coverage who is a “qualified beneficiary.” An employee, spouse, domestic partner or LDA, and their dependent children could become qualified beneficiaries and would be entitled to elect Continuation Coverage if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under a Qualified Medical Child Support Order (QMCSO) may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

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

NOTE: The plan does not provide Out-of-Area benefits to participants on Continuation Coverage.
WHO IS ENTITLED TO ELECT CONTINUATION COVERAGE?

If the participant is an employee, he or she will be entitled to elect Continuation Coverage if they lose group health coverage under the Plan because either one of the following qualifying events happens:

- the employee’s hours of employment are reduced; or
- the employee’s employment ends for any reason other than the employee’s gross misconduct.

If the participant is the spouse or domestic partner of an employee, he or she will be entitled to elect Continuation Coverage if they lose group health coverage under the Plan because any of the following qualifying events happens:

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

If the participant is the LDA of an employee, he or she will be entitled to elect Continuation Coverage if they lose group health coverage under the Plan because any of the following qualifying events happens:

- the participant no longer meets the definition of an LDA;
- the employee dies;
- the employee’s hours of employment are reduced; or
- the employee’s employment ends for any reason other than his or her gross misconduct.

If the participant is the dependent child of an employee, he or she will be entitled to elect Continuation Coverage if they lose group health coverage under the Plan because any of the following qualifying events happens:

- their parent-employee dies;
- their parent-employee’s hours of employment are reduced;
- their parent-employee’s employment ends for any reason other than his or her gross misconduct;
- they stop being eligible for coverage under the Plan as a “dependent child.”

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

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

WHEN IS CONTINUATION COVERAGE AVAILABLE?

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

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

In providing this notice, the qualified beneficiary must use the Plan’s form entitled “Notice of Qualifying Event (Form & Notice Procedures),” and must follow the procedures specified in the section below entitled “Notice Procedures for Notice of Qualifying Event.” If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, THE QUALIFIED BENEFICIARY WILL LOSE THE RIGHT TO ELECT Continuation Coverage. (A copy of the Notice of Qualifying Event (Form & Notice Procedures) may be obtained from the Plan Administrator.)
ELECTING CONTINUATION COVERAGE

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

Qualified Beneficiaries have 60 days from the date of the Continuation Coverage election notice provided at the time of the qualified beneficiaries qualifying event to decide whether they want to elect Continuation Coverage under the Plan. Mail or hand deliver the completed Election Form to the Plan Administrator.

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

If mailed, the election must be postmarked (and if hand-delivered, the election must be received by the individual at the address specified above) no later than 60 days after the date of the Continuation Coverage election notice provided to the qualified beneficiary at the time of his or her qualifying event. IF A COMPLETED ELECTION FORM IS NOT SUBMITTED BY THIS DUE DATE, THE RIGHT TO ELECT CONTINUATION COVERAGE WILL BE LOST.

If the qualified beneficiary rejects Continuation Coverage before the due date, he or she may change their mind as long as a completed Election Form is furnished before the due date.

Important additional information about payment for Continuation Coverage is included below.

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

When the qualified beneficiary completes the Election Form, he or she must notify the Plan Administrator if any qualified beneficiary has become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare entitlement. If a qualified beneficiary becomes entitled to Medicare (or first learn that they are entitled to Medicare) after submitting the Election Form, he or she must immediately notify the Plan Administrator of the date of their Medicare entitlement at the address specified above for delivery of the Election Form.

Qualified beneficiaries are not eligible for continuation coverage if they are enrolled in a group health plan or entitled to Medicare benefits at the time of the qualifying event.
SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT CONTINUATION COVERAGE

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

LENGTH OF CONTINUATION COVERAGE

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

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

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, Continuation Coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, Continuation Coverage under the Plan's components for his or her spouse and children who lost coverage as a result of his or her termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). This Continuation Coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

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

Legally Domiciled Adult (LDA) continuation coverage is limited to the earlier of three months, or coverage under another group health plan. Application and premium payment must be received within 60 days of termination of coverage to be eligible.
EXTENSION OF MAXIMUM COVERAGE PERIOD

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

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

The disability extension is available only if the qualified beneficiary notifies the Plan Administrator in writing of the Social Security Administration’s determination of disability within 60 days after the latest of:

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

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

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

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

The maximum amount of Continuation Coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, or a dependent child’s
ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare.)

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

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

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

Continuation Coverage will automatically terminate before the end of the maximum period if:

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

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

The qualified beneficiary must notify the Plan Administrator in writing within 30 days if, after electing Continuation Coverage, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). The qualified beneficiary must use the Plan’s form entitled “Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures),” and must follow the procedures specified below in the section entitled “Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability.” (A copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures) may be obtained from the Plan Administrator.)
Continuation Coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary). The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the qualified beneficiary provided notice to the Plan Administrator of Medicare entitlement or other group health plan coverage.

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

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

**COST OF CONTINUATION COVERAGE**

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

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

All Continuation Coverage premiums must be paid by check.

The qualified beneficiary’s first payment and all monthly payments for Continuation Coverage must be mailed or hand-delivered to the Plan Administrator.

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

The qualified beneficiary must make their first payment for Continuation Coverage no later than 45 days after the date of the election. (This is the date the Election Form is postmarked, if mailed, or the date the Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered.) See the section above entitled “Electing Continuation Coverage.”

The qualified beneficiary’s first payment must cover the cost of Continuation Coverage from the time coverage under the Plan would have otherwise terminated up through the end of the month before the month in which the qualified beneficiary makes the first payment. (For example, Sue’s employment terminates on September 30, and she loses coverage on September 30. Sue elects Continuation Coverage on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45th day after the date of her Continuation Coverage election.) Qualified beneficiaries are responsible for making sure that the amount of their first payment is correct. Contact the Plan Administrator using the contact information provided below to confirm the correct amount of the first payment.

Claims for reimbursement will not be processed and paid until the qualified beneficiary has elected Continuation Coverage and made the first payment for it.

If the qualified beneficiary does not make their first payment for Continuation Coverage in full within 45 days after the date of their election, they will lose all Continuation Coverage rights under the Plan.

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

Although monthly payments are due on the first day of each month of Continuation Coverage, a qualified beneficiary will be given a grace period of 30 days after the first day of the month to make each monthly payment. Continuation Coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment.
If a qualified beneficiary fails to make a monthly payment before the end of the grace period for that month, he or she will lose all rights to Continuation Coverage under the Plan.

MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES

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

A child of the covered employee who is receiving benefits under the Plan pursuant to a qualified medical child support order (QMCSO) received by the Plan Administrator during the covered employee’s period of employment with PeaceHealth is entitled to the same rights to elect Continuation Coverage as an eligible dependent child of the covered employee.

QUESTIONS

Questions concerning the Plan or Continuation Coverage rights should be addressed to the Plan Administrator.

KEEP THE PLAN INFORMED OF ADDRESS CHANGES

In order to protect the qualified beneficiary and family’s rights, keep the Plan Administrator informed of any changes in the addresses of family members. The qualified beneficiary should also keep a copy, for their records, of any notices sent to the Plan Administrator.

PLAN CONTACT INFORMATION

Qualified beneficiaries may obtain information about the Plan and Continuation Coverage on request from the Plan Administrator. The contact information for the Plan may change from time to time.

NOTICE PROCEDURES

PeaceHealth Employee Health Care Plan

NOTICE PROCEDURES FOR NOTICE OF QUALIFYING EVENT

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

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

Use the Plan’s form entitled “Notice of Qualifying Event (Form & Notice Procedures)” to notify the Plan Administrator of a qualifying event (i.e., a divorce or legal separation or a child’s loss of dependent status), and all of the applicable items on the form must be completed. (A copy of the Notice of Qualifying Event (Form & Notice Procedures) may be obtained from the Plan Administrator.

The notice must contain the following information:

- the name of the Plan (PeaceHealth Employee Health Care Plan);
- the name and address of the employee or former employee who is or was covered under the Plan;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the qualifying event (divorce, legal separation, or child’s loss of dependent status);
- the qualifying event (divorce, legal separation, or child’s loss of dependent status);
- the date that the divorce, legal separation, or child’s loss of dependent status happened; and
- the signature, name, and contact information of the individual sending the notice.

If the qualified beneficiary is notifying the Plan Administrator of a divorce or legal separation, the notice must include a copy of the decree of divorce or legal separation.

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

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

- the notice is mailed or hand-delivered to the individual and address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan;
- from the written notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies), the qualifying event (divorce,
legal separation, or child’s loss of dependent status), and the date on which the qualifying event occurred; and

- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan’s requirements (as described in these Notice Procedures for Notice of Qualifying Event) within 15 business days after a written or oral request from the Plan Administrator for more information (or, if later, by the deadline for the Notice of Qualifying Event described above).

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

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

If the qualified beneficiaries notice was regarding a child’s loss of dependent status, the qualified beneficiary must, if the Plan Administrator requests it, provide documentation of the date of the qualifying event that is satisfactory to the Plan Administrator (for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution). This will allow the Plan Administrator to determine if the qualified beneficiary gave timely notice of the qualifying event and was consequently entitled to elect Continuation Coverage. If the qualified beneficiary does not provide satisfactory evidence within 15 business days after a written or oral request from the Plan Administrator that the child ceased to be a dependent on the date specified in the Notice of Qualifying Event, his or her Continuation Coverage may be terminated (retroactively if applicable) as of the date that Continuation Coverage would have started. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

NOTICE PROCEDURES FOR NOTICE OF DISABILITY

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

The qualified beneficiary must mail or hand deliver this notice to the Plan Administrator.

The notice must be in writing (using the Plan’s form described below) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, the notice must be postmarked no later than the deadline described above. If hand-delivered, the notice must be received by the individual at the address specified above no later than the deadline described above.
The qualified beneficiary must use the Plan’s form entitled “Notice of Disability (Form & Notice Procedures)” to notify the Plan Administrator of a qualified beneficiary’s disability, and all of the applicable items on the form must be completed. (A copy of the Notice of Disability (Form & Notice Procedures) may be obtained from the Plan Administrator.)

The notice must contain the following information:

- the name of the Plan (PeaceHealth Employee Health Care Plan);
- the name and address of the employee or former employee who is or was covered under the Plan;
- the initial qualifying event that started the qualified beneficiary’s Continuation Coverage (the covered employee’s termination of employment or reduction of hours);
- the date that the covered employee’s termination of employment or reduction of hours happened;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving Continuation Coverage at the time of the notice;
- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary became disabled;
- the date that the Social Security Administration made its determination of disability;
- a statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name, and contact information of the individual sending the notice.

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

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

- the notice is mailed or hand-delivered to the individual and address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan and a qualified beneficiary’s disability;
- from the written notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies) and the date on which the covered employee’s termination of employment or reduction of hours occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan’s requirements (as described in these Notice Procedures for Notice of Disability) within 15 business days after a written or oral request from the Plan Administrator for more information (or, if later, by the deadline for the Notice of Disability described above).
If any of these conditions are not met, the incomplete notice will be rejected and Continuation Coverage will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

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

NOTICE PROCEDURES FOR NOTICE OF SECOND QUALIFYING EVENT

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

The qualified beneficiary must mail or hand deliver this notice to the Plan Administrator.

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

The qualified beneficiary must use the Plan’s form entitled “Notice of Second Qualifying Event (Form & Notice Procedures)” to notify the Plan Administrator of a second qualifying event (i.e., a divorce or legal separation, the covered employee’s death, or a child’s loss of dependent status), and all of the applicable items on the form must be completed. (A copy of the Notice of Second Qualifying Event (Form & Notice Procedures) may be obtained from the Plan Administrator).

The notice must contain the following information:

- the name of the Plan (PeaceHealth Employee Health Care Plan);
- the name and address of the employee or former employee who is or was covered under the Plan;
- the initial qualifying event that started the qualified beneficiary’s Continuation Coverage (the covered employee’s termination of employment or reduction of hours);
- the date that the covered employee’s termination of employment or reduction of hours happened;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving Continuation Coverage at the time of the notice;
the second qualifying event (a divorce or legal separation, the covered employee’s death, or a child’s loss of dependent status);

the date that the divorce or legal separation, the covered employee’s death, or a child’s loss of dependent status happened; and

the signature, name, and contact information of the individual sending the notice.

If the qualified beneficiary is notifying the Plan Administrator of a divorce or legal separation, the notice must include a copy of the decree of divorce or legal separation.

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

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

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

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

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

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

NOTICE PROCEDURES FOR NOTICE OF OTHER COVERAGE, MEDICARE ENTITLEMENT, OR CESSION OF DISABILITY

If the qualified beneficiary is providing a Notice of Other Coverage (a notice that a qualified beneficiary has become covered, after electing Continuation Coverage, under other group health plan coverage), the deadline for this notice is 30 days after the other coverage becomes effective or, if later, 30 days after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary.

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

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

The qualified beneficiary must mail or hand deliver this notice to the Plan Administrator.

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

The qualified beneficiary should use the Plan’s form entitled “Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures)” to notify the Plan Administrator of any of these events, and all of the applicable items on the form should be completed. (A copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures) may be obtained from the Plan Administrator.)
The notice should contain the following information:

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

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

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

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

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

If a qualified beneficiary is covered by another group health plan as of the date of or after electing Continuation Coverage, that qualified beneficiary’s Continuation Coverage terminates (retroactively if applicable) as described above in the section entitled “Termination of Continuation Coverage Before the End of the Maximum Coverage Period,” regardless of whether or when a Notice of Other Coverage is provided.

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

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

Pre-authorization from the Health Services Department does not constitute Plan liability for any pre-existing condition charges during the pre-existing waiting period.

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

When this Plan replaces another group health coverage program previously held by the Employer, the waiting periods will be credited for the time those employees and their eligible dependents were enrolled under the prior coverage.

PRE-EXISTING CONDITIONS

A pre-existing condition, whether physical or mental, and regardless of the cause of the condition, is a condition for which medical advice, diagnosis, care, or treatment has been recommended or received within the three (3) month period ending on the enrollment date. In order to be taken into account, the medical advice, diagnosis, care, or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under State law and who operates within the scope of practice authorized by the State law.

PRE-EXISTING CONDITIONS EXCLUSION

The exclusion period for pre-existing conditions commences on the participants enrollment date and will be no longer than six (6) months, less any period of creditable coverage. Participants have the right to demonstrate any creditable coverage, and the applicable exclusion period will be reduced by any creditable coverage unless it occurred before a significant break in coverage.

For purposes of applying the preexisting conditions exclusion, the term “enrollment date” is defined as the effective day of coverage, or if there is a waiting period for coverage to begin under the Plan, the first day of the waiting period. The term “waiting period” refers to the period after employment starts in an eligible class and the first day of coverage under the Plan. The waiting periods are set forth on page 18 of this handbook. For a person who is a late enrollee (who does not enroll when first eligible), or who enrolls on a special enrollment date, the “enrollment date” will be the effective date of coverage. If an individual is receiving benefits under this Plan and changes benefit options, or if the Plan changes group health insurance carriers, the individual’s enrollment date does not change.

The pre-existing conditions exclusion does not apply to pregnancy, genetic information, or to any participant (whether covered as an employee or dependent) under the age of 19.
DEDUCTIBLES - ONLY APPLIES TO OPEN NETWORK PPO PLAN AND OPEN NETWORK PLUS PPO PLAN.

Individual

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

Family

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

DEDUCTIBLE CARRYOVER (PPO PLANS ONLY)

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

DEDUCTIBLES – APPLIES TO HDHP ONLY

Self Only Coverage

The self only deductible is the amount of eligible medical expenses each calendar year that an employee must incur before any benefits for the employee are payable by the Plan. The employee deductible amount is listed in the Summary of Benefits.

Family Coverage

When the deductible amounts accumulated by one or more covered participants of the family reach the family deductible shown in the Summary of Benefits during one calendar year, no further deductibles will apply to any family member for the rest of that calendar year.

AMOUNTS NOT CREDITED TOWARD THE DEDUCTIBLE

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

- Expenses for services or supplies not covered by this Plan.
- Charges in excess of the usual, customary, and reasonable (UCR) charges.
- Copays (PPO Plans only).
• Claims denied due to non-compliance with pre-authorization requirements.

COINSURANCE PERCENTAGE

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

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

COPAY

A copay is a fixed amount paid by the participant to their provider or facility each time they receive a service subject to copay as specified in the Summary of Benefits.

OUT-OF-POCKET MAXIMUM

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

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

PPO Plans Only:

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

• Deductibles.
• Durable medical equipment expenses.
• Prosthetics expenses.
• Chiropractic copays.
• Orthotics expenses.
• Infertility expenses.
• Alternative medicine expenses.
• Bariatric surgery expenses.
- Expenses not covered under this Plan.

- Expenses incurred as a result of failure to meet Plan pre-authorization requirements.

**HDHP Only**

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

- Bariatric surgery expenses.

- Expenses not covered under this Plan.

- Expenses incurred as a result of failure to meet Plan pre-authorization requirements.

**IN-NETWORK PPO PLAN ANNUAL OUT-OF-POCKET MAXIMUMS**

The In-Network PPO Plan has both a per person and per family annual (calendar year) out-of-pocket maximum. These amounts are listed on the In-Network Plan Summary of Benefits. The maximums are the total amount a participant or the participant’s covered dependents will pay out-of-pocket in any calendar year for covered services. The family maximum combines out-of-pocket costs made by all family members. Once the participant or the participant’s family have paid the maximum amounts listed on the Summary of Benefits, the participant will have no additional out-of-pocket costs for covered services for the remainder of the calendar year.

**OPEN NETWORK PPO PLAN ANNUAL OUT-OF-POCKET MAXIMUMS**

The Open Network Plus PPO and Open Network PPO plans have both a per person and per family annual (calendar year) out-of-pocket maximum. The Open Network Plus PPO and Open Network PPO plans have two different sets of per person/per family maximums: one for payments the participant makes for covered services when he or she uses the in-network benefit and one for payments the participant makes for covered services when he or she uses the out-of-network benefit. In-network and out-of-network maximums accumulate separately and are not combined. The maximums are listed on the Open Network Plus PPO Plan and Open Network PPO Plan Summary of Benefits.

The maximums are the total amount the participant or the participant’s covered dependents will pay out-of-pocket in any calendar year for covered services. The family maximum combines out-of-pocket costs made by all family members. Once the participant or the participant’s family have paid the maximum amounts listed on the Summary of Benefits, the participant will have no additional out-of-pocket costs for covered services for the remainder of the calendar year.
The Open Network Plus PPO plan has a per person and per family out-of-network deductible. For out-of-network benefits only, the deductible must be met each year before the Plan will begin paying for covered services. Deductible amounts should be paid directly to the participant’s providers. A per person deductible needs to be met by each individual family member. If three individual family members meet this deductible, then the family deductible will be met. No further per person deductibles will need to be met by any other family members. Payments toward meeting the participant’s deductible do not apply to the out-of-pocket maximums.

**Deductible carryover - PPO Plans Only:**

Applicable charges used to meet any portion of the deductible during the fourth quarter of a calendar year will be applied toward the next year’s deductible.

The Open Network PPO plan has a per person and per family common deductible. **One common deductible applies to both in-network and out-of-network benefits.** Once the participant meets his or her deductible, the Plan will begin paying for covered services for either in-network or out-of-network benefits. Deductible amounts should be paid directly to the participant’s providers. A per person deductible needs to be met by each individual family member. If three individual family members meet this deductible, then the family deductible will be met. No further per person deductibles will need to be met by any other family members. Payments toward meeting the participant’s deductible do not apply to the out-of-pocket maximums.

**Deductible carryover - PPO Plans Only:**

Applicable charges used to meet any portion of the deductible during the fourth quarter of a calendar year will be applied toward the next year’s deductible.

For all plans except the HDHP, the following out-of-pocket costs do not apply toward the annual out-of-pocket maximum or any applicable deductibles:

- Services not covered under the Plan.
- Services in excess of any maximum benefit limit.
- Fees in excess of the usual, customary, and reasonable (UCR) charges.
- Durable medical equipment and medical supplies and devices.
- Services relating to the diagnosis of infertility.
- Any penalties a participant must pay if he or she does not follow the Plan’s pre-authorization requirements.
• Payments the participant makes toward meeting any applicable calendar year deductibles do not apply to the annual out-of-pocket maximum.

• Copayments or coinsurance for any supplemental benefits the plan may have such as alternative care or chiropractic care.

• Services related to Bariatric Surgery.

OUT-OF-POCKET COSTS THAT DO NOT APPLY TO DEDUCTIBLES OR MAXIMUMS (HDHP ONLY)

The following out-of-pocket costs do not apply toward the annual out-of-pocket maximum or any applicable deductibles:

• Services not covered under the Plan.

• Services in excess of any maximum benefit limit.

• Fees in excess of the usual, customary, and reasonable (UCR) charges.

• Any penalties a participant must pay if he or she does not follow the Plan’s pre-authorization requirements.

• Services related to Bariatric Surgery.
COORDINATION OF BENEFITS

Definitions

The term “allowable expense” shall mean the usual, customary and reasonable (UCR) expense, at least a portion of which is paid under at least one of any multiple plans covering the participant for whom the claim is made. In no event will more than 100% of total allowable expenses be paid between all plans, nor will total payment by both Plans exceed the amount which this Plan would have paid as primary Plan. For participants who are receiving kidney dialysis due to End Stage Renal Disease with Medicare as their primary coverage, this Plan will coordinate benefits with Medicare. In this case, total payment by this Plan, shall not exceed the amount which this Plan would have paid as the primary plan.

The term “order of benefits determination” shall mean the method for ascertaining the order in which the Plan renders payment. The principle applies when another plan has a Coordination of Benefits (COB) provision. Below are a few examples of how COB works:

### Scenario #1

<table>
<thead>
<tr>
<th>Primary Plan</th>
<th>PeaceHealth Plan is:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claims Amount</strong></td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>Less Deductible</strong></td>
<td>$100</td>
</tr>
<tr>
<td><strong>Adjusted Total</strong></td>
<td>$4,900</td>
</tr>
<tr>
<td><strong>Claim paid at 50%</strong></td>
<td>$2,450</td>
</tr>
<tr>
<td><strong>Other Plan pays</strong></td>
<td>$2,450</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claims Amount</strong></td>
</tr>
<tr>
<td><strong>Less Deductible</strong></td>
</tr>
<tr>
<td><strong>Adjusted Total</strong></td>
</tr>
<tr>
<td><strong>Paid at 90%</strong></td>
</tr>
</tbody>
</table>

Other Plan pays $2,450

Less Primary Insurance payment $2,450

PeaceHealth Plan pays $1,600

Participant pays $950

### Scenario #2

<table>
<thead>
<tr>
<th>Primary Plan</th>
<th>PeaceHealth Plan is:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claims Amount</strong></td>
<td>$5,000</td>
</tr>
<tr>
<td><strong>Less Deductible</strong></td>
<td>$100</td>
</tr>
<tr>
<td><strong>Adjusted Total</strong></td>
<td>$4,900</td>
</tr>
<tr>
<td><strong>Claim paid at 90%</strong></td>
<td>$4,410</td>
</tr>
<tr>
<td><strong>Other Plan pays</strong></td>
<td>$4,410</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Secondary Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Claims Amount</strong></td>
</tr>
<tr>
<td><strong>Less Deductible</strong></td>
</tr>
<tr>
<td><strong>Adjusted Total</strong></td>
</tr>
<tr>
<td><strong>Paid at 90%</strong></td>
</tr>
<tr>
<td><strong>Less Primary Insurance payment</strong></td>
</tr>
</tbody>
</table>

PeaceHealth Plan pays $0

Participant pays $590

Application

Under the order of benefits determination method, the plan that is obligated to pay its benefits first is known as the primary Plan. The plan that is obligated to pay additional benefits for allowable expenses not paid by the primary Plan is known as the secondary Plan. For individuals enrolled on the HDHP, this Plan will only coordinate benefits with other HDHP coverage. When a participant is enrolled under two or more plans (policies), an order
of benefits determination will be made regarding which plan will pay first. The order of benefit determination is as follows:

1. The plan which does not include a Coordination of Benefits provision will be primary.
2. The plan covering the person as a retiree will be secondary.
3. The plan covering the person as the employee (or insured, member, or subscriber) of the policy will be primary.
4. This Plan will pay primary to any individual policy.
5. When a covered participant has coverage under the Canadian Universal Health Care System, this Plan will pay secondary, when services are received in Canada. This Plan will pay primary, when services are received outside of Canada.
6. When a covered participant has coverage through the VA Health Care System, this Plan will be primary, unless the injury or illness is in connection with or a result of active military service.
7. When a dependent child is covered under more than one plan, the following rules apply. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:
   a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      i. The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
      ii. If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.
   b. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
      i. If a court decree states that one of the parents is responsible for the dependent child’s health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child’s health care expenses, but that parent’s spouse does, that parent’s spouse’s plan is the primary plan. This item shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;
      ii. If a court decree states that both parents are responsible for the dependent child’s health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;
      iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits; or
iv. If there is no court decree allocating responsibility for the child’s health care expenses or health care coverage, the order of benefits for the child are as follows:

1. The plan covering the custodial parent;
2. The plan covering the custodial parent’s spouse;
3. The plan covering the non-custodial parent; and then
4. The plan covering the non-custodial parent’s spouse.

c. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

8. Where the order of payment cannot be determined in accordance with (1), (2), (3), (4), (5), (6), or (7) above, the primary Plan shall be deemed to be the plan which has covered the patient for the longer period of time.

9. Where the order of payment cannot be determined in accordance with (1), (2), (3), (4), (5), (6), (7), or (8) above, the primary Plan shall be deemed to be the plan which has covered the employee for the longest time.

**Coordination of Benefits with Medicaid**

In all cases, benefits available through a state or Federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

**Coordination of Benefits with Medicare**

Coordination of benefits with Medicare is governed by the Medicare Secondary Payer rules.
INTRODUCTION

This section lists covered benefits in alphabetical order. Please refer to the Summary of Benefits for participant copayments/coinsurance as well as other details of the participant’s specific coverage.

IN-NETWORK PPO PLAN PARTICIPANTS

Except as otherwise stated in the “Using The Plans In-Network Benefits,” section, the participant must use network providers to receive benefits for the covered services listed in this section.

OPEN NETWORK PLUS PPO PLAN, OPEN NETWORK PPO PLAN, AND HDHP PARTICIPANTS

Participants must use network providers to receive in-network benefits for the covered services listed in this section. If a participant uses non-network providers, the out-of-network benefits will apply. See the “Using The Plans Out-of-Network Benefit,” section, for details on using the out-of-network benefit.

ELIGIBLE EXPENSES

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

ALLERGY INJECTIONS/TESTING

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

ALTERNATIVE SERVICES – Open Network Plus PPO Plan Only

The alternative medicine benefit consists of services provided by chiropractors, naturopaths, and acupuncturists. Services are paid as shown in the Open Network Plus PPO Plan Summary of Benefits. Massage therapy performed by a chiropractor is not covered.
AMBULANCE (AIR AND GROUND)

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

BARIATRIC SURGERY

The Plan covers expenses for bariatric surgery, related doctor’s visits, and laboratory tests for individuals ages 21 through 69. Treatment must be provided by a Designated Provider according to a written treatment plan. The benefit is limited to one course of treatment. A course of treatment begins and ends as specified in the treatment plan, or sooner if the participant discontinues treatment. The Plan will cover one (1) surgical procedure under this benefit.

All of the following criteria must be met prior to the commencement of surgery:

1. Body Mass Index (BMI) greater than or equal to 50 kg/m², or BMI of 45 kg/m² to 49.9 and 1 qualifying co-morbid condition, or BMI of 40 kg/m² with 2 or more qualifying co-morbid conditions which have not responded to medical management and which are generally expected to be ameliorated, reversed, or muted by obesity surgical treatment:

2. Qualifying Co-morbid Conditions are:
   a. Hypertension
   b. Dyslipidemia
   c. Type 2 diabetes
   d. Coronary heart disease
   e. Moderate obstructive sleep apnea
   f. Degenerative joint disease hips, knees, ankles, feet and lumbosacral spine

3. Documented five-year history of morbid obesity by a healthcare provider, such as chart notes (BMI greater than or equal to specifications above).

4. Evaluation by a licensed psychologist or psychiatrist documents the absence of significant psychopathology that can limit an individual's understanding of the procedure or ability to comply with medical/surgical recommendations (e.g., active substance abuse, schizophrenia, borderline personality disorder, uncontrolled depression).

5. Documentation of willingness to comply with preoperative and postoperative treatment plans.

6. Six months documentation of participation in a designated bariatric pre-surgical program which includes information on weight loss, lifestyle changes, and dietary understanding, 12 weeks of which includes successful completion of the Weight Intervention Program covered under the PeaceHealth Medical Plan.

7. Has not had previous bariatric surgery.

The surgery must be pre-authorized by HMA’s Medical Management Department prior to services being rendered. When all the above information has been accumulated, the information should be referred to HMA’s Medical Management Department.

For the purposes of the Bariatric Surgery benefit participants enrolled in the In-Network PPO Plan may utilize a Designated PeaceHealth Provider to receive coverage under the In-Network benefit level payable at 80%. Benefits for bariatric surgery may also be provided by the Designated non-PeaceHealth Providers listed with benefits payable at 60%. All other bariatric-related services must be provided by network providers to be eligible for benefits.
All services must be provided by the following providers in order to be eligible for coverage under the plan:

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sacred Heart Medical Center, Oregon Bariatric Center (Eugene, OR)</td>
<td>Designated PeaceHealth provider (80% coverage)</td>
</tr>
<tr>
<td>St. Francis Hospital, Center for Weight Management (Federal Way, WA)</td>
<td>Designated non-PeaceHealth provider (60% coverage)</td>
</tr>
<tr>
<td>Stevens Hospital (Edmonds, WA)</td>
<td>Designated non-PeaceHealth provider (60% coverage)</td>
</tr>
<tr>
<td>Puget Sound Surgical Center (Edmonds, WA)</td>
<td>Designated non-PeaceHealth provider (60% coverage)</td>
</tr>
<tr>
<td>Pacific Rim Outpatient Surgery Center (Bellingham, WA)</td>
<td>Designated non-PeaceHealth provider (60% coverage)</td>
</tr>
</tbody>
</table>

The Plan does not pay for anything not included in the written treatment plan. In addition, cosmetic surgery, including body sculpting desired as a result of significant weight loss is excluded from coverage. Travel expenses other than the normal travel benefit provided for Southeast Alaska Region participants are not a covered benefit.

The Plan may cover a revision/replacement surgery of a previously approved bariatric surgical procedure that has failed when due to medical complications that require the removal of the previous bariatric procedure. The second surgical procedure must be medically necessary meet all of the Plan’s criteria above for a bariatric procedure and is limited to one corrective surgical procedure. Inadequate weight loss due to individual noncompliance with postoperative nutrition and exercise recommendations is not a medically necessary indication for revision surgery and is not covered by the Plan. Failure of a bariatric procedure due to end of useful life expectations requiring a replacement surgery is also not covered under the Plan.

Bariatric surgery or related expenses incurred during the first 12 months of an Enrollee's coverage under this Plan are not covered. The Enrollee will be allowed a credit toward this bariatric surgery waiting period for any period of time he or she was continuously covered under another medical plan with equal or better coverage for bariatric surgery, immediately preceding the time the Enrollee’s coverage under this Plan began or any period of time in which he or she was previously covered under the PeaceHealth medical plan during their current employment period. Other than described herein, this 12-month exclusion period will not be waived or credited for any reason.
BLOOD BANK

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

CHEMICAL DEPENDENCY

See Mental Health and Chemical Dependency Treatment

CHIROPRACTIC CARE

Chiropractic services are paid as shown in the Summary of Benefits for the In-Network PPO Plan, the Open Network Plus PPO Plan, and the HDHP only.

DENTAL SERVICES

Covered services include restoration and management of head and facial structures, including teeth, dental implants and bridges, that cannot be replaced with living tissue and that are impaired because of trauma, disease or birth or development deformities.

Conditions for receiving this benefit:

- All treatment, except emergency services, must be pre-authorized by the Plan.
- Conditions related to trauma must be diagnosed within 30 days of injury and treatment must be completed within twelve months of the injury.

Covered services do NOT include:

- Cosmetic services.
- Services rendered to improve a condition that falls within the normal range of such conditions.
- Orthodontia.
- Services to treat tooth decay, periodontal conditions and deficiencies in dental hygiene.
- Removal of impacted teeth.
- The making or repairing of dentures.
- Orthognathic surgery to shorten or lengthen the upper or lower jaw, unless related to a traumatic injury or to a neoplastic or degenerative disease.
- Services to treat TMJ joint disorder, except as specified in the covered TMJ services section.

Outpatient hospitalization and anesthesia for dental services:

Benefits for outpatient hospitalization and anesthesia for dental services are covered the same as relevant services listed on the Summary of Benefits.
Services must be pre-authorized by the Plan and are only provided for participants with complicating medical conditions. Examples of these conditions include, but are not limited to:

- mental handicaps.
- physical disabilities.
- a combination of medical conditions or disabilities that cannot be managed safely and efficiently in a dental office.
- emotionally unstable, uncooperative, combative patients where treatment is extensive and impossible to accomplish in the office.
- healthy children, under 7 years of age, with physician documented necessity.

All other dental services are excluded.

**DIABETIC AND DIETARY EDUCATION**

Dietary education is a covered benefit, if provided by a physician as defined under this Plan. Benefits will be provided for education, guidance, and nutritional therapy for individuals with illnesses or diseases that can be improved with diet, including, but not limited to diabetes, high blood pressure, and high cholesterol. HMA will be the final authority on which education programs will meet the criteria of eligibility. Coverage does not include: food, vitamins, or diet supplements; health club memberships, gym memberships, exercise program, or similar expenses; Weight Watchers, Jenny Craig or similar self-directed weight-loss programs.

**DIAGNOSTIC X-RAY AND LABORATORY**

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

**DURABLE MEDICAL EQUIPMENT**

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

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

Diabetic needles, syringes, lancets, and blood glucose test strips are not covered under this benefit. Please see the Prescription Drug Card Program section for coverage information.
Purchase or rental of durable medical equipment that is over $500 must be reviewed and pre-authorized by HMA's Health Services Department.

**E-VISITS**

Electronic provider visits (E-visits) are consultations with the participant’s provider through e-mail. This benefit allows the participant to take advantage of the conveniences of e-mail when receiving health care services from a network provider who has agreed to provide this benefit. **Not all network providers offer the E-visit benefit.** Medical doctors (MD), Doctors of Osteopathy (DO), Nurse Practitioners (NP), and Physician Assistants (PA) are the only categories of providers approved for E-visit services. Please check with the provider’s office to see if the provider offers the E-visit benefit.

The Plan will provide benefits for medically necessary E-visits provided by a designated network provider for the treatment of a covered illness or injury. The E-visit benefit supplements the other benefits listed in the Medical Summary of Benefits.

When the participant has an E-visit with his or her provider, the provider’s office will invoice the participant for a $10 copayment. This copayment applies to the annual medical out-of-pocket maximum. Covered E-visits are not subject to the medical deductible on plans with medical deductibles.

To be eligible for the E-visit benefit the participant must have had at least one prior office visit with the provider within the last 12 months.

**E-visit confidentiality**

Protecting participant’s confidential medical information is important to us. Because of this, we have established quality standards for the e-mail service the provider uses for managing e-mail communications with participants. Our standards specify that appropriate Internet security technology be used to protect participant information from unauthorized access or release. The provider must use a secure interface system to administer e-mail communications with a participant.

**E-visit covered services**

E-visits include, but are not limited to:

- Communications of a new or existing diagnosis or treatment when the equivalent service received through an office visit would have led to a claims submission to be covered by HMA.
- Communications by the physician about the management of complex chronic conditions that require extensive education and ongoing monitoring.
- Communications of treatment for relapses of a previous condition that involves extended dialogue and significant physician time and judgment.
- Discussion of lab results that require significant changes in medication or further testing.
- Extended counseling when person-to-person contact would involve an unwise delay.

**E-visit exclusions**
E-mail communications that do not involve significant provider time will not be covered by the Plan. Examples of excluded E-visits include, but are not limited to:

- Prescription renewal.
- Scheduling a test.
- Scheduling an appointment.
- Reporting normal test results.
- Recommending a referral to another physician.
- A consultative message exchange from a patient who is seen in-person immediately afterward as a result of the consultative message.
- A brief follow-up of an office visit, medical procedure or other treatment to confirm stable condition.
- A brief discussion to confirm stability of a chronic problem and continuity of present management of the problem.

**EMERGENCY ROOM & SERVICES**

Benefits will be provided for emergency room treatment of an accidental injury or a medical emergency. Benefits are paid at the level shown in the Summary of Benefits. If you are traveling or receive emergency services inside or outside the network area, eligible emergency room and services will be reimbursed at the preferred network benefit level. Use of an Emergency room in a non-emergent situation is not covered.

**HOME HEALTH CARE**

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

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

- Part-time or intermittent nursing care by a registered nurse, a licensed vocational nurse or by a licensed practical nurse.
- Physical therapy by a licensed, registered, or certified physical therapist.
- Speech therapy services by a licensed, registered, or certified speech therapist.
- Occupational therapy services by a registered, certified, or licensed occupational therapist.
- Nutritional guidance by a registered diettian.
- Nutritional supplements such as diet substitutes administered intravenously or by enteral feeding.
- Respiratory therapy services by a certified inhalation therapist.
- Home health aide services by an aide who is providing intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in the participant's condition and needs, completing appropriate records.
- Medical supplies, drugs and medicines prescribed by a physician, and laboratory services normally used by a patient in a skilled nursing facility, medical facility or hospital, but only to the extent that they would have been covered under this Plan if the participant had remained in the hospital or medical facility.
- Assessment by a Masters of Social Work (M.S.W.).

**Exclusions to Home Health Care**

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

**HOSPICE CARE**

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

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

- Confinement in a hospice facility or at home.
- Ancillary charges furnished by the hospice while the participant is confined.
- Medical supplies and drugs prescribed by the attending physician, but only to the extent such items are necessary for pain control and management of the terminal condition.
- Physician services and/or nursing care by a registered nurse, licensed practical nurse, Masters of Social Work (M.S.W.), or a licensed vocational nurse.
- Home health aide services and home health care.
- Nutritional advice by a registered dietitian, nutritional supplements, such as diet substitutes, administered intravenously or through hyperalimentation.
- Physical therapy, speech therapy, occupational therapy, respiratory therapy.
- Respite care up to a maximum of 120 hours, to relieve anyone who lives with and cares for the terminally ill enrollee.

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

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

If the Lifetime Maximum for Hospice Care has been reached, HMA’s Health Services Department shall have the right to extend the normal provisions of this Plan. Any extension will be determined on the merits of each individual case and any care or treatment provided will not be considered setting any precedent or creating any future liability, with respect to that covered participant or any other covered participant.

**Exclusions to Hospice Care**

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

Services for the diagnosis of infertility are covered the same as relevant services as listed on the Summary of Benefits. Participants must see a Network provider, even if he or she is an Open Network Plus PPO Plan or Open Network PPO Plan participant for services to be covered. (Out-of-Area participants enrolled on the HDHP may use a non-Network provider for these services.)

**Covered services are limited to:** Diagnostic testing and associated office visits to determine the cause of infertility. This includes the physical examination, related laboratory testing, instruction, and medical/surgical procedures when performed for the sole purpose of diagnosing an infertile state. Diagnostic services for infertility include, but are not limited to hysterosalpingogram, laparoscopy, and pelvic ultrasound.

**All other infertility services are not covered. These include, but are not limited to:**

- In-vitro fertilization;
- In-vivo fertilization
- Gamete inter-fallopian transfer (GIFT);
- Reversal of sterilization (tubal ligation or vasectomy); and
- Any method of artificial insemination, including any and all supplies, services, drugs, and treatments leading up to the procedure of artificial insemination, and until impregnation is confirmed.

INFUSION THERAPY BENEFIT

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

KIDNEY DIALYSIS (OUTPATIENT SERVICES) (DOES NOT APPLY TO HDHP)

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

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

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

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

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

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

**MATERNITY SERVICES**

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

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

**Newborns’ and Mothers’ Health Protection Act**

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

Inpatient Care

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

- Room and board in a semi-private room.
- Intensive care, cardiac care, isolation or other special care unit.
- Private room accommodations, if medically necessary.
- Nursing care services.
- Prescribed drugs and medications administered in the hospital or the medical facility.
- Anesthesia and its administration.
- Oxygen and its administration.
- Dressings, supplies, casts, and splints.
- Diagnostic services, including but not limited to x-ray, laboratory, and radiological services.
- The use of durable medical equipment.

Outpatient Care

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

Miscellaneous

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

MEDICAL SUPPLIES

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

Non–emergency outpatient, inpatient, residential, and day treatment mental health and chemical dependency services are covered benefits. Inpatient, residential and day treatment are covered only when pre-authorized. Outpatient services do not require pre-authorization or review.

Please contact the Plan’s authorizing agent for services at:

- **Mental Health Match at 1-800-457-3798** (System Office - Bellevue, Southeast Alaska Region, Lower Columbia Region, Oregon Region, Siuslaw Region, PeaceHealth Laboratories and System Services employees located in the Southeast Alaska, Oregon and Lower Columbia Regions).

- **Health Promotion Network at 1-800-244-6142 or 360-715-6575** (Whatcom Region and System Services employees located in the Whatcom Region).

Arranging mental health or chemical dependency services.

The Plan’s authorizing agent and the participant’s qualified practitioner will coordinate inpatient and residential mental health and chemical dependency care.

For **emergency** inpatient mental health or chemical dependency services, go directly to a hospital emergency room. Participants do not need pre-authorization for emergency inpatient treatment. The participant, or a relative, should notify the Plan within 48 hours of emergency inpatient treatment, or as soon as reasonably possible.

Benefits are limited to covered services provided in the least costly treatment setting which, in the judgment of the Plan and its authorizing agent, is medically necessary for the individual patient’s condition.

Covered services:

- Outpatient diagnostic evaluation and mental health treatment including individual, family, and group therapy.

- Inpatient, residential and day or partial hospitalization for the treatment of mental disorders. These services must be obtained at a treatment facility approved by the Plan’s authorizing agent.

- Eating Disorders such as anorexia nervosa, bulimia, or other eating disorders are covered under the mental health benefits when diagnosed by a mental health professional and treated by either a mental health professional or a Registered Dietitian. Services in a Licensed Residential Care Facility are provided when pre-authorization by the Plan’s Mental Health Authorizing Agent.

Chemical Dependency Services

Benefits include covered services necessary for the diagnosis and treatment of chemical dependency (drug and alcohol treatment), including detoxification.

Covered services:

- Outpatient diagnosis and treatment for chemical dependency including, detoxification. Treatment includes individual and group therapy.
• Inpatient, residential and day or partial hospitalization for the treatment of chemical dependency disorders. These services must be obtained at a treatment facility approved by the Plan’s authorizing agent.
Medically necessary detoxification

Medically necessary detoxification will be treated as an emergency medical condition when participants are not enrolled in other chemical dependency treatment programs at the time services are received. Participants do not need pre-authorization for this emergency treatment; however, the Plan's authorizing agent must be notified within 48 hours following the onset of inpatient treatment, or as soon as reasonably possible, in order for coverage to continue. If a participant is to be transferred to a Network Provider for continued inpatient care, the cost of medically necessary transportation will be covered. Continuing or follow-up inpatient care is not a covered service unless pre-authorized by our authorizing agent.

Exclusions that apply to mental health and chemical dependency:

- Conditions that are not responsive to therapeutic management after a diagnosis is made by a physician who has treated or examined the patient, except when the treatment or services provided are effective in maintaining existing functionality or preventing a decline in functionality.
- Conditions other than mental disorders specified in the current edition of the Diagnostic and Statistical Manual of Disorders (DSM).
- Services provided under a court order or as a condition of parole, probation or instead of incarceration.
- Services related to personal growth services such as assertiveness training or consciousness raising, mental retardation and learning disabilities.
- Any mental health service (except psychopharmacological treatment performed by a psychiatrist or psychiatric nurse practitioner) or supply related to the condition of autism.
- Counseling related to sex and career, in the absence of illness.
- Vocational, pastoral, or spiritual counseling.
- Dance, poetry, music, or art therapy, except as part of a treatment program in an inpatient setting.
- Non-organic therapies including, but not limited to, bioenergetics therapy, confrontation therapy, crystal healing therapy, educational remediation, marathon therapy, primal therapy, rolfing, sensitivity training, training psychoanalysis, transcendental meditation, and Z therapy.
- Organic therapies including, but not limited to, aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, narcotherapy with LSD, and sedative action electrostimulation therapy.
- Treatments which do not meet the national standards for mental health professional practice.
NEURODEVELOPMENTAL THERAPY

Benefits will be provided for medically necessary neurodevelopmental therapy treatment to restore and improve bodily function for children to age 7. This benefit includes maintenance services where significant deterioration of the patient's condition would result without the service. Neurodevelopmental therapy means therapy designed to treat structural or functional abnormalities of the central or peripheral nervous system. Its purpose is to restore, maintain, or develop age appropriate functions in a child. **Neurodevelopmental therapy is available until age 7 and is limited to $2,000 per calendar year.**

NEWBORN NURSERY CARE BENEFIT

Medical facility charges incurred by a well newborn during the initial period of confinement will be covered as charges of the baby. In addition, a circumcision performed in an outpatient setting within 31 days of the birth of the baby will be covered under this benefit.

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

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

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

ORTHOTICS

Benefits are payable, at the coinsurance level indicated in the Summary of Benefits. Expenses for orthotic appliances include, but are not limited to, foot supports, supplies, devices, and corrective shoes.

OUTPATIENT SURGICAL FACILITY

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

PHENYLKETONURIA (PKU) DIETARY FORMULA

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

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

PRE-ADMISSION TESTING

Charges for laboratory and x-ray examinations to determine if the participant is suitable for surgery prior to admission are covered.

PRESCRIPTION DRUGS

Inpatient drugs are covered when administered to an individual for the treatment of a covered illness or accident, while confined. Inpatient prescription drugs will be paid under the Hospital Benefit as shown in the Summary of Benefits and are subject to the deductible.

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

PREVENTIVE HEALTH

This benefit covers routine physician services and related diagnostic tests that are regularly performed without the presence of symptoms. The participant's provider determines the frequency and appropriateness of the several preventive services that may be part of a periodic health exam for adults age 18-75. Routine exams and tests are covered according to the following:

Exam

- Well baby care, up to eight provider office visits during a child’s first 24 month.
- For children age 2-6, one exam per year.
- For children age 7-17, one exam every 24 months.

Diagnostic Screenings

- Cholesterol, every five years from age 35-65.
- Mammogram, as recommended by physician between ages 40-70.
- Sigmoidoscopy, every 5-10 years from age 50-70, or Fecal Occult Blood yearly from age 50-75.

If, at the time of a routine physical examination or well child care, the participant needs paperwork completed for a third party such as school, camp, team sports, etc., the provider may charge the participant a fee to complete the paperwork. The Plan will not cover this additional fee.

Immunizations/Vaccinations

Routine immunizations/vaccinations (shots) are covered. Coverage for immunizations is provided when ordered or arranged by the participant's provider and received in the provider’s office. Visits to the provider’s office for immunizations are subject to a copayment or coinsurance. Immunizations required for travel, employment, insurance, licensing purposes or solely for the purpose of participation in camps, sports activities, recreation
programs, or college entrance are not covered. Flu shots are covered at 100% regardless of whether the provider is PPO or Non-PPO. Shingles vaccines are only covered if the member is 50 years of age or older.

Children's Vision and Hearing Screenings

Annual vision and hearing screenings by a personal physician/provider are covered for children through age 17. If a vision or hearing problem is discovered, the Plan will pay for one visit per calendar year to an eye or hearing specialist to determine the need for vision or hearing correction.

Covered vision and hearing screening services do NOT include:

- Services for laser surgery, radial keratotomy and any other surgery to correct myopia, hyperopia or stigmatic error; vision therapy, or orthoptic treatment (eye exercises).
- Services for routine eye and vision care, refractive disorders, eyeglass frames and lenses, and contact lenses.
- Hearing aids, including all services related to the examination and fitting of the hearing aids.

Participants Diagnosed With Diabetes

Participants diagnosed with either insulin dependent or non–insulin dependent diabetes mellitus, have the following preventive health care benefits:

**Diabetes Education:** See the plan’s Summary of Benefits for details on the participant’s copayment/coinsurance responsibility.

**Weight Management:** The Plan provides nutritional counseling (up to $500 per calendar year) for treatment of obesity when medically necessary, as determined by the physician’s provider. Fasting and rapid weight loss programs are NOT covered. See the “Weight Intervention Program” and “Diabetic and Dietary Education” sections for information on other covered health improvement benefits.

PROSTHETIC APPLIANCES

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

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

REHABILITATION BENEFIT

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

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

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

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

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

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

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

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

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

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

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

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

No benefits will be provided for custodial care; maintenance, non-medical self-help, recreational, educational, or vocational therapy; psychiatric care; learning disabilities or developmental delay; chemical dependency rehabilitative treatment; and gym or swim therapy.

SECOND SURGICAL OPINION

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

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

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

SKILLED NURSING FACILITY CARE

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

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

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

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

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

SURGERY AND RELATED SERVICES

Benefits are provided for the following inpatient or outpatient services:

- Surgeon’s charges
- Assistant surgeon’s charges
- Anesthesia

If two or more surgical procedures are performed through the same incision during an operation, full benefits are only provided for the primary procedure and one half for the lesser procedure. Please note that all non-emergency surgery other than surgery done in the doctor’s own office must be pre-authorized by the HMA’s Health Services Department to avoid denial of a claim.

TEMPOROMANDIBULAR JOINT DISORDER (TMJ)

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

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

The participant must contact HMA’s Health Services Department prior to any testing that may occur to determine whether he or she is a transplant candidate. A written treatment plan must be submitted in order to obtain pre-authorization.

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

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

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

- Medical facility or Hospital room and board and medical supplies.

- Diagnosis, treatment, and surgery by a doctor.

- The rental of wheelchairs, hospital-type beds, and mechanical equipment required to treat respiratory impairment.

- Local ambulance services, medications, x-rays and other diagnostic services, laboratory tests, and oxygen.

- Rehabilitative therapy consisting of: speech therapy (not for voice training or lisp), audio therapy, visual therapy, occupational therapy, and physiotherapy. Any of these must be in direct respect to rehabilitation from the covered transplant procedure.

- Surgical dressing and supplies.

- Transportation, lodging, and meals. Limited to $5,000 per transplant.

- Other services approved by HMA’s Health Services Department.

Benefits for a donor are payable only in the absence of other coverage and are limited to $25,000 per transplant. Donor expenses are payable only when the organ recipient is covered under this Plan and are considered expenses of the recipient.

No benefits will be provided for the following:

- Transplant services or supplies received during the first 12 months of an Enrollee’s coverage under this Plan are not covered. The Enrollee will be allowed a credit toward this transplant services waiting period for any period of time he or she was continuously covered under another medical plan with equal or better transplant coverage, immediately preceding the time the Enrollee’s coverage under this Plan began or any period of time in which he or she was previously covered under the PeaceHealth medical plan during their current employment period. Other than
described herein, this 12-month exclusion period will not be waived or credited for any reason.

- Any procedure that has not been proven effective, is experimental or investigative, or is not standard of care for the community. *(See definition of Experimental and Investigative.)*

- Private nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).

- When donor benefits are available through other group coverage.

- When government funding of any kind is available.

- When the recipient is not covered under this Plan.

**TRAVEL BENEFITS – FOR EMPLOYEES WORKING IN THE SOUTHEAST ALASKA REGION ONLY**

Eligible employees who work in the Southeast Alaska Region, and any covered dependents may be eligible for travel benefits related to medical treatment received outside of Ketchikan. Travel benefits may include up to two round trips per calendar year at an equivalent of coach airfare to Seattle. When travel benefits are covered for a covered dependent child, airfare is also provided for one parent, who is covered under the plan, to accompany the child.

**WEIGHT INTERVENTION PROGRAM**

PeaceHealth provides a weight intervention program for adult plan participants who meet the program criteria. The Plan pays 80% for this program. The Plan will cover the Weight Intervention Program a maximum of one time for each enrolled participant. Participation is limited due to class size. Contact the Caregiver Resource Center (CRC)/My HR for detailed information. To qualify for the program the participant must meet the following criteria:

1. a Body Max Index (BMI) of 30 or higher, or

2. a BMI of 27 or higher with 2 or more of the following conditions:
   - Established but stable coronary heart disease and graduate of cardiac rehab program and referral from cardiologist
   - Type 2 diabetes
   - Sleep apnea
   - Metabolic syndrome
   - Hypertension
   - LDL-cholesterol greater than or equal to 160 mg/dL or on drug treatment for elevated LDL-c
   - HDL-cholesterol less than 40 mg/dL or on drug treatment for reduced HDL-c
   - Depression
WOMEN'S HEALTH CARE SERVICES

Annual Gynecological Exams

Benefits for annual gynecological examinations include breast, pelvic and Pap examinations once every 12 months.

Female participants may receive preventive women’s care exams from their personal physician/provider or from any other qualified provider who specializes in women’s health care. Women’s health care providers include physicians specializing in obstetrics or gynecology, nurse practitioners, certified nurse midwives, or physician assistants specializing in women’s health care. Women’s health care services received from a naturopath or any other alternative care provider are not covered benefits.

Benefits also include follow-up exams for any medical conditions discovered during an annual gynecological exam that require additional treatment. The follow-up visit copayment/coinsurance may differ from the participant’s annual gynecological exam copayment/coinsurance. See the Plan’s Summary of Benefits for details on the participant’s copayment/coinsurance responsibility.

Mammograms

Mammograms are provided for women at the recommendation of the participant’s personal physician/provider or women’s health care provider between ages 40-70.

Other Services

Counseling, exams, and some services for voluntary family planning are covered. Contact HMA or the Caregiver Resource Center (CRC)/My HR for detailed information.
GENERAL EXCLUSIONS TO THE MEDICAL PLAN

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

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

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

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

Allergy Testing and Therapy -- Therapy and testing for treatment of allergies including, but not limited to, services related to clinical ecology, environmental allergy and allergic immune system dysregulation and sublingual antigen(s), extracts, neutralization tests and /or treatment UNLESS such therapy or testing is approved by the American Academy of Allergy and Immunology or the Department of Health and Human Services or any of its offices or agencies.

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

Appointments (Missed, Cancelled, Telephonic) -- Missed or canceled appointments or for telephone consultations.

Bariatric Surgery -- Bariatric surgery or related expenses incurred during the first 12 months of an Enrollee's coverage under this Plan are not covered. The Enrollee will be allowed a credit toward this bariatric surgery waiting period for any period of time he or she was continuously covered under another medical plan with equal or better coverage for bariatric surgery, immediately preceding the time the Enrollee's coverage under this Plan began or any period of time in which he or she was previously covered under the PeaceHealth medical plan during their current employment period. Other than described herein, this 12-month exclusion period will not be waived or credited for any reason.

Biofeedback -- Charges for biofeedback treatment.

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

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

1. When related to an illness or injury.

2. Except as specifically excluded by this plan, for correction of congenital deformity. To be covered, the surgery must be done within 18 years of the date of birth.

3. A member receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will also receive coverage for:
• Reconstruction of the breast on which the mastectomy has been performed
• Surgery and reconstruction of the other breast to produce a symmetrical appearance
• Prostheses
• Treatment of physical complications of all stages of mastectomy, including lymphedemas

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

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

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

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

Dental -- Dental services including treatment of the mouth, gums, teeth, mouth tissues, jawbones or attached muscle, upper or lower jaw augmentation reduction procedures, orthodontic appliances, dentures and any service generally recognized as dental work. Hospital and Physician services rendered in connection with dental procedures are only covered if adequate treatment cannot be rendered without the use of hospital facilities, and if the participant has a medical condition besides the one requiring dental care that makes hospital care medically necessary. The only exceptions to this exclusion are the services and supplies covered under the Dental Services Benefit and the Temporomandibular Joint Disorder Benefit.

Exclusions that apply to dental services:

• Oral surgery (non-dental or dental) or other dental services (all procedures involving the teeth; wisdom teeth; areas surrounding the teeth), except as approved by the Plan, and described under the “Dental Services” benefit.

• Services for temporomandibular joint syndrome (TMJ) and orthognathic surgery, except as provided by the Plan and described under the Temporomandibular Joint (TMJ) Disorder Benefit.

• Dentures and orthodontia.

• Upper or lower jaw augmentation or reduction procedures (orthognathic surgery).
Driving Under the Influence (DUI)/Driving While Intoxicated (DWI) -- Charges for any injury to a participant sustained while driving a vehicle that is involved in an accident where the participant is found guilty of Driving Under the Influence (DUI) or Driving While Intoxicated (DWI); guilt of driving under the influence of alcohol or illegal drugs.

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

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

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

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

Foot Care Services -- Exclusions that apply to foot care services:

- Routine foot care, such as removal of corns and calluses, trimming of nails, routine hygienic care, and other symptomatic complaints of the feet, except for diabetes.
- Services for insoles, arch supports, heel wedges, lifts and orthopedic shoes. Covered Services for orthotics are described under the Orthotics Benefit.

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

Genetic Testing -- Services for genetic testing in the absence of disease.

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

Growth Hormone Therapy -- Medications, drugs or hormones to stimulate growth, except for children through age 18 when diagnosis of growth hormone deficiency is laboratory confirmed, and for adults only when they are being treated for pituitary destruction. Covered services are limited and subject to pre-authorization and may be accessed through the prescription drug benefit or through the participant's provider.

Habilitative, Education, or Training Services -- Habilitative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor, or social skills, including evaluations therefore, except as provided herein under the Neurodevelopmental Therapy or Mental Health & Chemical Dependency Services benefits.
**Hearing Exams and Hearing Aids** -- Charges or supplies with regard to routine hearing exams and hearing aids, except as provided under the Children’s vision and hearing screenings of the Preventive Health benefits.

**Hospice Bereavement** -- Charges for hospice bereavement treatment.

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

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

**Jaw Augmentation/Reduction** -- The Plan does not cover congenital reconstructive or cosmetic upper or lower jaw augmentation or reduction procedures (orthognathic surgery) unless related to a traumatic injury or to a neoplastic or degenerative disease.

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

**Light Therapy** -- Light therapy for seasonal affective disorder, including equipment.

**Mail Expenses** -- Mailing and/or shipping and handling expenses.

**Massage Therapy** -- Charges for massage therapy treatment, except as provided under the Rehabilitation Benefit, when administered by a registered, certified, or licensed physical therapist as part of an approved treatment plan.

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

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

**Mental Health** -- Treatment for mental health (psychiatric) conditions and eating disorders, such as anorexia nervosa, bulimia or any other similar condition, except as specifically provided under the Mental Health benefits.

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

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

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

**Non-Covered Services** -- Services or supplies directly related to any condition, service, or supply that are not covered by this plan. This includes any complications arising from any treatment, services or supplies not covered by this plan.
Not Medically Necessary -- Services and supplies not medically necessary (as defined in the General Definitions Section) for the diagnosis or treatment of an illness or injury, unless otherwise listed as covered.

Nutritional Supplements -- Any vitamins, dietary supplements, and other non-prescription supplements, except when prescribed as part of a nutrition therapy plan for the treatment of diabetes.

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

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

Oregon Death with Dignity Act -- Services and supplies received by a qualified participant under the Oregon Death with Dignity Act.

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

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

Personal Injury Protection Coverage -- Payment or expense coverage is provided under a motor vehicle insurance policy, as required by Oregon state mandated minimum personal injury protection (PIP) limits.

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

Physical Therapy and Rehabilitation Services -- Physical therapy and rehabilitation services, including exercise programs, Rolfing, polarity therapy and similar therapies, and growth and cognitive therapies, except as defined herein under the Rehabilitation Benefit.

Pre-existing conditions -- Coverage will be provided for covered services and supplies for pre-existing conditions after the pre-existing condition exclusion period ends. This exclusion does not apply to pregnancy, genetic information, or to any participant (whether covered as an employee or dependent) under the age of 19.

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

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

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

Reproductive Services -- Exclusions that apply to reproductive services:
• Sexual disorders or dysfunctions regardless of gender, including, but not limited to, services, surgery, prescription drugs; and services, supplies and medications related to preparation for sex change operations and medical or psychological counseling or hormonal therapy in preparation for, or subsequent to, any such procedure.

• Termination of pregnancy, unless there is a severe threat to the mother, or if the life of the fetus cannot be sustained.

• Condoms.

• All services for non-participant surrogate mothers.

• All services associated with non-participant surrogate parenting, including costs for any artificial means of conception, any maternity expense, and/or birth expense.

• All services associated with infertility treatment for a participant or participant’s spouse or domestic partner.

• Home births and all related services.

• Services provided in a premenstrual syndrome clinic or holistic medicine clinic.

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

**Reversal of Sterilization** -- Charges for reversal or attempted reversal of sterilization.

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

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

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

**Skin Abrasion Procedures** -- Salabrasion, chemosurgery, or other such skin abrasion procedures associated with the removal of scars or tattoos, or in the treatment of acne.

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

**Training** -- Services or supplies for learning disabilities; vocational assistance and outreach; job training or other education or training services; except as provided herein.
Transplants -- Charges for transplant services or supplies received during the first 12 months of an Enrollee’s coverage under this Plan. (The Enrollee will be allowed a credit toward this transplant waiting period for any period of time he or she was continuously covered under another medical plan with the Company, immediately preceding the time the Enrollee’s coverage under this Plan began or any period of time in which he or she was previously covered under the PeaceHealth medical plan during their current employment period. Other than described herein, this 12-month exclusion period will not be waived or credited for any reason.)

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

Travel Expenses -- Travel, whether or not recommended by a physician, except as provided herein under the Ambulance, Transplant, and Travel Benefits for Ketchikan General Hospital Employees Only benefits.

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

Vision Services -- Exclusions that apply to vision services:

- Surgical procedures which alter the refractive character of the eye, including, but not limited to laser eye surgery, radial keratotomy, myopic keratomeleleusis, and other surgical procedures of the refractive keratoplasty type, the purpose of which is to cure or reduce myopia, hyperopia, or astigmatism.

- Services for routine eye and vision care, routine vision exams, refractive disorders, except as stated under “Children’s Vision and Hearings Screenings.”

- Eyeglass frames and lenses, contact lenses and other routine vision supplies.

- Orthoptics and vision training.

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

Washington Death with Dignity Act -- Services and supplies received by a qualified participant under the Washington Death with Dignity Act (RCW 70.245).

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

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

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

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

CUSTOMER SERVICE

We want participants to understand how to use the PeaceHealth Employee Prescription Drug Plan benefits. We also want participants to be satisfied with this Plan. We are here to help and are always glad to answer any questions a participant has about using this Plan. For help, contact the Caregiver Resource Center (CRC)/My HR or:

For participants enrolled in the In-Network, Open Network and Open Network Plus Plans:

MedImpact – Pharmacy Benefit Manager (PBM)
1-800-788-2949

For participants enrolled in the High Deductible Health Plan:

CVS/Caremark – Pharmacy Benefit Manager (PBM)
866-885-4944

For Participant Information

The participant’s right to obtain prescription drugs under the Plan will be dependent upon eligibility at the time the participant requests that a prescription be filled and all terms and conditions of the Plan.

PRESCRIPTION DRUG CARD PROGRAM

Benefits will be provided as described below and as shown in the Summary of Benefits for state and federal approved legend drugs requiring a prescription and for other items as specifically provided, when such drug or other items are furnished by an approved pharmacy. Benefits will be subject to any waiting periods, limitations, and exclusions.

Legend Drugs are those drugs which cannot be purchased without a prescription written by a physician or other lawful prescriber and include compound medications in which at least one ingredient is a legend drug.
GENERIC DRUGS

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

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

BRAND NAME PERFORMANCE DRUGS

An important element of your Prescription Drug Card Program is the opportunity to select drugs from the Formulary Drug List. The Formulary Drug List is a guide to the best values within select therapeutic categories which helps the provider identify products that will provide optimal clinical results at a lower cost. The Formulary Drug List undergoes a thorough review and/or revision annually. Interim changes could occur to reflect changes in the market. These changes could include; entry of new products, entry of a generic option to a brand drug, or other events that alter the clinical or economic value of the products on the Formulary Drug List. Please visit the MedImpact website address www.medimpact.com for a copy of the Formulary Drug List.

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

MAINTENANCE DRUGS

Up to a 90-day supply of maintenance drugs, as limited by the prescriber or manufacturer, is available through the PeaceHealth employee pharmacy. Using the employee pharmacy reduces the participant’s out-of-pocket cost. Information on how to use the pharmacy benefits available online (http://www.peacehealth.org/employees/pharmacy/Online.htm).

ELIGIBLE PROVIDERS

For participants enrolled on one of the PPO Plans, prescription drugs may be obtained under this Plan only from MedImpact Pharmacies and PeaceHealth participating pharmacies. The list of approved network pharmacies may be obtained online on Crossroads, at the Pharmacy Benefits website or by contacting MedImpact at 800/788-2949 or via the MedImpact website at www.medimpact.com.

For participants enrolled in the HDHP, prescription drugs may only be obtained from CVS/Caremark pharmacies. For additional information regarding participating pharmacies please contact CVS/Caremark Customer Service at 800/552-8159 or via the CVS/Caremark website at www.caremark.com.

If the participant purchases a prescription drug from a pharmacy that is not an eligible provider, the participant will not be entitled to any reimbursement under this Plan unless it is due to an out-of-area emergency.
PRE-AUTHORIZATION

Some prescription drugs require pre-authorization. Drugs requiring pre-authorization may be found on the MedImpact website at www.medimpact.com. Participants must register in order to access this information.

COORDINATION OF BENEFITS

Coordination of Benefits does apply to this Plan.

DRUGS COVERED

The Plan provides a three-tiered benefit and is applied to a formulary. In most instances, generic drugs will be covered on the first or lowest tier, brand drugs on the formulary will be covered under the middle tier, and drugs not on the formulary list (non-formulary drugs) will be covered under the third or highest tier.

The following is a list of those drugs covered by the Plan:

- Legend drugs. Exceptions: See the Exclusions and Limitations section below.
- Insulin.
- Disposable insulin needles/syringes/lancets covered at 80%.
- Disposable blood glucose/testing agents (e.g., Chemstrips) covered at 80%.
- Any other drug which under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber.

Services that are covered include:

- Necessary refills. The pharmacy plan has the right to require a new prescription when the number of refills has not been specified or appears to be excessive.
- Prescription drugs that are ordered by a physician or practitioner whose services are covered under the plan for necessary medical treatment of a covered illness, injury, or physical disability.
- Prescription drugs that are prescribed for use as specifically labeled by the Federal Food and Drug Administration (unless otherwise required by law), and listed in the United States Pharmacopoeia and National Formulary.

For this benefit, "prescription drug" means antigen and allergy vaccines dispensed by a physician; insulin; and any medicine required by the Federal Food, Drug, and Cosmetic Act to bear the legend: "Caution: federal law prohibits dispensing without prescription."
EXCLUSIONS AND LIMITATIONS

Some limits to coverage include:

- Prescriptions are limited to a supply sufficient for 34 consecutive days or up to a 90-day supply may be purchased when filled through a PeaceHealth Pharmacy.
- Participants are eligible for a refill once 70% of the prescribed medication has been utilized based on the prescribed dosage.
- Nicotine deterrent products and supplies requiring a prescription are covered for one 90-day treatment per calendar year.
- Not all FDA-approved drugs are covered by the Plan. Covered drugs may have set quantity limits per month or per copay or require a “step edit.” A “step edit” would require that a trial of a covered drug(s) be tried and failed before another covered drug may be used and paid by the prescription benefit as determined by the Plan’s prescription benefit using evidence based medicine.
- Covered drugs may require prior authorization. Prior authorization requests are submitted to MedImpact for approval.

Services that are not covered include:

- Over-the-counter (non-prescription) drugs and vitamins except as approved by the plan (see Formulary for specific information).
- Infertility drugs.
- Prescription drugs and supplies for sex transformation, sexual dysfunction, or sexual inadequacy.
- Fluoride for participants over age 10.
- Retin-A for conditions other than acne (over age 25 requires pre-authorization).
- Nicotine deterrent products and supplies that do not require a prescription, with the exception of nicotine patches which are covered.
- Topical Minoxidil (hair growth stimulant).
- Anorectics (diet pills).
- Administration or injection of any drugs (except for flu shots).
- Drugs for cosmetic use.
- Experimental or investigational drugs, or drugs not generally recognized by the medical community.
- Drugs provided at no cost.
- Drugs delivered, administered or dispensed by a physician.
- Charges for the administration or injection of any drug (except flu shots).
- Prescriptions which an eligible individual is entitled to receive without charge from any Worker's Compensation Laws.
- Drugs labeled Caution-limited by federal law to investigational use or experimental drugs, even though a charge is made to the individual.
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed medical facility, rest home, sanitarium, extended care facility, convalescent medical facility, nursing home or similar
institution which operates on its premises, or allows to be operated on its premises or a facility for dispensing pharmaceuticals.

- Any prescription refilled in excess of the number specified by the provider, or any refill dispensed after one year from the provider's original order.

- Prescription drugs which may be obtained without charge under local, state, or federal programs.

- Drugs purchased outside the U.S. that are not legal inside the U.S.

If you would like to know more information about the drug coverage policies under this program, or if you have a question or concern about your pharmacy benefit, please contact MedImpact at 800/788-2949 or Caremark if you are enrolled on the HDHP at 866/885-4944.
GENERAL DEFINITIONS

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

ACUTE CARE -- Shall mean care received in an inpatient hospital setting.

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

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

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

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

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

COINSURANCE PERCENTAGE -- The coinsurance is the percentage of the usual, customary, and reasonable (UCR) charge that the Plan will pay for non-Network providers, or the percentage of the negotiated rate for Network providers. Once the deductible is satisfied, the Plan shall pay benefits for covered expenses incurred during the remainder of the calendar year at the applicable coinsurance as specified in the Summary of Benefits. The participant is responsible for paying the remaining percentage. The participant's portion of the coinsurance represents their out-of-pocket expense. The non-Network provider of service may charge more than the UCR. The portion of the non-Network provider's bill in excess of UCR is not a covered expense under this Plan and is the responsibility of the participant.

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

COSMETIC TREATMENT -- Medical or surgical treatment primarily for the purpose of improving appearance or self esteem.

COPAY -- A copay is a fixed amount paid by the participant to his or her provider or facility each time the participant receives a service subject to copay as specified in the Summary of Benefits.

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

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

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

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

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

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

- Employee - their inability to engage, as a result of accident or illness, in their normal occupation with PeaceHealth;
- Dependent - their inability to perform the usual and customary duties or activities of a participant in good health and of the same age.

DOMESTIC PARTNER – An individual who meets the PeaceHealth eligibility criteria for coverage under the medical plan.

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

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

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

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

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

**EMPLOYER** -- PeaceHealth or a Participating Unit

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

**EXPERIMENTAL OR INVESTIGATIVE TREATMENT** -- For the purpose of determining eligible expenses under this Plan (other than off-label drug use, see definition for “Off-Label Drug Use”), a treatment will be considered by the Plan to be experimental or investigative if:

1. The treatment is governed by the United States Food and Drug Administration ("FDA") or another United States governmental agency and the FDA or the other United States governmental agency has not approved the treatment for the particular condition at the time the treatment is provided; or
2. The treatment is the subject of ongoing Phase I, II or III clinical trials as defined by the National Institute of Health, National Cancer Institute or the FDA; or
3. There is documentation in published U.S. peer-reviewed medical literature that states that further research, studies, or clinical trials are necessary to determine the safety, toxicity, or efficacy of the treatment.

**FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA) as Amended** - A leave of absence granted to an eligible participant by the Employer in accordance with Public Law 103-3 for the birth or adoption of the participant’s child; placement in the participant’s care of a foster child; the serious health condition of the participant’s spouse, child or parent; the participant’s own disabling serious health condition; the participant’s spouse, son, daughter, or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation and this results in a qualifying exigency (as determined by the Secretary of Labor); or the participant is the spouse, son, daughter, parent, or next of kin of a member of the Armed Forces who suffered a serious injury or illness in the line of duty while on active-duty.
GENERIC DRUG - A drug that is generally equivalent to a higher-priced brand name drug and meets all FDA bioavailability standards.

HEALTH SERVICES -- The individual or organization (HMA 425/974-3886 or 866/206-7786) designated by the Plan Administrator to authorize medical facility admissions and surgeries and to determine the medical necessity of treatment for which Plan benefits are claimed.

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

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

IDENTIFICATION CARD -- A card issued to each participant enrolled in the Plan. The card identifies the individual as a Plan participant and includes important information about his or her coverage. Participants should always present the identification card when seeking medical care or benefits.

ILLNESS - The term “illness” means an illness causing loss to the participant whose illness is the basis of the claim. For the purposes of this Plan only, “illness” shall also be deemed to include disability caused or contributed to by pregnancy of the covered employee, spouse, or domestic partner, including miscarriage, childbirth, and recovery therefrom. It shall only mean illness or disease which requires treatment by a physician.

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

INFERTILITY -- The inability to become pregnant after a year of unprotected intercourse. Or, the inability to carry pregnancy to term as evidenced by three (3) consecutive spontaneous abortions (miscarriages).

INJURY – See Accident/Accidental Injury.

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

LEGALLY DOMICILED ADULT -- Adult who meets the PeaceHealth eligibility criteria for coverage under the Medical Plan.

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

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

MEDICAL EMERGENCY - An illness or injury which is life threatening or one that must be treated promptly to avoid serious adverse health consequences to the participant.
MEDICAL FACILITY (HOSPITAL) - An institution accredited by the Joint Commission on Accreditation of Healthcare Organizations and which receives compensation from its patients for services rendered. On an inpatient basis, it is primarily engaged in providing all of the following:

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

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

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

MEDICALLY NECESSARY - Medical services and/or supplies which are absolutely needed and essential to diagnose or treat an illness or injury of a covered participant while covered by this Plan. The following criteria must be met. The treatment must be:

- Consistent with the symptoms or diagnosis and treatment of the participant's condition.
- Appropriate with regard to standards of good medical practice.
- Not solely for the convenience of the participant, family members or a provider of services or supplies.
- The least costly of the alternative supplies or levels of service which can be safely provided to the participant. When specifically applied to a medical facility inpatient, it further means that the service or supplies cannot be safely provided in other than a medical facility inpatient setting without adversely affecting the participant's condition or the quality of medical care rendered.

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

NETWORK PROVIDERS -- A provider who is part of a network of providers contracted to accept a negotiated rate as payment in full for services rendered.

NON-EMERGENCY MEDICAL FACILITY ADMISSIONS - A medical facility admission (including normal childbirth) which may be scheduled at the convenience of a participant without endangering such participant's life or without causing serious impairment to that participant's bodily functions.
OFF-LABEL DRUG USE -- The use of a drug for a purpose other than that for which it was approved by the FDA. For purposes of determining whether off-label use for a FDA approved drug is eligible for coverage under the Plan versus investigative, the following will apply:

1. Medically necessary off-label drug use will be accepted if the drug is otherwise covered by the Plan and if one of the following criteria are met:

   A. Drug Compendia: One of the following drug compendia indicates that the drug is recognized as effective for the indication:
      - The American Hospital Formulary Service Drug Information;
      - Drug Facts and Comparison;
      - The U.S. Pharmacopoeia Dispensing Information;
      - American Medical Association Drug Evaluation;
      - National Cancer Care Network;
      - National Cancer Institute; or
      - Other authoritative compendia as identified from time to time by the Federal Secretary of Health and Human Services.

   B. Scientific Evidence/Substantially Accepted Peer-Reviewed Medical Literature: The majority of the scientific evidence indicates that the drug is effective for the off-label indication. The evidence must:
      1. Consist of an adequate number of well-designed studies with sufficient numbers of patients in relation to the incidence of the disease;
      2. Be published in peer reviewed journals. The studies must be printed in journals or other publications that publish original manuscripts only after the manuscripts have been critically reviewed by unbiased independent experts for scientific accuracy, validity, and reliability;
      3. There must be enough information in the peer-reviewed literature to allow judgment of the safety and efficacy;
      4. Demonstrate consistent results throughout all studies; and
      5. Document positive health outcomes and demonstrate:
         i. That the drug is as effective as or more effective than established alternatives; and
         ii. Improvements that are attainable outside the investigational setting.

   C. Recognized as effective for treatment of such indication by the Federal Secretary of Health and Human Services.

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

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

OUT-OF-AREA DEPENDENT -- An eligible dependent of a subscriber, who does not reside in the Plan's service area and who is properly enrolled in the Plan as an Out-of-Area Dependent. A dependent child who is an eligible dependent and who resides out of the service area for the purpose of attending school is eligible to be enrolled as an Out-of-Area Dependent. The subscriber's legal spouse or domestic partner is also eligible to be enrolled as an Out-of-Area Dependent. An LDA may not be an Out-of-Area dependent unless the subscriber is an Out-of-Area participant.

OUT-OF-AREA PARTICIPANT -- An eligible participant, who does not reside in the Plan’s service area. An Out-of-Area Participant's dependents also are eligible to receive the same
benefits as the Out-of-Area Participant. Participants are not eligible to become Out-of-Area Participants when enrolled in Continuation Coverage.

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

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

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

PERSONAL PHYSICIAN OR PROVIDER -- A Network provider specializing in family practice, general practice, internal medicine, or pediatrics; a nurse practitioner; a certified nurse midwife; or a physician assistant, when providing services under the supervision of a physician; who agrees to be responsible for the participant’s continuing medical care by serving as case manager.

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

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

**PLAN** - Shall mean the Benefits described in the Plan Document. The Plan is the Covered Entity as defined in HIPAA §160.103.

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

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

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

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

**PRE-AUTHORIZED SERVICES** -- Services which require the participant and/or the provider to seek Plan confirmation before seeking or receiving care. Final determination will be based on the covered benefits and eligibility on the date of service.

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

**PROTECTED HEALTH INFORMATION (PHI)** – Individually Identifiable Health Information, as defined in HIPAA §164.501 (see §164.514(2)(b)(i) for individual identifiers), whether it is in electronic, paper or oral form that is created or received by or on behalf of the Plan Sponsor or HMA.
RECIPIENT - The recipient is the participant who receives the organ for transplant from the organ donor. The recipient shall be a participant covered under the provisions of this Plan. Only those organ transplants not considered experimental in nature and specifically covered herein are eligible for coverage under this Plan.

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

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

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

SERVICE AREA -- A defined geographical area. The geographical area in Oregon and Washington in which Regence Network Providers provide services.

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

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

- It is licensed to provide and is engaged in providing, on an inpatient basis, for participants convalescing from injury or disease, professional nursing services rendered by a Registered Graduate Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Graduate Nurse, physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.

- Its services are provided for compensation from its patients and patients are under the full-time supervision of a physician or Registered Graduate Nurse (R.N.).

- It provides 24 hours per day nursing services by a licensed nurse, under the direction of a full-time Registered Graduate Nurse (R.N.).

- It maintains a complete medical record on each patient.

- It has an effective utilization review plan.

- It is not, other than incidentally, a place for rest for the aged, drug addicts, alcoholics, the mentally handicapped, custodial, or educational care, or care of mental disorders.
SPouse - For the purposes of determining coverage under this Group health plan, spoue refers only to a person of the opposite gender who is the employee’s husband or wife, not including a common-law marriage.

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

Summary of Benefits - The description of the plan’s benefits and copayments/coinsurance.

Summary of the Plan - The document containing a summary of the benefits provided under the Plan. In the event of a discrepancy between the summary and the Plan Document, the provisions stated in the Plan Document will supersede.

Surgical Procedure - A surgical procedure is defined as:

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

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

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

Usual, Customary and Reasonable (UCR) - A reasonable fee that is commonly accepted as payment for a given service by physicians or suppliers of services in a geographical area.

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

Women's Health Care Provider -- An obstetrician, gynecologist, physician assistant specializing in women’s health, advanced registered nurse practitioner specializing in women’s health, or a certified nurse midwife practicing within the applicable lawful scope of practice. Naturopaths or any other alternative care providers are NOT considered women’s health care providers.
GENERAL PROVISIONS

ADMINISTRATION OF THE GROUP MEDICAL PLAN

The Plan is administered through PeaceHealth. PeaceHealth has retained services of an independent Plan Supervisor, HMA, experienced in claims processing. PeaceHealth shall have complete and absolute discretion and authority to make all fiduciary decisions relative to the benefits payable under the Plan, including without limitation, interpretations of Plan documentation, determinations of eligibility and benefit entitlement, and all other decisions necessary to administer the Plan. PeaceHealth has made HMA its minister to carry out its decisions.

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

AMENDMENT OF PLAN DOCUMENT

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

APPEALING A CLAIM

Informal Participant Problem Resolution

Every HMA employee shares responsibility for ensuring participant satisfaction. If a participant has a problem or concern about his or her coverage, or services received, let us know what the problem or concern is and how it should be addressed.

The HMA Customer Service Team is available to provide information and assistance to Plan participants. Please contact us so we may help with any special needs.

Claims Procedure

The Group Health Plan offered by PeaceHealth is not subject to the Employee Retirement Income Security Act of 1974 (the Act). The claims procedure which follows is designed to comply with the requirements of the Act, and PeaceHealth and its third party administrator will normally in good faith administer the claims procedure in accordance with its terms but may not strictly adhere to its requirements. There may be circumstances in which the third party administrator or PeaceHealth will deviate from the requirements of the procedure. Other and/or additional procedures may be imposed by PeaceHealth and/or its third party administrator in its or their sole discretion. By way of example, but not limitation, PeaceHealth and its third party administrator may not at all times comply with the timing
requirements imposed by the procedure but will exercise good faith to notify a claimant of a benefit determination (adverse or not) within a reasonable time period.

Initiating A Claim

To initiate a claim, whether for pre-authorization or for payment for services received, contact HMA's Customer Service Team at 425/974-3886 or 866/206-7786. Pre-authorization is required for certain services. See Pre-Authorization of Inpatient Medical Facility Admissions And Outpatient Surgeries in the Important Information Section on how to obtain pre-authorization. If a participant receives a bill from a provider for which he or she wants payment, send it to Healthcare Management Administrators, Inc., PO Box 85008, Bellevue, Washington 98015-5008. The period of time within which the claim will be processed depends upon whether it is a Pre-Service claim or a Post-Service claim and whether or not it is an Urgent Pre-Service claim.

- **Urgent Pre-Service Claim.** The participant will be notified as soon as possible but not later than 72 hours after receipt of the claim unless the participant or his or her physician provide insufficient information.

- **Other Pre-Service Claims.** The participant will be notified not later than 15 days after receipt of the claim by HMA.

- **Post-Service Claims.** The participant will be notified not later than 30 days after receipt of the claim by HMA.

Urgent Care Claims are defined as claims that involve a decision that, if treated as non-urgent, could seriously jeopardize the claimant’s life, health, or ability to regain maximum function; or would, according to a physician, subject the claimant to severe pain.

**Urgent Pre-Service Claim**

Urgent Care Claims are defined as claims that involve a decision that, if treated as non-urgent, could seriously jeopardize the claimant's life, health, or ability to regain maximum function; or would, according to a physician, subject the claimant to severe pain. If an Urgent Pre-Service claim (or Pre-Authorization) is denied in whole or in part, the participant will receive verbal and written notification of the decision, and the reason for the determination, and if applicable, a description of any additional information needed. If additional information is needed, the participant may be requested to provide the information prior to payment of the claim.

**First & Second Level:** The participant may request a review within 180 days by filing a written appeal with HMA. The appeal must clearly state that it is an appeal, and clearly state the reason for the appeal. It is also recommended that the participant supply any additional information to support the appeal. HMA will make a decision within 72 hours to include both the First and Second level appeals. This decision will be delivered to the participant verbally and in writing setting forth specific references to the pertinent Plan provision rule, protocol, or guidelines upon which the decision is based. The participant will also be given a description of any additional information needed to overturn the decision. The first level review will be conducted by someone other than the individual who made the initial decision who is not a subordinate of that individual. The second level review will be conducted by someone other than the individual and who made the initial decision and the individual or individuals who conducted the first level review. The person or committee conducting the second level review will not be subordinate to the person making the initial claim decision or the first level review.
Subsequent Action: Upon exhaustion of the full appeals process, participants have no further rights to review of the claim. However, participants are entitled to seek redress in the court system.

Pre-Service Claim

If the participant’s Pre-Service claim (or Pre-Authorization) is denied in whole or in part, the participant will receive written notification of the decision, and the reason for the determination, and if applicable, a description of any additional information needed. If additional information is needed, the participant may be requested to provide the information prior to payment of the claim.

First Level: The participant may request a review within 180 days by filing a written appeal with HMA. The written appeal must clearly state that it is an appeal, and clearly state the reason for the appeal. The participant must supply any additional information to support the appeal reason. HMA will make a decision within 15 days. This decision will be delivered to the participant in writing setting forth specific references to the pertinent Plan provision rule, protocol, or guidelines upon which the decision is based. The participant will also be given a description of any additional information that will aid in making a determination. The review will be conducted by someone other than the individual who made the initial decision and who is not a subordinate of that individual. If the participant is dissatisfied with the result of the first level review, he or she may request a second level review.

Second Level: The participant may request a review within 180 days by filing a written appeal with HMA. The written appeal must clearly state that it is an appeal, and clearly state the reason for the appeal. The participant must supply any additional information to support the appeal reason. HMA will make a decision within 15 days. This decision will be delivered to the participant in writing setting forth specific references to the pertinent Plan provision rule, protocol, or guidelines upon which the decision is based. The participant will also be given a description of any additional information that will aid in making a determination. The review will be conducted by someone other than the individual who made the initial decision on the claim and the adverse decision at the first level review. The person or committee conducting the second level review will not be subordinate to the person making the initial claim decision or the first level review.

Subsequent Action: Upon exhaustion of the full appeals process, participants have no further rights to review of the claim. However, participants are entitled to seek redress in the court system.

Post-Service Claim

If the participant’s claim is denied in whole or in part, he or she will receive an Explanation of Benefits showing the calculation of the total amount payable, charges not payable, the reason for the determination, and if applicable, a description of any additional information needed. If additional information is needed, the participant may be requested to provide the information prior to payment of the claim.

First Level: The participant may request a review within 180 days by filing a written appeal with HMA. The written appeal must clearly state that it is an appeal, and clearly state the reason for the appeal. The participant must supply any additional information to support the appeal reason. HMA will make a decision within 30 days. This decision will be delivered to the participant in writing setting forth specific references to the pertinent Plan provision rule, protocol, or guidelines upon which the decision is based. The participant will also be given a description of any additional information needed to overturn the decision. The review will be conducted by someone other than the individual who made the initial decision and who is not
a subordinate of that individual. If the participant is dissatisfied with the result of the first level review, he or she may request a second level review.

**Second Level:** The participant may request a review *within 180 days* by filing a written appeal with HMA. The written appeal must clearly state that it is an appeal, and clearly state the reason for the appeal. The participant must supply any additional information to support the appeal reason. HMA will make a decision *within 30 days*. This decision will be delivered to the participant in writing setting forth specific references to the pertinent Plan provision rule, protocol, or guidelines upon which the decision is based. The participant will also be given a description of any additional information needed to overturn the decision. The review will be conducted by someone other than the individual who made the initial decision on the claim and the adverse decision at the first level review. The person or committee conducting the second level review will not be subordinate to the person making the initial claim decision or the first level review.

**Subsequent Action:** Upon exhaustion of the full appeals process, participants have no further rights to review of the claim. However, participants are entitled to seek redress in the court system.

**APPLICABLE LAW**

This Plan is a Church (sponsored) plan and as such it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a federal law regulating employee welfare and pension plans. Rights as a participant in the Plan are governed by the plan documents and applicable state law and regulations. This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations.

**APPLICATION AND IDENTIFICATION CARD**

To obtain coverage, an eligible employee must complete an online enrollment. Acceptance of this enrollment will be evidenced by the delivery of an identification card showing the employee's name.

**ASSIGNMENT OF PAYMENT**

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

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

CANCELLATION

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

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

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

Upon termination of this Plan, or the cancellation of PeaceHealth's participation in the Plan, all claims incurred prior to termination, but not submitted to HMA within 75 days of the effective date of termination of this Plan, will be excluded from any benefit consideration.

CONDITIONS PRECEDENT TO THE PAYMENT OF BENEFITS

The employee or dependent shall present the Plan identification card to the provider of service upon admission to a medical facility or upon receiving service from a physician.

Written proof of the nature and extent of service performed by a physician or other provider of service shall be furnished to HMA within one year after the service was rendered. Claim forms are available through HMA, and are required along with an itemized statement with a diagnosis, the employee's name and participant identification number and the name of the Plan Administrator.

The employee and all dependents agree that in order to receive benefits, any physician, nurse, medical facility or other provider of service, having rendered service or being in possession of information or records relating thereof, is authorized and directed to furnish HMA, at any time, upon request, any and all such information and records, or copies thereof.

HMA shall have the right to review these records with any medical consultant or with the Health Services Department as needed to determine the medical necessity of the treatment being rendered.

CREDIT FOR PRIOR GROUP COVERAGE

This Plan amends and replaces the prior Plan. Employees and dependents who were covered under the prior Plan sponsored by the Employer immediately prior to the time this Plan became effective shall not lose their eligibility or benefits due to the change in Plans. All charges incurred on or after the effective date of this Plan will be subject to the benefits available under this Plan and not the prior Plan. Credit will be given for time enrolled under the prior Plan in meeting the pre-existing waiting periods and for payments towards coinsurance and deductibles.
EFFECT OF TERMINATION OF THE PLAN

Upon complete or partial termination of the Plan, the Plan Administrator may, after the payment or provision for payment of all benefits to each employee who has incurred covered expenses and charges properly payable, including all expenses incurred and to be incurred in the liquidation and distribution of the Trust Fund or separate account, direct the disposition of all assets held in the Trust Fund or separate account to PeaceHealth, subject to any applicable requirement of an accompanying Trust Document or applicable law or regulation.

FACILITY OF PAYMENT

If, in the opinion of HMA, a valid release cannot be rendered for the payment of any benefit payable under this Plan, HMA may, at its option, make such payment to the individuals as have, in HMA opinion, assumed the care and principal support of the covered person and are therefore equitably entitled thereto. In the event of the death of the covered person prior to such time as all benefit payments due him/her have been made, HMA may, at its sole discretion and option, honor benefit assignments, if any, prior to the death of such covered person.

Any payment made by HMA in accordance with the above provisions shall fully discharge the Plan and HMA to the extent of such payment.

FIDUCIARY OPERATION

Each fiduciary shall discharge their duties with respect to the Plan solely in the interest of the employees and beneficiaries and: (1) for the exclusive purposes of providing benefits to employees and their beneficiaries and defraying reasonable expenses of administering the Plan, (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a like character and with like aims, and (3) in accordance with the documents and instruments governing the Plan.

FREE CHOICE OF PHYSICIAN

The employee and dependents shall have free choice of any licensed physician or surgeon, and the physician-patient relationship shall be maintained. Please refer to the Summary of Benefits for the appropriate coinsurance reimbursement level.

Nothing contained herein shall confer upon an employee or dependent any claim, right, or cause of action, either at law or in equity, against the Plan for the acts of any medical facility in which he/she receives care, for the acts of any physician from whom he/she receives service under this Plan, or for the acts of the Health Services Department in performing their duties under this Plan.
FUNDING

If contributions are required of employees or dependents covered under this Plan, the Plan Administrator will maintain a Trust or otherwise account for the receipt of money and property to fund the Plan, for the management and investment of such funds and for the payment of claims and expenses from such funds. The terms of the Trust (when applicable) are hereby incorporated by reference, as of the effective date of the Trust, as a part of this Plan.

PeaceHealth shall deliver from time to time to the Plan Administrator or the Trust such amounts of money and property as shall be necessary to provide the Trust with sufficient funds to pay all claims and reasonable expenses of administering the Plan as the same shall be due and payable. The Plan Administrator may provide for all or any part of such funding by insurance issued by a company duly qualified to issue insurance for such purpose in the state of situs, and may pay the premiums therefore directly or by funds deposited in the Trust.

All funds received by the Trust and all earnings of the Trust shall be applied toward the payment of claims and reasonable expenses of administration of the Plan except to the extent otherwise provided by the Plan Documents. The Plan Administrator may appoint an investment manager or managers to manage (including the power to acquire and dispose of) any assets of the Plan.

Any fiduciary, employee, agent, representative, or other individual performing services to or for the Plan or Trust shall be entitled to reasonable compensation for services rendered, unless such individual is the Plan Administrator, and for reimbursement of expenses properly and actually incurred.

HIPAA PRIVACY AND SECURITY

Use and Disclosure of Protected Health Information

Under the HIPAA privacy rules effective April 14, 2003, the Plan Sponsor must establish the permitted and required uses of Protected Health Information (PHI).

Plan Sponsor’s Certification of Compliance

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Enrollees’ Protected Health Information to the Employer (Plan Sponsor) unless the Employer (Plan Sponsor) certifies its compliance with 45 Code of Federal Regulations §164.504(f)(2) (collectively referred to as The Privacy Rule) as set forth in this Article, and agrees to abide by any revisions to The Privacy Rules.

Restrictions on Disclosure of Protected Health Information to Employer (Plan Sponsor)

The Plan and any health insurance issuer or business associate servicing the Plan will disclose Plan Enrollees’ Protected Health Information to the Employer (Plan Sponsor) only to permit the Employer (Plan Sponsor) to carry out plan administration functions for the Plan consistent with the requirements of the Privacy Rule. Any disclosure to and use by the Employer (Plan Sponsor) of Plan Enrollees’ Protected Health Information will be subject to and consistent with the provisions of paragraphs on Employer (Plan Sponsor) Obligations Regarding Protecting Health Information and Adequate Separation Between the Employer (Plan Sponsor) and the Plan of this Article.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Enrollees’ Protected Health Information to the Employer (Plan Sponsor) unless
the disclosures are explained in the Notice of Privacy Practices distributed to the Plan Enrollees.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Enrollees’ Protected Health Information to the Employer (Plan Sponsor) for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (Plan Sponsor).

Employer (Plan Sponsor) Obligations Regarding Protecting Health Information

The Employer (Plan Sponsor) will:

- Neither use nor further disclose Plan Enrollees’ Protected Health Information, except as permitted or required by the Plan Documents, as amended, or required by law.
- Ensure that any agent, including any subcontractor, to whom it provides Plan Enrollees’ Protected Health Information, agrees to the restrictions and conditions of the Plan Documents, including this Article, with respect to Plan Enrollees’ Protected Health Information.
- Not use or disclose Plan Enrollees’ Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (Plan Sponsor).
- Report to the Plan any use or disclosure of Plan Enrollees’ Protected Health Information that is inconsistent with the uses and disclosures allowed under this Article promptly upon learning of such inconsistent use or disclosure.
- Make Protected Health Information available to the Plan Enrollee who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524.
- Make Plan Enrollees’ Protected Health Information available for amendment, and will on notice amend Plan Enrollees’ Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526.
- Track disclosures it may make of Plan Enrollees’ Protected Health Information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.
- Make available its internal practices, books, and records, relating to its use and disclosure of Plan Enrollees’ Protected Health Information, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.

Adequate Separation Between the Employer (Plan Sponsor) and the Plan

The following classes of employees or other workforce members under the control of the Employer (Plan Sponsor) may be given access to Plan Enrollees’ Protected Health Information received from the Plan or a health insurance issuer or business associate servicing the Plan:
- Directors of Human Resources;
- Benefit Manager;
- Benefit Administrator;
- Benefit Specialist (in HR);
- Benefit Advisors;
- Human Resources Advisor;
- Human Resources Associate;
- HR Assistant/Associate;
- Pharmacy Benefit Manager;
- Clinic Pharmacy Director/Manager;
- Coordinator Clinical Pharmacy;
- Pharmacist;
- Pharmacy Clerk;
- Pharmacy Technician;
- Clinical Pharmacy Specialist;
- Buyer (pharmacy); and
- Internal Auditors when performing Health Plan Audits.

This list includes every class of employees or other workforce members under the control of the Employer (Plan Sponsor) who may receive Plan Enrollees’ Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The identified classes of employees or other workforce members will have access to Plan Enrollees’ Protected Health Information only to perform the plan administration functions that the Employer (Plan Sponsor) provides for the Plan.

The identified classes of employees or other workforce members will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer (Plan Sponsor), for any use or disclosure of Plan Enrollees’ Protected Health Information in breach or violation of or noncompliance with the provisions of this Article to the Plan Documents. Employer (Plan Sponsor) will promptly report such breach, violation or noncompliance to the Plan, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Enrollee, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.
Employer (Plan Sponsor) Obligations Regarding Electronic Protecting Health Information

Effective April 21, 2005, the Employer (Plan Sponsor) will:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.
- Ensure that the adequate separation between the Plan and Plan Sponsor with respect to electronic PHI is supported by reasonable and appropriate security measures.
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI, agrees to implement reasonable and appropriate security measures to protect the electronic PHI.
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

INADVERTENT ERROR

Inadvertent error by the Plan Administrator in the keeping of records or in the transmission of employee's applications shall not deprive any employee or dependent of benefits otherwise due, provided that such inadvertent error is corrected by the Plan Administrator within ninety (90) days after it was made.

MEDICARE

Medicare - As used in this section shall mean Title XVIII (Health Insurance for the Aged) of the United States Social Security Act, as added to by the Social Security Amendments of 1965, the Tax Equity and Fiscal Responsibility Act of 1982, or as later amended.

Person - As used in this section means a person who is eligible for benefits as an employee in an eligible class of this Plan and who is or could be covered by Medicare Parts A and B, whether or not actually enrolled.

Eligible Expenses - As used in this section with respect to services, supplies and treatment shall mean the same benefits, limits, and exclusions as defined in this Plan Document. However, for participants with End Stage Renal Disease (ESRD), if the provider accepts Medicare assignment as payment in full, then Eligible Expenses shall mean the lesser of the total amount of charges allowable by Medicare, whether enrolled or not, and the total eligible expenses allowable under this Plan exclusive of coinsurance and deductible.

Order of Benefits Determination - As used in this section shall mean the order in which Medicare benefits are paid, in relation to the benefits of this Plan.

Total benefits of this Plan shall be determined as follows:

Active Employees - For active employees and/or non-working spouses of active employees age 65 or over: This Plan will be primary and Medicare will be secondary.

Disabled Employees with Medicare (Except those with End-Stage Renal Disease) - For persons eligible for Medicare by reason of Disability the order of determination will be as shown below:
This Plan will be primary and Medicare will be secondary. The Employer will remain the primary payor of medical benefits until the earliest of the following events occurs: (1) the group coverage ends for all employees; (2) the group coverage as an active individual ends.

**Disabled Employees with End-Stage Renal Disease (ESRD)**

This Plan shall be primary for ESRD Medicare beneficiaries during the initial 30 months of Medicare coverage, in addition to the usual three month waiting period, or a maximum of 33 months. ESRD Medicare Entitlement usually begins on the fourth month of renal dialysis, but can start as early as the first month of dialysis for individuals who take a course in self-dialysis training during the three month waiting period.

**MISREPRESENTATION**

Any material misrepresentation on the part of the Plan Administrator or the employee in making application for coverage, or any application for reclassification thereof, or for service thereunder shall render the coverage null and void.

**NOTICE**

Any notice given under this Plan shall be sufficient, if given to the Plan Administrator when addressed to it at its office; if given to HMA, when addressed to it at its office; or if given to an employee, when addressed to the employee at their address as it appears on the records of HMA on the employee's enrollment form and any corrections made to it.

**PHOTOCOPIES**

Reasonable charges made by a provider for photocopies of medical records when the copies are requested by HMA shall be payable.

**PLAN ADMINISTRATION**

The Plan Administrator shall be responsible for compliance by the Plan.

**PLAN IS NOT A CONTRACT OF EMPLOYMENT**

The Plan shall not be deemed to constitute a contract of employment between the Plan Administrator or PeaceHealth and any employee or to be a consideration for or an inducement to or condition of the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Plan Administrator or PeaceHealth or to interfere with the right of the Plan Administrator or PeaceHealth to discharge any employee at any time; provided however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the Plan Administrator or PeaceHealth with the bargaining representative of any employees.
PLAN SUPERVISOR NOT A FIDUCIARY

HMA is not a fiduciary with respect to this engagement and shall not exercise any discretionary authority or control over the management or administration of the Plan, or the management or disposition of the Plan's Assets. The Plan has no assets and claims are paid from the assets of the employer. HMA shall limit its activities to carrying out ministerial acts of notifying Plan Participants and making benefit payments as required by the Plan and processing benefit determinations on appeal according to the benefits as outlined in this Summary Plan Description. Any matters for which discretion is required shall be referred by Plan Supervisor to the Plan Administrator, and Plan Supervisor shall take direction from Plan Administrator in all such matters. HMA shall not be responsible for advising the Company or Plan Administrator with respect to their fiduciary responsibilities under the Plan. HMA may rely on all information provided to it by the Company, Plan Administrator, and the Trustees, if any, as well as the Plan's other vendors.

PRIVILEGES AS TO DEPENDENTS

The employee shall have the privilege of adding or withdrawing the name or names of any dependent(s) to or from this coverage, as permitted by the Plan, by submitting to the Plan Administrator an application for reclassification on the enrollment form furnished by HMA. Each dependent added to the coverage shall be subject to all conditions and limitations contained in this Plan.

RIGHT OF RECOVERY

Whenever payments have been made (or benefits have been quoted) by HMA in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Plan, HMA shall have the right to recover such payment (or avoid making such payment), to the extent of such excess, from among one or more of the following as HMA shall determine: any individuals to or for, or with respect to whom such payments were made, and/or any insurance companies and other organizations.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT – THE PLAN'S RIGHT TO RESTITUTION

The Plan does not provide benefits for any accident, injury or sickness for which a participant or eligible Dependents have, or may have, any claim for damages or entitlement to recover from another party or parties arising from the acts or omissions of such third party (for example, an auto accident). In the event that another party fails or refuses to make prompt payment for the medical expenses incurred by a participant or eligible Dependents which expenses arise from an accident, injury, or sickness, subject to the terms of the Plan, the Plan may conditionally advance the payment of the eligible medical benefits.

Benefits Conditional upon Cooperation

The Plan's payment of eligible benefits is conditional upon:

- The cooperation of the participant and eligible Dependents, or his or her respective agent(s) (including attorneys) or guardian (of a minor or incapacitated individual) working on his or her behalf to recover damages from another party. The participant may be asked to complete, sign, and return a questionnaire and possibly a restitution agreement.
If the participant or eligible Dependents, or his or her agent(s) or guardian (of a minor or incapacitated individual) refuse to sign and return a restitution agreement, or to cooperate with the Plan or its assignee, the Plan and/or its assignee, such refusal and non-cooperation may be grounds to deny payment of any medical benefits.

By participating in the Plan, participants and eligible Dependents acknowledge and agree to the terms of the Plan’s equitable or other rights to full restitution. Participants will take no action to prejudice the Plan’s rights to restitution. Participants and eligible Dependents agree that they are required to cooperate in providing and obtaining all applicable documents requested by the Plan Administrator or the Company, including the signing of any documents or agreements necessary for the Plan to obtain full restitution.

Participants and eligible Dependents are also required to:

- Notify HMA at 866/206-7786 as soon as possible, that the Plan may have a right to obtain restitution of any and all benefits paid by the Plan. The participant will later be contacted by HMA, and he or she must provide the information requested. If the participant retains legal counsel, the counsel must also contact HMA;

- Inform HMA in advance of any settlement proposals advanced or agreed to by another party or another party’s insurer;

- Provide the Plan Administrator all information requested by the Plan Administrator regarding an action against another party, including an insurance carrier; this includes responding to letters from HMA (and other parties designated by Plan Administrator acting on behalf of the Plan) on a timely basis;

- Not settle, without the prior written consent of the Plan Administrator, or its designee, any claim that the participant or eligible Dependents may have against another party, including an insurance carrier; and

- Take all other action as may be necessary to protect the interests of the Plan.

In the event a participant or eligible Dependents do not comply with the requirements of this section, the Plan may deny benefits to the participant or eligible Dependents or take such other action as the Plan Administrator deems appropriate.

Right of Full Restitution

If the participant or his or her eligible Dependents are eligible to receive benefits from the Plan for injuries caused by another party or as a result of any accident or personal injury, or if the participant or eligible Dependents receive an overpayment of benefits from the Plan, the Plan has the right to obtain full restitution of the benefits paid by the Plan from:

- Any full or partial payment which an insurance carrier makes (or is obligated or liable to make) to the participant or eligible Dependents; and

- The participant or his or her eligible Dependents, if any full or partial payments are made to the participant or eligible Dependents by any party, including an insurance carrier, in connection with, but not limited to, the participant’s or another party’s:
  - Uninsured motorist coverage;
  - Under-insured motorist coverage;
Other medical coverage;
- No fault coverage;
- Workers’ compensation coverage;
- Personal injury coverage;
- Homeowner’s coverage; or
- Any other insurance coverage available.

This means that, with respect to benefits which the Plan pays in connection with an injury or accident, the Plan has the right to full restitution from any payment, settlement or recovery received by the participant or his or her eligible Dependents from any other party, regardless of whether the payment, recovery or settlement terms state that there is a separate allocation of an amount for the restitution of medical expenses or the types of expenses covered by the Plan or the benefits provided under the Plan.

**Surrogacy Arrangement or Agreement**

If the participant enters into a Surrogacy Arrangement or Agreement and receives compensation or reimbursement for medical expenses, the participant must reimburse the Plan for covered services received, related to conception, pregnancy, or delivery in connection with that arrangement (“Surrogacy Health Services”), except that the amount the participant must pay will not exceed the compensation received under the Surrogacy Arrangement or Agreement. A Surrogacy Arrangement or Agreement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Note: This “Surrogacy Arrangement or Agreement” section does not affect the participant’s obligation to pay their portion of the coinsurance for these services, but we will credit any such payments toward the amount the participant must reimburse the Plan under this provision.

By accepting Surrogacy Health Services, the participant automatically assigns to the Plan the right to receive payments that are payable to the participant or chosen payee under the Surrogacy Arrangement or Agreement, regardless of whether those payments are characterized as being for medical expenses. To secure the rights of the Plan, the Plan will also have a lien on those payments. Those payments shall first be applied to satisfy the lien. The assignment and our lien will not exceed the total amount of the participant’s obligation to the Plan under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement or Agreement, the participant must provide written notice of the arrangement, including the names and addresses of the other parties to the arrangement, and a copy of any contracts or other documents, explaining the arrangement, to the Plan.

The participant must complete and provide to the Plan all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this Surrogacy Arrangement or Agreement section and to satisfy those rights. The participant may not agree to waive, release, or reduce the Plan’s rights under this provision without prior written consent from the Plan.

If the participant’s estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Arrangement or Agreement, the estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to the Plan’s liens and other rights to the same extent as if the
participant had asserted the claim against the third party. The Plan may assign its rights to enforce the Plan’s liens and other rights.

**Payment Recovery to be Held in Trust**

The participant, eligible Dependents, the participants agents (including attorneys) and/or the legal guardian of a minor or incapacitated person agree by request for and acceptance of the Plan’s payment of eligible medical benefits, to maintain 100% of the Plan’s payment of benefits or the full extent of any payment from any one or combination of any of the sources listed above in trust and without dissipation except for reimbursement to the Plan or its assignee.

Any payment or settlement from another party received by the participant or his or her eligible Dependents must be used first to provide restitution to the Plan to the full extent of the benefits paid by or payable under the Plan. The balance of any payment by another party must, first, be applied to reduce the amount of benefits which are paid by the Plan for benefits after the payment and, second, be retained by the participant or his or her eligible Dependents. The participant and his or her eligible Dependents are responsible for all expenses incurred to obtain payment from any other parties, including attorneys’ fees and costs or other lien holders, which amounts will not reduce the amount due to the Plan as restitution.

The Plan is entitled to obtain restitution of any amounts owed to it either from funds received by the participant or his or her eligible Dependents from other parties, regardless of whether the participant or his or her eligible Dependents have been fully indemnified for losses sustained at the hands of the other party. A Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Plan’s equitable (or other) right to obtain full restitution.

**TAXES**

Charges for surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) and other state imposed surcharges (as applicable to the Plan), will be considered covered expenses by this Plan. Local, State and Federal taxes, associated with supplies or services covered under this Plan, will also be considered covered expenses by this Plan.
This document is the Summary Plan Description.

<table>
<thead>
<tr>
<th>NAME OF PLAN</th>
<th>PeaceHealth Employee Health Care Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>NAME &amp; ADDRESS OF EMPLOYER/</td>
<td>PeaceHealth</td>
</tr>
<tr>
<td>PARTICIPATING GROUP</td>
<td>14432 SE Eastgate Way, Suite 300</td>
</tr>
<tr>
<td></td>
<td>Bellevue, WA 98007-6412</td>
</tr>
<tr>
<td></td>
<td>425/747-1711</td>
</tr>
<tr>
<td>EMPLOYER IDENTIFICATION NUMBER</td>
<td>91-0939479</td>
</tr>
<tr>
<td>PLAN NUMBER</td>
<td>501</td>
</tr>
<tr>
<td>TYPE OF PLAN</td>
<td>Employee Health Care Plan providing Medical and</td>
</tr>
<tr>
<td></td>
<td>Prescription benefits</td>
</tr>
<tr>
<td>TYPE OF PLAN ADMINISTRATION</td>
<td>Contract Administration</td>
</tr>
<tr>
<td>ORIGINAL PLAN EFFECTIVE DATE</td>
<td>January 1, 2001</td>
</tr>
<tr>
<td>LAST AMENDED DATE</td>
<td>January 1, 2012</td>
</tr>
<tr>
<td>PLAN YEAR</td>
<td>January 1&lt;sup&gt;st&lt;/sup&gt; through December 31&lt;sup&gt;st&lt;/sup&gt;</td>
</tr>
<tr>
<td>PLAN ADMINISTRATOR/SPONSOR</td>
<td>PeaceHealth</td>
</tr>
<tr>
<td>&amp; NAMED FIDUCIARY &amp; DESIGNATED</td>
<td>14432 SE Eastgate Way, Suite 300</td>
</tr>
<tr>
<td>LEGAL AGENT</td>
<td>Bellevue, WA 98007-6412</td>
</tr>
<tr>
<td>EMPLOYEES</td>
<td>Eligible Employees of PeaceHealth, when they meet</td>
</tr>
<tr>
<td></td>
<td>the eligibility requirements described herein.</td>
</tr>
<tr>
<td>GROUP NUMBER</td>
<td>020183</td>
</tr>
<tr>
<td>CONTRIBUTION REQUIRED</td>
<td>Employee Coverage - Yes</td>
</tr>
<tr>
<td></td>
<td>Dependent Coverage - Yes</td>
</tr>
<tr>
<td>PLAN SUPERVISOR</td>
<td>Healthcare Management Administrators, Inc.</td>
</tr>
<tr>
<td></td>
<td>PO Box 85008</td>
</tr>
<tr>
<td></td>
<td>Bellevue, Washington 98015-5008</td>
</tr>
<tr>
<td></td>
<td>425/974-3886 Seattle Area</td>
</tr>
<tr>
<td></td>
<td>866/206-7786 All Other Areas</td>
</tr>
<tr>
<td>FUNDING MEDIUM</td>
<td>Benefits are paid through a trust and through the</td>
</tr>
<tr>
<td></td>
<td>general assets of the employer.</td>
</tr>
</tbody>
</table>
PeaceHealth, of Bellevue, Washington hereby establishes this Plan for the payment of certain expenses for the benefit of its eligible employees to be known as the PeaceHealth Employee Health Care Plan.

PeaceHealth assures its covered employees that during the continuance of the Plan, all benefits herein described shall be paid to or on behalf of the employees in the event they become eligible for benefits.

The Plan is subject to all the terms, provisions and conditions recited on the preceding pages hereof.

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

PeaceHealth, of Bellevue, Washington hereby establishes this Plan for the payment of certain expenses for the benefit of its eligible employees to be known as PeaceHealth Employee Health Care Plan.

PeaceHealth assures its covered employees that during the continuance of the Plan, all benefits herein described shall be paid to or on behalf of the employees in the event they become eligible for benefits.

The Plan is subject to all the terms, provisions and conditions recited on the preceding pages hereof.

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

PeaceHealth has caused this Plan to take effect as of 12:01 A.M. on January 1, 2012 at Bellevue, Washington.

PeaceHealth

Authorized Signature

Printed Name and Title

Date
Plan Effective January 1, 2001

Plan Restated and Amended January 1, 2012

Claim Administration By:

HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
PO Box 85008
Bellevue, WA 98015-5008

425/974-3886 Seattle Area
866/206-7786 Nationwide