



**NORTHWEST HOSPITAL
& MEDICAL CENTER**

SUMMARY PLAN DESCRIPTION

Medical Plan Summary

Basic Plan

Preferred Plan

PreferredPlus Plan

Final
2007

BENEFITS DIRECTORY

Call ...	For Questions About ...
<p>First Choice Health Administrators at (800) 430-3818, or (206) 268-2350 www.1stchoiceadmin.com</p>	<ul style="list-style-type: none">• Plan benefit details (covered expenses, limitations, exclusions)• Network providers• Out-of-area coverage• Service areas• Specific medical conditions or treatment• Identification cards• Filing non-network claims• Preauthorizing in-patient care• Preauthorizing care at non-network facility
<p>Express Scripts at (866) 590-5890 www.express-scripts.com</p>	<ul style="list-style-type: none">• Network pharmacies• Mail-order prescription drugs• Prescription formulary
<p>Benefits Department at (206) 368-1106 http://nwhweb/hr/benefits/</p>	<ul style="list-style-type: none">• Northwest Hospital & Medical Center's benefit program• Eligibility• Cost• When coverage begins• Enrollment• Qualifying change in family status

HOW TO USE THIS BOOKLET

This booklet is the Summary Plan Description of the medical coverage available to you and your family members through the Basic Plan, Preferred Plan and PreferredPlus Plan if you are an eligible Northwest Hospital & Medical Center employee. It summarizes the coverage, describes when coverage begins and explains how to use these plans. See your enrollment materials for information on enrollment procedures and deadlines, coverage options and required payroll deductions.

This booklet uses a number of technical terms you will need to know to understand your benefits. For reference, we've defined many unfamiliar terms in "Definitions" starting on page 58. More definitions are contained in the Details of Coverage – Covered Expenses, available on request.

Keep this booklet and refer to it whenever you have a question about your medical coverage. If you still have questions, contact First Choice Health Administrators toll free at (800) 430-3818. You may also contact the Benefits Department in Human Resources at (206) 368-1106.

Although this booklet includes certain key features and brief summaries of Northwest Hospital & Medical Center's medical coverage through the Basic Plan, Preferred Plan and PreferredPlus Plan, it does not provide detailed descriptions. If you have questions about specific plan details, contact First Choice Health Administrators, or the Benefits Department. Details of plan coverage and exclusions are available upon request and are not a part of this SPD.

Every attempt has been made to ensure the accuracy of this information. However, if there is any discrepancy between this Summary Plan Description and other legal documents, the legal documents will always govern. In addition, if applicable, certain plan features shown in this booklet may be modified by collective bargaining agreements.

Northwest Hospital & Medical Center intends to continue these plans indefinitely but reserves the right to amend or terminate them at any time, for any reason, according to the amendment and termination procedures described in the legal documents.

This booklet does not create a contract of employment with Northwest Hospital & Medical Center.

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HIGHLIGHTS

Medical coverage provides financial protection for you and your family in the event of a serious illness or injury.

Northwest Hospital & Medical Center's medical plans are "self-funded", which means claims and administrative costs are paid using contributions made by you and Northwest Hospital & Medical Center. First Choice does not insure the plans.

Here are a few highlights of your coverage under the Plans:

- The Basic Plan offers network benefits after you've met a \$1,000 per person, or \$3,000 per family annual deductible. After the deductible has been met, benefits are generally paid at 80%, after a \$20 co-pay. A network provider must provide health care services.
- The Preferred Plan offers network benefits after you've met a \$200 per person, or \$600 per family annual deductible. After the deductible has been met, benefits are generally paid at 90%, after a \$20 co-pay. The annual deductible is waived for Preventive Care and Pharmacy benefits. A network provider must provide health care services.
- The PreferredPlus Plan offers two levels of benefits – network benefits, generally paid at 100% after a \$15 co-pay; and, non-network benefits, generally paid at 60% of usual, customary and reasonable fees after an out-of-network deductible has been paid. You have a choice of these two benefit levels each time you need care. The level of benefits you receive depends on how you access your care.

For more information on network and non-network benefits, see "Definitions" beginning on page 58.

WHO'S ELIGIBLE

Employees

If you are classified as a 0.4 FTE through 1.0 FTE and are in a paid status, you are eligible to enroll in one of the medical plans. Temporary, contract, or reserve employees are not eligible for the benefits described in this booklet.

No person will be covered both as an employee and as a dependent under these plans. A child may not be covered as a dependent of more than one employee.

Family Members of Employees

The following family members are eligible for medical coverage:

- Your spouse, unless legally separated or divorced. The term Spouse means one person of the opposite gender who is the lawful spouse as recognized by Federal laws.
- Unmarried children who are:
 - Younger than age 19 and primarily dependent on you for support, or
 - Younger than age 24 if they rely on you for half of their financial support and are a full time student enrolled in an accredited educational institution
Beginning with your child's 19th birthday, First Choice Health Administrators will verify, on a semi-annual basis, their full time student status.
 - Incapacitated due to developmental or physical disability and chiefly dependent on you for support. You must submit proof of your child's disability at the time coverage is extended and annually thereafter unless otherwise requested by the Plan. The child must have become incapacitated while covered by one of these plans and before age 19 (or before age 24 if a full time student).
 - Named in a Qualified Medical Child Support Order (QMCSO) as defined under federal law and authorized by the Plan. See page 35 for details.

Eligible children include unmarried:

- *Natural children*
- *Legally adopted children or children legally placed for adoption*
- *Stepchildren*
- *Legally designated wards*

The newborn child of an enrolled dependent child is not eligible for coverage under these plans unless the newborn child becomes the legal dependent of the employee.

Active Employees and Their Spouses with Medicare Coverage

Active employees and/or their spouses who have Medicare coverage due to age or disability will receive the same benefits as employees and spouses who do not have Medicare coverage, unless the individual elects Medicare as the primary payor of health care benefits. If Medicare coverage is selected as primary payor, no benefits will be provided under this Plan.

See "Coordination of Benefits with Medicare" on page 38 for more information.

Retirees

If you are at least age 60 but under age 65 and have 15 years of service with Northwest Hospital & Medical Center, you are eligible for retiree medical coverage until you reach age 65. This booklet describes your benefits; contact the Benefits Department in Human Resources for cost and enrollment information. Your cost of coverage may change.

Spouses of Retirees

- The Spouse, unless legally separated or divorced, of a Retiree meeting the definition above is eligible for retiree medical coverage if the Retiree is enrolled for retiree medical coverage.

PREMIUMS

Employees who are classified as a 0.6 FTE or greater, who are eligible participants, contribute a percentage of the premiums to provide spouse and/or dependent coverage. Employee coverage under the plan is paid 100% by Northwest Hospital & Medical Center, with the exception of the PreferredPlus Plan, which requires an employee contribution.

Employees who are classified as a 0.4 FTE to 0.59 FTE, who are eligible participants, contribute 100% of the premiums to provide coverage for themselves and eligible dependents.

COST

When you receive medical care, you pay:

- Deductibles, if applicable
- Required co-pays, paid at the time of the service
- Coinsurance amounts not covered by the Plan
- Amounts in excess of usual, customary and reasonable fees (see page 63 for a definition)
- Amounts in excess of limitations and maximums
- Expenses for services or supplies not covered by the Plan

See “Medical Plan Summary” starting on page 7 for the Basic Plan, page 11 for the Preferred Plan, and page 15 for the PreferredPlus Plan for more information on deductibles, co-pays, and coinsurance amounts.

ENROLLING IN THE PLANS

If you are a newly hired employee, your eligibility date for coverage under the Plan is the first day of the calendar month following 90 days of continuous service. You must submit a completed enrollment form to the Benefits Department in Human Resources by your eligibility date. If you do not submit your enrollment information by your eligibility date, you will be automatically enrolled in the Preferred Plan with Employee Only coverage. See your enrollment materials for details.

Making Changes

Each year during open enrollment, you may change your elections.

Qualifying Change in Family Status

If you have a qualifying change in status as defined by the Internal Revenue Service that affects your eligibility, or your dependent’s eligibility, you may drop or add family

members' coverage during the plan year. Examples of qualifying changes (events) include:

- Marriage
- Divorce or legal separation
- Birth, adoption or placement for adoption of a child
- Placement of a legal ward
- Loss of your child's eligibility under another health plan
- Death of a family member
- Significant change in your spouse's coverage due to his or her employment

Any change you make must be on account of and correspond with the change in status. For example, if your child loses coverage under your spouse's plan, you may add this child to your Northwest Hospital & Medical Center Plan. If you get married, you may enroll your new spouse and his or her eligible children.

To add or drop family members' coverage during the plan year, notify the Benefits Department in Human Resources and submit a completed Change in Family Status form within 31 days of the status change (60 days for newborns and adoption or legal placement of a child). Otherwise, you must wait until the next open enrollment period. In the case of a newborn, newly adopted or legally placed child, retroactive payroll deductions will be taken if necessary.

Special Enrollment Rules

Loss of Coverage: If you decline coverage for yourself, or your family members, because of other health insurance coverage, you may, in the future, be able to enroll yourself, or your family members, in these medical plans if you lose the other coverage as described below; and, if you (or your family members) are otherwise eligible.

You must make any change to your elections within 31 days of the loss of other coverage; otherwise, you must wait until the next open enrollment period. Contact the Benefits Department in Human Resources for details.

Loss of other coverage means:

- You or your family member(s) were covered under other health insurance or group health plan at the time coverage under this Plan was previously offered to the individual; and

The other coverage was lost due to one of the following reasons:

- The other coverage was under COBRA and the COBRA coverage has been exhausted, or
- The other coverage was not under COBRA and employer contributions toward the other coverage was terminated; or
- The other coverage was not under COBRA and the other coverage was terminated as a result of loss of eligibility for the other coverage. Loss of eligibility includes:
 - Loss of eligibility due to divorce, legal separation, death, cessation of dependent status, termination of employment, or reduction in the number of hours of employment

- Loss of eligibility due to the other coverage no longer offering any benefits to a class of similarly situated individuals
- Loss of eligibility on the earliest date the individual incurs a claim that reaches or exceeds the lifetime maximum benefit under the other coverage
- Loss of eligibility when coverage is offered through an HMO (or other arrangement) in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual)
- Loss of eligibility when coverage is offered through an HMO (or other arrangement) in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual) and no other benefit package is available to the individual.

Newly Acquired Family Member: If you have a new family member as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your family members.

You must make any change to your elections within 31 days of the status change due to marriage or within 60 days of the status change due to birth, adoption or placement for adoption; otherwise, you must wait until the next open enrollment period. Contact the Benefits Department in Human Resources for details.

WHEN COVERAGE BEGINS

If you enroll during the year as a newly hired employee, and enroll by your eligibility date, coverage for you and your dependents begin on the first day of the calendar month following 90 days of continuous employment with Northwest Hospital & Medical Center.

If you become eligible because your employment status changes, for example from temporary status to a 0.4 FTE, your service as a temporary employee is credited to the 90-day eligibility period.

If you enroll during open enrollment, coverage is effective beginning January 1 of the next plan year and remains in effect for the entire plan year, if you remain eligible.

If enrolled by the deadline, described in “Making Changes”, coverage for your:

- Newborn, newly adopted or legally placed child is retroactive to the date of birth, adoption or placement
- New spouse begins on the first day of the calendar month following receipt of a completed Change in Family Status form
- Dependents named in a Qualified Medical Child Support Order (QMCSO) will begin on the first day of the calendar month following receipt of the order, but only after the order has been determined to be a QMCSO.

FALSE STATEMENTS, FRAUDULENT ACTS and MATERIAL MISREPRESENTATIONS

If you or your dependent or anyone acting on your or your dependents behalf makes a false statement in enrollment or eligibility records or withholds information with intent to deceive or affect the acceptance of enrollment or otherwise misleads the Plan into providing benefits it would not otherwise have provided, this Plan will be entitled to recover its damages from you, from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided. In addition, the Plan may retroactively terminate coverage for a person who commits fraud or material misrepresentation in connection with obtaining coverage or benefits such as providing false or misleading information on a claim. Coverage will not be offered to an employee or the employee's dependents whose coverage was previously terminated for fraud or material misrepresentation or was not accepted for the same reasons.

MAXIMUM LIFETIME BENEFIT

Benefits under these plans are limited to \$1,000,000 for all health care combined during your lifetime.

Basic Plan

HOW THE BASIC PLAN WORKS

Medical Plan Summary

The following table summarizes covered services and supplies under the Basic Plan and identifies related deductibles, coinsurance, co-pays, maximums and limitations. For more detailed information on “Covered Expenses” and “Expenses Not Covered,” you may request a separate Details of Coverage – Covered Expenses description.

With the Basic Plan you may see any network provider for covered services and receive benefits.

	Basic Plan
Annual deductible ⁽¹⁾	\$1,000/person \$3,000/family
Annual out-of-pocket maximum ⁽²⁾	\$3,000/person \$9,000/family
Lifetime maximum	\$1,000,000
Covered Expenses	Plan Pays
Acupuncture	80% after \$20 co-pay/visit
Ambulance services ⁽³⁾ (up to annual \$2,000/person maximum)	80%
Chemical dependency treatment ⁽³⁾ (up to \$10,000 in plan payments in 24 months)	80%
Chiropractic care	80% after \$20 co-pay/visit
Durable medical equipment ⁽³⁾	80%
Emergency care ⁽⁴⁾ (in an emergency room) – Emergency care – Nonemergency care	(co-pay waived if admitted within 24 hours of ER visit) 80% after \$75 co-pay/visit Not covered
Hearing (\$2,000/ear; \$4,000 maximum per lifetime)	80%
Home health care ⁽³⁾ (up to 130 visits/year)	80%
Hospice care ⁽³⁾ (maximum 10 days of inpatient care; respite care covered up to 120 hours during each 3-month period)	80%
Hospital care and surgical services ^{(3) (5) (6)} (Inpatient and outpatient)	80% if services provided at NWH 60% at any other network hospital
Lab, x-ray and other diagnostic tests ⁽³⁾	MRI, CT and Ultrasound at 80% if provided at NWH. 60% after \$20 co-pay at any other network location X-rays included in physician office co-pay. All other diagnostic test at 80%
Massage therapy (prescription required)	80% after \$20 co-pay/visit

Basic Plan

	Basic Plan
Maternity care ^{(7) (8)}	80%
Mental health care ⁽³⁾	
– Inpatient (up to 10 days/year)	80%
– Residential or day treatment (also subject to inpatient maximum; each day of care counts as ½ an inpatient day)	60%
– Outpatient (up to 20 visits/year)	100% after \$20 co-pay/visit
Naturopathic care (up to annual \$500/person maximum)	80% after \$20 co-pay/visit
Neurodevelopmental therapy (up to annual \$1,000/person maximum)	
– Outpatient (up to 45 visits/year)	80%
PKU formula	80%
Prescription Drug Deductible Applies to drugs purchased at the pharmacy or through mail order Prescription drugs ⁽⁹⁾ (up to 30-day supply)	\$200/person \$600/family
– Generic drugs	100% after \$10 co-pay/prescription
– Preferred brand-name drugs	100% after \$20 co-pay/prescription
– Non-preferred brand-name drugs	50% coinsurance/prescription
Mail-order prescription drugs ⁽¹⁰⁾ (up to 90-day supply)	
– Generic drugs	100% after \$10 co-pay/prescription
– Preferred brand-name drugs	100% after \$20 co-pay/prescription
– Non-preferred brand-name drugs	100% after \$40 co-pay/prescription
Preventive care (exams, mammograms and routine immunizations)	After deductible, 100% after \$15 co-pay/visit for routine visits
Professional services (including most physician services regardless of location, purpose or other applicable benefits)	100% after \$20 co-pay/office or home visit
Prosthetics ⁽³⁾ and other medical supplies	80%
Rehabilitative care ⁽³⁾ (up to annual \$30,000/person maximum)	
– Inpatient	80% if services provided at NWH 60% at any other network facility
– Outpatient ⁽⁷⁾ (up to 45 sessions/person/year)	80% if services provided at NWH 60% at any other network facility
Skilled nursing care ⁽³⁾	80%
Smoking cessation programs and prescribed drugs (up to \$500 lifetime maximum)	100%
TMJ (up to annual \$1,000/person maximum; \$5,000/person lifetime maximum)	80% after \$20 co-pay/visit
Transplants ^{(3) (6)} (certain transplants only; \$250,000 recipient lifetime maximum benefit; \$25,000 donor lifetime maximum benefit, charged against recipient maximum)	80% if services provided at NWH. 60% at any other network hospital.
Urgent care	80% after \$20 co-pay/visit

Basic Plan

	Basic Plan
Women's health care	80% after \$20 co-pay/visit

- (1) Deductible is waived for prescription drugs and smoking cessation programs.
- (2) Out of pocket does not include annual deductible, prescription drug deductible or prescription drug copays.
- (3) You must obtain precertification for certain benefits and for all inpatient care by calling First Choice Health Administrators at: (800) 430-3818.
- (4) You must notify First Choice Health Administrators at (800) 430-3818 within 24 hours of emergency care or emergency admission.
- (5) Allowable expenses for hospital care and surgical services will be paid at the higher Northwest Hospital & Medical Center level of reimbursement for participants whose permanent home address zip code is 75 miles, or more, away from the Northwest Hospital & Medical Center zip code of 98133.
- (6) In those instances where Northwest Hospital & Medical Center does not perform a particular surgical procedure, or provide a particular service, the Plan will cover those procedures or services as if they had been provided by Northwest Hospital & Medical Center.
- (7) Office co-pay still applies.
- (8) Notify First Choice Health Administrators of maternity admissions by calling (800) 430-3818.
- (9) You must see an Express Scripts network pharmacy. There is no non-network benefit. Certain drugs require precertification.
- (10) You must use the Express Scripts mail order program. There is no non-network benefit. Certain drugs require precertification.

Annual Deductible

Before you receive plan benefits, you must meet the \$1,000 per person (\$3,000 per family) annual deductible each calendar year. The deductible is waived for Prescription Drugs and Smoking Cessation Programs.

The following do not go toward meeting the Annual Deductible:

- Co-pays
- Prescription Drug Deductible
- Any charges that exceed usual, customary and reasonable fees or benefit maximums
- Services or supplies not covered by the Plan
- Any charges you pay that exceed annual or lifetime benefit limits

If three or more family members together meet \$3,000 in individual deductibles, you meet the family deductible. This means no further deductible will be required from any family member for the rest of that calendar year.

If two or more family members are involved in the same accident, only one deductible will apply.

The amount of annual deductible you satisfy under this Plan during the last three months of a calendar year is credited toward the deductible for the following calendar year.

Prescription Drug Deductible

Before you receive prescription drug benefits, you must meet the \$200 per person (\$600 per family) Prescription Drug Deductible each calendar year.

Basic Plan

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is:

- \$3,000 per person
- \$9,000 per family

The out-of-pocket maximum is the most you pay toward most co-pays and coinsurance each calendar year. This means once you reach your out-of-pocket maximum, the Plan pays 100% of most covered expenses for the rest of that calendar year. Each participant has a separate out-of-pocket maximum.

The following do not go toward meeting the out-of-pocket maximum:

- Annual Deductible
- Prescription Drug Deductible
- Co-pays for prescription drugs
- Any charges that exceed usual, customary and reasonable fees or benefit maximums
- Services or supplies not covered by the Plan
- Any charges you pay that exceed annual or lifetime benefit limits

Preferred Plan

HOW THE PREFERRED PLAN WORKS

Medical Plan Summary

The following table summarizes covered services and supplies under the Preferred Plan and identifies related deductibles, co-pays, coinsurance, maximums and limitations. For more information on “Covered Expenses” and “Expenses Not Covered” you may request a separate Details of Coverage – Covered Expenses description.

With the Preferred Plan, you may see any network provider for covered services and receive benefits.

	Preferred Plan
Annual deductible ⁽¹⁾	\$200/person \$600/family
Annual out-of-pocket maximum ⁽²⁾	\$2,500/person \$7,500/family
Lifetime maximum	\$1,000,000
Covered Expenses	Plan Pays
Acupuncture	90% after \$20 co-pay/visit
Ambulance services ⁽³⁾ (up to annual \$2,000/person maximum)	80%
Chemical dependency treatment ⁽³⁾ (up to \$10,000 in plan payments in 24 months)	90%
Chiropractic care	90% after \$20 co-pay/visit
Durable medical equipment ⁽³⁾	80%
Emergency care ⁽⁴⁾ (in an emergency room) – Emergency care – Nonemergency care	(co-pay waived if admitted within 24 hours of ER visit) 90% after \$75 co-pay/visit Not covered
Hearing (\$2,000/ear; \$4,000 maximum per lifetime)	90%
Home health care ⁽³⁾ (up to 130 visits/year)	90%
Hospice care ⁽³⁾ (maximum 10 days of inpatient care; respite care covered up to 120 hours during each 3-month period)	90%
Hospital care and surgical services ^{(3) (5) (6)} (inpatient and outpatient)	90% if services provided at NWH 60% at any other network hospital
Lab, x-ray and other diagnostic tests ⁽³⁾	MRI, CT and Ultrasound at 90% if provided at NWH. 60% after \$20 co-pay at any other network location. X-rays included in physician office co-pay. All other diagnostic tests at 90%
Massage therapy (prescription required)	90% after \$20 co-pay/visit

Preferred Plan

	Preferred Plan
Maternity care ^{(7) (8)}	90%
Mental health care ⁽³⁾ <ul style="list-style-type: none"> – Inpatient (up to 10 days/year) 80% – Residential or day treatment (also subject to inpatient maximum; each day of care counts as ½ an inpatient day) 60% – Outpatient (up to 20 visits/year) 100% after \$20 co-pay/visit 	
Naturopathic care (up to annual \$500/person maximum)	90% after \$20 co-pay/visit
Neurodevelopmental therapy (up to annual \$1,000/person maximum) <ul style="list-style-type: none"> – Outpatient (up to 45 visits/year) 90% 	
PKU formula	90%
Prescription drugs ⁽⁹⁾ (up to 30-day supply) <ul style="list-style-type: none"> – Generic drugs 100% after \$10 co-pay/prescription – Preferred brand-name drugs 100% after \$20 co-pay/prescription – Non-preferred brand-name drugs 50% coinsurance/prescription 	
Mail-order prescription drugs ⁽¹⁰⁾ (up to 90-day supply) <ul style="list-style-type: none"> – Generic drugs 100% after \$10 co-pay/prescription – Preferred brand-name drugs 100% after \$20 co-pay/prescription – Non-preferred brand-name drugs 100% after \$40 co-pay/prescription 	
Preventive care – (Deductible Waived) (exams, mammograms and routine immunizations)	100% after \$15 co-pay/visit for routine visits
Professional services (including most physician services regardless of location, purpose or other applicable benefits)	100% after \$20 co-pay/office or home visit
Prosthetics ⁽³⁾ and other medical supplies	90%
Rehabilitative care ⁽³⁾ (up to annual \$30,000/person maximum) <ul style="list-style-type: none"> – Inpatient 90% if services provided at NWH. 60% at any other network facility. – Outpatient ⁽⁷⁾ (up to 45 sessions/person/year) 90% if services provided at NWH. 60% at any other network facility. 	
Skilled nursing care ⁽³⁾	90%
Smoking cessation programs and prescribed drugs (up to \$500 lifetime maximum)	100%
TMJ (up to annual \$1,000/person maximum; \$5,000/person lifetime maximum)	90% after \$20 co-pay/visit
Transplants ^{(3) (6)} , (certain transplants only; \$250,000 recipient lifetime maximum benefit; \$25,000 donor lifetime maximum benefit, charged against recipient maximum)	90% if services provided at NWH. 60% at any other network hospital.
Urgent care	90% after \$20 co-pay/visit
Women’s health care	90% after \$20 co-pay/visit

Preferred Plan

- (1) Deductible is waived for preventive care, prescription drugs and smoking cessation programs.
- (2) Out of pocket does not include annual deductible or prescription drug copays.
- (3) You must obtain precertification for certain benefits and for all inpatient care by calling First Choice Health Administrators at: (800) 430-3818.
- (4) You must notify First Choice Health Administrators at (800) 430-3818 within 24 hours of emergency care or emergency admission.
- (5) Allowable expenses for hospital care and surgical services will be paid at the higher Northwest Hospital & Medical Center level of reimbursement for participants whose permanent home address zip code is 75 miles, or more, away from the Northwest Hospital & medical Center zip code of 98133.
- (6) In those instances where Northwest Hospital & Medical Center does not perform a particular surgical procedure, or provide a particular service, the Plan will cover those procedures or services as if they had been provided by Northwest Hospital & Medical Center.
- (7) Office co-pay still applies.
- (8) Notify First Choice Health Administrators of maternity admissions by calling (800) 430-3818.
- (9) You must see an Express Scripts network pharmacy. There is no non-network benefit. Certain drugs require precertification.
- (10) You must use the Express Scripts mail order program. There is no non-network benefit. Certain drugs require precertification.

Annual Deductible

Before you receive plan benefits, you must meet the \$200 per person (\$600 per family) annual deductible each calendar year. The deductible is waived for Preventive Care, Prescription Drugs and Smoking Cessation Programs.

The following do not go toward meeting the Annual Deductible:

- Co-pays
- Any charges that exceed usual, customary and reasonable fees or benefit maximums
- Services or supplies not covered by the Plan
- Any charges you pay that exceed annual or lifetime benefit limits

If three or more family members together meet \$600 in individual deductibles, you meet the family deductible. This means no further deductible will be required from any family member for the rest of that calendar year.

If two or more family members are involved in the same accident, only one deductible will apply.

The amount of annual deductible you satisfy under this Plan during the last three months of a calendar year is credited toward the deductible for the following calendar year.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is:

- \$2,500 per person
- \$7,500 per family

The out-of-pocket maximum is the most you pay toward most co-pays and coinsurance each calendar year. This means once you reach your out-of-pocket maximum, the Plan pays 100% of most covered expenses for the rest of that calendar year. Each participant has a separate out-of-pocket maximum.

Preferred Plan

The following do not go toward meeting the out-of-pocket maximum:

- Annual deductible
- Co-pays for prescription drugs
- Any charges that exceed usual, customary and reasonable fees or benefit maximums
- Services or supplies not covered by the Plan
- Any charges you pay that exceed annual or lifetime benefit limits

HOW THE PREFERREDPLUS PLAN WORKS

Medical Plan Summary

The following table summarizes covered services and supplies under the PreferredPlus Plan and identifies related co-pays, coinsurance, maximums and limitations. For more information on “Covered Expenses” and “Expenses Not Covered,” you may request a separate Details of Coverage – Covered Expenses description.

	Network Benefits	Non-Network Benefits
Annual deductible	None	\$300/person \$900/family
Annual out-of-pocket maximum ⁽¹⁾	\$ 1,500/person (no family maximum)	\$5,000/person (no family maximum)
Lifetime maximum	\$1,000,000	
Covered Expenses	Plan Pays	
Acupuncture	100% after \$15 co-pay/visit	Not covered
Ambulance services ⁽³⁾ (up to annual \$2,000/person maximum)	80%	80%
Chemical dependency treatment ⁽³⁾ (up to \$10,000 in plan payments in 24 months)	100%	Not covered
Chiropractic care	100% after \$15 co-pay/visit	Not covered
Durable medical equipment ⁽³⁾	80%	80%
Emergency care ⁽⁴⁾ (in an emergency room; co-pay waived if admitted within 24 hours of ER visit) – Emergency care – Nonemergency care	100% after \$75 co-pay/visit Not covered	100% after \$75 co-pay/visit Not covered
Hearing (\$2,000/ear; \$4,000 maximum per lifetime)	100%	60%
Home health care ⁽³⁾ (up to 130 visits/year)	100%	60%
Hospice care ⁽³⁾ (maximum 10 days of inpatient care; respite care covered up to 120 hours during each 3- month period)	100%	60% ⁽²⁾

PreferredPlus Plan

Covered Expenses	Network Benefits	Non-Network Benefits
Hospital care and surgical services ^{(3) (5) (6)} (inpatient and outpatient)	100% if services provided at NWH. 60% at any other network hospital	60% ⁽²⁾
Lab, x-ray and other diagnostic tests ⁽³⁾	MRI, CT and Ultrasound at 100% if provided at NWH. 60% after \$15 co-pay at any other network location. X-rays included in physician office co-pay. All other diagnostic tests at 100%	60%
Massage therapy (prescription required)	100% after \$15 co-pay/visit	Not covered
Maternity care ^{(7) (8)}	100%	60% ⁽²⁾
Mental health care ⁽³⁾		
– Inpatient (up to 10 days/ year)	80%	Not covered
– Residential or day treatment (also subject to inpatient maximum; each day of care counts as ½ an inpatient day)	60%	Not covered
– Outpatient (up to 20 visits/year)	100% after \$20 co-pay/visit	Not covered
Naturopathic care (up to annual \$500/person maximum)	100% after \$15 co-pay/visit	Not covered
Neurodevelopmental therapy (up to annual \$1,000/person maximum)	100%	60% ⁽²⁾
PKU formula	100%	60%
Prescription drugs ⁽⁹⁾ (up to 30-day supply)		
- Generic drugs	100% after \$10 co-pay/30-day prescription	Not covered
- Preferred brand-name drugs	100% after \$20 co-pay/30-day prescription	Not covered
- Non-preferred brand-name drugs	100% after \$40 co-pay/30-day prescription	Not covered

PreferredPlus Plan

Covered Expenses	Network Benefits	Non-Network Benefits
Mail-order prescription drugs ⁽¹⁰⁾ (up to 90-day supply) - Generic drugs - Preferred brand-name drugs - Non-preferred brand-name drugs	100% after \$10 co-pay/prescription 100% after \$20 co-pay/prescription 100% after \$40 co-pay/prescription	Not covered Not covered Not covered
Preventive care (exams, mammograms, and immunizations)	100% after \$15 co-pay/office visit for routine visits	Not covered
Professional services (including most physician services regardless of location, purpose or other applicable benefits)	100% after \$15 co-pay/office, home or hospital visit	60%
Prosthetics ⁽³⁾ and other medical supplies	100%	60%
Rehabilitative care ⁽³⁾ (up to annual \$30,000/person maximum) – Inpatient – Outpatient ⁽⁷⁾ (up to 45 sessions/person/year)	100% 100%	60% 60% ⁽²⁾
Skilled nursing care	100%	60%
Smoking cessation programs and prescribed drugs (up to \$500 lifetime maximum)	100%	Not covered
TMJ (up to annual \$1,000/person maximum; \$5,000/person lifetime maximum)	100% after \$15 co-pay/visit	Not covered
Transplants ⁽³⁾⁽⁶⁾ (certain transplants only; \$250,000 recipient lifetime maximum benefit; \$25,000 donor lifetime maximum benefit, charged against recipient maximum)	100% if services provided at NWH. 60% at any other network hospital.	Not covered
Urgent care	100% after \$15 co-pay/visit	60%
Women's health care	100% after \$15 co-pay/visit	60%

PreferredPlus Plan

- (1) Out of pocket does not include annual deductible or prescription drug copays.
- (2) You must obtain precertification for certain non-network benefits by calling First Choice Health Administrators at: (800) 430-3818.
- (3) You must obtain precertification for certain benefits and for all inpatient care by calling First Choice Health Administrators at: (800) 430-3818.
- (4) You must notify First Choice Health Administrators at (800) 430-3818 within 24 hours of emergency care or emergency admission.
- (5) Allowable expenses for hospital care and surgical services will be paid at the higher Northwest Hospital & Medical Center level of reimbursement for participants whose permanent home address zip code is 75 miles, or more, away from the Northwest Hospital & medical Center zip code of 98133.
- (6) In those instances where Northwest Hospital & Medical Center does not perform a particular surgical procedure, or provide a particular service, the Plan will cover those procedures or services as if they had been provided by Northwest Hospital & Medical Center.
- (7) Office co-pay still applies.
- (8) Notify First Choice Health Administrators of maternity admissions by calling (800) 430-3818.
- (9) You must see an Express Scripts network pharmacy. There is no non-network benefit. Certain drugs require precertification.
- (10) You must use the Express Scripts mail order program. There is no non-network benefit. Certain drugs require precertification.

How the Plan Pays Benefits

The following chart shows how benefits are determined for most covered expenses.

Plan Feature	PreferredPlus Plan
You pay any required co-pays and meet the annual deductible, if any	See "Medical Plan Summary" for amounts
After the co-pays, the plan pays for most covered services at this level	100% Network 60% Non-network
Once you pay this amount toward covered expenses (your annual out-of-pocket maximum)	\$ 1,500 Network \$5,000 Non-network
The balance of most covered expenses for the year is paid at	100%

Annual Deductible

Before you receive plan benefits for non-network care, you must meet the \$300 per person (\$900 per family) annual deductible per calendar year.

The following do not go toward meeting the Annual Deductible:

- Co-pays
- Any charges that exceed usual, customary and reasonable fees or benefit maximums
- Services or supplies not covered by the Plan
- Any charges you pay that exceed annual or lifetime benefit limits

If three or more family members together meet \$900 in individual deductibles, you meet the family deductible. This means no further deductible will be required from any family member for the rest of that calendar year.

PreferredPlus Plan

If two or more family members are involved in the same accident, only one deductible will apply.

The amount of annual deductible you satisfy under this Plan during the last three months of a calendar year is credited toward the deductible for the following calendar year.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is:

- Network care is \$1,500 per person (there is no family maximum)
- Non-network care is \$5,000 per person (there is no family maximum)

The out-of-pocket maximum is the most you pay toward most co-pays and coinsurance each calendar year. This means once you reach your out-of-pocket maximum, the Plan pays 100% of most covered expenses for the rest of that calendar year. Each participant has a separate out-of-pocket maximum.

The following do not go toward meeting the out-of-pocket maximum:

- Annual deductible
- Co-pays for prescription drugs
- Any charges that exceed usual, customary and reasonable fees or benefit maximums
- Services or supplies not covered by the Plan
- Any charges you pay that exceed annual or lifetime benefit limits

PRECERTIFICATION REQUIREMENTS – ALL PLANS

Precertification means prior approval for medical services, supplies, or specialty care.

To precertify, call First Choice Health Administrators at (800) 430-3818.

You are responsible for precertifying your care as described in this section. If your care is not precertified, benefits subject to precertification will not be paid under the Plan.

Precertification is required for:

- Prior to inpatient care or hospitalization:

Call First Choice Health Administrators at (800) 430-3818 to precertify inpatient care or hospitalization, including inpatient hospital admissions, inpatient chemical dependency treatment, inpatient mental health treatment, inpatient rehabilitation treatment, or skilled nursing facility admissions.

- Prior to the following services:

Call First Choice Health Administrators at (800) 430-3818 to precertify the following:

- Air ambulance services (for non-emergencies) / inter-facility ambulance transport
 - Breast reduction / removal of breast implants
 - Dental trauma services (follow up services)
 - Durable medical equipment and prosthetics if purchase exceeds \$1,000 or \$250 a month rental
 - Eyelid surgery (blepharoplasty, etc.)
 - Home health services / home infusion therapy
 - Hospice care
 - Non-network facility when there is no network facility able to render medically necessary care
 - Transplants
 - PET scans
 - Reconstructive and/or cosmetic surgery
 - Surgical interventions for sleep apnea
 - Stereotactic radiosurgery (i.e. gamma knife)
 - Vein ligation/sclerotherapy
- For the PreferredPlus Plan only, prior to the following services when using non-network providers:

Call First Choice Health Administrators at (800) 430-3818 to precertify the following:

- Outpatient surgeries
- Outpatient maternity care
- Neurodevelopmental therapy
- Outpatient rehabilitative care

Emergency Care:

You do not need to precertify for emergency care. However, you (or a family member or hospital staff member) must call First Choice Health Administrators within 24 hours from the start of your emergency care or emergency admission, or as soon as you are reasonably able to do so.

Any follow up care by a non-network provider must be precertified by First Choice Health Administrators.

Maternity Admissions:

You do not need to precertify for maternity admissions. However, you are expected to call First Choice Health Administrators to notify them of your admission.

Prescription Drugs:

Certain prescription drugs through Express Scripts must be preauthorized. Refer to Details of Coverage – Covered Expenses for a list of prescription drugs requiring preauthorization.

NETWORK PROVIDERS AND ACCESSING CARE

First Choice Health Network (FCHN) is this Plan’s network provider. FCHN providers are listed in your Plan Directory and located in Washington (FCHN), Alaska (FCHN), Idaho (FCHN), Oregon (Providence Preferred Network of Oregon), and Montana (Health InfoNet). You may access an up to date list of providers at the websites listed below.

If you are traveling or you have a covered dependent residing outside the states of Washington, Alaska, Idaho, Oregon, or Montana, this Plan’s provider network is the Beech Street Network.

Network For the state in which care is received:	State in which care is received:	Website:
First Choice Health Network and Healthcare Direct	Washington, Oregon, Alaska & Idaho	www.1stchoiceadmin.com
Health InfoNet	Montana	www.healthinfonetmt.com
Beech Street Network	All Other States	www.beechstreet.com

To receive Network Benefits (the higher level of benefit), you must use providers that participate in these provider networks (First Choice Health Network, Healthcare Direct, Health InfoNet, or Beech Street Network), with limited exceptions described below.

Network Benefits:

In order to receive network benefits under this Plan, you must receive services from a network provider as described above.

When you use a network provider, most covered services are paid at 80% under the Basic Plan, 90% under the Preferred Plan and 100% under the PreferredPlus Plan after any applicable co-pay and there are no forms or paperwork to complete. Any co-pay

that may be required must be paid at the time you receive health care services. For those benefits or services that require precertification, a network provider might precertify your care when necessary; however, it is your responsibility to ensure that benefits or services requiring precertification are obtained.

For the Basic Plan and Preferred Plan, benefits will not be covered under this Plan when services are received from a non-network provider unless services are provided by a licensed non-network provider under the following conditions:

- emergency medical services are required
- there is no network facility within the First Choice Health Network Service Area which is able to render medically necessary treatment. If this is the case, documentation must be provided and is subject to approval by First Choice Health Administrators.
- you are transported by ambulance or other emergency medical personnel to the nearest medical facility equipped to render medically necessary care due to a medical emergency. If this is the case, documentation must be provided and you must be transferred to a network facility as soon as medically possible.
- you have used a non-network ambulance due to a medical emergency for transportation to the nearest medical facility equipped to render medically necessary care.
- you have used the services of a network x-ray facility which subsequently uses a non-network radiologist for reading the x-ray
- you have used the services of a network provider who subsequently uses a non-network laboratory to process test material
- you have used the services of a network facility and a network surgeon and have received services from a non-network assistant surgeon or non-network anesthesiologist
- in the case of a medical emergency, you have used a network facility and have received services from a non-network surgeon, non-network anesthesiologist, other non-network ancillary provider, or non-network urgent care clinic that is affiliated with that network facility.
- For the following benefits: Durable medical equipment, prosthetics, and medical supplies

Non-network Benefits Under the PreferredPlus Plan:

When you use a non-network provider, most covered services are paid at 60% of usual, customary and reasonable charge, after the annual deductible has been satisfied. You are responsible for 100% of the charges that are above the usual, customary and reasonable fees. You pay the bill in full and file a claim with First Choice Health Administrators for reimbursement. In addition to those benefits or services that require precertification, the following benefits and services also require precertification when you use a non-network provider: outpatient surgeries, outpatient maternity care, neurodevelopmental therapy, and outpatient rehabilitation care.

Except as noted below, benefits covered under the PreferredPlus Plan will be paid at the non-network benefit level when services are received from a non-network provider unless services are provided by a licensed non-network provider under the following conditions:

- emergency medical services are required

- there is no network facility within the First Choice Health Network Service Area which is able to render medically necessary treatment. If this is the case, documentation must be provided and is subject to approval by First Choice Health Administrators.
- you are transported by ambulance or other emergency medical personnel to the nearest medical facility equipped to render medically necessary care due to a medical emergency. If this is the case, documentation must be provided and you must be transferred to a network facility as soon as medically possible.
- you have used a non-network ambulance due to a medical emergency for transportation to the nearest medical facility equipped to render medically necessary care.
- you have used the services of a network x-ray facility which subsequently uses a non-network radiologist for reading the x-ray
- you have used the services of a network provider who subsequently uses a non-network laboratory to process test material
- you have used the services of a network facility and a network surgeon and have received services from a non-network assistant surgeon or non-network anesthesiologist
- in the case of a medical emergency, you have used a network facility and have received services from a non-network surgeon, non-network anesthesiologist, other non-network ancillary provider, or non-network urgent care clinic that is affiliated with that network facility.
- For the following benefits: Durable medical equipment, prosthetics, and medical supplies

Prescription Drugs: Except in the case of an emergency, or if there is no network pharmacy available, you must have your prescription filled at a network pharmacy to receive benefits. If you use a non-network pharmacy because there is no network pharmacy available, you must pay for the prescription in full and file a claim for reimbursement.

In this case, your benefits are paid at the network level and you may be responsible for additional payment if your pharmacy charges exceed that level.

Call Express Scripts at (866) 590-5890 or visit www.express-scripts.com for a list of pharmacies in your area or a nationwide list of participating pharmacies.

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.

Breast Reconstruction Surgery

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides benefits for reconstructive surgery and associated procedures following a mastectomy, regardless of when the mastectomy was performed, and determined in consultation with the patient and attending physician including:

- Reconstruction of the breast on which the mastectomy has been performed
- Surgery and reconstruction of the healthy breast to produce a symmetrical appearance
- Prosthesis and treatment of physical complication of all stages of mastectomy, including lymphedemas.

WHEN COVERAGE IS AVAILABLE UNDER MEDICARE

When this Plan is secondary to Medicare, the Plan will coordinate benefits (i.e. reduce this Plan's benefits in most circumstances) by the amount Medicare would have paid, even if the person is not enrolled under Medicare. See "Coordination of Benefits with Medicare" on page 38.

SPECIAL SITUATIONS

If You Need Care While Traveling

Emergency and urgent care is covered while you travel. All other care is generally not covered, unless it is received from a network provider.

If you need care while traveling, contact your physician for guidance.

If Your Family Member Lives Away From Home

See "Accessing Care" on page 21 for details.

If You Take a Leave of Absence

If you are eligible for a leave of absence under the Family and Medical Leave Act of 1993 (FMLA), your health insurance coverage will be maintained for up to 12 weeks whether you are in a paid, or unpaid status. If you normally pay a portion of the premiums, you will be required to continue to pay those premiums.

If You Take a Leave of Absence to Perform Military Service

Please see section "USERRA Notice" beginning on page 50.

If You Enter Into a Labor Dispute

If your pay is suspended directly or indirectly as a result of a strike, lockout, or other labor dispute, you may continue medical coverage for up to 6 months for yourself and your eligible family members if you pay the full cost of coverage directly to the Benefits Department in Human Resources. At the end of 6 months, you may be eligible for up to 18 months more coverage under COBRA; see "Continuation of Coverage under COBRA" starting on page 40 for details.

If You Are Laid Off

If you are laid off while a plan participant, coverage for you and your eligible family members may continue for a limited time if you, or your eligible family members, pay the full cost of coverage under COBRA. See “Continuation of Coverage under COBRA” starting on page 40 for details.

If you return to work in a regular position for Northwest Hospital & Medical Center within three months of the date you were laid off, coverage begins the first of the month following your return. If you return after three months, you will be considered a newly hired employee.

If You Die

If you die while a plan participant, coverage for your eligible family members may continue for a limited time if they pay the full cost of coverage under COBRA. See “Continuation of Coverage under COBRA” starting on page 40 for details.

If You Become Disabled

If you become disabled, you may be eligible to continue coverage under COBRA. See “Continuation of Coverage under COBRA” starting on page 40 for details.

If You Retire

If you retire and are at least age 60 but less than age 65 and have 15 years of service with Northwest Hospital & Medical Center, you may be able to continue your coverage as a retiree, as well as your eligible spouse’s coverage, until you reach age 65. If your coverage ends and you are not eligible to continue coverage as a retiree, you may continue your coverage under COBRA. See “Continuation of Coverage under COBRA” starting on page 40 for details.

HOW TO SUBMIT A CLAIM

Benefits under the Plan shall be paid only if the Plan Administrator decides, in its discretion, that a Covered Person is entitled to them.

When there is no indication the bill has been fully paid, payment will be made to the provider.

Your provider, typically, will be able to submit claims for you directly to First Choice Health Administrators. In the event that you have to pay for health care services, you may submit a claim for reimbursement to First Choice Health Administrators. When you have a claim for reimbursement to submit, you must do the following:

- Obtain and complete a claim form from the Benefits Department in Human Resources or First Choice Health Administrators
- Attach supporting documentation such as bills for services rendered. The documentation/bills must show:
 - Name of the Plan
 - Employee’s name
 - Name of the patient
 - Name, address, and telephone number of the provider of care

- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Dates of services
- Charges
- Send the claim to First Choice Health Administrators:
 First Choice Health Administrators
 PO Box 12659
 Seattle, WA 98111-4659

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with First Choice Health Administrators within 30 days of the date charges for the service was incurred. Benefits are based on the Plan's provisions at the time the services were provided. Claims filed later than that date may be declined or reduced unless:

- It is not reasonably possible to submit the claim in that time; and
- The claim is submitted within one year from the date incurred

First Choice Health Administrators will determine if enough information has been submitted to enable to proper consideration of the claim. If not, more information may be requested from the participant.

The Plan will not pay a claim submitted more than 12 months after the date of service.

CLAIMS PROCEDURE

When the Plan receives a claim for benefits, certain procedures and timeframes are used to process the claim. A claim is defined as any request for a Plan benefit, made by a participant or by a representative of a participant, that complies with the Plan's reasonable procedure for making benefit claims.

The timeframes listed below are maximum times only.

A period of time begins at the time the claim for benefits is filed.

Decisions will be made within a reasonable period of time appropriate to the circumstances.

"Days" mean calendar days.

There are different kinds of claims and each one has a specific timeframe for either approval, payment, request for further information, or notice of adverse action (denial of the claim). If you have any questions regarding this procedure, please contact First Choice Health Administrators at (800) 430-3818.

Types of claims include:

Urgent Care Claim

A claim involving Urgent Care is any claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the participant; or the ability of the participant to regain maximum function; or in the opinion of the attending or consulting physician, would subject the participant to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.

A physician with knowledge of the participant's medical condition may determine if a claim is one involving Urgent Care. If there is no such physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

The following timeframes apply to Urgent Care claims:

A participant will be notified of a benefit determination within 72 hours.

If there is insufficient information on the claim, or there is a failure to follow the Plan's procedure for filing a claim, the participant will be notified, either orally or in writing within 24 hours. The participant will have up to 48 hours to respond, either orally or in writing to the Plan. The Plan will notify the participant, either orally or in writing of a benefit determination within 48 hours.

If there is/are ongoing courses of treatment, the Plan will provide notification to the participant of a reduction or termination of benefits within 72 hours before the end of treatment. Within 24 hours the Plan will provide a determination as to extending a course of treatment.

If there is an adverse benefit determination on a claim involving Urgent Care, a request for an expedited appeal may be submitted orally or in writing by the participant. All necessary information, including the Plan's benefit determination review, may be transmitted between the Plan and the participant by telephone, facsimile, or other similarly expeditious method.

Pre-Service Claim

A Pre-service Claim means any claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

The following timeframes apply to Pre-Service claims:

A participant will be notified of a benefit determination within 15 days.

If the Plan cannot notify a participant of a benefit determination within 15 days due to matters beyond its control, the Plan may extend notifying a participant an additional 15 days.

If there is insufficient information on the claim, the participant will be notified within 15 days. The participant will have up to 45 days to respond to the Plan.

If there is a failure to follow the Plan's procedure for filing a Pre-Service claim, the participant will be notified, either orally or in writing, within 5 days.

If there is/are ongoing courses of treatment, the Plan will provide notification to the participant of a reduction or termination of benefits within 15 days before the end of treatment. If there is a request to extend a course of treatment, the Plan will provide notification to the participant within 15 days.

Post-Service Claim

A Post-service Claim means any claim for a Plan benefit that is not a claim involving Urgent Care. A Post-Service Claim, is a claim that is a request for payment under the Plan for covered medical services already received by the participant.

The following timeframes apply to Post-service claims:

A participant will be notified of a benefit determination within 30 days.

If the Plan cannot notify a participant of a benefit determination within 30 days due to matters beyond its control, the Plan may extend notifying a participant an additional 15 days.

If there is insufficient information on the claim, the participant will be notifying within 30 days. The participant will have up to 45 days to respond to the Plan.

NOTICE OF ADVERSE BENEFIT DETERMINATIONS

Except with Urgent Care claims, when the notification may be provided orally, followed by written notification within three days, First Choice Health Administrators shall provide written notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the participant:

1. The specific reason or reasons for the adverse determination.
2. Reference to the specific Plan provision(s) on which the determination was based.
3. A description of any additional material or information necessary for the participant to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the Plan's review procedures and the time limits applicable to such procedure. This will include a statement of the participant's right to bring civil action under § 502 of ERISA following an adverse benefit determination on review.
5. A statement that the participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
6. If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in

making the adverse benefit determination and a copy will be provided free of charge to the participant upon request.

7. If the adverse benefit determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge upon request.

APPEALING A CLAIM

You have the right to appeal any adverse benefit determination, or any claim decision made by the Plan to deny, modify, reduce or terminate payment, coverage, authorization, and/or any provision of health care services or benefits including the admission to or continued stay in a facility.

An appeal of any adverse benefit determination, or claim decision made by the Plan to deny, modify, reduce or terminate payment, coverage, authorization, and/or any provision of health care services or benefits including the admission to or continued stay in a facility must be received by the Plan within 180 days of the original Notice of Adverse Benefit Determination. Your rights to appeal an adverse benefit determination, or claim decision will be forfeited if you fail to follow the Plan's provisions, as described in this section. In addition, failing to file a timely Standard Appeal within the required timeframe will result in the loss of your right to file civil action under § 502 of ERISA.

To file an appeal, contact First Choice Health Administrators at:

First Choice Health Administrators
PO Box 12659
Seattle, WA 98111-4659
(800) 430-3818
Fax: (888) 206-3092

The Plan offers a two-step appeals procedure.

Step 1 – Standard Appeal

You or your representative, including the treating provider acting on your behalf, may appeal an adverse benefit determination in writing, to First Choice Health Administrators, within 180 days of your receipt of written notification of that adverse determination.

You may submit written comments, documents, records, and other information relating to the claim.

If you request, you will be provided, free of charge, reasonable access to, and copies of all documents, records, and other information relevant to the claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan.

This timing is without regard to whether all the necessary information accompanies the filing.

First Choice Health Administrators will make an appeal determination within the following timeframes:

For Urgent Care, and concurrent Urgent Care appeals, a determination will be made within 72 hours.

For Pre-service, and concurrent Pre-Service claims appeals, a determination will be made within 30 days.

For Post-service claims appeals, a determination will be made within 60 days.

No extensions are permitted in appeal determination.

When reviewing an appeal, First Choice Health Administrators will consider a document, record, or other information relevant to the claim if it:

- Was relied on in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- Demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all participants; or
- Constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The review will not afford deference to the initial adverse benefit determination and will be conducted by an individual associated with the Plan who is neither the individual who made the adverse benefits determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Plan shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

First Choice Health Administrator's written response to the participant shall cite the specific Plan provision(s) upon which the denial is based.

Step 2 – Optional Appeal

If, after completing the Standard Appeal procedure, First Choice Health Administrators affirms its original benefits determination, you may, if you choose, appeal that decision directly to the Northwest Hospital & Medical Center Benefits Committee.

The Benefits Committee will re-examine the findings, recommendations, and decisions of the initial standard appeal made by First Choice Health Administrators. At its discretion, the Benefits Committee may consult with external and/or internal medical professionals that can provide relevant information to the claim decision.

To initiate a Step 2 – Optional Appeal, you must inform First Choice Health Administrators in writing within 30 days from the receipt of the decision from the Standard Appeal. First Choice Health Administrators will forward the Step 2 – Optional Appeal to the Benefits Committee. Identifying information such as names and social security numbers will be withheld to the extent possible, to protect the confidentiality of the participant.

For a Step 2 – Optional Appeal it is recommended that a new written request be provided so that the participant may present any additional information they feel is relevant, and wish to have the Benefits Committee consider.

You and your representatives have the right to appear in person to present your case and your intention to do so must be stated in your written request to the Benefits Committee.

The Northwest Hospital & Medical Center Benefits Committee will make the final claim determination. Once initiated, this appeal process will follow the timelines as described in the Standard Appeal process.

PRIVACY AND SECURITY OF YOUR PROTECTED HEALTH INFORMATION

Northwest Hospital & Medical Center (“Plan Sponsor”) sponsors the Health Resources Northwest Employee Benefit Medical Plan. Employees of the Plan Sponsor have access to individually identifiable health information of Plan participants for administrative functions of the Plans. When this health information is provided from the Plan to the Plan Sponsor, it is Protected Health Information (“PHI”).

The Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) and its implementing regulations restrict the Plan Sponsor’s ability to use and disclose PHI. The following definition of PHI applies to the Plan:

Protected Health Information – means information that is created or received by the Plan and relates to the past, present, or future physical or mental health condition of a participant; the provision of health care to a participant; or the past, present, or future payment of the provision of health care to a participant; and that identifies the participant or for which there is a reasonable basis to believe the information can be used to identify the participant. Protected health information includes information of persons living or deceased.

The Plan Sponsor shall have access to PHI only as permitted under this section, or as otherwise required or permitted by HIPAA.

Permitted Disclosure of Enrollment/Disenrollment Information

The Plan may disclose to the Plan Sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from the Plan.

Permitted Uses and Disclosure of Summary Health Information

The Plan may disclose Summary Health Information to the Plan Sponsor, provided that the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending, or terminating the Plan.

Summary Health Information means information:

- That summarizes the claims history, claims expenses or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefit under a health plan; and
- From which the information described at 42 CFR § 164.514(b)(2)(i) has been deleted, except that the geographical information described in 42 CFR § 164.514(b)(2)(i)(B) need only be aggregated to the level of a five digit zip code.

Permitted and Required Uses and Disclosure of Protected Health Information for Plan Administration Purposes

Unless otherwise permitted by law, and subject to the conditions of disclosure described below, and obtaining written certification, the Plan may disclose PHI to the Plan Sponsor, provided that the Plan Sponsor uses or discloses such PHI only for Plan administration purposes.

Plan Administration Purposes means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. It does not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plans of the Plan sponsor, and they do not include any employment related functions.

Notwithstanding the provision of the Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

Conditions for Disclosure for Plan Administration Purposes

The Plan Sponsor agrees that with respect to any PHI (other than enrollment, or disenrollment, information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan, the Plan Sponsor shall:

- Not use or further disclose the PHI other than as permitted or required by the Plan or as required by law

- Ensure that any agent, including a subcontractor, to who it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI
- Not use or disclose the PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor
- Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware
- Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR § 164.524
- Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR § 164.526
- Make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528
- Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plans with HIPAA's privacy requirements
- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible
- Ensure that adequate separation between the Plan and the Plan Sponsor, required in 45 CFR § 504(f)(2)(iii), is satisfied

The Plan Sponsor further agrees that if it creates, receives, maintains, or transmits any electronic PHI (other than enrollment, or disenrollment information, and Summary Health Information, which are not subject to these restrictions) on behalf of the covered entity, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information and it will ensure that any agents, including subcontractors, to who it provides such electronic PHI agrees to implement reasonable and appropriate security measures to protect the information.

The Plan Sponsor will report to the Plan any security incident for which it becomes aware.

Adequate Separation Between the Plan and the Plan Sponsor

As, and if, their job positions require it, the following departments or job titles may have access to PHI:

- Human Resources
- Controller
- NWHMC Privacy/Security Officer
- NWHMC CEO
- NWHMC CFO
- NWHMC VP, Operations

No other persons shall have access to PHI. These specified employees shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the Plan. In the event that any of these specified employees does not comply with the provisions of this section, that employee shall be subject to corrective action by Northwest Hospital & Medical Center for non-compliance pursuant to the Plan Sponsor's corrective action policies and procedures.

The Plan Sponsor will ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the designees have access to electronic PHI.

Certification

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that the plans have been amended to incorporate the provision of 45 CFR § 164.504(f)(2)(II), and that the Plan Sponsor agrees to the conditions of disclosure set forth above.

ADDITIONAL INFORMATION

Access to Care

You and your covered family member(s) have the right to timely access to both emergent and non-emergent medical care. Please contact the Benefits Department in Human Resources if you have difficulty finding a network provider for you, or your family members.

Your Responsibilities

As plan members, you and your covered family member(s) have the responsibility to:

- Read this booklet and be sure you understand how to use your health plan before you need care. Refer to "Your Liability" below.
- Provide accurate and complete information about your health history and status to health professionals who provide your care.
- Follow the advice of your health care providers and ask questions about any aspect of your care that you don't understand
- Keep scheduled appointments or call your health care provider if you must cancel or reschedule
- Show your member identification card to the providers, and pay any required co-pays
- Treat your health care providers and their employees with respect – refrain from behavior that is threatening, disruptive or abusive

Your Liability

You and your covered family member(s) are responsible for any and all deductibles, co-pays and coinsurance amounts applicable to covered services provided under the Plan. You and your covered family member(s) are also responsible for the entire cost of any non-covered services you receive.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Northwest Hospital & Medical Center will provide medical coverage to certain children (called alternate recipients) if directed by a Qualified Medical Child Support Order (QMCSO). A medical child support order:

- Is an decree, judgment, order (including approval of settlement agreement) or administrative notice from a state court or state agency with jurisdiction over the child's support
- Recognizes the child as an alternate recipient for plan benefits
- Provides for, based on a state domestic relations law (including a community property law), the child's support or health plan coverage.

A QMCSO is a medical child support order qualified under the Omnibus Budget Reconciliation Act of 1993. A medical child support order is qualified if it creates or recognizes the existence of an alternate recipient's right to receive plan benefits and specifies this information:

- Employee's name and last known address
- Each alternate recipient's name and address (or state official/agency name and address if the order provides)
- Reasonable description of coverage the alternate recipient is entitled to receive
- Coverage effective date
- How long the child is entitled to coverage
- That the plan is subject to the order

If the medical child support order is a QMCSO:

- The Plan Administrator notifies you and the alternate recipient of the Plan's procedures and allows the alternate recipient to name a representative to receive copies of any QMCSO notices
- Alternate recipient coverage begins on the first of the month after the QMCSO is received. If you, the employee, are eligible for coverage but not enrolled, you will also be enrolled.
- If a dependent contribution is required, your specific authorization isn't needed to establish the payroll deduction, which would be retroactive to the alternate recipient's coverage effective date
- The Plan pays network providers directly for covered services; when an alternate recipient, custodial parent, legal guardian or employee pays a covered expense, the Plan reimburses the person who paid the expense.

If the medical child support order is not a QMCSO, the Plan Administrator notifies you and each alternate recipient of the specific reasons it does not qualify, along with procedures for submitting a corrected medical child support order.

COORDINATION OF BENEFITS (COB)

Benefits Subject to this Provision

The benefits provided under the Plan do not duplicate other coverage you or your family member(s) may have for medical care or treatment. The purpose of this Coordination of Benefits (COB) provision is to ensure that the sum of claim benefits paid by your Northwest Hospital & Medical Center health plan and other plans with concurrent coverage does not exceed 100% of the allowable expense under the Basic Plan, the Preferred Plan, and the PreferredPlus Plan. If you or your family member(s) is entitled to receive benefits under another plan, Northwest Hospital & Medical Center will recover the reasonable cash value of the services provided under the Basic Plan, the Preferred Plan, and the PreferredPlus Plan that exceeds 100% of the allowable expense. All benefits in the Plan are subject to this COB provision.

Allowable Expense

If benefits are provided in the form of services rather than cash payments, the reasonable cash value of each service rendered or supply provided is considered an allowable expense.

“Allowable Expense” means the usual, customary and reasonable value or charge for any necessary health care service or supply when the service or supply is covered, at least in part, under any of the plans involved.

The difference between the cost of a private hospital room and the cost of a semiprivate room is not considered an allowable expense under the above definition unless the covered person’s stay in a private hospital room is medically necessary.

Plan

The term “plan” in this section means any agreement for benefits or services from any of the following sources for medical, dental or other health care services:

- The Basic Plan, the Preferred Plan, and the PreferredPlus Plan
- Any group, individual or blanket disability insurance policy
- Any group or individual contract prepayment or indemnity plan such as those issued by health care service contractors, health maintenance organizations and other health carriers
- Any labor-management trust plan or union welfare plan
- Any employer or multi-employer plan or employee benefit plan
- Any government program
- Any insurance coverage required or provided by statute, or
- Any other similar source

Each health contract or other arrangement for benefits or services from one of the above sources is considered a plan in this section.

Claim Determination Period

The claim determination period used when applying this COB provision is defined as a calendar year beginning January 1 and ending December 31. However, for new

participants, the claim determination period begins on the effective date of coverage and ends on December 31. When you terminate coverage before December 31, the claim determination period ends on the last day you are covered under the Basic Plan, the Preferred Plan, and the PreferredPlus Plan.

Effect on Benefits

If there are no COB provisions in effect, your total allowable expenses paid under this medical coverage or any other plan during a claim determination period may not exceed the total allowable expenses paid under this medical coverage. If the allowable expenses paid under all plans exceed the total allowable expenses paid under the Basic Plan, the Preferred Plan, or the PreferredPlus Plan, your payments under this medical coverage will be reduced accordingly.

Right of Recovery

This provision does not reduce the benefits allowed under the Basic Plan, the Preferred Plan, or the PreferredPlus Plan when one of them is the primary plan. However, if benefits have been paid by Northwest Hospital & Medical Center for allowable expenses in excess of the maximum payment necessary at that time to satisfy the intent of this provision, Northwest Hospital & Medical Center may recover the excess payments from any person(s), insurer(s), or other organizations, as Northwest Hospital & Medical Center deems appropriate.

Facility of Payment

Whenever another plan makes payments that should have been provided under the Basic Plan, the Preferred Plan, or the PreferredPlus Plan and in accordance with this COB provision, Northwest Hospital & Medical Center may, at its sole discretion, reimburse to the plan making the other payments any amount necessary to satisfy the intent of this COB provision. Any amount paid under this subsection is considered to be benefits paid under these medical coverages, and Northwest Hospital & Medical Center will be fully discharged from liability to the extent of these payments.

Determination of Plan Priority

When you or your family member(s) is covered under more than one plan, the plan that does not have a COB provision is always considered the primary plan. If more than one plan has a COB provision, the primary plan is determined in the following order:

- The plan covering the individual as an employee rather than the dependent is primary.
- When a participant is covered as a dependent under more than one plan, the plan of the parent whose date of birth occurs earlier in a calendar year is the primary plan. However, in the absence of a court decree to the contrary, the following rules apply to dependents of legally separated or divorced parents:
 - The plan of the custodial parent is primary, provided the custodial parent has not remarried
 - If the custodial parent has remarried, the plan of the custodial parent is primary to a plan covering the child as a dependent of a stepparent, or
 - The plan of a stepparent is primary to the plan of the non-custodial parent

- If none of the above rules applies, the plan that has covered the participant the longest is the primary plan.
- If the participant is retired, the Basic Plan, the Preferred Plan, and the PreferredPlus Plan are considered secondary to all other plans.

Right to Receive and Release Information

First Choice Health Administrators may, with the consent required by law, receive or release to another insurer or organization any information about the participant and covered benefits necessary to implement this COB provision. Any person claiming benefits under the Basic Plan, the Preferred Plan, or the PreferredPlus Plan must furnish First Choice Health Administrators the information necessary for that purpose.

COORDINATION OF BENEFITS WITH MEDICARE

Notwithstanding all other provisions of this Plan, individuals eligible for coverage under this Plan who are eligible for Medicare benefits will be entitled to benefits under this Plan in addition to Medicare.

This Plan will be primary (i.e. pays benefits before Medicare) for active employees who are considered to be in “current employment status” as defined by Medicare who have Medicare coverage and/or their eligible family member(s) who have Medicare coverage in the following circumstances:

- For the individual who has Medicare coverage because of age;
- For the individual who has Medicare coverage because of an SSA Disability;

This Plan will be secondary (i.e. pays benefits after Medicare) for retirees who have Medicare coverage and/or their eligible spouse who has Medicare coverage in the following circumstances:

- For the individual who has Medicare coverage because of age (NOTE: retirees are no longer eligible for retiree benefits under this Plan when they reach age 65);
- For the individual who has Medicare coverage because of an SSA Disability;

For individuals with Medicare coverage because of End-Stage Renal Disease (ESRD), this Plan will be primary (i.e. pays benefits before Medicare) for the first 30 months of Medicare coverage; then this Plan will be secondary (i.e. pays benefits after Medicare).

Note: When this Plan is secondary to Medicare, the Plan will coordinate benefits (i.e. reduce this Plan’s benefits in most circumstances) by the amount Medicare would have paid, even if the person is not enrolled under Medicare.

WHEN COVERAGE ENDS

Employees

Your medical coverage ends on the last day of the calendar month:

- You are no longer eligible as defined on page 1

- You resign, retire or are terminated
- You don't pay your premiums/payroll deductions

Your medical coverage also ends

- on the day you die
- on the day the plan terminates
- Retroactively to your first day of coverage if you commit fraud or material misrepresentation in connection with obtaining coverage or benefits

If the Plan terminates, or is canceled, the Plan will continue to cover any participants who are hospital inpatients on the date the plan terminates, or is canceled. Coverage will end on the first of these dates:

- *Date of discharge*
- *When you reach the plan maximums*
- *First Choice Health Administrator's Medical Director determines inpatient care is no longer medically necessary, or*
- *Three consecutive months have elapsed*

Family Members

Your family member's medical coverage ends on the last day of the calendar month:

- Your coverage ends
- Your family member is no longer eligible as defined on page 2

Your family member's medical coverage also ends:

- on the day your family member dies
- on the day the plan terminates
- Retroactively to your family member's first day of coverage if your family member commits fraud or material misrepresentation in connection with obtaining coverage or benefits

If the Plan terminates, or is canceled, the Plan will continue to cover any participants who are hospital inpatients on the date the plan terminates, or is canceled. Coverage will end on the first of these dates:

- *Date of discharge*
- *When you reach the plan maximums*
- *First Choice Health Administrator's Medical Director determines inpatient care is no longer medically necessary, or*
- *Three consecutive months have elapsed*

Retirees and Spouses of Retirees

Your and your spouse's medical coverage ends on the last day of the calendar month in which you turn age 65 as defined on page 2. Coverage also ends retroactively to the first day of coverage if you or your spouse commits fraud or material misrepresentation in connection with obtaining coverage or benefits.

CERTIFICATE OF COVERAGE

You have the right to receive a certificate of prior health coverage. First Choice Health Administrators will provide a certificate of health coverage for you and your family member(s) upon termination of coverage under any of these plans. This is an important document and should be kept in a safe place. You may take this certificate to another health plan to receive credit against a preexisting condition limit for the time you were covered under the Plan. You will need to do this only if the other health plan has a preexisting condition limit.

This certificate is provided as part of the Federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). More information about HIPAA is available through the U.S. Department of Labor, 200 Constitution Avenue, NW, Washington D.C. 20210.

CONTINUATION OF COVERAGE UNDER COBRA

This section generally explains COBRA coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The description of COBRA coverage contained in this SPD applies only to the group health benefits offered under the Medical Plan. Your COBRA rights under other health benefit plans offered by Northwest Hospital & Medical Center are explained in their respective SPD's. The Plan provides no greater COBRA rights than what COBRA requires. Nothing in this SPD is intended to expand your rights beyond COBRA's requirements.

What is COBRA Coverage?

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

After a qualifying event occurs and any required notice of that event is properly provided to Northwest Hospital & Medical Center, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary". You, your spouse, and your dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. Certain newborns, newly adopted children, and alternate recipients under QMCSO's may also be qualified beneficiaries.

Who is Entitled to Elect COBRA?

Qualifying Events for the Covered Employee

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

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

Qualifying Events for the Covered Spouse

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

- Your spouse dies
- Your spouse's hours of employment are reduced
- Your spouse's employment ends for any reason other than his or her gross misconduct
- You become divorced or legally separated from your spouse. Also, if your spouse reduces or eliminates your 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 you even though your coverage was reduced or eliminated before the divorce or separation, or
- Your spouse becomes entitled to Medicare

Qualifying Events for Dependent Children

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

- Your parent-employee dies
- Your parent-employee's hours of employment are reduced
- Your parent-employee's employment ends for any reason other than his or her gross misconduct
- The parents become divorced or legally separated
- Your parent-employee becomes entitled to Medicare
- You stop being eligible for coverage under the Plan as a "dependent child"

Qualifying Event for Retirees and their Spouses covered under Retiree medical benefits

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Northwest Hospital & Medical Center, and that bankruptcy results in the loss of coverage of any retired employee covered under the retiree medical benefits, the retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse covered under the retiree medical benefits, will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the retiree medical benefits.

Electing COBRA after leave under the Family and Medical Leave Act (FMLA)

Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some individuals may be entitled to elect COBRA even if they were not covered under the Plan during the leave. Contact the Benefits Department in Human Resources for more information about these special rules.

When is COBRA Coverage Available

When the qualifying event is the end of employment, reduction of hours of employment, death of the employee, or in the case of retiree medical coverage, the commencement of a proceeding in bankruptcy with respect to Northwest Hospital & Medical Center, the Plan will offer COBRA coverage to qualified beneficiaries. You do not need to notify Northwest Hospital & Medical Center of any of these events.

You Must Notify the Plan Administrator of Certain Qualifying Events by this Deadline

For the other qualifying events, divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, a COBRA election will be available to you only if you notify the Benefits Department in Human Resources 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.

No COBRA Election will be Available Unless You Follow the Plan's Notice Procedures and Meet the Notice Deadline

In providing this notice, you must follow the notice procedures specified in the section below entitled "Notice Procedures". If these procedures are not followed or if the notice is not provided during the 60-day period, **YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

Electing COBRA Coverage

How to Elect COBRA

To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and mail or hand deliver it to First Choice Health Administrators.

Deadline for COBRA Election

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

Independent Election Rights

Each qualified beneficiary will have an independent right to elect COBRA.

Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.

Special Considerations in Deciding Whether to Elect COBRA

In considering whether to elect COBRA, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right

to avoid having preexisting condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of COBRA may help you not have such a gap. Second, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible, such as a plan sponsored by your spouse's employer, within 30 days after your group health coverage under the Plan end because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

Length of COBRA Coverage

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods.

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

Death, divorce, legal separation, or child's loss of dependent status

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

If the covered employee becomes entitled to Medicare within 18 months before his or her termination of employment or reduction of hours

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

Termination of employment or reduction of hours

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

Extension of Maximum Coverage Period

If the qualifying event that resulted in your COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying

event occurs. You must notify First Choice Health Administrators of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage.

Disability extension of COBRA coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled within the first 60 days of COBRA coverage and you notify First Choice Health Administrators in a timely fashion, all of the qualified beneficiaries in your family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The disability must have started at some time before the 60th day of COBRA coverage and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months, as described above). Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

You must notify First Choice Health Administrators of a qualified beneficiary's disability by this deadline. The disability extension is available only if you notify First Choice Health Administrators 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

In addition, you must provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

No disability extension will be available unless you follow the Plan's notice procedures and meet the notice deadline. In providing this notice, you must follow the notice procedures specified in the section below entitled "Notice Procedures". If these procedures are not followed or if the notice is not provided during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.

Second qualifying event extension of COBRA coverage

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months, or in the case of a disability extension, the 29 months following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, the employee's

entitlement to Medicare, 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.

You must notify First Choice Health Administrators of a second qualifying event by this deadline. This extension due to a second qualifying event is available only if you notify First Choice Health Administrators 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.

No extension will be available unless you follow the Plan's notice procedures and meet the notice deadline. In providing this notice, you must follow the notice procedures specified in the section below entitled "Notice Procedures". If these procedures are not followed or if the notice is not provided during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.

For Retiree Coverage only: Proceeding in Bankruptcy

When retiree medical coverage is lost due to Northwest Hospital & Medical Center filing a proceeding in bankruptcy under Title 11 of the United State Code, the retiree's COBRA continuation coverage, generally, can last indefinitely. The COBRA continuation coverage for your spouse will also generally continue indefinitely; however, upon your death, your surviving spouse will be eligible for up to 36 months of COBRA continuation coverage from the date of your death.

Termination of COBRA Coverage Before the End of the Maximum Coverage Period

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

- Any required premium is not paid in full on time
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan, but only after any exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied
- A qualified beneficiary becomes entitled to Medicare benefits under Part A, Part B, or both, after electing COBRA
- Northwest Hospital & Medical Center 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, COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate. For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period"

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

You must notify First Choice Health Administrators if a qualified beneficiary becomes entitled to Medicare or obtains other group health plan coverage

You must notify First Choice Health Administrators in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare benefits under Part A, Part B, or both, or becomes covered under other group health plan coverage. You must follow the notice procedures specified below in the section entitled “Notice Procedures”. In addition, if you were already entitled to Medicare before electing COBRA, notify First Choice Health Administrators of the date of your Medicare entitlement at the address shown in the section below entitled “Notice Procedures”.

You must notify First Choice Health Administrators if a qualified beneficiary ceases to be disabled

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify First Choice Health Administrators of that fact within 30 days after the Social Security Administration’s determination. You must follow the notice procedures specified below in the section entitled “Notice Procedures”.

Cost of COBRA Coverage

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

Payment for COBRA Coverage

How premium payments must be made

All COBRA premiums must be paid by check, or money order. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the individual at the payment address specified in the election notice provided to you at the time of your qualifying event, and on the monthly payment invoice. However, if the Plan notifies you of a new address for payment, you must mail or hand deliver all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

When premium payments are considered to be made

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

First payment for COBRA coverage

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. This is the date your Election Form is postmarked, if mailed, or the date your Election Form is received by the individual at the address specified for delivery of the Election Form, if hand delivered. See the section above entitled "Electing COBRA Coverage".

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

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

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

Monthly payments for COBRA coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without a break. It is your responsibility to pay your COBRA premiums on time.

Grace periods for monthly COBRA premium payments

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

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

More Information About Individuals Who May Be Qualified Beneficiaries

Children born to or placed for adoption with the covered employee during a period of COBRA coverage

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

Alternate recipients under QMCSO's

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

NOTICE PROCEDURES

If your notice is late or if you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA, or will lose the right to an extension of COBRA coverage, as applicable.

Notices Must Be Written

Any notice that you provide must be in writing.

Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable.

How, When, and Where to Send Notices

You must mail or hand deliver your notice to:

COBRA Administrator
First Choice Health Administrators

Mailing Address:
PO Box 12659
Seattle, WA 98111-4659

Physical Address:
600 University Street, Suite 1400
Seattle, WA 98101

However, if a different address for notices to the Plan appears in the Plan's most recent summary plan description, you must mail or hand deliver your notice to that address. If

you do not have a copy of the Plan's most recent summary plan description, you may request one from the Benefits Department in Human Resources.

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the individual at the address specified above no later than the last day of the applicable notice period. The applicable notice periods are described in the paragraphs above entitled "You must notify the plan administrator of certain qualifying events by this deadline", "You must notify First Choice Health Administrators of a qualified beneficiary's disability by this deadline", and " You must notify First Choice Health Administrators of a second qualifying event by this deadline".

Information Required for All Notices

Any notice you provide must include:

- The name of the Plan
- The name and address of the employee who is (or was) covered under the Plan
- The name(s) and address(es) of all qualified beneficiary(ies) who lost coverage as a result of the qualifying event
- The qualifying event and the date it happened
- The certification, signature, name, address, and telephone number of the person providing the notice

Additional Information Required for Notice of Qualifying Event

If the qualifying event is divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying Northwest Hospital & Medical Center, or First Choice Health Administrators that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to Northwest Hospital & Medical Center, or First Choice Health Administrators that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional Information Required for Notice of Disability

Any notice of disability that you provide must include:

- The name and address of the disabled qualified beneficiary
- The date that the qualified beneficiary become disabled
- The names and addresses of all qualified beneficiaries who are still receiving COBRA coverage
- The date that the Social Security Administration made its determination
- A copy of the Social Security Administration's determination
- A statement whether the Social Security Administration has subsequently determined that the disabled qualified beneficiary is no longer disabled

Additional Information Required for Notice of Second Qualifying Event

Any notice of a second qualifying event that you provide must include:

- The names and addresses of all qualified beneficiaries who are still receiving COBRA coverage
- The second qualifying event and the date that it happened
- If the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation

Who May Provide Notices

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 qualifying event described in the notice, or a representative acting on behalf of either may provide notices. 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.

USERRA NOTICE

The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) established requirements that employers must meet for certain employees who are involved in the uniformed services. In addition to the rights that you have under COBRA, and described above, you (the employee) are entitled under USERRA to continue the coverage that you, and your covered dependents, if any, had under the Northwest Hospital & Medical Center Medical Plan.

You Have Rights Under Both COBRA and USERRA

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you, or your covered spouse or dependent children, different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described for COBRA above (for example, the procedures for how to elect COBRA coverage and paying premiums for COBRA coverage) also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

Definitions

“Uniformed Services” – means the Armed Forces, the Army National Guard, and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (i.e., pursuant to orders issued under federal law), the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

“Service in the uniformed services” or “service” – means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty

training, full-time National Guard duty, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response personnel of the National Disaster Medical System.

All of the undefined words used in this USERRA notice have the meanings assigned to them under COBRA.

Duration of USERRA Coverage

When a covered employee takes a leave for service in the uniformed services, USERRA coverage for the employee, and for covered dependents for whom coverage is elected, begins the day after the employee, and covered dependents, lose coverage under the Plan, and it can continue for up to 24 months. However, USERRA coverage will end earlier if one of the following events takes place:

- A premium payment is not made within the required time
- You fail to return to work within the time required under USERRA following the completion of your service in the uniformed services; or
- You lose your rights under USERRA as a result of a dishonorable discharge or other conduct specified in USERRA

Your right to continue coverage under USERRA will end if you do not notify us of your intent to return to work within the time required under USERRA following the completion of your service in the uniformed services by either reporting to work, if your uniformed services was for less than 31 days, or applying for reemployment, if your uniformed service was for more than 30 days. The time for returning to work depends on the period of uniformed service, as follows:

Period of Service	Return-to-Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible.
More than 30 days but less than 181 days	Within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, the first day on which it is possible to do so.
More than 180 days	Within 90 days after completion of your service.
Any period if for purposes of an examination for fitness to perform uniformed service	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible.

Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Same as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years, but the two-year period may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods.
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COBRA and USERRA coverage are concurrent.

Premium Payments for USERRA Continuation Coverage

If you elect to continue your health coverage, or your spouse or dependent children’s coverage, pursuant to USERRA, you will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA). However, if your uniformed service period is less than 31 days, you are not required to pay more than the amount that you pay as an active employee for that coverage.

ASSIGNMENT OF BENEFITS

In paying for services, the plan always pays the provider unless you show proof of payment. The plan also will make payments on behalf of an enrolled child to his or her non-enrolled parent or a state Medicaid agency when the plans are required to do so by federal or state law. In these cases, the plan also has the right to make payment jointly.

All payments are subject to applicable federal and state laws and regulations. Payments made according to this section will discharge Northwest Hospital & Medical Center to the extent of the amount paid, so that the plan will not be liable to anyone aggrieved by their choice of payee.

The right to payment under the Plan is not subject to attachment or garnishment, and the Plan will not honor any assignment of benefits to anyone.

THIRD PARTY CLAIMS

The Plan is not obligated to pay for services necessary because of an injury or condition for which you may have other recovery rights unless or until you, or someone legally qualified and authorized to act for you, promise in writing to:

- Include any amount paid by the Plan for services necessary because of an injury or condition for which you may have other recovery rights in any claim you or your representative makes for the injury or condition
- Repay or assign to the plan any recovery you receive from any third party for services paid by the Plan
- Cooperate fully with the Plan in asserting their rights, supply the Plan with any and all information and execute any and all documents the Plan Administrator reasonably needs for that purpose

The Plan has a lien on any sums collected by, or on behalf of, you or your covered family members by legal action settlement or otherwise, on account of benefits provided under another plan. Such sums are payable to the Plan only after and to the extent those sums exceed the amount required to fully compensate you for your loss as determined by the Plan.

You must notify First Choice Health Administrators in writing of whatever benefits are paid under this plan that may be subject to subrogation by the Plan. You also must keep First Choice Health Administrators informed in advance of any settlement proposals advanced or agreed to by the third party or third party's insurer.

If you receive benefits for any condition or injury for which a third party is liable, Northwest Hospital & Medical Center reserves the right to recover the money they paid for benefits under the Plan.

RECOVERY OF OVERPAYMENTS

The Plan has the right to recover amounts paid that exceed the amount for which the Plan is liable. This amount may be recovered from one or more of the following (to be determined by the Plan): any persons to, or for, or with respect to, whom such payments were made, any other insurers, any service plans or any organizations or other plans. These amounts may be deducted from your future benefits, or your family members' benefits, even if the original payment was not made on that family member's behalf.

The Plan's right of recovery includes benefits paid in error due to any false or misleading statements made by you or your family members.

PAYMENT OF MEDICAL BENEFITS

The medical benefits offered by the Plan are self insured and unfunded. Current contributions made by Northwest Hospital & Medical Center and employees will pay only current benefit claims and do not fund future benefit claims. First Choice Health Administrators and Express Scripts pay claims on behalf of Northwest Hospital & Medical Center, however, they do not insure or guarantee that claims will be paid. First Choice Health Administrators and Express Scripts rely on Northwest Hospital & Medical Center to provide funding to pay claims and cannot do so if Northwest Hospital & Medical Center does not provide the funds.

TERMINATION AND AMENDMENT OF THE PLANS

Northwest Hospital & Medical Center fully intends to continue plan benefits indefinitely, but it also reserves the absolute right to amend or terminate the Plan for any reason at any time. If Northwest Hospital & Medical Center terminates the Plan, you will receive details about your coverage options (if any), and bona fide claims incurred before termination of the Plan will be paid.

YOUR ERISA RIGHTS

These plans were established or sponsored by Northwest Hospital & Medical Center for the exclusive benefit of Plan Participants.

As a plan participant, you have certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that, as a plan participant, you are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reason beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

No one may terminate your employment or otherwise discriminate against you in any way to prevent you from receiving benefits or exercising your rights under ERISA.

Assistance with Your Questions

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

PLAN ADMINISTRATION

Following is Plan information you might need when dealing with benefit claims and questions.

Plan Administrator/Plan Sponsor/Agent for Service of Legal Process

The Plan is maintained and administered by:

Northwest Hospital & Medical Center
1550 North 115th Street, MS-P1
Seattle, WA 98133
(206) 368-1106

Employer Identification Number

The Employer Identification Number (EIN) assigned to the Plan by the Internal Revenue Service is 91-0637400.

Plan Year

January 1 – December 31.

Plan Name

The Plan is called the Health Resources Northwest Employee Benefit Plan - Medical Plan.

Plan Number

The Plan number assigned to the Plan in accordance with U.S. Department of Labor instructions is 501.

Plan Type

The Plan described in this booklet is a self-funded welfare benefit plan that provides medical benefits. This Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA) as amended and is intended to comply with all applicable federal laws.

Plan Funding

The Plan is funded through a combination of employee pre-tax contributions and Northwest Hospital & Medical Center general assets.

Plan Administration

The Plan is a self-funded health plan and certain administrative services are provided through a third party administrator, First Choice Health Administrators.

Power of Authority of Plan Administrator

The Plan Administrator is responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan;
- Prescribing procedures to be followed and the forms to be used by employees pursuant to this Plan

The Plan Administrator may delegate any of these administrative duties among one or more entities, provided that such delegation is in writing. The written delegation shall describe the nature and scope of the delegated relationship.

The Plan Administrator has the authority to amend or eliminate benefits under the Plan. The Plan Administrator also has the authority to require employees to furnish it with such information as it determines is necessary for the proper administration of the Plan.

Discretionary Authority

The Plan Administrator has the authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan

Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive benefits under the Plan.

Claim Administration

Medical claims are administered by:

First Choice Health Administrators
P.O. Box 12659
Seattle, WA 98111-4659
(800) 430-3818
Fax: (888) 206-3092

Prescription drug claims are administered by:

Express Scripts, Inc.
P.O. Box 66773
St. Louis, MO 63166
(866) 590-5890

FOR MORE INFORMATION

In addition to the information in this booklet, you may contact First Choice Health Administrators for:

- More information about how the Plan works
- Any documents, instrument or other information referred to in this booklet
- Precertification procedures
- A description of reimbursement and payment arrangements between Northwest Hospital & Medical Center and the providers
- Circumstances where the Plan may retrospectively deny coverage for care with precertification
- A copy of all grievance procedures
- Descriptions and justifications for all provider compensation programs

You may contact Express Scripts for details about the Plan's prescription formulary and payment of drugs not in the formulary.

DEFINITIONS

To help you better understand your medical benefits, here is a list of important definitions.

Adverse Benefit Determination	A denial, decrease, or ending of a benefit. This includes a failure to provide or make payment (in whole or in part) for a benefit including claims based on medical necessity or experimental and investigational exclusions.
Allowed Amount	The maximum amount paid by the Plan for a medically necessary covered service. Generally, this is an amount agreed to contractually by First Choice Health Network and network providers. The allowable amount paid by the Plan for services from non-network providers and for out-of-area providers is based on usual, customary and reasonable (UCR) rates.
Annual Deductible	The amount plan participants pay each year before the Plan pays benefits.
Annual Out-of-Pocket Maximum	The most a plan participant pays toward most coinsurances and some copays each plan year.
Brand Name Drugs	Trademark drugs patented for a limited period by a single pharmaceutical company.
Calendar Year	The twelve (12) month period beginning January 1 and ending December 31 of the same year.
Certificate of Creditable Coverage	A certificate issued by a health plan which describes a person's prior period(s) of creditable health care coverage as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Claim	Any request for a Plan benefit, made by you or your authorized representative. A participant making a claim for benefits is a "claimant" under ERISA regulations.

Coinsurance	The amount you and the Plan share toward covered expenses. For example, if the Plan pays 90% coinsurance for the care you receive, your coinsurance is 10%.
Concurrent Claim	Any claim that is reconsidered after an initial approval for ongoing course of treatment was made and results in a reduced or terminated benefit.
Co-pay	The fixed amount you pay at the time you receive certain covered services.
Custodial or Convalescent Care	Care primarily to assist the patient with activities of daily living, including inpatient care mainly to support self-care and provide room and board. Examples are helping the participant to walk, get in and out of bed, bathe, dress, eat or prepare special diets or take medication that is normally self-administered.
Eligibility Date	The first day of the calendar month following 90 days of continuous service in which you meet the hourly requirement.
Emergency	<p>A medical condition that manifests itself by acute symptoms of sufficient severity that, in the reasonable judgment of a prudent person, the absence of immediate medical attention could reasonably be expected to result in serious:</p> <ul style="list-style-type: none"> • Impairment to body functions • Dysfunction of any body organ or part • Jeopardy of the patient's health

Experimental or Investigational

Experimental and investigational services mean any procedure, therapy or other service determined to be:

- Not in general use in the medical community; or
- Not proven safe and effective or to show a demonstrable benefit for a particular illness or disease; or
- Under continued scientific testing and research; or
- A significant risk to the health or safety of the patient; or
- Not proven to result in greater benefits for a particular illness or disease than other generally available services; or
- Not medically reasonable and/or necessary, unproven, investigational, or experimental as determined by the Centers for Medicare and Medicaid Services.

Full Time Student

A full time student is an eligible dependent, under the age of 24, who is enrolled with at least 12 credit hours a quarter or semester, at an accredited educational institution.

Legally Designated Ward

A person, especially a child or an individual unable to care for him or herself, placed by a court under the care of a legal guardian.

Lifetime Maximum

The maximum benefit amount a plan participant may receive in total under these plans combined in his or her lifetime.

Medically Necessary	<p>To be considered medically necessary, a medical service or supply should meet all the following criteria:</p> <ul style="list-style-type: none"> • It is required for the treatment or diagnosis of a covered medical condition • It is the most appropriate supply or level of service that is essential for the diagnosis or treatment of the patient's covered medical condition • It is known to be effective in improving health outcomes for the patient's medical condition in accordance with sufficient scientific evidence and professionally recognized standards • It is not furnished primarily for the convenience of the patient or provider of services, and • It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the patient <p>The fact that a service or supply is furnished, prescribed, or recommended by a physician or other provider does not, of itself, make it medically necessary. A service or supply may be medically necessary in part only.</p>
Network Provider	<p>A contracted provider with First Choice Health Network who has signed a preferred provider agreement. Network providers offer medical care to participants on a discounted fee-for-service or other non-capitated payment basis.</p>
Non-network Provider	<p>A person, organization, health facility or institution licensed by Washington State to deliver or furnish health care services, but not under contract with First Choice Health Network.</p>
Out-of-Area Benefits	<p>The benefits provided under the Plan for enrollees outside the Plan's service area <i>and</i> more than 30 miles away from the nearest available network provider for at least nine months each year.</p>
Open Enrollment	<p>The annual period in which eligible Northwest Hospital & Medical Center employees may join, drop or change plans and add or drop family members' coverage.</p>
Plan Document	<p>The instrument or instruments that set forth and govern the duties of the Plan Sponsor and eligibility and benefit provisions of the Plan which provide for the payment or reimbursement of covered services.</p>

Plan Year	The twelve (12) month period beginning January 1 and ending December 31 of the same year.
Post-service Claim	Any claim for a Plan benefit under the Plan that is not a pre-service claim and is a request for payment or reimbursement for covered services already received.
Precertification	Precertification is the process of obtaining coverage determination from First Choice Health Administrators before receiving inpatient and certain outpatient services as described in this Plan.
Pre-service Claim	Any claim for a Plan benefit for which the Plan requires approval or precertification before medical care is obtained.
Provider	A person, organization, health facility or institution licensed to deliver or furnish health services.
Representative	An individual acting on your behalf in obtaining or appealing a benefit claim.
Reserve Employee	An employee who works on a continuing, unscheduled, on-call basis.
Service Area	The geographic area where First Choice Health Network has agreements with plan providers.
Significantly Similar Benefits	When the actuarial value of the hospital, physician, medical, surgical and emergency care benefits under these plans is not more than 25% greater than the value of benefits under your prior health plan, after considering all cost-sharing and benefit limits.
Urgent Care	A condition that is not life threatening but requires immediate medical attention.

Urgent Care Claim

A claim for medical care or treatment that if normal pre-service standards are applied:

- Would seriously jeopardize the participant's life, health or ability to regain maximum function, or
- In the opinion of a physician with knowledge of the participant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested

Usual, Customary and Reasonable Fees (UCR)

The rates typically charged for comparable medical services provided by health care professionals in a given region with similar training and experience.