This Summary Plan Description is designed to provide general information about the Swedish Health Services medical plan, including pharmacy. The terms of your benefit plans are governed by plan documents. This summary may not include all plan rules and details. Swedish Health Services reserves the right to amend, modify or terminate any plan, in whole or in part, at any time for any reason.

In the event there is a discrepancy between information provided during open enrollment and the contents of this Benefits Summary, the contents herein shall prevail.
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Important Information About This Plan

Every employee is unique, each with different needs and family situations. The Swedish Health Services medical plan (the Plan) is designed to meet the diverse medical and pharmacy needs of Swedish Health Services employees — and their families.

This Summary Plan Description ( SPD) provides detailed information about the Swedish Health Services medical plan as of January 1, 2014. Within this SPD, you will find a description of your coverage and payment levels under the Plan, as well as information on eligibility, enrollment, termination and continuing coverage, administration, claims procedures and other legally required material.

Swedish Health Services is the employer and Plan Sponsor. Providence Health & Services, under a shared services agreement with Swedish Health Services, is the Plan Administrator of this self-funded plan. The following parties perform certain services, including making decisions on benefit coverage, medical management, claim payment and certain other administrative services according to Swedish Health Services' policies and procedures.

• First Choice Health Administrators (FCHA) administers all benefits under the Plan with the exception of prescription drug benefits
• MedImpact Healthcare Systems, Inc., a separate provider not affiliated with FCHA, administers prescription drug benefits

Swedish Health Services (the Plan Sponsor) and Providence Health & Services (the Plan Administrator) retain at all times the ultimate fiduciary authority, responsibility and control over Plan assets, management and administration.

Please review this booklet carefully and share it with your family. If you have questions, contact the Plan’s Benefits Department (Plan Administrator) or FCHA. If you have questions about whether a provider is considered in-network, contact the appropriate network listed under How to Obtain Health Services.

Coverage under this Plan will take effect for eligible employees and dependents when all eligibility requirements are satisfied. Swedish Health Services intends to maintain this Plan, but reserves the right to terminate, suspend, discontinue or amend the Plan at any time, for any reason. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

The Plan will pay benefits only for expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after it terminated, even if the expenses resulted from an accident, injury or disease that occurred, began or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished. If the Plan terminates, the rights of participants and beneficiaries are limited to charges incurred before termination.

These materials do not create a contract of employment or any rights to continued employment with Swedish Health Services.
Contacting First Choice Health Administrators

First Choice Health Administrators (FCHA) administers all benefits under the Plan except for prescription drug benefits. This means FCHA performs certain services, including making decisions on benefit coverage, medical management, claim payment and certain other administrative services in accordance with the Swedish Health Services medical plan.

You may call FCHA Customer Service directly whenever you have questions or concerns at the number printed on your ID card or contact FCHA by mail, fax or Internet:

- **First Choice Health Administrators**
- **Customer Service Department**
- **PO Box 12659**
- **Seattle, WA 98111-4659**
- **(800) 750-5202**
- **Local: (206) 268-2360**
- **Fax: (888) 206-3092**
- **Medical pre-authorization: (800) 808-0450**
- **Mental health/chemical dependency pre-authorization: (800) 640-7682; TTY: (866) 876-5924**
- **www.myFirstChoice.fchn.com**

- **Spanish (Español)** – Para obtener asistencia en Español, llame al (800) 750-5202.
- **Tagalog (Tagalog)** – Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 750-5202.
- **Chinese** (中文) – 如果需要中文的帮助，请拨打这个号码 (800) 750-5202.
- **Navajo (Dine)** – Dinek’ehgo shika at’ohwol ninisingo, kwijigo holne’ (800) 750-5202.

FCHA’s Customer Service Department business hours are Monday through Friday, 8:00 AM to 5:00 PM Pacific Standard Time (PST). The office closes on New Year’s Day, Memorial Day, Independence Day (4th of July), Labor Day, Thanksgiving, the day after Thanksgiving, Christmas Eve and Christmas Day. FCHA offices close at 3:00 PM on the day before Thanksgiving and on December 23rd (or on the Friday before if the 23rd falls on a weekend). If the holiday falls on a Saturday, the office is closed on Friday; if the holiday falls on Sunday, the office is closed Monday (the holiday is recognized during the same calendar week in which the holiday falls).

You can access benefit information or your specific claim and enrollment status anytime at **www.myFirstChoice.fchn.com** or by calling FCHA Customer Service’s automated voice response system at (800) 750-5202.
Contacting MedImpact Healthcare Systems, Inc.

MedImpact Healthcare Systems, Inc., a separate provider not affiliated with FCHA, administers prescription drug benefits for the Plan. This means MedImpact performs certain services, including making decisions on benefit coverage, claim payment and certain other administrative services in accordance with the Swedish Health Services medical plan.

You may call MedImpact Customer Service directly whenever you have questions or concerns regarding your prescription coverage at the number printed on your ID card or contact MedImpact by mail or Internet:

MedImpact Healthcare Systems, Inc.
Customer Service Department
10680 Treena St.
San Diego, CA 92131
888-678-7779
www.medimpact.com

MedImpact’s Customer Service Representatives are available 24 hours a day, 7 days a week, 365 days a year.

You may have the need for specialty medications. You may call MedImpact at the numbers indicated above, or contact Providence Specialty Pharmacy at (800) 772-7053, option 4. Providence Specialty Pharmacy has Customer Service Representatives available from 9:00 am to 5:00 pm (Pacific Time).
How to Obtain Health Services

Your ID Card

Your ID card identifies you as a Plan participant and contains important information about your coverage and benefits. Please present your ID card each time you receive care. If you lose your ID card, you may order a new one either through contacting FCHA Customer Service at (800) 750-5202, or logging into www.myFirstChoice.fchn.com. Under no circumstances should you give your ID card to another person for their use.

Choosing a Provider

You can seek care at any provider, but you will have the highest level of coverage if you use a Swedish Preferred Network provider. The next highest level of coverage is available if you use a First Choice Health PPO Network provider or a First Health Network provider, as described in the table below.

<table>
<thead>
<tr>
<th>In-Network Coverage</th>
<th>Networks</th>
<th>State/Area</th>
<th>Phone</th>
<th>Websites</th>
</tr>
</thead>
<tbody>
<tr>
<td>Highest level of coverage</td>
<td>Swedish Preferred Network</td>
<td>Washington</td>
<td>(800) 231-6935</td>
<td><a href="http://www.MySwedishBenefits.com">www.MySwedishBenefits.com</a></td>
</tr>
<tr>
<td></td>
<td>First Health Network</td>
<td>All states/areas not served by FCHN</td>
<td>(800) 226-5116</td>
<td>firsthealth.coventryhealthcare.com</td>
</tr>
</tbody>
</table>

When a particular service is not offered within the Swedish Preferred Network, covered services will be paid at the in-network level, and not at the higher Swedish Preferred Network level. If you are traveling outside the regions listed above but within the United States, you will receive the network level of benefits coverage.

If you seek care from a non-network provider inside the regions listed above, you will receive out-of-network coverage. More information on coverage levels is provided in the Payment Provisions and Summary of Medical Benefits sections.

Note: In certain cases, pre-authorization may be required to obtain coverage from the Plan. Please review the Medical Management section for more information. Please refer to the Pharmacy Benefits section for more information on how to obtain prescription drugs.
Services Received Outside of the United States

If you are traveling outside of the United States and require treatment for an injury or medical emergency, any payments you make for medical treatment may be reimbursed, provided the following guidelines are met:

• Participants must pay for medical services at the time of service.
• Upon returning to the U.S., submit an itemized statement of charges that includes diagnosis and all charges paid. The exchange rate for foreign currency must also be noted on submitted forms.
• Charges submitted must be for an Emergency or Urgent Care as defined in Plan Definitions section.
• Claims must be submitted in English.

For more information on how to submit a claim for reimbursement, please review the Claim and Appeal Procedures section.
Medical Management

Pre-authorization Requirements

All inpatient admissions and certain outpatient services and procedures require FCHA pre-authorization, as noted in the Summary of Medical Benefits section. If pre-authorization is not obtained for these services you will be assessed a $300 penalty (applied to the facility charge).

You are responsible for obtaining pre-authorization directly from FCHA. You may have your provider contact FCHA for you, but you are ultimately responsible to ensure pre-authorization occurs.

• For mental health or chemical dependency service pre-authorization, call (800) 640-7682
• For medical service pre-authorization, call (800) 808-0450
• For prescription drugs that you receive via mail order or local pharmacies, if pre-authorization is required, you, your provider, or your pharmacist can call (888) 678-7779
• For prescription specialty medications, contact Providence Specialty Pharmacy at (800) 772-7053, option 4
• For certain injectables and other drugs you receive while an inpatient or while seeing your physician in his/her office that require pre-authorization, the provider can call (800) 808-0450

The following sections provide additional information on how to request pre-authorization in advance or for emergencies.

Pre-authorization is required for:

• Air or inter-facility transport ambulance services (except in life-threatening circumstances)
• Clinical trials (any treatment provided under a clinical trial)
• Dental trauma services (follow-up services)
• Durable medical equipment, medical supplies and prosthetics
  — When purchase exceeds $1,500; or
  — When rental exceeds $500 per month
• Genetic testing
  — Over $500
• Hemodialysis (for chronic kidney disease)
• Home health care services
  — Home health visits
  — Home infusion therapy (enteral and IV)
• Hospice
• Hyperbaric therapy
• Imaging
  — PET scans
• Inpatient admissions
  — Chemical dependency and mental health admissions (including residential)
  — Inpatient hospice
  — Inpatient rehabilitation admissions
  — Long-term acute care facility
  — Medical/surgical admissions (excluding routine maternity deliveries)
  — Skilled nursing admissions
• **Medical injectables and other drugs**
  — Abatacept
  — Aflibercept (Eylea®)
  — Alpha-1 proteinase inhibitor
  — Bevacizumab (Avastin®)
  — Blood clotting factors
  — Botulinum toxin (all types and brands)
  — Cytarabine Liposome
  — Epoprostenol
  — Imiglucerase
  — Infliximab
  — Intravenous immunoglobulin (IVIG) therapy
  — Ixabepilone
  — Palivizumab (Synagis)
  — Pegaptanib (Macugen®)
  — Ranibizumab (Lucentis®)
  — Rituximab
  — Sipuleucel-T (Provenge)
  — Ustekinumab

• **Organ and bone marrow transplants** (includes evaluation of, services for both recipient and donor, and travel and lodging expenses)

• **Radiation Therapy**
  — Intensity-Modulated Radiation Therapy
  — Proton Beam Radiation Therapy
  — Stereotactic radiosurgery (Gamma Knife, Cyberknife)

• **Reconstructive procedures** - All procedures that may be considered cosmetic, including but not limited to:
  — Breast reduction
  — Eyelid surgery (i.e. blepharoplasty)
  — Removal of breast implants
  — Rhinoplasty

• **Spinal injections that require conscious sedation** (any location)

• **Surgery**
  — Bone Anchored Hearing Aid (BAHA) devices (surgical benefit applies)
  — Cochlear Implants (surgical benefit applies)
  — Lumbar fusions
  — Orthognathic Surgery
  — Surgical interventions for sleep apnea
  — Varicose vein procedure

**Reminder:** If you neglect to obtain pre-authorization for services which require it, you will be assessed a $300 penalty. Payments of claims denied due to lack of pre-authorization do not apply toward your calendar year deductible or out-of-pocket maximums.
**Advance Requests for Pre-authorization**

Your provider may submit an advance request to FCHA Medical Management for benefit or medical necessity determinations. **Experimental and investigational services are not covered**, except as may be allowed under the Clinical Trials benefit. If a service could be considered experimental and investigational for a given condition, a benefit determination should be requested in advance.

**Notification for Emergency Admissions**

Admissions directly from the emergency room do not require pre-authorization. However, notification is required within two business days after the admission, or as soon as possible. Emergency admissions related to Mental Health or Chemical Dependency do not require pre-authorization or notification. You, or your provider, may call FCHA at the number on your ID card.

**Concurrent Review and Discharge Coordination**

Continued hospitalization is subject to periodic clinical review to ensure timely, quality care in the appropriate setting. Discharge coordination assists those transferring from the hospital to home or another facility.

**Case Management**

A catastrophic medical condition may require long-term, perhaps lifetime care involving extensive services in a facility or at home. With Case Management, a nurse monitors these patients and explores coordinated and/or alternative types of appropriate care. The case manager consults with the patient, family and attending physician to develop a plan of care that may include:

- Offering personal support to the patient
- Contacting the family for assistance and support
- Monitoring hospital or skilled nursing facility stays
- Addressing alternative care options
- Assisting in obtaining any necessary equipment and services
- Providing guidance and information on available resources

Case Management may identify an alternative or customized treatment plan to hospitalization and other high-cost care to make more efficient use of this Plan’s benefits. Such a customized plan might include services involving expenses not usually covered or an exchange of benefits. The decision to provide alternative or customized benefits is within the Plan’s sole discretion. Your participation in such a treatment plan, as any through Case Management, is voluntary. You, or your legal representative, the attending physician and the Plan Administrator must all agree to any such treatment plan.

Once agreement is reached, the specific medically necessary services stated in the treatment plan will be reimbursed, subject to all terms and conditions of the medical plan.

**Case management is a voluntary service.** There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis. The final decision on the course of treatment rests with patients and their providers.
24x7 Nurse Line

Because questions about your health, symptoms and conditions can come up anytime, Registered Nurses (RNs) are available 24 hours a day, 7 days a week to offer reliable, timely information. Call (800) 756-7751 to access the 24x7 Nurse Line.

Maternity Management Program

Expecting a baby? First Choice Health offers the Maternity Management Program, which provides prenatal education to help mothers carry their babies to term. To enroll, or if you want additional information, call (800) 756-7751.
Payment Provisions

Highlights of Medical Plan Provisions

• The Plan provides benefits only for covered services and supplies that are medically necessary for the treatment of a covered illness or injury, rendered by a physician, practitioner, nurse, hospital, or specialized treatment facility (See Plan Definitions). The treatment must be generally accepted by medical professionals in the United States and considered non-experimental/investigational.

• The Plan covers care from any provider, but with in-network providers, you will pay less. In-network providers charge a lower, negotiated rate and the Plan pays higher benefits if you use in-network providers.

• The Plan pays benefits at three tiers, depending on which provider you use.
  — Tier 1: The Swedish Preferred Network provides you with the highest level of coverage.
  — Tier 2: The First Choice Health PPO Network or First Health Network gives you the next highest level of coverage.
  — Tier 3: The Plan pays the lowest benefits for services from out-of-network providers.

• You (or your family) must pay a deductible each year before the Plan will pay for covered services. After the deductible is met, the Plan will pay a share of the cost for covered services – called coinsurance – and you pay the rest until you reach the annual out-of-pocket maximum. See Annual Deductible, below.

• When you reach your annual out-of-pocket maximum, the Plan provides benefits for many covered services at 100% for the remainder of that calendar year. See Annual Out-of-Pocket Maximum, below.

• Plan benefits are based on the Allowable Amounts (See Plan Definitions section) agreed upon by network providers. The allowed amount is the maximum amount considered for payment by the Plan. If you use an out-of-network provider, you will be responsible for paying the difference (if any) between the Allowed Amount and the billed charges. This difference will not count toward your deductible or your out-of-pocket (OOP) maximum.

Annual Deductible

The annual deductible is the amount you (or your family) must pay each Plan year before the Plan will pay for covered services. Your deductible depends on which providers you use, as shown in the table below. Charges from providers in the Swedish Preferred Network count toward the network and non-network deductibles. Charges from network providers count toward the non-network deductible, but not the Swedish Preferred Network deductible.

<table>
<thead>
<tr>
<th></th>
<th>Swedish Preferred Network</th>
<th>Network</th>
<th>Non-Network (Out-of-network)</th>
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<tr>
<td><strong>Annual Deductible (per calendar year)</strong></td>
<td></td>
<td></td>
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<tr>
<td>Employee only</td>
<td>$500</td>
<td>$650</td>
<td>$1,300</td>
</tr>
<tr>
<td>Family</td>
<td>$1,000</td>
<td>$1,300</td>
<td>$2,600</td>
</tr>
</tbody>
</table>
Once you satisfy the deductible, the Plan pays a share of the costs for covered services — called coinsurance — and you pay the rest. Coinsurance amounts are provided in the Summary of Medical Benefits.

As each individual pays for covered care, it counts toward an individual deductible as well as the family deductible. As soon as they meet the individual deductible, the Plan begins paying a share of the costs for that individual. If the family meets their deductible, the Plan begins paying a share of the costs for all covered members of the family. In this case, some individuals may meet less than the individual deductible if the family deductible is met.

When an employee transfers from Swedish to Swedish/Edmonds or vice-versa, amounts credited to his or her deductible for the current Plan year will be applied to the new plan’s deductible.

The following do not apply toward the annual deductible:

- Charges for services and treatment that are not covered by the Plan
- Charges for services that are denied as not medically necessary
- Charges from out-of-network providers over the allowable amount
- Charges that exceed any applicable benefit maximum (see Benefit Maximums below)
- Copayments
- Penalties incurred due to lack of pre-authorization
- Weight management benefit

Please refer to the Summary of Medical Benefits section for other benefits that are not subject to the deductible.

**Annual Out-of-Pocket Maximum**

The annual out-of-pocket maximum is the most you will need to pay in a Plan year. Your out-of-pocket maximum depends on which providers you use, as shown in the table below. Charges from providers in the Swedish Preferred Network count toward the network and non-network maximums. Charges from network providers count toward the non-network maximum, but not the Swedish Preferred Network maximum.

<table>
<thead>
<tr>
<th></th>
<th>Swedish Preferred Network</th>
<th>Network</th>
<th>Non-Network (Out-of-network)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Out-of-Pocket Maximum (per calendar year)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Employee only</td>
<td>$3,000</td>
<td>$6,350</td>
<td>$7,300</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
<td>$12,700</td>
<td>$14,600</td>
</tr>
</tbody>
</table>

Just as with the deductible, each individual’s payments for covered care counts toward an individual maximum as well as the family maximum. As soon as the individual meets their maximum, the Plan begins paying 100% of the costs for that individual. If the family meets their out-of-pocket maximum, the Plan begins paying 100% of the costs for all covered members of the family. In this case, some individuals may meet less than the individual amount if the family amount is met.

When an employee transfers from Swedish to Swedish/Edmonds or vice-versa, amounts credited to his or her out-of-pocket maximum for the current Plan year will be applied to the new plan out-of-pocket maximum.

The following do not apply toward the annual out-of-pocket maximum:

- Charges for services and treatment that are not covered by the Plan
- Charges for services that are denied as not medically necessary
- Charges from out-of-network providers over the allowable amount
- Charges that exceed any applicable benefit maximum (see Benefit Maximums below)
- Charges for services paid by the Plan at 100%
- Penalties incurred due to lack of pre-authorization
- Weight management benefit

**Benefit Maximums**

For certain benefits, the Plan pays up to a maximum amount during a lifetime or during a calendar year, as noted below.

<table>
<thead>
<tr>
<th>Lifetime Maximum Benefits</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice</td>
<td>6 months</td>
</tr>
<tr>
<td>Mobility Scooters</td>
<td>$800</td>
</tr>
<tr>
<td>Transplant Travel</td>
<td>$250 per day up to $5,000 lifetime benefit maximum for transportation, food and lodging</td>
</tr>
<tr>
<td>Wigs or Other Hair Coverings (charges associated with an initial purchase after chemotherapy)</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calendar Year Maximums</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternative Care</td>
<td>10 visits, all therapies combined</td>
</tr>
<tr>
<td>• Acupuncture</td>
<td></td>
</tr>
<tr>
<td>• Massage Therapy</td>
<td></td>
</tr>
<tr>
<td>• Nutritional Counseling (first 3 visits are considered preventive and not subject to this limit)</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>10 visits</td>
</tr>
<tr>
<td>Foot Orthotics</td>
<td>$350</td>
</tr>
<tr>
<td>Hearing</td>
<td></td>
</tr>
<tr>
<td>• Exams (routine)</td>
<td>1 exam</td>
</tr>
<tr>
<td>• Aids/Appliances</td>
<td>$1,000 per year every three calendar years</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>40 visits</td>
</tr>
<tr>
<td>Oral Appliances</td>
<td>1 appliance</td>
</tr>
<tr>
<td>Rehabilitation Therapy</td>
<td>90 days, combined with Skilled Nursing Facility 45 visits, all therapies combined</td>
</tr>
<tr>
<td>• Inpatient</td>
<td></td>
</tr>
<tr>
<td>• Outpatient (includes physical, speech and occupational therapies and cardiac rehab)</td>
<td></td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>90 days, benefit combined with Inpatient Rehabilitation</td>
</tr>
</tbody>
</table>
### Summary of Medical Benefits

The table below provides coverage information for medical benefits. Please keep the following definitions in mind as you review this table:

- **OON** indicates coverage with out-of-network providers
- **IN** indicates coverage within Tier 1, the Swedish Preferred Network, and Tier 2, the First Choice Health PPO Network or First Health Network

For example, "(OON only)" means services received from an out-of-network provider apply to the deductible or out-of-pocket maximum, as noted in the *Payment Provisions* section.

<table>
<thead>
<tr>
<th>Swedish Medical Plan – Participant Cost-Sharing</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allergy Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Office Visits</strong></td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>• <strong>Testing (provided in office)</strong></td>
<td>✓ (OON only)</td>
<td>✓ (OON only)</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
</tr>
<tr>
<td>• <strong>Injections (provided in office)</strong></td>
<td>✓ (OON only)</td>
<td>✓ (OON only)</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Alternative Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 visits per calendar year, all therapies</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Acupuncture</strong></td>
<td>✓</td>
<td>✓</td>
<td>20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>20% (Tier 1 deductible &amp; OOP max apply)</td>
<td></td>
</tr>
<tr>
<td>• <strong>Massage Therapy</strong></td>
<td>✓</td>
<td>✓</td>
<td>20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>20% (Tier 1 deductible &amp; OOP max apply)</td>
<td></td>
</tr>
<tr>
<td>• <strong>Nutritional Counseling</strong></td>
<td>✓</td>
<td>✓</td>
<td>20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>20% (Tier 1 deductible &amp; OOP max apply)</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Applies to</td>
<td>Applies to</td>
<td>Tier 1 -</td>
<td>Tier 2 -</td>
<td>Tier 3 -</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>------------</td>
<td>------------</td>
<td>----------</td>
<td>----------</td>
<td>----------</td>
</tr>
<tr>
<td></td>
<td>Deductible</td>
<td>Out-of-Pocket</td>
<td>Swedish</td>
<td>Network</td>
<td>Out-of-</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Maximum (OOP max)</td>
<td>Preferred</td>
<td>Providers</td>
<td>Network</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>$75 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>$75 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
</tr>
<tr>
<td>* Ambulance service related to Mental Health or Chemical Dependency</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>$75 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>$75 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
</tr>
<tr>
<td>* All other ambulance services</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>$75 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>$75 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
</tr>
<tr>
<td><strong>Anesthesia</strong></td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>See Anesthesia for anesthesia services related to Dental Trauma</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Biofeedback</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td><strong>Blood Donation/Blood Transfusion</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FCHA pre-authorization required if inpatient</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Inpatient Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>$200 copay + 10%</td>
<td>$200 copay + 40%</td>
<td>$200 copay + 40%</td>
</tr>
<tr>
<td>* Outpatient Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>10%</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td>* Inpatient/outpatient Professional Services</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Chemical Dependency</strong></td>
<td>✓</td>
<td>✓</td>
<td>$200 copay + 10% (Tier 1 deductible &amp; OOP max apply)</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>FCHA pre-authorization required for inpatient, residential and partial hospitalization</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Inpatient Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>$200 copay + 10% (Tier 1 deductible &amp; OOP max apply)</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>* Inpatient Professional Services</td>
<td>✓</td>
<td>✓</td>
<td>10%</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>* Outpatient Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>10%</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>* Outpatient Professional</td>
<td>✓</td>
<td>✓</td>
<td>10%</td>
<td>10%</td>
<td>40%</td>
</tr>
</tbody>
</table>
## Swedish Medical Plan – Participant Cost-Sharing

<table>
<thead>
<tr>
<th>Service</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>20% (Tier 1 deductible &amp; OOP max apply)</td>
</tr>
<tr>
<td>10 visits per calendar year</td>
<td></td>
<td></td>
<td>20%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Clinical Trials

FCHA pre-authorization required  
Usual care services are covered as specifically outlined under the *Clinical Trials* benefit

### Dental Trauma

FCHA pre-authorization required for follow-up services

<table>
<thead>
<tr>
<th>Service</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Facility Fees</strong></td>
<td>✓</td>
<td>✓</td>
<td>$200 copay + 10%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Facility Fees</strong></td>
<td>✓</td>
<td>✓</td>
<td>10%</td>
<td>40%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Inpatient/Outpatient Professional Services</strong></td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Office Visits</strong></td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>30%</td>
<td>30%</td>
</tr>
</tbody>
</table>

### Diabetic Education and Diabetic Nutrition Education

(OON only) (OON only) 0% 0% 0%

### Durable Medical Equipment

FCHA pre-authorization required if purchases exceed $1,500 or $500 per month rental

<table>
<thead>
<tr>
<th>Service</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Breast Pumps</strong></td>
<td>✓</td>
<td>(OON only)</td>
<td>N/A</td>
<td>0%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Durable Medical Equipment</strong></td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Medical Supplies</strong></td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Mobility Scooters</strong></td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>$800 lifetime maximum</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Oral Appliances</strong></td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>One appliance per calendar year maximum. When related to the treatment of Sleep Apnea. If related to TMJ, see TMJ benefits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Orthopedic Appliances</strong></td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Prosthetic Devices</strong></td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td><strong>Wigs</strong></td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>$1,000 lifetime maximum</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Swedish Medical Plan – Participant Cost-Sharing

<table>
<thead>
<tr>
<th>Emergency Care</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emergency Room Facility Fees – All visits related to Mental Health and Chemical Dependency</td>
<td>✓</td>
<td>$75 copay + 20%</td>
<td>$75 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>$75 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>$75 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
</tr>
<tr>
<td>• Emergency Room Professional Services – All visits related to Mental Health and Chemical Dependency</td>
<td>✓</td>
<td>20%</td>
<td>20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>20% (Tier 1 deductible &amp; OOP max apply)</td>
</tr>
<tr>
<td>• All other Emergency Room Facility Fees – 1st visit per calendar year</td>
<td>✓ Swedish Preferred</td>
<td>$75 copay + 20%</td>
<td>$75 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>$75 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>$75 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
</tr>
<tr>
<td>• All other Emergency Room Facility Fees – 2nd visit per calendar year</td>
<td>✓ Swedish Preferred</td>
<td>$100 copay + 20%</td>
<td>$100 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>$100 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>$100 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
</tr>
<tr>
<td>• All other Emergency Room Facility Fees – 3rd and subsequent visits per calendar year</td>
<td>✓ Swedish Preferred</td>
<td>$150 copay + 20%</td>
<td>$150 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>$150 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>$150 copay + 20% (Tier 1 deductible &amp; OOP max apply)</td>
</tr>
<tr>
<td>• All other Emergency Room Professional Services</td>
<td>✓</td>
<td>20%</td>
<td>20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>20% (Tier 1 deductible &amp; OOP max apply)</td>
<td>20% (Tier 1 deductible &amp; OOP max apply)</td>
</tr>
<tr>
<td>• Urgent Care Professional Services</td>
<td>✓</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
<td></td>
</tr>
</tbody>
</table>

### Family Planning

<table>
<thead>
<tr>
<th>Family Planning</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Office Visits</td>
<td>✓ (OON only)</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>• Devices, Implants and Injections</td>
<td>✓ (OON only)</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>• Sterilizations</td>
<td>✓ (OON only)</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>• Termination of Pregnancy Inpatient/Outpatient Professional Services</td>
<td>✓ (OON only)</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>• Termination of Pregnancy Inpatient/Outpatient Facility Fees</td>
<td>✓</td>
<td>10%</td>
<td>40%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>• Termination of Pregnancy (In Office with Primary Care Provider)</td>
<td>✓</td>
<td>$20 copay + 0%</td>
<td>$35 copay + 0%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>• Termination of Pregnancy (In Office with Specialist)</td>
<td>✓</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
<td></td>
</tr>
</tbody>
</table>

**Foot Orthotics**

$350 maximum per calendar year

2014 Summary Plan Description – Swedish Health Services medical plan

SMC/SMG (rev.03.2014)
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Genetic Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FCHA pre-authorization required for genetic testing over $500</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• BRCA Testing</td>
<td>✓</td>
<td>✓</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
</tr>
<tr>
<td>(OON only)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• All other genetic testing/testing/counseling</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Covered as any other medical service, refer to place of service</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hearing</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Exams (routine and non-routine) - Specialist</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>1 routine exam per calendar year; no limit for medically necessary exams</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Exams (routine and non-routine) - Primary Care Provider (PCP)</td>
<td>✓</td>
<td>✓</td>
<td>$20 copay + 0%</td>
<td>$35 copay + 0%</td>
<td>40%</td>
</tr>
<tr>
<td>1 routine exam per calendar year; no limit for medically necessary exams</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hearing aids/appliances</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>$1,000 per ear every 3 calendar years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FCHA pre-authorization required.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Home Health Care Visits</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>40 visits per calendar year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Phototherapy (home)</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Infusion Therapy</strong></td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>provided in the home</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hospice</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FCHA pre-authorization required</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 months lifetime maximum.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospice Care Inpatient Facility Services</td>
<td>✓</td>
<td>✓</td>
<td>$200 copay + 10%</td>
<td>$200 copay + 40%</td>
<td>$200 copay + 50%</td>
</tr>
<tr>
<td><strong>Hospital Inpatient Medical and Surgical Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FCHA pre-authorization required.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>$200 copay + 10%</td>
<td>$200 copay + 40%</td>
<td>$200 copay + 50%</td>
</tr>
<tr>
<td>• Inpatient Doctor Visits/Consultations</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Inpatient Professional Services (surgeon, radiologist, pathologist)</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Inpatient Professional Services (assistant surgeon)</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>20% if provided at a network facility</td>
</tr>
</tbody>
</table>

2014 Summary Plan Description – Swedish Health Services medical plan
SMC/SMG (rev.03.2014) 17
### Swedish Medical Plan – Participant Cost-Sharing

<table>
<thead>
<tr>
<th>Hospital Outpatient Surgery and Services</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Facility Fees</td>
<td>✓</td>
<td>10%</td>
<td>40%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>• Ambulatory Surgery Center (ASC)</td>
<td>✓</td>
<td>10%</td>
<td>40%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>• Outpatient Professional Services (surgeon, radiologist, pathologist)</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>• Outpatient Professional Services (assistant surgeon)</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>20% if provided at a network facility</td>
<td>40% if provided at a non-network facility</td>
</tr>
</tbody>
</table>

### Infertility Diagnostic Services

<table>
<thead>
<tr>
<th>• Office Visits (initial visit only)</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Primary Care Provider (PCP)</td>
<td>✓</td>
<td>$20 copay + 0%</td>
<td>$35 copay + 0%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>• Specialists</td>
<td>✓</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
<td></td>
</tr>
</tbody>
</table>

### Diagnostic Testing Outpatient Professional Services

<table>
<thead>
<tr>
<th>• Diagnostic Testing – Outpatient Facility Fees</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• In Office</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Primary Care Provider (PCP)</td>
<td>✓</td>
<td>$20 copay + 0%</td>
<td>$35 copay + 0%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>• Specialists</td>
<td>✓</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>• Outpatient Facility Fees</td>
<td>✓</td>
<td>10%</td>
<td>40%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>• Outpatient Professional Services</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td>Lab and Radiology Services</td>
<td>Tier 1 - Swedish Preferred Network</td>
<td>Tier 2 - Network Providers</td>
<td>Tier 3 - Out-of-Network Providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------</td>
<td>-----------------------------------</td>
<td>-----------------------------</td>
<td>----------------------------------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(non-routine, facility and professional services)</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FCHA pre-authorization required for PET scans.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Professional Services</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Outpatient Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>10%</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>• Outpatient Professional Services</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• In office – billed as part of the primary care or specialist office visit</td>
<td>✓ (OON only)</td>
<td>✓ (OON only)</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
</tr>
<tr>
<td>• In office – billed separately from the primary care or specialist office visit</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• MRI and CT scans Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>$100 copay + 10%</td>
<td>$100 copay + 40%</td>
<td>$100 copay + 50%</td>
</tr>
<tr>
<td>Only one copay per day will be applied.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• MRI and CT scans Professional Services</td>
<td>✓</td>
<td>✓</td>
<td>$100 copay + 20%</td>
<td>$100 copay + 20%</td>
<td>$100 copay + 40%</td>
</tr>
<tr>
<td>Only one copay per day will be applied.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity and Newborn Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Initial visit to determine pregnancy</td>
<td>✓</td>
<td>✓</td>
<td>$20 copay + 0%</td>
<td>$35 copay + 0%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>$200 copay + 10%</td>
<td>$200 copay + 40%</td>
<td>$200 copay + 50%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Professional Services (including global fee)</td>
<td>✓ (OON only)</td>
<td>✓ (OON only)</td>
<td>$350 copay + 0%</td>
<td>$350 copay + 0%</td>
<td>40%</td>
</tr>
</tbody>
</table>
## Mental Health Care
FCHA pre-authorization required for inpatient, residential and partial hospitalization.

<table>
<thead>
<tr>
<th>Description</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inpatient Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>$200 copay + 10%</td>
<td>$200 copay + 10%</td>
<td>40%</td>
</tr>
<tr>
<td>• Inpatient Professional Services</td>
<td>✓</td>
<td></td>
<td>10%</td>
<td>10% (Tier 1 deductible &amp; OOP max apply)</td>
<td>40%</td>
</tr>
<tr>
<td>• Partial Day Treatment (PDT) – facility</td>
<td>✓</td>
<td></td>
<td>$200 copay + 10%</td>
<td>$200 copay + 10%</td>
<td>40%</td>
</tr>
<tr>
<td>• Partial Day Treatment (PDT) – professional</td>
<td>✓</td>
<td></td>
<td>10%</td>
<td>10% (Tier 1 deductible &amp; OOP max apply)</td>
<td>40%</td>
</tr>
<tr>
<td>• Outpatient Facility Fees</td>
<td>✓</td>
<td></td>
<td>10%</td>
<td>10% (Tier 1 deductible &amp; OOP max apply)</td>
<td>40%</td>
</tr>
<tr>
<td>• Outpatient Professional Services</td>
<td>✓</td>
<td></td>
<td>10%</td>
<td>10% (Tier 1 deductible &amp; OOP max apply)</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Naturopathic Care</strong></td>
<td>✓</td>
<td></td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
</tr>
</tbody>
</table>

## Neurodevelopmental Therapy
(through age 6)

<table>
<thead>
<tr>
<th>Description</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Inpatient Facility Fees</td>
<td>✓</td>
<td></td>
<td>$200 copay + 10%</td>
<td>$200 copay + 10%</td>
<td>$200 copay + 40%</td>
</tr>
<tr>
<td>• Inpatient Professional Services</td>
<td>✓</td>
<td></td>
<td>10%</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>• Outpatient Facility Fees</td>
<td>✓</td>
<td></td>
<td>10%</td>
<td>10%</td>
<td>40%</td>
</tr>
<tr>
<td>• Outpatient Professional Services</td>
<td>✓</td>
<td></td>
<td>10%</td>
<td>10%</td>
<td>40%</td>
</tr>
</tbody>
</table>

## Nutritional and Dietary Formulas
Covered as any other medical service, refer to place of service.

## Oral Surgery
Covered as any other medical service, refer to place of service.

## Orthognathic Surgery
FCHA preauthorization required. Covered as any other medical service, refer to place of service.
### Plastic and Reconstructive Services
FCHA pre-authorization required. Limited benefit, see Plastic and Reconstructive Services for details.

<table>
<thead>
<tr>
<th>Service</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>$200 copay + 10%</td>
<td>$200 copay + 40%</td>
<td>$200 copay + 50%</td>
</tr>
<tr>
<td>Outpatient Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>10%</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>Professional Services</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
</tbody>
</table>

### Podiatric Care
See Podiatric Care for details on routine foot care.

<table>
<thead>
<tr>
<th>Service</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routine Foot Care (covered for diabetics only)</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>20%</td>
<td>40%</td>
</tr>
</tbody>
</table>

### Non-routine services
Covered as any other medical service, refer to place of service.

### Preventive Care

#### Immunizations
Immunizations for children and adults are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention. See Preventive Care for details.

Travel immunizations are not covered. Immunizations for influenza and pneumonia are covered 100% out-of-network.

<table>
<thead>
<tr>
<th>Service</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(OON only)</td>
<td>✓</td>
<td>✓</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
</tr>
</tbody>
</table>

#### Periodic Exams
- Children 12 and under
- Adult and Children 13+

<table>
<thead>
<tr>
<th>Service</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(OON only)</td>
<td>✓</td>
<td>✓</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
</tr>
</tbody>
</table>

#### Nutritional Counseling
(diabetic and non-diabetic) – first 3 visits per calendar year

Subsequent visits are covered under Diabetic Education (if diabetes-related) or Nutritional Counseling (if not related to diabetes)

<table>
<thead>
<tr>
<th>Service</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td>(OON only)</td>
<td>✓</td>
<td>✓</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
</tr>
</tbody>
</table>
### Screening Tests

Screening tests are covered in accordance with the recommendations set forth by the US Preventive Service Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See Preventive Care for more details.

<table>
<thead>
<tr>
<th>Service</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>✓ (OON only)</td>
<td>✓ (OON only)</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
</tr>
<tr>
<td>Fecal Occult Blood Test</td>
<td>✓ (OON only)</td>
<td>✓ (OON only)</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
</tr>
<tr>
<td>Mammogram</td>
<td>✓ (OON only)</td>
<td>✓ (OON only)</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
</tr>
<tr>
<td>Pap Test/Pelvic Exams</td>
<td>✓ (OON only)</td>
<td>✓ (OON only)</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
</tr>
<tr>
<td>Sigmoidoscopy</td>
<td>✓ (OON only)</td>
<td>✓ (OON only)</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
</tr>
<tr>
<td>All Other Routine Screening Tests</td>
<td>✓ (OON only)</td>
<td>✓ (OON only)</td>
<td>0%</td>
<td>0%</td>
<td>40%</td>
</tr>
</tbody>
</table>

### Professional/Physician Services (office visits)

<table>
<thead>
<tr>
<th>Service</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Provider (PCP)</td>
<td>✓</td>
<td>✓</td>
<td>$20 copay + 0%</td>
<td>$35 copay + 0%</td>
<td>40%</td>
</tr>
<tr>
<td>Specialist</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td>Swedish Medical Plan – Participant Cost-Sharing</td>
<td>Applies to Deductible</td>
<td>Applies to Out-of-Pocket Maximum (OOP max)</td>
<td>Tier 1 - Swedish Preferred Network</td>
<td>Tier 2 - Network Providers</td>
<td>Tier 3 - Out-of-Network Providers (OON)</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
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<td>----------------------------------------</td>
</tr>
<tr>
<td><strong>Rehabilitation Therapy</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Rehabilitation</td>
<td>✓</td>
<td>✓</td>
<td>$200 copay + 10%</td>
<td>$200 copay + 40%</td>
<td>$200 copay + 50%</td>
</tr>
<tr>
<td>FCHA pre-authorization required. 90 days per calendar year combined with Skilled Nursing Facility benefit.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Professional Services</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Outpatient Facility Fees / Professional Services (includes physical, speech and occupational therapies and cardiac rehab)</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>90 days per calendar year combined with Inpatient Rehabilitation</td>
<td>✓</td>
<td>✓</td>
<td>$200 copay + 10%</td>
<td>$200 copay + 40%</td>
<td>$200 copay + 50%</td>
</tr>
<tr>
<td><strong>Sleep Apnea</strong> (all services related to sleep apnea)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FCHA pre-authorization required for surgical interventions.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>$200 copay + 10%</td>
<td>$200 copay + 40%</td>
<td>$200 copay + 50%</td>
</tr>
<tr>
<td>• Outpatient Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>10%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Professional Services</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Office Visits – Primary Care Provider (PCP)</td>
<td>✓</td>
<td>✓</td>
<td>$20 copay + 0%</td>
<td>$35 copay + 0%</td>
<td>$200 copay + 50%</td>
</tr>
<tr>
<td>• Office Visits – Specialist</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>30%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Spinal Surgery</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-week waiting period applies, unless urgent/emergent symptoms are present.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>$200 copay + 10%</td>
<td>$200 copay + 40%</td>
<td>$200 copay + 50%</td>
</tr>
<tr>
<td>• Outpatient Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>10%</td>
<td>40%</td>
<td>50%</td>
</tr>
<tr>
<td>• Inpatient/Outpatient Professional Services</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Temporomandibular Joint (TMJ) Disorder</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>FCHA pre-authorization required if inpatient.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>$200 copay + 10%</td>
<td>$200 copay + 50%</td>
<td>$200 copay + 50%</td>
</tr>
<tr>
<td>• Outpatient Facility Fees</td>
<td>✓</td>
<td>✓</td>
<td>10%</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>• Professional Services</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>• Lab/radiology (in office) – billed as part of the primary care or specialist office visit.</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>• Lab/radiology (in office) – billed separately from the primary care or specialist office visit.</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>• Office visits – Primary Care Provider (PCP)</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>• Office visits – Specialist</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>• Oral Appliance</td>
<td>✓</td>
<td>✓</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td>Tobacco Cessation</td>
<td>✓</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
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</table>
### Swedish Medical Plan – Participant Cost-Sharing

<table>
<thead>
<tr>
<th>Transplants (Oral and Bone Marrow)</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum (OOP max)</th>
<th>Tier 1 - Swedish Preferred Network</th>
<th>Tier 2 - Network Providers</th>
<th>Tier 3 - Out-of-Network Providers (OON)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Recipient/Donor Inpatient Facility Fees</strong></td>
<td>✓ ✓</td>
<td>$200 copay + 10%</td>
<td>$200 copay + 40%</td>
<td>$200 copay + 50%</td>
<td></td>
</tr>
<tr>
<td><strong>Recipient/Donor Outpatient Facility Fees</strong></td>
<td>✓ ✓</td>
<td>10%</td>
<td>40%</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td><strong>Recipient/Donor Professional Services</strong></td>
<td>✓ ✓</td>
<td>20%</td>
<td>20%</td>
<td>40%</td>
<td></td>
</tr>
<tr>
<td><strong>Travel Expenses</strong></td>
<td>✓ ✓</td>
<td>N/A</td>
<td>20%</td>
<td>20%</td>
<td></td>
</tr>
</tbody>
</table>

Transplants (Oral and Bone Marrow)
FCHA pre-authorization required for all services.

Vision (routine eye exams and hardware) Not covered (available through optional coverage with VSP)

**Weight Management**

- **Office visits**
  - N/A
  - N/A
  - 20%
  - Not Covered

- **Gastric Band Adjustment**
  (covered only when surgery was previously paid for under the Plan)
  - **Facility Fees**
    - N/A
    - N/A
    - $0
    - Not Covered
  - **Professional Services**
    - N/A
    - N/A
    - 20%
    - Not Covered

- **Swedish Weight Loss Service**
  - N/A
  - N/A
  - 20%
  - Not Covered

- **Bariatric Surgery**
  - Not Covered
Medical Benefits

First Choice Health Administrators (FCHA) administers the benefits described in this section for Plan participants. All benefits are subject to plan exclusions and limits. All coinsurance, deductibles and inpatient, outpatient, or office visit copayments apply. See Payment Provisions, Summary of Medical Benefits and Plan Exclusions and Limitations for more details, as well as Plan Definitions.

Coverage is available only when all these conditions are met:

- The service or supply is a listed covered benefit,
- Specific benefit limits or lifetime maximums are not exhausted,
- All pre-authorization and benefit requirements are met,
- The participant is eligible for coverage and enrolled in this plan at the time the service or supply is received, and
- The service or supply is considered Medically Necessary for a covered medical condition (See Plan Definitions section).

Allergy Care

Benefits include allergy tests, injections, and serums, though serum is covered only when received and administered within the provider’s office. If received from a pharmacy, the serum may be covered under the pharmaceutical benefit.

Alternative Care

Benefits include services of an acupuncturist, massage therapist and/or nutritionist/registered dietician (see Nutritional Counseling below) to treat a covered illness or injury. Maintenance therapy is not covered.

Nutritional Counseling

Coverage provided for health services rendered by a registered dietician or other licensed professional for individuals with medical conditions that require a special diet. Some examples of such medical conditions include: coronary heart disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria and hyperlipidemias. Nutritional counseling for diabetes is covered under the Diabetic Education & Diabetic Nutrition Education benefit.

Ambulance Services

In an emergency, the plan covers licensed ground ambulance transportation to the nearest hospital where emergency care can be rendered if both of the following conditions apply:

- Other forms of transportation would likely endanger the participant’s health, and
- The transportation is not for personal or convenience reasons.

Air and inter-facility transport ambulance services are covered, but require FCHA pre-authorization, except in life-threatening circumstances.
Anesthesia

Benefits for anesthesia are covered if and when required for certain procedures or surgeries. Anesthesia must be administered within a hospital or ambulatory surgical center.

**General Anesthesia for Dental Care**

Coverage is provided for general anesthesia in conjunction with dental care provided to a participant if such participant is:

- Six years of age or younger,
- Is physically developmentally disabled, or
- Is an individual with a medical condition, which his/her physician determines, will place the person at undue risk if the procedure is performed in a dental office. The covered participant’s physician must approve the procedure.

**Blood Transfusions/Donation**

Autologous blood donations are those in which the blood being transfused during surgery was donated by the patient. Blood transfusions are the replacement of blood or one of its components, depending on the condition being treated. Coverage for either is provided when ordered by your physician.

**Chemical Dependency**

All planned inpatient admissions require FCHA pre-authorization by calling (800) 640-7682. The plan covers treatment of individuals requiring chemical dependency rehabilitation for abuse of substances such as alcohol or DEA-controlled oral, intravenous or inhaled medications and materials. Care must be medically necessary and provided at the least restrictive level of care. A clear treatment plan containing measurable progress toward a rehabilitative goal(s), including but not limited to movement to a less restrictive setting (if applicable), or other medically necessary goals as determined by your provider and FCHA’s medical management.

Care may be received at a hospital, a chemical dependency rehabilitation facility, and/or received through residential treatment programs, partial hospital programs and intensive outpatient programs or through group or individual outpatient services.

**Chiropractic Care**

Coverage includes manipulation of the spine, diagnostic radiology, and diagnosis and treatment of musculoskeletal disorders when performed within the scope of the chiropractor’s license. Maintenance therapy is not covered.

**Clinical Trials**

Although the Plan does not cover experimental or investigational treatments or services, an exception may be made if you, or a covered family member, receive therapeutic interventions as part of an approved clinical trial when this participation has been preauthorized.
An approved clinical trial is defined as follows:

- The principal purpose of the trial intervention must be *therapeutic* with the intent to potentially improve health outcomes, and not for diagnosis or supportive care; Phase 1 trials are excluded.
- The clinical trial intervention must be intended for a condition covered by the health plan.
- The clinical trial must be conducted as approved by a national organization such as the National Institutes of Health (NIH), the National Cancer Institute (NCI), the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), the federal Department of Veterans Administration (VA) or Department of Defense (DOD), or the Centers for Medicare & Medicaid Services (CMS).
- The clinical trial must be conducted under a written research protocol approved by an appropriate Institutional Review Board (IRB). This protocol must demonstrate that the trial is in compliance with Federal regulations relating to the protection of human subjects.

In addition, **prior authorization for clinical trial participation must be granted by FCHA** as described below:

- The clinical trial must provide a thorough informed consent document to the participating member, and this document must be signed by the member and reviewed by the Plan prior to member’s participation in the clinical trial.
- All applicable Plan limitations for coverage of out-of-network care along with all applicable plan requirements for precertification, registration, and referrals will apply to any costs associated with member participation in the trial.

Costs associated with clinical trial participation may be covered as follows:

- Interventions, services, or tests that would be expected for the member’s condition absent clinical trial participation.
- Items, services, or tests that are required to safely provide the investigational intervention to include clinically appropriate monitoring of the effects of the intervention.
- Medically necessary treatments for conditions that are medical complications resulting from the member’s participation in the clinical trial.

Costs associated with clinical trial participation that are not covered include:

- Interventions, services, tests, or devices that are the object of investigation in the clinical trial.
- Interventions, services, tests, or devices provided by the trial sponsor without charge.
- Data collection or record keeping costs that would not be required absent the clinical trial; this exclusion extends to any activity (e.g., imaging, lab tests, biopsies) necessary only to satisfy the data collection needs of the trial.
- Interventions associated with treatment for conditions not covered by the Plan.

**Dental Trauma**

This coverage is not intended as dental coverage. This benefit coverage is provided for repair of sound natural teeth, and repair of the jawbone or supporting tissues, due to accidental injury. After the initial examination by your dentist, a pre-authorization for further services is required by FCHA. All services related to the repair must be completed within six months of the date of the injury. Any services received after six months have elapsed, or after you are no longer enrolled in this Plan — regardless of whether six months have elapsed or not — are not covered.
Injury due to biting or chewing is not covered, and is not considered an accidental injury. For the purposes of this coverage, a *sound natural tooth* is a tooth that is (i) free of active or chronic clinical decay, (ii) contains at least fifty percent (50%) bony structure, (iii) is functional in the arch, and (iv) has not been excessively weakened by multiple dental procedures.

Please see *Anesthesia* for information regarding anesthesia benefits for dental services.

**Diabetic Education and Diabetic Nutrition Education**

Diabetic education regarding nutrition and insulin management of diabetes is covered. The education may take place in classes through approved diabetic courses or as individual instruction.

**Durable Medical Equipment (DME)**

DME is medical equipment that can withstand repeated use, is not disposable, is used for a medically therapeutic purpose, is generally not useful in the absence of sickness or injury and is appropriate for use in the home. DME may be rented or purchased (at FCHA’s discretion) and total cost for rental must not exceed the purchase price. **Pre-authorization is required when the purchase exceeds $1,500 or when the rental exceeds $500 per month.**

Repair or replacement is only covered when needed due to normal use, a change in the patient’s physical condition or the growth of a child. Duplicate items are not covered. When more than one option exists, benefits will be limited to the least expensive model or item appropriate to treat the patient’s covered condition.

Examples of DME include, but are not limited to:

- Crutches
- Oxygen and equipment for administering oxygen
- Walkers
- Wheelchairs

This benefit also covers:

- **Breast pumps**
- **Diabetic monitoring equipment** – such as the initial cost of an insulin pump and blood glucose monitor (including supplies related to such equipment). Diabetic supplies such as insulin, syringes, needles, lancets, etc., are covered under the pharmacy benefit.
- **Medical supplies** – needed for the treatment or care of an appropriate covered condition, including but not limited to compression garments, mastectomy supplies and ostomy supplies. Supplies available over-the-counter are excluded.
- **Medically necessary glasses and/or contact lenses** – when needed for any of the following:
  - After cataract surgery
  - To correct extreme visual acuity problems that cannot be corrected with spectacle lenses
  - Under certain conditions of anisometropia
  - Keratoconus
- **Mobility scooters** – Covered in lieu of a custom wheelchair to treat an appropriate covered condition. Coverage is limited to the initial purchase only; maintenance, repairs and duplicate items are not covered. An $800 lifetime maximum applies to this benefit.
- **Oral appliances** when related to the treatment of Sleep Apnea (TMJ-related appliances are covered under the TMJ benefits).
• **Orthopedic appliances** – These include appliances used to support abnormal joints, limit pressure on a joint after injury to allow it to heal or correct abnormal curves in the spine.

• **Prosthetic devices** – Benefits include external prosthetic appliances, which are used to replace all or part of a missing body part and are necessary for the alleviation or correction of illness, injury, or congenital defect.

• **Wigs** – Benefits are provided for the initial purchase of a wig following chemotherapy. A lifetime benefit maximum of $1,000 applies to this benefit.

• **Surgically implanted devices** – may be covered under the appropriate surgical benefit and are not considered DME. Benefits for durable medical equipment are determined by the type of device and its intended use, and not by the entity that provides or bills for the device.

### Emergency and Urgent Care

The Plan covers emergency room and urgent care visits in network and non-network facilities. Emergency (or emergent) means the sudden and acute onset of a symptom(s), including severe pain, that would lead a person, acting reasonably, to believe a health condition exists that requires immediate medical attention and that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.

**Emergent conditions** include severe pain, difficulty breathing, deep cuts or severe bleeding, poisoning, drug overdose, broken bones, unconsciousness, stab or gunshot wounds, automobile accidents, and pain or bleeding during pregnancy.

**Urgent conditions** include cuts and lacerations, diarrhea, allergic reactions, sprains, urinary tract infections and vomiting.

In the case of an emergency, home or away, seek the most immediate care available. To receive the network level of benefits, you must obtain all follow-up care from network providers. If you require follow-up services from non-network providers, you must obtain a pre-authorization from FCHA in order to receive coverage.

### Family Planning

Voluntary sterilization procedures and FDA-approved birth control methods are covered. Oral contraceptives are covered under the prescription drug benefit. Over-the-counter products are not covered except as may be required under the Patient Protection and Affordable Care Act.

**Termination of Pregnancy**

Voluntary termination of pregnancy is covered for an employee and spouse/domestic partner only.

### Foot Orthotics

Custom-designed foot orthotics, when ordered by a physician and required for all normal, daily activities are covered by the Plan. Coverage includes related office visits, diagnostic and lab services, castings, molds, fittings and necessary adjustments or replacements.

### Genetic Services

Genetic testing, counseling, interventions, therapy and other genetic services are covered when determined to be an essential component of medically necessary care or treatment of a covered condition, or a medically necessary precursor to obtaining prompt treatment of a covered condition. Pre-authorization is required for genetic testing over $500.
Breast Cancer Assay

The Plan will cover breast cancer assays when the following criteria are met:

- The ordering physician is at the Swedish Cancer Institute; and
- The member has estrogen-receptor positive, node-negative carcinoma of the breast.

Hearing Exams, Aids and Appliances

A routine hearing exam by a licensed provider is covered once every calendar year to determine the need for corrective treatment. Hearing aids and appliances are covered when needed for auditory deterioration. Costs for these device(s), repairs and any other related services such as surgical implantation are all subject to the limit(s) noted within the Summary of Medical Benefits for Hearing Aids/Appliances.

Note: Cochlear implants and Bone Anchored Hearing Aids are not considered a hearing aid/appliance and may be covered under the surgical benefit, and not under the Hearing Aids/Appliances benefit.

Home Health Care

FCHA pre-authorization is required for home health benefits and home infusion therapy (enteral and IV). Home health care is covered when prescribed by your physician. The patient must be homebound and require skilled care services (as defined by the Plan). Benefits are limited to intermittent visits by a licensed home health care agency and home infusion services.

For this benefit, a visit is a time-limited session or encounter with any of the following home health agency providers:

- Nursing services (RN, LPN)
- Licensed or registered physical, occupational or speech therapist (or an assistant working under the supervision of one of these providers)
- Home health aide working directly under the supervision of one of the above providers
- Medical Social Worker (MSW)

Services not covered include: private duty nursing, shift or hourly care services, custodial care, maintenance care, housekeeping services, respite care and meal services.

If FCHA determines care in a skilled nursing facility or a hospital is more cost-effective, then home health will not be covered. Any charges for home health care that qualify under this plan will be covered under the most appropriate benefit, as determined by FCHA.

Hospice Care

FCHA pre-authorization is required for inpatient hospice and all respite care. Hospice care is covered for you or your covered dependent(s) when prescribed by the patient’s physician once he/she has determined that life expectancy is six months or less and a palliative, supportive care treatment approach has been chosen. A six-month lifetime maximum applies to this benefit.

This benefit includes acute, respite, and home care to meet the physical, psychosocial, and special needs of a patient-family unit during the final stages of illness and dying. Hospice care is provided at a variety of levels to meet the individual needs of the patient-family unit.
Levels offered are:

- **Intermittent in-home visits** are provided on an as-needed basis by the hospice team, which includes health care professionals, support staff, and a 24-hour-a-day, on-call registered nurse. This level of care does not cover room and board while a member resides in a skilled nursing facility, adult family home, or assisted living facility.
- **Inpatient Hospice** care is needed when care cannot be managed where the patient resides. The care will be provided at an inpatient facility until the patient's condition stabilizes.
- **Continuous home care** is provided when a medical crisis occurs where the patient resides and care can be provided at the residence. During such periods, the hospice team can provide around-the-clock care for up to five days.
- **Inpatient respite care** is available to provide the patient’s caregiver a rest of up to five days during one period of time. This acknowledges that caring for a dying person can be difficult. Care for the patient is provided at an inpatient facility and includes room and board costs.

When provided within the above-defined levels of care, additional covered expenses include:

- Approved medications and infusion therapies furnished and billed by an approved hospice agency
- Durable Medical Equipment
- Supplies required for palliative care.

If the patient exhausts the hospice benefit maximum, limited extensions may be granted if it is determined that the treatment is medically necessary. Any charges for hospice care that qualify under the Plan will be covered under the most appropriate benefit as determined by FCHA.

**Hospital Inpatient Medical and Surgical Care**

Hospital inpatient and facility charges for medically necessary care are covered. **FCHA pre-authorization is required for all non-emergency inpatient admissions to a hospital or facility.** Covered inpatient care includes room and board, operating room and anesthesia, radiology, lab and pharmacy services furnished by and used while in the hospital.

**Hospital Outpatient Surgery and Services**

**Certain outpatient surgery/procedures require FCHA pre-authorization.** Please see **Pre-authorization Requirements** for details. Covered outpatient care includes outpatient surgery, procedures and services, operating room and anesthesia, radiology, lab and pharmacy services furnished by and used while at a hospital or ambulatory surgical center.

**Infertility Diagnostic Services**

Coverage is provided for the initial evaluation and diagnosis only. Examples of covered services for the initial diagnosis of infertility include: endometrial biopsy, hysterosalpingography, reproductive screening services, or sperm count. **A pre-authorization must be obtained from FCHA if care is provided inpatient.** Treatments and procedures for the purposes of producing a pregnancy are not covered.
Infusion Therapy

**FCHA pre-authorization is required if performed in the home or a freestanding infusion suite.** Infusion therapy is the administration of medications using intravenous, subcutaneous, and epidural routes (into the bloodstream, under the skin, and into the membranes surrounding the spinal cord). Drug therapies commonly administered via infusion include, but are not limited to, antibiotics, chemotherapy, pain management, parenteral nutrition, and immune globulin.

Diagnoses commonly requiring infusion therapy include infections that are unresponsive to oral antibiotics; cancer and cancer-related pain; gastrointestinal diseases or disorders which prevent normal functioning of the GI system; congestive heart failure; immune disorders; and more.

Lab and Radiology Services

The plan covers lab and radiology services for diagnostic purposes when medically necessary and ordered by a qualified provider. **FCHA pre-authorization is required for PET scans.**

Maternity and Newborn Care

Coverage for pregnancy and childbirth, for employees or his/her spouse/domestic partner (not dependent children), in a hospital or birthing center, is provided on the same basis as any other medical condition, as are complications of pregnancy.

Medically necessary screening(s) and diagnostic procedures during pregnancy for prenatal diagnosis of congenital disorders of the fetus are covered. The services of a licensed physician, an advanced registered nurse practitioner (ARNP), a licensed midwife, or a certified nurse midwife (CNM) are covered under this benefit.

Coverage for newborns is provided when he/she is enrolled as an eligible dependent under this Plan (see **Eligibility and Enrollment** for details). Benefits are subject to the newborn child’s own coinsurance and deductible requirements.

Newborn care includes inpatient hospital services and professional care (including circumcision) performed during the initial period of hospitalization immediately following birth. Any services performed after the baby is discharged from the hospital are not considered newborn care but may be covered under other plan benefits. Circumcisions are covered up to 28 days following birth. Circumcisions performed after 28 days must be medically necessary as determined by FCHA.

First Choice Health offers a Maternity Management Program to provide prenatal education to help mothers carry their babies to term. To enroll, or to receive additional information, call (800) 756-7751.

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**Newborns’ and Mothers’ Health Protection Act of 1996**

This Act states that group health plans may 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 less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or newborn earlier than these periods. In any case, the Plan may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer or TPA for prescribing a length of stay not in excess of these periods.
Mental Health Care

The plan covers treatment of mental health or psychiatric conditions. **All planned inpatient admissions require FCHA pre-authorization.** To request pre-authorization, call (800) 640-7682.

Care must be medically necessary and provided at the least restrictive level of care. A clear treatment plan must contain measurable progress toward a rehabilitative goal(s), including but not limited to movement to a less restrictive setting (if applicable), or other medically necessary goals as determined by your provider and FCHA's medical management.

Care may be received at a hospital, a chemical dependency rehabilitation facility, and/or received through residential treatment programs, partial hospital programs, and intensive outpatient programs or through group or individual outpatient services.

Family counseling, psychological testing and psychotherapeutic programs are covered only if related to the treatment of an approved clinical mental health diagnosis, specifically, those noted in the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Neurodevelopmental Therapy

Neurodevelopmental therapy services are covered to restore and improve function in children with neurodevelopmental disabilities ages six or younger. Children over seven years of age are not covered. Benefits include:

- Neurological and psychological testing, evaluations and assessments
- Ongoing maintenance in cases where serious significant deterioration would result without ongoing treatment
- Outpatient physical, occupational and speech therapy.

Once the benefits under this provision are exhausted, coverage may not be extended by using the benefits under any other provision.

Nutritional and Dietary Formulas

Coverage for nutritional and dietary formulas is provided when medically necessary. The following conditions must be met:

- The formula is specialized for treatment of a recognized life-threatening metabolic deficiency such as phenylketonuria, or
- The formula is the significant source of a patient’s primary nutrition or is administered in conjunction with intravenous nutrition, and
- The formula is administered through a feeding tube (nasal, oral or gastrostomy).

Oral Surgery

Coverage for oral surgery is offered when a medical diagnosis is present. Oral Surgery required for a dental diagnosis such as periodontal disease is not covered. Examples of covered services include:

- The reduction or manipulation of fractures of facial bones
- Excision of lesions, cysts, and tumors of the mandible, mouth, lip or tongue
• Incision of accessory sinuses, mouth salivary glands or ducts
• Extraction of teeth damaged due to radiation therapy that occurred while under this Plan.

Please see Anesthesia for information regarding anesthesia benefits for dental services.

Orthognathic Surgery

Orthognathic surgery is surgery to correct conditions of the jaw and face related to structure and growth. Bones can be cut and re-aligned, held in place with either screws or plates and screws. This Plan will cover this surgery only when related to birth defects, such as cleft palate or facial injuries.

Plastic and Reconstructive Services

Reconstructive/plastic procedures (including reconstructive breast surgery as outlined below by the Women’s Health and Cancer Rights Act of 1998) require FCHA pre-authorization and are covered when performed to correct or repair abnormal structures of the body caused by congenital defects, trauma, infection, tumors, disease, accidental injury or prior surgery (if the prior surgery is covered under this Plan).

• Services performed to correct congenital defects of a child must be completed before the child’s 18th birthday.
• In the case of accidental injury, services must be completed within 12 months of the initial injury.

Women’s Health and Cancer Rights Act of 1998

The federal law titled Women’s Health and Cancer Rights Act of 1998 states group health plans that are providing medical and surgical benefits for mastectomy resulting from disease, illness or injury must also cover, for those affected participants:

• Reconstruction of the breast on which the mastectomy was performed
• Reconstruction of the other breast to produce a symmetrical appearance
• Internal or external prostheses
• Treatment of physical complications in all stages of post-mastectomy reconstruction, including lymphedema

Podiatric Care

Coverage is provided for certain surgical podiatric services, including incision and drainage of infected tissue of the foot, removal of lesions of the foot, removal or debridement of infected toenails, and treatment of fractures and dislocations of bones of the foot. Routine foot care, such as the treatment of corns, calluses, non-surgical care of toenails, fallen arches and other symptomatic complaints of the feet is not covered, except for diabetics.

Preventive Care

Coverage is provided by or under the supervision of your provider, including:

• Routine physicals
• Periodic examinations including the specific diagnostic testing/screening and laboratory services as recommended by the U.S. Preventive Services Task Force and the Health Resources and Services Administration
• Adult, child and adolescent immunizations as recommended by the Centers for Disease Control (CDC).
Preventive care does not include diagnostic treatment, lab, x-ray, follow-up care, or maintenance care of existing conditions or chronic disease.

For more information on the recommendations of the CDC, U.S. Preventive Services Task Force, and the Health Resources and Services Administration, visit the following website: www.healthcare.gov/center/regulations/prevention/recommendations.html

**Professional/Physician Services**

This benefit covers office visits and in-office surgical procedures related to a covered medical condition. Only in-person and Telemedicine visits are covered — not charges for care provided over the phone, or via fax, email or Internet.

**Rehabilitation Therapy**

Coverage for disabling conditions is provided through inpatient and outpatient rehabilitation therapy. Examples of such therapies include, but are not limited to: physical therapy, speech therapy, and occupational therapy.

The following conditions must be met:

- Services are to restore and significantly improve function that was previously present but lost due to acute injury or illness,
- Services are not for palliative, recreational, relaxation or maintenance therapy, and
- Loss of function was not the result of a work-related injury.

Coverage for cardiac rehabilitation services require all the following conditions be met:

- Performed under the supervision of a physician,
- In connection with a myocardial infarction, coronary occlusion or coronary bypass surgery, and
- Initiated within 12 weeks after other treatment for the medical condition ends.

**Inpatient Rehabilitation**

Inpatient rehabilitation requires FCHA pre-authorization and must be furnished and billed by a rehabilitative unit of a hospital or by another approved rehabilitation facility. When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day the care becomes primarily rehabilitative. Inpatient care includes all room and board, services provided and billed by the inpatient facility and therapies performed during the rehabilitative stay.

**Outpatient Rehabilitation**

Outpatient rehabilitation benefits are subject to the following provisions:

- You must not be confined in a hospital or other medical facility.
- Services must be billed by a hospital, a physician, or a physical, occupational or speech therapist.

Coverage for outpatient rehabilitative services is limited to those services that are reasonably expected to result in significant self-sustaining functional improvement within 90 days of initiation. (Maintenance therapy is not included.)
Speech therapy is covered only when required as a result of brain or nerve damage secondary to an accident, disease or stroke.

Once the benefits under this provision are exhausted, coverage may not be extended by using the benefits under any other provision of the Plan.

**Skilled Nursing Facility**

Inpatient skilled nursing facility care requires FCHA pre-authorization. Benefits include room and board and ancillary services. The care must be therapeutic or restorative and require in-facility delivery by licensed professional medical personnel, under the direction of a physician, to obtain the desired medical outcome. (Neither maintenance care nor custodial care are covered.)

**Sleep Apnea and Sleep Centers**

Surgical interventions and durable medical equipment (DME) purchases over $1,500/$500 per month rental require FCHA pre-authorization. Sleep studies and oral appliances to treat obstructive sleep apnea are covered.

**Spinal Surgery**

There is a six-week waiting period for this benefit from the date of diagnosis unless urgent/emer gent symptoms are present. The Plan covers spine surgery when considered medically necessary. FCHA pre-authorization is required and based on the following criteria:

1: The surgery is intended for the treatment of non-elective (urgent/emergent) indications, such as trauma, infection, tumor or severe neurological impairment; or

2: The surgery is intended for the elective treatment of on-going (chronic) back/neck pain, and all of the following criteria are met:
   - Documentation of back or neck pain for at least three consecutive months
   - Documentation of conservative treatment for at least six weeks
   - Documentation of diagnostic imaging (MRI or CT) that supports the diagnosis that is the indication for surgery
   - Documentation showing no apparent contraindications for spine surgery

**Temporomandibular Joint Syndrome (TMJ)**

FCHA pre-authorization is required for inpatient admissions related to TMJ. Medical, dental, surgical and related hospital services are covered for the treatment of TMJ including the correction of malocclusion of the jaw or any dental treatment for dental conditions involved in temporomandibular joint pain dysfunction, syndrome or disease collectively referred to as Temporomandibular Joint Dysfunction (TMJ).

**Tobacco Cessation**

To find a program, call your county health district, or check with your local FCHN preferred provider hospital. Smoking cessation pharmacy products and over-the-counter (OTC) products are also covered under this benefit, including Zyban nasal spray and inhaler.
For reimbursement, send a copy of your receipts along with a claim form to:

FCHA Claims Department
PO Box 12659
Seattle, WA 98111-4659

Transplants, Organ and Bone Marrow

FCHA pre-authorization is required for transplant services. Services directly related to organ transplants must be coordinated by your participating provider. Proposed transplants will not be covered if considered experimental or investigational for the participant’s condition, except as may be allowed under the Clinical Trials benefit.

FCHA pre-authorization approval for transplants is based on these criteria:

• A written recommendation with supporting documentation received from your provider
• The request for the transplant is based on medical necessity
• The requested procedure and associated protocol is not considered experimental or investigational treatment for your condition, except as may be allowed under the Clinical Trials benefit
• The procedure is performed at a Medicare approved transplant facility, Center of Excellence facility with a national transplant network, or any Swedish Health Services or Providence Health & Services facility
• Upon evaluation you are accepted into the approved facility’s transplant program and comply with all program requirements

Have your provider send a written request, prior to evaluation, to:

FCHA Medical Management
600 University St., Suite 1400
Seattle, WA 98101

Note: Corneal transplants are not considered an organ transplant and are covered under the medical-surgical benefit, and not under the transplant benefit.

Recipient Services

Covered transplant recipient services include:

• Medical and surgical services directly related to the transplant procedure and follow-up care
• Diagnostic tests and exams directly related to the transplant procedure and follow-up care
• Inpatient facility fees and pharmaceutical fees incurred while an inpatient
• Pharmaceuticals administered in an outpatient setting
• Anti-rejection drugs

Donor Services

Donor expenses are covered if all of the following criteria are met:

• FCHA approves the transplant procedure
• The recipient is enrolled in this plan
• Expenses are for services directly related to the transplant procedure
• Donor services are not covered under any other health plan or government program
Covered donor expenses include:
• Donor typing, testing and counseling
• Donor organ selection, removal, storage and transportation of the surgical/harvesting team and/or the donor organ or bone marrow

When both the recipient and the donor are participants under this Plan, covered charges for all covered services and supplies received by both the donor and the recipient will be payable.

Note: If you, as a participant, choose to donate an organ or bone marrow, donor expenses are not covered under this Plan unless the recipient is also enrolled in this Plan. However, complications arising from the donation would be covered to the extent that they are not covered under the recipient’s health plan.

**Travel expenses**

Travel expenses require pre-authorization by FCHA and are available for either the recipient and one caregiver companion, or the recipient and the donor, for medically necessary services related to an approved transplant. Travel benefits are payable for the recipient if the recipient is required to travel 30 miles or more from his or her home address for the medically necessary services related to an approved transplant, or if the facility requires the patient to remain within a certain distance of the facility during the transplant process.

Travel expenses are not available for both the donor and the caregiver companion of the recipient. Travel expenses are subject to a combined $5,000 lifetime benefit maximum for transportation, food and lodging. Food and lodging are subject to a $250 per diem limit that applies to the $5,000 travel expenses benefit maximum. The following are not eligible for reimbursement as part of the per diem:

• Alcohol
• Car Rental
• Entertainment (i.e., movies or rentals compact discs, games etc.)
• Expenses for persons other than the patient, and his/her covered caregiver or donor
• Expenses for lodging when member or caregiver companion is staying with relative or friend
• Gasoline/Mileage
• Hotel/Lodging costs when the patient is in the hospital
• Household products
• Laundry/Laundry Supplies/Dry Cleaning
• Parking fees incurred other than at hotel/motel or clinic visits
• Personal hygiene items (i.e., toothbrush, deodorant, etc.)
• Personal services (i.e., childcare, house sitting, kennel care, etc.)
• Telephone bills/calls/phone cards
• Tobacco
• Valet parking

**Weight Management and Wellness Programs**

The Swedish Medical Plan offers Swedish Healthy Weighs, The Swedish Center for Medical Weight Management programs and other wellness programs sponsored by Swedish Health Services, which include lifestyle management and cardiovascular risk assessment.
Swedish Healthy Weighs

Healthy Weighs is a 12-week Swedish Medical Center program, where personal attention in a small group teaches effective ways of maintaining a healthy weight. For more information about Healthy Weighs and how you can become a program participant, call (206) 215-2090.

The Swedish Center for Medical Weight Management (The Center)

The Plan covers visits at The Center under this benefit, however nutritional counseling visits, laboratory testing, psychological treatment/evaluations and services related to sleep apnea are covered under their own respective benefits, regardless of whether these services are provided at The Center or are otherwise related to a diagnosis of obesity.

Plan participants with diagnosed obesity who meet the following criteria may be eligible for The Center weight management program:

- Body Mass Index (BMI) greater than 35 or
- BMI greater than 30 with one of the following conditions:
  - ASHD – angina, MI (myocardial infarction), stent replacement, CABG (coronary artery bypass graft), angioplasty or positive heart scan or c-cath
  - Diabetes
  - High blood pressure and taking prescription
  - High cholesterol (LD) and taking prescription
  - Sleep apnea

This 12-month program for medical treatment for obesity includes:

- Behavioral modification techniques and personal behavior tracking support
- Emotional and psychological evaluation and support
- Integration and written communication with each participant’s other significant health care providers
- Nutritional instruction and ongoing support and education
- Pharmacological and/or nutriceutical prescribing as needed
- Physical activity prescriptions with ongoing modification and enhancements.

Frequency of visits is tailored to the patient’s condition.

Dependent children ages 8 through 17 (up to 18th birthday) may enter the program by special arrangement, after The Center performs child and parent interviews as well as an assessment of readiness and commitment.

You are not eligible for The Center program if you:

- Are unable to walk
- Have uncontrolled diabetes, hypertension, depression, liver disease or kidney disease
- Have unstable coronary artery disease
- Are taking prednisone or other steroids (long term use, not a short 5-day course)
- Have untreated Cushing’s syndrome
- Experienced brain damage or other serious cognitive compromise
- Have untreatable or currently active cancer.
Plan Exclusions and Limitations

Covered services are limited to the diagnosis, therapeutic care or treatment, and prevention of disease, sickness or injury as described in this document. In addition to limits and exclusions stated elsewhere in this document, coverage is specifically excluded for each of the following items and any related services and charges:

• Adoption expenses
• Amounts over and above the Allowed Amount, as defined by the Plan
• Amounts for which the covered person has no obligation to pay
• Any charges by a facility owned or operated by the U.S. or any state or local government unless the participant is legally obligated to pay (excluding: (i) covered expenses rendered by a medical facility owned or operated by the United States Veteran's Administration (VA) when the services are provided to a participant for a non-service related illness or injury, and (ii) covered expenses rendered by a U.S. military medical facility to participants who are not on active military duty)
• Any condition resulting from participation in declared or undeclared acts of terrorism, war, military service, participation in a riot or civil disobedience
• Any service not medically necessary for the diagnosis, treatment or prevention of injury or illness, even if it is not specifically listed as an exclusion (except for specific services offered through the Preventive Care benefit)
• Any service received before the participant’s effective date of coverage or after the coverage termination date
• Any service received outside the U.S. except emergency care
• Aromatherapy
• Athletic training, body-building, fitness training or related expenses
• Autopsies
• Biofeedback
• Botanical medicines, as well as other over-the-counter medications
• Care provided by phone, fax, email or internet, except telemedicine (see Plan Definitions)
• Charges for failure to keep a scheduled visit, for the copying of medical records or for the completion of a claim or administrative forms
• Charges that are the result of any injury or illness incurred by a participant while that participant is participating in the commission of a felony
• Chemical Dependency treatments listed below:
  — Alcoholics Anonymous or other similar chemical dependency programs or support groups
  — Biofeedback, pain management and/or stress reduction classes
  — Care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior
  — Chemical dependency benefits not specifically listed
  — Court-ordered or other assessments to determine the medical necessity of court-ordered treatments
  — Court-ordered treatments or treatments related to deferral of prosecution, deferral of sentencing or suspended sentencing or treatments ordered as a condition of retaining driving rights, when no medical necessity exists
  — Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
  — Emergency patrol services
  — Information or referral services
  — Information schools
— Long-term or custodial care
— Non-substance related disorders
— Treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required

• Cognitive therapy
• Court ordered examinations or treatment of any kind, except when medically necessary
• Dental, oral surgery or orthodontic related services, such as (but not limited to) those listed below (unless accident related or otherwise specifically covered by the Plan):
  — Care of the teeth or dental structures, including related anesthesia or facility charges
  — Tooth damage due to biting or chewing
  — Dental implants related to a dental diagnosis such as gingivitis, periodontal disease, etc.
  — Dental X-rays
  — Extractions of teeth, impacted or otherwise (except as covered under the Plan)
  — Orthodontia
  — Services to correct malposition of teeth
• Developmental delay treatment or services, except as covered by the Plan
• Durable Medical Equipment (DME) and medical supply charges listed below:
  — Biofeedback equipment
  — Electronic and/or keyboard communication devices
  — Equipment or supplies whose primary purpose is preventing illness or injury
  — Exercise equipment
  — Items not manufactured exclusively for the direct therapeutic treatment of an illness or injured patient
  — Items primarily for comfort, convenience, sports/recreational activities or use outside the home
  — Oral appliances except to treat obstructive sleep apnea and TMJ
  — Over-the-counter items (except medically necessary crutches, walkers, standard wheelchairs, diabetic supplies and ostomy supplies are covered)
  — Personal comfort items including but not limited to air conditioners, lumbar rolls, heating pads, diapers or personal hygiene items
  — Phototherapy devices related to seasonal affective disorder
  — Supportive equipment/environmental adaptive items including, but not limited to, hand rails, chair lifts, ramps, shower chairs, commodes, car lifts, elevators, and modifications made to the patient’s home, place of work, or vehicle.
  — The following medical equipment/supplies: regular or special car seats or strollers, push chairs, air filtration/purifier systems or supplies, water purifiers, allergenic mattresses, orthopedic or other special chairs, pillows, bed-wetting training equipment, corrective shoes, whirlpool baths, vaporizers, room humidifiers, hot tubs or other types of tubs, home UV or other light units, home blood testing equipment and supplies (except diabetic equipment and supplies, and home anticoagulation meters)
  — Wigs or other hair coverings (except for initial purchase after chemotherapy, see Summary of Medical Benefits)
• Dyslexia treatment
• Experimental, investigational, or unproven services, except as may be allowed under the Clinical Trials benefit
• FDA-approved drugs, medications or other items for non-approved indications, except when an FDA-approved drug has been proven clinically effective to treat such indication and is supported in peer-reviewed scientific medical literature
• Growth hormone treatment (except as may be covered under the pharmacy benefits)
• Hair analysis
• Home births
• Home health care listed below:
  — Custodial care
  — Housekeeping or meal services
  — Maintenance care
  — Shift or hourly care services
• Hospice care listed below:
  — Bereavement counseling
  — Custodial care or maintenance care, except palliative care to the terminally ill patient subject to the stated limits
  — Financial or legal counseling services (including estate planning and the drafting of a will)
  — Funeral arrangements
  — Housekeeping or meal services
  — Pastoral counseling
  — Services by a participant or the patient’s family or volunteers
  — Services not specifically listed as covered hospice services under the Plan
  — Supportive equipment such as handrails or ramps
  — Transportation
• Immunizations for travel
• Infertility services or treatments to achieve pregnancy (regardless of the cause) including but not limited to:
  — Artificial insemination
  — In vitro fertilization (IVF)
  — Gamete intra-fallopian transplant (GIFT)
• Injuries while under the influence of a controlled substance and/or alcohol
• Learning disabilities and related services, educational testing or associated training
• Mental health care listed below:
  — Adventure-based and/or wilderness programs that focus primarily on education, socialization or delinquency
  — Biofeedback, pain management, and stress reduction classes
  — Court-ordered assessments
  — Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
  — Developmental delay disorders
  — Eating disorders such as, but not limited to, anorexia nervosa and bulimia
  — Marriage and couples counseling
  — Family therapy, in the absence of an approved mental health diagnosis
  — Nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories
  — Sensitivity training
  — Sexual dysfunctions, gender dysphoria, personality disorders, and paraphilic disorders
• Non-covered services, or complications arising from non-covered services, except as covered by the Plan
• Orthodontic treatment, appliances or services; dentures or related services
• Over-the-counter products such as Acetaminophen, Aspirin, Ibuprofen, cold medicines, except as covered by the Plan
• Personal, convenience or comfort services, supplies, or items including but not limited to phones, TVs, guest services, deluxe or suite hospital room, air conditioners, diapers or hygiene items
• Physical examinations, reports or related services for the purpose of obtaining or maintaining employment, insurance, or licenses or permits of any kind, school admission, school sports clearances, immigration, foreign travel, medical research, camps, or government licensure, or other reasons not related to medical needs
• Plastic and reconstructive services such as those listed below:
  — Abdominoplasty/panniculectomy
  — Complications resulting from non-covered services
  — Cosmetic services, supplies or surgery to repair, modify or reshape a functioning body structure for improvement of the patient’s appearance or self-esteem;
  — Dermabrasion, chemical peels or skin procedures to improve appearance or to remove scars or tattoos
  — Gynecomastia surgery
• Pregnancy or complications of pregnancy for dependent children
• Private duty nursing
• Procedures, regardless of medical necessity, outside the scope of the provider’s license, registration or certification
• Repair or replacement of items not used in accordance with manufacturer’s instructions or recommendations
• Replacement of lost or stolen items, such as but not limited to prescription drugs, prostheses or Durable Medical Equipment (DME)
• Respite care, except as covered by the Plan as in the Hospice benefit
• Reversal of sterilization
• Services for any condition, illness or injury that arises from or during the course of work for wages or profit that is covered by state insurance workers’ compensation and federal act or similar law
• Services or supplies payable under a contract or insurance for uninsured or underinsured (UIM) coverage, motor vehicle, motor vehicle no-fault, or personal injury protection (PIP) coverage, commercial premises or homeowner’s medical premise coverage or other similar type of contract or insurance
• Services or supplies received without charge from a medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar group
• Services or supplies required by an employer as a condition of employment
• Services provided by a family member (spouse, parent or child)
• Services provided by, or that could be provided by, a spa, health club or fitness center
• Services provided by clergy
• Sex change operations or treatment for transsexualism (non-congenital transsexualism, gender dysphoria or sexual reassignment or change); related medications, implants, hormone therapy, surgery, medical or psychiatric treatment
• Sexual dysfunction treatment
• Snoring treatment (surgical or other)
• Special diets, nutritional supplements, vitamins and minerals or other dietary formulas or supplements except as covered by the Plan
• Special education for the developmentally disabled
• Specialized intraocular lenses associated with cataract surgery that correct vision disorders, such as Multifocal and Toric intraocular lenses
• Surrogate mother medical expenses, unless the surrogate mother is eligible under the Plan at the time the services were rendered
• Tooth damage due to biting or chewing
• Transportation, except as covered by the Plan as in the Transplant benefit
• Transplant services listed below (Organ and Bone Marrow):
  — Animal-to-human transplants
— Artificial or mechanical devices designed to replace human organs
— Complications arising from the donation procedure if the donor is not a Plan participant
— Donor expenses for a Plan participant who donates an organ or bone marrow, however complications arising from the donation would be covered as any other illness to the extent they are not covered under the recipient’s health plan.
— Meals and lodging (except for lodging specified by the Plan)
— Transplants considered experimental and investigational, as defined by the Plan, except as may be allowed under the Clinical Trials benefit

• Treatment furnished without charge or paid directly or indirectly by any government or for which a government prohibits payment of benefits
• Vision care, the following vision benefits are not covered as part of the medical plan:
  — Non-prescription or prescription sunglasses or safety glasses
  — Radial keratotomy, Lasik or any other refractive surgery, orthoptics, pleoptics, visual analysis
  — therapy or training related to muscular imbalance of the eye; optometric therapy
  — Routine eye exams
  — Vision hardware such as frames, lenses or contact lenses
• Vitamin B-12 injections except to treat Vitamin B-12 deficiency
• Vocational rehabilitation, work hardening or training programs regardless of diagnosis or symptoms that may be present, or for non-medically necessary education
• Weight-loss services outlined below:
  — Surgery, including related services and supplies intended to result in weight reduction, regardless of diagnosis (except non-surgical medically supervised weight-loss programs as specifically outlined in this Plan under the Weight Management benefit).
  — Replacement of a gastric band, regardless of whether the initial placement was covered under this Plan. (However, gastric band adjustments will be covered for members whose gastric band placement was covered under this Plan)
  — A second bariatric surgical procedure or revision of bariatric surgery, regardless of whether the initial procedure was covered under this Plan.
  — Complications related to any type of bariatric surgery, unless the surgery was covered under this Plan.
# Summary of Pharmacy Benefits

<table>
<thead>
<tr>
<th>Administered by MedImpact</th>
<th>Applies to Deductible</th>
<th>Applies to Out-of-Pocket Maximum</th>
<th>Tier 1: Swedish Pharmacy</th>
<th>Tier 2: Network Providers</th>
<th>Tier 3: Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retail or Swedish Pharmacy – 30 day supply</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Generic</td>
<td>N/A</td>
<td>N/A</td>
<td>$7.50 copay</td>
<td>$15 copay</td>
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<tr>
<td>• Preferred Brand</td>
<td>N/A</td>
<td>N/A</td>
<td>$30 copay*</td>
<td>$40 copay*</td>
<td>Not Covered</td>
</tr>
<tr>
<td>• Non-preferred Brand</td>
<td>N/A</td>
<td>N/A</td>
<td>$60 copay*</td>
<td>$70 copay*</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Mail order or Swedish Pharmacy – 90 day supply</td>
<td>Note: the initial fill on all medications is limited to a 30-day supply</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>• Generic</td>
<td>N/A</td>
<td>N/A</td>
<td>$18.75 copay</td>
<td>$37.50 copay</td>
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<tr>
<td>• Preferred Brand</td>
<td>N/A</td>
<td>N/A</td>
<td>$75 copay*</td>
<td>$100 copay*</td>
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<tr>
<td>• Non-preferred Brand</td>
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<td>N/A</td>
<td>$150 copay*</td>
<td>$175 copay*</td>
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<tr>
<td>Specialty Pharmacy** – 30 day supply</td>
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<td>N/A</td>
<td>$75 copay</td>
<td>$75 copay**</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

*If you obtain a brand name drug when a generic equivalent drug is available, in addition to the applicable copay amount, you will be responsible for paying the difference in price between the brand name drug and the generic drug. In no event, however, will the total out-of-pocket expense (copay plus difference between brand name and generic priced) be greater than the cost of the brand name drug.

**As of 2/1/2014, mail-order specialty medication is fulfilled by Providence Specialty Pharmacy via mail order.
Pharmacy Benefits

Prescription drug benefits for Plan participants are administered by MedImpact Healthcare Systems, Inc., a separate provider not affiliated with FCHA. To be covered, medications must meet these requirements:

- Prescribed by a licensed physician,
- Approved by the Food and Drug Administration (FDA), and
- Be warranted to treat a covered condition.

See the Filling a Prescription section below for more detailed information on how and where you can obtain your prescription drugs.

The Summary of Pharmacy Benefits section notes the amounts for which you are responsible. To assist in keeping your out-of-pocket costs down when purchasing a prescription, it may be helpful to know that three tiers exist within the pharmacy structure:

- **Tier 1 or Generic Drugs** — The generic version of a drug has the same chemical compound as its brand counterpart. Generic drugs offer a simple, safe alternative to help reduce prescription costs.
- **Tier 2 or Preferred Brand Drugs** — This level includes preferred brand name drugs that have no generic equivalent.
- **Tier 3 or Non-Preferred Brand Drugs** — This level includes brand drugs that are not listed in Tier 2. In most cases there are reasonable alternatives in Tier 1 or 2 for drugs found in this highest tier.
- **Tier 4 or Specialty Pharmacy** — Certain high cost medications for complex, chronic conditions must be purchased from a MedImpact specialty pharmacy. Effective February 1, 2014, specialty medications must be purchased from the Providence Specialty Pharmacy, which are sent to you via mail order. These drugs often have special storage needs and require a higher level of patient monitoring.

If a brand name drug is prescribed by your physician because he/she feels it is medically necessary, or selected by you, when a generic equivalent drug is available, you will be responsible for paying the difference in price between the brand name drug and the generic, plus the applicable copay. Your out-of-pocket expense will never exceed the cost of the drug.

In addition to a copay you are responsible for the cost of any prescription not covered under your pharmacy benefit and for any prescription purchased without presenting your medical benefit ID card.

Please note: Some prescriptions require step therapy. Generic medications provide the same therapeutic benefits as brand name medications, and at a significantly lower cost in most cases. The Step Therapy Program requires trial and failure of a generic medication prior to filling a prescription for a brand name or non-generic medication.
Filling a Prescription

You have multiple options for filling your prescription, including Swedish pharmacies, retail network pharmacies and mail order.

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<thead>
<tr>
<th>You may fill a prescription at...</th>
<th>If you need...</th>
<th>To find a pharmacy or ask questions...</th>
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</thead>
</table>
| • Retail network pharmacies      | • 30-day supply | • Visit [www.medimpact.com](http://www.medimpact.com)  
|                                  |                | • Call (888) 678-7779                 |
| • Swedish pharmacies             | • 90-day supply (through Choice90 program) | • Visit [www.medimpact.com](http://www.medimpact.com)  
|                                  |                | • Call (888) 678-7779                 |
| • MedImpact mail order (Postal Prescription Services) | • 90-day supply for chronic, long-term conditions | • Visit [www.ppsrx.com](http://www.ppsrx.com)  
|                                  |                | • Call (880) 552-6694                 |
| • Providence Specialty Pharmacy mail order | • 30-day supply of specialty medication | • Call (800) 772-7053, Option 4 |

Note: If you use the MedImpact mail order service, you will pay the 90-day copay even if your prescription is written for less than a 90-day supply.

MedImpact guarantees that all prescriptions will meet the highest pharmaceutical standards for safety, quality and effectiveness. A record of your prescriptions is maintained by MedImpact to monitor for adverse reactions with other prescriptions you may receive from a Swedish pharmacy, a retail network pharmacy or the mail order service. A pharmacist will contact you or your doctor before dispensing a medication if there is a concern for possible drug interactions or adverse reactions.

**Swedish Pharmacy or Retail Network Pharmacy**

With the retail pharmacy program, you may receive up to a 30-day supply of medication. With a Swedish pharmacy, you may receive up to a 90-day supply.

An extensive nationwide network of pharmacies has agreed to dispense covered prescription drugs to Plan participants at a discounted cost and not to bill you for any amounts over the copays. All major chain pharmacies and most independent pharmacies participate in the MedImpact network. Please refer to the website [www.medimpact.com](http://www.medimpact.com) or contact customer service at (888) 678-7779 for a complete list of participating pharmacies. A partial list includes:

- Albertsons/CVS
- Bartell Drug
- Costco
- Fred Meyer
- Kmart
- Rite Aid
- Safeway
- Target
- Walgreens
- Wal Mart

Non-network pharmacies are not covered. To avoid a delay in receiving your prescription, access the MedImpact Pharmacy Locator at [www.medimpact.com](http://www.medimpact.com) or contact MedImpact at (888) 678-7779 to confirm your pharmacy is included in the network.

**Mail Order Service**

If you or a covered family member regularly take medication for chronic, long-term conditions such as diabetes, arthritis, high blood pressure, heart conditions, etc., you may receive up to a 90-day supply of these maintenance medications through Postal Prescription Services. The prescription will be delivered directly to your home.
How to use the Mail Order Program

- If your doctor prescribes a maintenance drug, have your prescription written for up to a 90-day supply with three refills. By law, a prescription can only be filled for the quantity indicated by your doctor.
- If you need medication immediately, ask your doctor for two separate prescriptions — one for a 21-day supply to be filled at a retail network pharmacy and one to be filled by mail.
- Examine the prescription to make sure it includes the dosage and the doctor’s signature along with your name, address and phone number.
- Complete the Confidential Patient Profile and Enrollment Form — which you’ll receive along with ID cards, for you and your eligible family members — and mail the form with your first prescription order in the postage-paid envelope. This form needs to be completed only with your first mail order service prescription. If you have additions or changes to your medical condition, please notify the mail order service in writing.
- Make sure to write your ID number on the back of each prescription.
- If your medications are not delivered to your home within 7 to 10 working days, call the MedImpact Customer Service Center at (888) 678-7779.
- Order refills through Postal Prescription Services at the www.ppsrx.com website (member will need to register online first) or call Postal Prescription Services at (800) 552-6694.

Please place your order for a refill by mail three (3) weeks before your current supply runs out and allow fourteen (14) days for delivery of your medication. Your copay can be made by check or credit card. Do not send cash.

To obtain additional details about the mail order pharmacy benefit, please contact Postal Prescription Services at (888) 678-7779, or www.medimpact.com.

Covered Medications

The following is a partial list of covered prescription items. Please access the MedImpact Formulary Lookup tool at www.medimpact.com or contact MedImpact at (888) 678-7779 to verify your prescription is covered:

- Contraceptives (oral, injectable, vaginal, topical and implantable)
- Controlled substance 5 drugs (federal legend drugs under jurisdiction of the Controlled Substances Act; medications consist of preparations containing limited quantities of certain narcotic drugs, generally for cough and anti-diarrheal purposes)
- Emergency allergic reaction kits
- Emergency contraceptives
- Insulin and diabetic supplies including alcohol swabs, blood glucose monitoring kits, diagnostic testing agents, glucose tablets, lancets, insulin injections (including auto injections) and insulin syringes
- Legend drugs unless otherwise specified
- Nutritional supplements (may require prior authorization)
- Smoking cessation drugs requiring a prescription (One treatment cycle lifetime maximum benefit).
Questions and Answers about Generic Drugs

Q. Are there any important differences between generic drugs and brand drugs?

A. No. Generic drugs are made from the same chemical compound as their brand name counterparts and are manufactured according to the same standards as brand drugs, with FDA approval for safety and effectiveness.

Q. Why do generic drugs cost less?

A. When a company develops a new drug, it has a 20-year patent period when no other company can sell the drug. This eliminates competition and causes the price to stay high. During this 20 years, the company is able to recover research and development costs. In contrast, generic drugs do not encounter these high costs.

Q. What happens after the 20-year patent period ends?

A. A generic version of the drug will be released and you can switch to the generic from the brand. However, many physicians continue to prescribe the drug by its brand name because of its familiarity, which keeps the brand price high. The competition between companies offering the generic version keeps the generic price low. Unlike brand drugs, generic drugs are not advertised, which also helps keep the price down. Whenever possible you should ask your doctor if a generic equivalent is available in place of your brand name medication.

Q. What does this mean to you and Swedish?

A. By asking your physician to prescribe a generic drug, you get a quality medication at a fraction of the brand price.

Q. Do companies test generic drugs?

A. Yes. The Food and Drug Administration (FDA) requires testing by generic manufacturers to prove their drugs will give the same results as the brand drugs.

Q. Does the FDA monitor the quality of generic drugs as closely as brand drugs?

A. Yes. Whether brand or generic versions, all approved drugs must meet the same FDA standards of quality. All manufacturers are subject to periodic inspection and all must follow the FDA’s Good Manufacturing Practice Regulations. The FDA periodically collects samples of all drug products — both generic and brand, from manufacturers and the marketplace — to be tested in the agency’s labs for purity and strength.

Q. Do shape and color affect generic drug performance?

A. No. You can be assured the difference in shape or color has no effect on the way the drug works. Medications have unique codings for ease in identification.

Q. Is there a generic version available to fill my prescription?

A. Ask your pharmacist. Chances are a lower-priced, generic version of the drug your doctor prescribed is available. The FDA has now approved over 8,000 generic versions of a wide variety of drugs.
Pharmacy Exclusions and Limitations

- Anorectics (any drug used for the purpose of weight loss)
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order
- Charges for the administration or injection of any drug
- Diagnostic tests
- Drugs labeled Caution: Limited by federal law to investigational use or experimental drugs, even though a charge is made to the individual
- Drugs used for cosmetic purposes, including but not limited to drugs such as Botox, Minoxidil (Rogaine), Tretinoin (Retin A)
- Fluoride
- Immunological agents, biological sera, blood or blood plasma
- Impotency drugs, including but not limited to Viagra
- Infertility medications
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed medical facility, rest home, sanitarium, extended care facility, convalescent medical facility, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Non-legend drugs other than insulin, except certain over-the-counter drugs required under the Patient Protection and Affordable Care Act
- Non-systemic contraceptives and implants, such as diaphragms, IUDs, cervical caps which would be covered through the medical benefits; or condoms which are over-the-counter, except over-the-counter contraceptives as required under the Patient Protection and Affordable Care Act
- Nutritional supplements
- Prescriptions which an eligible individual is entitled to receive without charge from any Workers’ Compensation laws
- Renova
- Replacement of lost or stolen medications/items
- Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, except those listed above
- Vitamins, singly or in combination, except prenatal and federal legend vitamins to treat covered medical conditions
Eligibility and Enrollment

Eligible Classes of Employees

Individuals are eligible to enroll for coverage if they meet the following criteria:

• Active Swedish Medical Center and Swedish Medical Group employees who complete the 30-day waiting period and have a payroll status of Full Time Equivalency (FTE) of .5 or above.

The following individuals are not eligible to enroll in the Plan:

• An employee who is enrolled as a dependent on another Swedish Health Services employee’s medical plan;
• An individual who performs services for Swedish Health Services under an independent contractor or consultant agreement or arrangement with Swedish Health Services;
• An individual who is a leased employee within the meaning of Internal Revenue Code Section 414(n);
• An individual who is classified on Swedish Health Services’ books or records as a temporary or contract employee;
• An individual covered by a collective bargaining agreement that does not specifically provide for participation in the Plan, provided that the type of benefits provided under the Plan were the subject to good faith bargaining between the individual’s bargaining representative and Swedish Health Services; or

Waiting Period

Regular employees (see Plan Definitions section), not including resident physicians, are eligible the first of the month following 30 days of employment in an eligible class.

Swedish Health Services resident physicians are eligible for benefits on the date of hire, regardless of the day of the month, if so stated in their individual contract, provided the completed benefits enrollment form is received by the HR Service Center on or before the resident physician’s start date.

The completed benefits enrollment must be completed within 31 days of hire date; once received, benefits become effective the first day of the following month (or if received on the first day of the month, benefits are effective that same day). Benefits for new hires cannot be effective retroactively.

Initial Enrollment

Eligible employees and dependents must enroll within 31 days of becoming eligible for coverage, unless otherwise specified (such as later adding a newborn dependent). The enrollment period begins with the date of the event. The 31-day period does not begin as of the date of data entry into Lawson or the date enrollment materials are sent during any open enrollment.

Note: Resident physicians and their eligible dependents must enroll on or before their date of hire for benefits to begin on their hire date.

Once you have submitted your enrollment and coverage is in effect (see Effective Date section), you will not be able to make a change to your elections without a qualifying event even if you are still within the enrollment period.
If a completed enrollment application is not received by the Plan Administrator within the 31 days of the employee’s initial eligibility date, the next opportunity to enroll is the open enrollment period unless the employee experiences a new qualifying event or special enrollment that allows coverage to be added prior to open enrollment. (see Changes in Enrollment section).

**How to Enroll**

To enroll, review the enrollment information on www.myswedishbenefits.com and then enroll for benefits by logging on to Lawson Employee Self Service.

- On the Swedish network: http://provcon.providence.org
- From outside the Swedish network: https://provconnect.providence.org

It is very important that the enrollment is complete and accurate within the 31 days of your hire or becoming eligible for benefits. Incomplete information will result in delayed eligibility, delayed access to benefits and non-payment of claims.

Discovery of false or misrepresented information will result in the complete nullification of coverage and you will be held financially responsible for any benefits paid. Examples of false or misrepresented information are failing to provide requested information, providing incorrect or incomplete information, enrolling an ineligible dependent, and failing to comply with the Plan’s requirements for eligibility. It is your responsibility to notify the HR Service Center at (888) 687-3753 of any dependent eligibility changes in a timely manner during the Plan year.

**Open Enrollment**

Open enrollment is a defined period when eligible employees may enroll or make changes to health care benefit coverage, including dependent coverage. Open enrollment occurs once each Plan year. Under no circumstances will you be able to change the medical plan elections outside of open enrollment, except as described in the Changes in Enrollment section.

**Changes in Enrollment**

You may enroll in the Plan or change your coverage elections outside of open enrollment if you experience one of the qualifying events described below.

To enroll or change your coverage elections, you must submit a Benefit Change Form and required documentation to the HR Service Center within 31 days of the qualifying event, or within 60 days for birth, adoption or placement for adoption. Generally, changes you request are considered qualifying status changes. However, if the requested change is also a special enrollment right, you are entitled to additional flexibility in adding other eligible dependents to your coverage.

Unless otherwise noted, coverage will begin on the first day of the month following the month in which your enrollment process is completed. If you need assistance in completing the enrollment process within the available period, contact the HR Service Center at (888) 687-3753 or submit an Ask HR ticket after logging into Lawson Employee Self Service.
**Change in Status Event**

You may request to change your coverage elections if you experience certain changes in status that affect your or your dependent’s eligibility under the Plan as described below:

- Gaining a new dependent through marriage, birth, adoption, or placement for adoption (see *Special Enrollment Rights*).
- Divorce, legal separation, and annulment, or change in domestic partner status.
- Gaining legal guardianship of a minor.
- Death of your spouse, domestic partner, or dependent.
- Your dependent child newly meeting eligibility requirements or no longer meeting eligibility requirements, (e.g. reaching the maximum age for coverage).
- Any change in your or your dependent's status with another employer that affects eligibility under the Plan or another employer-sponsored benefit plan under which you or your dependent are covered including: new employment, termination, changing from full-time to part-time, changing from part-time to full-time, leave of absence, change in worksite, strike or lockout (See *Special Enrollment Rights*).
- A significant change in contributions and coverage under your dependent’s employer’s plan.
- A change in benefit elections by you or your dependent during another employer’s annual open enrollment period if such open enrollment occurs at a different time than the Swedish Health Services open enrollment.

Any election change based on a change in status event must be consistent with and on account of the change. For example, if you get married, you may enroll your spouse under the Plan. Alternatively, if you get married and enroll in coverage under your spouse’s employer’s plan, you may drop your coverage under the Plan.

If you decide to change your election due to a change in status, you must notify the HR Service Center by completing the Benefits Change Form and providing the required documentation *within 31 days* of the later of the change in status event or loss of coverage due to the change in status event. If you acquire a new dependent as a result of birth, adoption, or placement for adoption, you must notify the Plan Administrator *within 60 days* of this change in status event. Coverage will begin on the first day of the month following the month in which your enrollment process is completed.

**Judgment, Decree, or Order**

If a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in custody (including, for example, a Qualified Medical Child Support Order) requires you to provide coverage for a child under the Plan, you may revoke your election for coverage mid-year and make a new election for the coverage required under the judgment, decree, or order. Similarly, if a judgment, decree, or order requires your former spouse to provide coverage for a dependent child who had been enrolled in the Plan, and your former spouse actually provides the coverage, you may drop coverage for your child and thereby change your election accordingly.

Changes made as a result of a judgment, decree, or order will be effective on the first of the month following the order date if the enrollment form and copy of the order is received by the HR Service Center within 31 days of the date of the order. If the enrollment form and copy of the order is received by the HR Service Center more than 31 days after the date of the order, coverage will become effective on the first of the month following the date the HR Service Center receives the enrollment information for coverage.
Medicare or Medicaid Entitlement

You may also change an election for Plan coverage mid-year if you or your dependent becomes entitled to coverage under Medicare (Part A or Part B) or Medicaid, or loses eligibility for coverage under Medicare (Part A or Part B) or Medicaid. However, you are limited to reducing your Plan coverage only for the individual who becomes entitled to Medicare or Medicaid, and you are limited to adding Plan coverage only for the individual who loses eligibility for Medicare or Medicaid.

If you decide to change your election under these circumstances, you must do so within 31 days of the date the individual becomes eligible for or loses eligibility for Medicare or Medicaid (within 60 days for a loss of Medicaid eligibility).

Significant Changes in Coverage

If the Plan’s coverage is significantly limited or improved (as determined by the Plan Administrator), you may make corresponding election changes for you and your affected dependents.

If you decide to change your election due to a significant change in coverage, you must do so within 31 days of the effective date of the change.

Significant Changes in Cost

If your share of the cost for a coverage option increases significantly due to your status changing from full-time to part-time benefits status during the Plan year, you may elect to pay the increased cost for your current coverage, remove enrolled dependents from your coverage, or revoke your coverage if there is no similar coverage option.

If your share of the cost for a coverage option decreases significantly due to your status changing from part-time to full-time benefits status during the Plan year, you may elect to add dependents to your coverage and pay the corresponding change in cost.

Any change in the cost of the Plan that is not significant (as determined by the Plan Administrator) will result in an automatic increase or decrease, as applicable, in your required contribution for coverage. You won’t be allowed to change your coverage elections if the cost change is not significant.

If you decide to change your election due to a significant change in cost, you must do so within 31 days of the effective date of the change in cost.

Changes in a Dependent’s Coverage under Another Employer-Sponsored Plan

If you or a covered dependent are covered under another employer’s plan you may make a change to your Swedish Health Services medical plan coverage under the following circumstances:

1. If the annual enrollment period under the other employer-sponsored plan occurs at a time of year that is different from the Swedish Health Services medical plan enrollment period and if you or your dependent changes his or her elections under the other employer-sponsored health plan, you may make an election change to the Swedish Health Services medical plan that corresponds with the election change under the other employer-sponsored plan.

2. If the other employer-sponsored plan allows you or your dependent to change elections during the Plan year, and if you or your dependent changes his or her elections, you may make an election change to this Plan that corresponds with the election change under the other employer-sponsored plan.

If you decide to change your election due to a coverage change under another employer’s group health plan, you must do so within 31 days of the effective date of such change.
**Special Enrollment Rights**

You may enroll yourself and your eligible dependents in the Plan outside of open enrollment when certain events occur that result in a loss of coverage under another health plan, when you acquire a new dependent, or when your eligibility for benefits under Medicaid or a state children’s health insurance program changes, as follows:

- **Loss of Coverage** – You or your dependent waived coverage under the Plan at the time this coverage was previously offered because you or your dependent had other medical coverage (an election to waive coverage acts as an affirmative statement of having such other coverage), but you or your dependent subsequently lost the other group health plan coverage for any of the following reasons:
  - You or your dependent exhausted COBRA continuation coverage under another employer’s group health plan (other than due to a failure to pay contributions or for cause).
  - Employer contributions toward the other group health plan coverage terminate.
  - You or your dependent loses eligibility under the other health plan (other than due to a failure to pay contributions or for cause), as a result of legal separation, divorce, cessation of dependent status, death, termination or reduction in hours of employment.

- **Changes to Eligibility for Medicaid or a State Children’s Health Insurance Program** – You or your dependent:
  - Lose eligibility for coverage under a Medicaid plan or a state children’s health insurance program, and as a result coverage is terminated; or
  - Become eligible for a premium assistance subsidy for the Plan under Medicaid or a state children’s health insurance program.

- **New Dependent** – When you gain a dependent through marriage, birth, adoption, or placement for adoption, you may enroll yourself and any eligible dependents who are not already enrolled in the Plan. For example, in the case of the birth or adoption of a child, you and your spouse may also enroll if you are otherwise eligible for coverage but not already enrolled.

If you enroll an eligible dependent child during the 60-day special enrollment period, the coverage becomes effective retroactively as of the date of birth, adoption or placement for adoption.

To take advantage of these special enrollment rights under Federal regulations, you must contact the HR Service Center at (888) 687-3753 to enroll yourself and/or your dependents who are eligible for special enrollment within 31 days for Loss of Coverage described above or your gaining a dependent through marriage.

You must contact the HR Service Center to enroll yourself and/or your dependents who are eligible for special enrollment within 60 days if the special enrollment event is your gaining a dependent through birth, adoption, or placement for adoption or is related to changes in Medicaid or state children’s health insurance program coverage.

**Late Enrollment**

Late enrollments are not accepted. An enrollment is late if it is not submitted within the timeframe set forth in the sections Enrollment Period, Open Enrollment and Special Enrollment Rights sections.
Effective Date

Effective Date of Coverage for You

For newly hired employees, coverage starts on the first day of the month after you have completed 30 days of service, as outlined in the table below.

<table>
<thead>
<tr>
<th>Hire date</th>
<th>Effective date for benefits</th>
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<tr>
<td>November 2 – December 1</td>
<td>January 1</td>
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<td>December 2 – January 2</td>
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<td>January 2 – January 29</td>
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<tr>
<td>October 2 – October 31</td>
<td>December 1</td>
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If you have a status change that makes you benefit-eligible and you have been employed by Swedish Health Services for more than 30 days, your coverage will begin on the first day of the month after you enroll, or on the same day if you enroll on the first day of the month – as long as you enroll within 31 days of the day you become eligible for benefits.

Note: You must enroll within 31 days of your hire date or the date you move to a benefits-eligible position.

If you do not complete your enrollment within 31 days of eligibility, you will automatically be enrolled into the Plan with employee-only coverage. You will not be able to change the default coverage until open enrollment for the next Plan year unless you experience a qualifying event (see Changes in Enrollment section).

If you have problems enrolling for coverage, contact the HR Service Center at (888) 687-3753 for assistance during your enrollment period.

Effective Date of Coverage for Your Dependents

If you have one or more eligible dependents on the date that you become covered under this Plan and you elect to enroll them, they will be covered on the date your coverage becomes effective. Only dependents for which you have submitted an enrollment election, not just added them to the Dependent Information, and paid any required premiums will be covered. Your dependent will not be covered if you do not enroll him or her within 31 days (60 days in the case of birth, adoption or placement for adoption) of the date he or she is eligible for coverage. Late enrollments are not accepted.
Deferred Effective Date of Your Coverage or an Increase in Coverage

If you are not at work due to an unpaid leave of absence on the effective date of insurance, your coverage will not become effective until the date you return to a benefits-eligible, scheduled basis.

You will be deemed to be at work on such date only if you were at work on the day before and the day after such period of time.

Effective Date for Adding Dependents (Other than Newborn and Adopted Children)

Any dependents added after your effective date of coverage will be covered on the first day of the month coincident with or following the HR Service Center receiving your completed Benefits Change Form and required documentation for any such dependent and payment of any required premiums. The HR Service Center must receive the form within 31 days of the date the dependent becomes eligible for coverage. If you do not complete the enrollment within 31 days, the dependent will be considered a late enrollee and cannot be enrolled until open enrollment for the next Plan year.

Employee and Spouse/Domestic Partner are Both Employees

If an employee and spouse/domestic partner are both employees of Swedish Health Services and are eligible for benefits, each employee must enroll separately, and may not cover each other as dependents.

Children whose parents are both Swedish Health Services employees may be enrolled under only one parent.

If you have a covered family member who becomes eligible for benefits due to his/her own employment status, you must contact the HR Service Center to cancel his/her coverage within 31 days.

Spouse/Domestic Partner Surcharge

A monthly surcharge of $250 will be applied to spouses/domestic partners who are eligible for their own primary group medical plan coverage (whether enrolled or not) and enroll in this Swedish Health Services medical plan as a dependent.

If you enroll your spouse/domestic partner on the Swedish Health Service medical plan, you may declare whether he or she has access to other coverage through a link on Lawson Employee Self Service. Or you will receive a request from ConSova, the Plan’s dependent eligibility administrator, that is to be completed by you and your spouse/domestic partner declaring whether other employer group coverage is available. ConSova will send the declaration to your home address on record at the time of mailing. Reminder emails may also be sent to your work email address.

If you do not return the declaration by the deadline indicated, the surcharge will be applied.

If your spouse/domestic partner gains or loses employer coverage mid-year, the change should be reported to the HR Service Center at (888) 687-3753 within 31 days so the surcharge can be adjusted prospectively.

Waiver of Group Health Plan Benefits

As an eligible employee, you may waive coverage only if you have other medical coverage and can provide proof of other coverage. If you waive coverage, you may not enroll your dependents — a dependent is not eligible for coverage unless the eligible employee also enrolled.
Dependents

Dependent Eligibility

Dependents become eligible to enroll in the Plan on either the day you become eligible or the day you acquire your dependent, whichever is later. Dependents are eligible for enrollment in the group health plan only if you are also enrolled. Dependents include:

- Lawful spouse (as defined by state law where the employee permanently resides)
- Domestic partner (same or opposite sex) who meets the criteria for eligibility (you must sign an affidavit regarding eligibility of your domestic partner, or be registered as domestic partners with the State of Washington); see Plan Definitions;
- Natural child, adopted child, child placed with you for legal adoption, stepchild, foster child, child of domestic partner, or other legally designated ward up to age 26 (through age 25); or,

Eligibility may be continued for your children if they are disabled and enrolled for coverage on the Plan at the time they reach age 26. See Continued Eligibility for a Disabled Child section for more information. Children age 26 or older are not eligible for new enrollment on the Plan.

A child who loses dependent status for coverage eligibility under this provision may be eligible for continuation of coverage under COBRA (See COBRA section).

A domestic partner, or child of a domestic partner, who loses coverage eligibility under any circumstances is not eligible for COBRA. However, the Plan Sponsor (Swedish Health Services) will offer comparable continuation coverage under the health benefit plan (see Continuing Coverage for Domestic Partners section).

Dependents do not include:

- A spouse who is legally separated or divorced;
- A spouse, domestic partner or child living outside the United States or Canada;
- A spouse, domestic partner or child employed by Swedish Health Services who is eligible for employee coverage under the Plan;
- Any person who is on active duty in any armed forces of any country;
- Your or your spouse’s natural child for whom you have given up rights through legal adoption;
- A parent of an employee, spouse/domestic partner; or
- The child, spouse/domestic partner or other dependent of an enrolled child.

Special Rules for Domestic Partners

- The domestic partner of an enrolled dependent is not eligible for coverage.
- A domestic partner who loses coverage eligibility under any circumstances is not eligible for COBRA as a Qualified Beneficiary. However, the Plan Sponsor (Swedish Health Services) offers comparable continuation coverage under this Plan.
- Coverage for a domestic partner (and children of a domestic partner) who is not a federal tax dependent, is subject to imputed income for the total value of coverage.
Dependents Acquired Through Marriage/Domestic Partnership

If you acquire a new dependent through marriage or domestic partnership and want to add the dependent to your coverage mid-year, the HR Service Center must receive a completed Benefit Change Form and a copy of the marriage certificate, affidavit of domestic partnership, or state certification of domestic partnership within 31 days after the marriage/start of the domestic partnership, or your new dependent will not be able to enroll until the next open enrollment.

Coverage for your new dependent will become effective on the first of the month following the month in which your enrollment process is completed, provided all required documentation is received within 31 days of the date of lawful marriage, or the date the domestic partnership is established.

Dependent Children

Children whose parents are both Swedish Health Services employees may enroll under only one parent (see Special Rule section).

Natural Newborn Children

If you have a baby, the HR Service Center must receive the Benefits Change Form and required documentation within 60 days from the date of birth. In order for coverage to exist for a newborn, the child must be enrolled within this timeframe. If enrolled, coverage becomes effective on the date of birth.

Adopted Children Acquired

Any child under age 18 you legally adopt or who is placed with you for adoption is eligible on the date of placement. A child is considered placed for adoption when you become legally obligated to support that child totally or partially as defined under the regulations before the legal adoption. If the child is placed but not adopted, all group health plan benefits stop when the placement ends and will not be continued.

If the Benefits Change Form, with documentation to support legal adoption or placement for adoption, is received by the HR Service Center within 60 days of placement, coverage becomes effective on the date of placement. The Plan Administrator may request added information.

Children Acquired Through Legal Guardianship

If the Benefits Change Form, with documentation of the court order of legal guardianship, is received within 31 days of obtaining legal guardianship, dependent coverage becomes effective on the first of the month coincident with or following the date the HR Service Center receives the completed enrollment. The Plan Administrator may request added information.

Judgment, Decree, or Order

If a judgment, decree, or order resulting from a divorce, legal separation, annulment, or change in custody (including, for example, a Qualified Medical Child Support Order) requires you to provide coverage for a child under the Plan, you may make a new election for the coverage required under the judgment, decree, or order. If you do not make an election due to a qualifying court order, an election may be made for you to comply with the qualifying court order. Similarly, if a judgment, decree, or order requires your former spouse to provide coverage for a dependent child who had been enrolled in the Plan, and your former spouse actually provides the coverage, you may drop coverage for the child.
Changes made as a result of a judgment, decree, or order will be effective on the first of the month following the date the Plan Administrator receives the court order and enrollment information for coverage.

**Dependent Children Out of Area**

To receive the network level of coverage, medically necessary care for covered services must be provided by First Choice Health PPO Network providers within Washington, Oregon, Alaska, Montana, Idaho, Wyoming, North Dakota and South Dakota.

The First Health Network is available for network benefits to:

- Participants who live outside the FCHA service area due to work, COBRA, student status or qualified charitable activity status.
- All participants for emergency and urgent care when traveling.

A full description of the provider networks is in the *How to Obtain Health Services* section.

**Continued Eligibility for a Disabled Child**

Coverage may be extended beyond age 26 if the following criteria are met:

- The child must have been diagnosed with the impairment and covered under the Swedish plans before age 26;
- The child is incapable of self-sustaining employment due to developmental disability or physical handicap, as defined and determined by the Social Security Administration (SSA). The impairment must be listed by SSA and documentation of the existence of a child's impairment must come from medical professionals defined by SSA regulations as acceptable medical sources; and
- The child depends primarily on you for support and can be claimed by you as a dependent on your federal tax return.

Contact the HR Service Center at (888) 687-3753 for details and enrollment forms. For continued eligibility of a disabled child, the enrollment form must be received within 31 days of the date the child reaches age 26. Thereafter, employees are required to resubmit proof of continued disability upon request by the Plan Administrator.

A disabled child will continue to be eligible for coverage until

- The employee participant fails to submit proof of dependence due to disability or physical handicap,
- The Plan Administrator determines that the child no longer meets the disabled child eligibility criteria of the Plan,
- The employee removes the dependent from coverage during open enrollment, or
- If coverage terminates for the employee or the dependent due to any of the reasons noted under *Termination of Coverage*.

**Qualified Medical Child Support Orders**

Swedish Health Services will provide medical coverage to certain children (called alternate recipients) if directed by a Qualified Medical Child Support Order (QMCSo) (defined in ERISA §609(a)), including benefits for adopted children in accordance with ERISA §609(c). The participant, the child’s custodial parent, or a state agency administering Medicaid may submit notification.
A medical child support order:

- Is any 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 date of the order if the enrollment form and a copy of the medical child support order is received within 31 days of the date of the order. If received after 31 days, coverage becomes effective on the first of the month after the QMCSO is received.
- 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.

The enrollment form, along with a copy of the medical child support order needs to be received within 31 days of the order in order for coverage to become effective on the first day of the month coincident with or following the receipt of the qualifying order. If the enrollment information is received after 31 days of the order, coverage will become effective on the first of the month following the date we receive the qualifying order or enrollment information for coverage.

Proof of Dependent Status

When you enroll a dependent for the first time, either during your initial enrollment, open enrollment or during the year due to a qualifying event, you will be asked to provide documentation showing that your dependent is eligible. If due to a qualifying event, you are required to provide the documentation with your Benefits Change Form.
ConSova Corporation (ConSova), a dependent eligibility administrator, verifies dependent eligibility upon your initial enrollment and following open enrollment. ConSova will send mail to your home or may email you at your Swedish email address with instructions on how to document your dependent’s eligibility. This communication will include a specific deadline for you to complete the process and provide necessary documentation.

If the requested documentation is not received in its entirety by the deadline, or within the enrollment/change period, or is incomplete, or does not provide sufficient evidence of meeting the eligibility requirements of the Plan, either the person will not be enrolled or an existing enrollment of the non-qualified individual will be cancelled for the Plan year on a prospective basis.

The Plan reserves the right to request documentation to verify the eligibility of your dependents after they are enrolled for coverage. The Swedish Health Services medical plan, Swedish, insurance carriers, third party administrators or other third parties designated by Swedish, may request documentation needed to verify the relationship, including but not limited to birth certificates, adoption records, marriage certificates, verification of domestic partnership, and tax documentation.

Additionally, requests for verification may originate from the Benefits Department, the HR Service Center or ConSova.

Employees who have ineligible dependents enrolled in the medical, dental, or vision Programs may be subject to other consequences as outlined under Consequences of Enrolling Ineligible Dependents.

Consequences of Enrolling Ineligible Dependents

If you enrolled an individual for coverage under the Plan who is not eligible for coverage, the Plan reserves the right to:

• Take employee disciplinary action up to and including termination for fraudulent use of the Swedish Health Services medical plan.
• Retroactively terminate dependent coverage to the original effective date or, effective the end of the month in which a dependent became ineligible but was not reported to the Plan.
• Cancel coverage retroactively to the date of ineligibility (rescission of coverage), if you commit fraud or material misrepresentation. You will have appeal rights under the rescission of coverage rules of the Patient Protection and Affordable Care Act.
• Hold you personally liable to refund to Swedish all medical, dental, and vision benefits provided during the ineligible period including claims costs or monthly premiums.
• Terminate any rights to temporary, continued coverage under COBRA.

Swedish is not liable to repay you for any medical, dental, or vision monthly premium share(s) paid by you during the ineligible period.

If your dependent is no longer eligible for coverage, you must notify the HR Service Center at (888) 687-3753 within 31 calendar days of the date that your dependent no longer meets the eligibility criteria under a Swedish medical plan.

COBRA and other continuation coverage will not be available to individuals removed from coverage due to a determination of ineligible for enrollment as a dependent on the Plan.
Termination of Coverage

For participating employees, coverage ends when:

• You do not make a payment for which you are responsible
• You no longer meet eligibility requirements for coverage (see Eligibility and Enrollment); coverage ends the last day of the month of the date you are no longer an eligible or active employee
• You or your dependent(s) perform an act or practice that constitutes fraud or intentionally misrepresents material facts under the terms of this policy
• The policy is materially breached
• The Plan Sponsor ceases to offer coverage

For participating dependents, coverage ends when:

• The date the employee’s coverage ends for any reason
• The last day for which any required Plan contributions are paid
• The last day of the month in which the participant dies
• The participating employee and spouse legally divorce (the HR Service Center must receive a copy of the decree); or there is a change in a qualifying condition for domestic partner eligibility
• The date a dependent child reaches age 26, unless disabled (see Continued Eligibility for a Disabled Child)

Rescission of Coverage

Your Plan coverage may be cancelled or discontinued retroactively only if: (1) you fail to make timely, required contributions for coverage, or (2) the cancellation or discontinuance is not considered to be prohibited under the Patient Protection and Affordable Care Act of 2010 (PPACA) and applicable guidance.

Your Plan coverage may be rescinded if you perform an act, practice or omission that constitutes fraud on an enrollment form or in a claim for benefits, or if you make an intentional misrepresentation of material fact to the Plan Administrator regarding any information material to your eligibility for benefits. The Plan Administrator will provide you with written notice at least 30 days in advance of the rescission of your coverage. Any rescission of coverage is treated as an adverse benefit determination. A retroactive termination due to your failure to pay is not considered a rescission.

Related Details

• Coverage is automatically extended through the last day of the month of the termination, provided the applicable contribution for the coverage period has been paid. Participants receive a Certificate of Creditable Coverage (see Continue Group Health Coverage/ Certificate of Creditable Coverage) that shows the coverage period under this Plan. (Contact the HR Service Center at (888) 687-3753 for more information.)
• If you lose coverage eligibility as a result of terminating employment, a reduction in your FTE status, or a general suspension of Plan coverage, then again become eligible because employment or Plan coverage resume, only the most recent eligibility period will be considered for determining whether you are a late enrollee.
• If your share of the Plan contribution is paid on a pre-tax basis through a §125 Cafeteria Plan, enrollment into this Plan is a one-year commitment. You can request to change your elections mid-year only as permitted under §125 regulations. Contact the HR Service Center with questions.
• The Plan requires 31 days written notice for dependent coverage termination.
• A terminated employee who is rehired more than 30 days after termination will be treated as a new hire for benefit purposes and be required to satisfy all eligibility and enrollment requirements. A terminated employee rehired after a termination period of 30 days or less will maintain all elections in place prior to the termination.

If you or your dependents lose coverage under this Plan, you may be eligible to continue coverage. For more information, read the COBRA section or ask your Plan Administrator.
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

If your coverage terminates under this group health plan, you may be eligible under COBRA to continue the same coverage you had when coverage ended, on a temporary self-pay basis.

COBRA requires this continuation of coverage be made available to covered persons — called qualified beneficiaries under COBRA — on the occurrence of a qualifying event, described below.

Continuation of coverage under COBRA is not automatic. You must elect COBRA by completing and properly providing an enrollment form to your Plan Administrator. Contact your Plan Administrator, or the Plan Administrator’s designated COBRA third party administrator and apply for continuation of your group health plan coverage within 60 days of the termination of coverage. You will also be required to pay applicable contributions for you and/or your dependent(s) directly to the Plan.

COBRA Plan Administrator:

First Choice Health Administrators
One Union Square,
600 University Street, Ste 1400,
Seattle, WA 98101.

If you have COBRA related questions you may call FCHA at (877) 749-2032 to speak with a COBRA representative.

This Plan provides no greater COBRA rights than what COBRA requires. Nothing in this Group Health Summary Plan Description is intended to expand your rights beyond COBRA’s requirements.

This section describes your COBRA coverage rights; contact the Plan Administrator for more information.

Who Is a COBRA Qualified Beneficiary?

Employees and covered eligible dependents who participate in the Plan may be eligible for COBRA in the case of a qualifying event if they are also a qualified beneficiary. Qualified beneficiaries include:

- Employees enrolled in the Plan on or before the date of the event that causes them to lose that coverage (called the qualifying event)
- An employee’s spouse enrolled in this Plan on the day before the qualifying event
- The employee’s dependent children enrolled in this Plan on the day before the qualifying event
- Dependent children born to, or placed for adoption with, the employee while the employee has COBRA coverage
- Dependent children acquired through legal guardianship while the employee has COBRA coverage
- Dependent children covered under medical child support orders while the employee has COBRA coverage

Please note: Domestic partners and children of domestic partners are not eligible for COBRA or other continuation of coverage, however Swedish Health Services will offer comparable continuation coverage under the Swedish Health Services medical plan for up to 18 months.
A qualified beneficiary may choose to continue any one benefit, or all of the benefits that he/she was enrolled in prior to the qualifying event.

Certain qualified beneficiaries may have additional COBRA rights and possible tax credits if they are certified by the Department of Labor or state labor agencies as eligible under the Trade Adjustment Assistance Reform Act of 2002. (Contact the Plan Administrator for more details.)

Qualifying Events and Continuation Periods

Qualifying events and continuation periods are explained below. A Qualified Beneficiary must lose coverage as a result of the listed event in order to be eligible for COBRA.

• If employment terminates (voluntary or involuntary), you and your covered dependents may continue coverage under this Plan for up to 18 months unless the cause is gross misconduct
• If your work hours are reduced, resulting in loss of group coverage, you and your covered dependents may continue coverage under this Plan for up to 18 months
• If you and your spouse legally divorce or are legally separated, your spouse and covered dependent children may continue coverage under this Plan for up to 36 months
• When your covered dependent child no longer meets the Plan’s definition of dependent child, the child may continue coverage under this Plan for up to 36 months
• When you become Medicare eligible, your Medicare-ineligible covered dependents may continue coverage under this Plan for up to 36 months
• If you die your spouse or covered dependents may continue coverage under this Plan for up to 36 months
• If you enter into uniformed service you may elect to continue Plan coverage for up to 24 months (See also Military Leave under Other Continuation of Coverage section)
• If while covered under COBRA you (or a COBRA-eligible dependent) become disabled, you may be eligible for a coverage extension. The 18-month COBRA coverage period may be extended another 11 months for a total of 29 months COBRA coverage. To qualify for this disability extension you must:
  ─ Meet the definition of disability under Title II or XVI of the Social Security Act at the time of the qualifying event or within the first 60 days of COBRA coverage
  ─ Provide the Plan Administrator with notice of the disability determination (from Social Security) on a date that is both within 60 days after the determination date and before the original 18-month coverage ends. If the disabled beneficiary is later determined by Social Security to no longer be disabled, the Plan Administrator must receive notice within 31 days of that determination date

Secondary COBRA Qualifying Events

If your spouse or dependent child experiences a secondary COBRA qualifying event during your 18- or 29-month COBRA period, he/she may continue COBRA coverage for up to a total of 36 months from the date you lost active coverage because of termination of employment or a reduction in your hours. During this extension period, COBRA coverage will cost 102% of the cost of coverage.

A secondary COBRA qualifying event occurs when your dependent loses coverage because one of these events occurs during your 18- or 29-month COBRA period:

• You die
• You divorce
• Your dependent child no longer satisfied the eligibility requirements of the plan.
When COBRA Coverage Ends

COBRA coverage ends before the 18-, 29-, or 36-month period expires for any of these reasons:

• The Plan no longer provides group health coverage to any employees
• The COBRA coverage premium is not paid within 31 days of the due date (the initial grace period is 45 days after the first COBRA election)
• The qualified beneficiary becomes covered under another group health plan with no applicable pre-existing condition exclusion or limit
• The qualified beneficiary enrolls in Medicare
• If an extension from 18 to 29 months was granted due to a disability and the individual receives a final determination from the Social Security Administration stating the individual is no longer disabled the individual must notify the plan administrator within 31 days after the date of that determination. Coverage ends on the last day of the month through which contribution payments have been received, so long as that date is within the first month that begins within 31 days after the final determination date, and after the initial 18-month COBRA coverage period.

**Please note: Once COBRA coverage ends it cannot be reinstated.**

Contribution Payment Requirements

You are required to pay any and all applicable contributions for you and your covered dependents. You must pay the first contribution for continuation of coverage within 45 days of the date you elect COBRA coverage. Contributions consist of the full cost of coverage, plus 2% (a total of 102%).

If you are eligible and receive a disability extension under Title II or XVI of the Social Security Act, your contribution may be 150% of the full cost of coverage.

If the cost for similarly situated active employees or dependents changes, then the COBRA coverage premium also changes. (This generally happens only once a year before the Plan year begins).

Failure to make payments within the designated timeframe will result in automatic termination of coverage to the last day of the month for which a complete payment was made. Payments need to be sent directly to First Choice Health Administrators at One Union Square, 600 University Street, Ste 1400, Seattle, WA 98101. If you have COBRA related questions you may call FCHA at (877) 749-2032 to speak with a COBRA representative.

Election Requirements

At the time of a qualifying event, such as termination of employment or reduction in hours, the qualified beneficiary must be notified of the right to continue coverage within 14 days of FCHA receiving notice of the qualifying event from the Plan Administrator.

In the case of divorce, legal separation or the ineligibility of a dependent, the employee or qualified beneficiary is responsible for notifying the Plan Administrator within 60 days of the divorce, legal separation or ineligibility of a dependent. The Plan is not obligated to offer COBRA benefits to beneficiaries if this notification is not received within the 60 days.
Notification must be sent to the attention of the Plan Administrator at:

Swedish Health Services
HR Service Center, Suite 500
2001 Lind Ave. SW
Renton WA 98057
(888) 687-3753

What Coverage Must Be Offered When Electing COBRA?

The Plan is required to continue the following coverage for COBRA participants:

- **Identical coverage** – you and your covered dependents must be offered the opportunity to continue the coverage received immediately before the qualifying event

- **Independent rights** – once a qualifying event occurs each you and your covered dependents have an independent right to elect continuation coverage. For example, if an employee and family are offered COBRA coverage, each individual can make an election. Although an active employee must be covered to cover a dependent, it is possible to have COBRA coverage for a dependent when the former employee does not elect to continue coverage

- **Open enrollment** – you and your covered dependents must be notified of any benefit or carrier changes at open enrollment and be given the opportunity to change coverage just like active employees. You have the same rights as active employees during open enrollment to add or drop family members, change coverages and change carriers, if available. However, if you add a family member during open enrollment who was not previously covered, that added family member does not become eligible for benefits

- **Modification of coverage** – if an employer modifies coverage for similarly situated active employees, your COBRA coverage must be modified similarly. Some examples of modifications include benefit enhancements, elimination of coverage and changes in carriers
Other Continuation of Coverage

Leaves of Absence

*Family Medical Leave Act of 1993 (FMLA) Leaves*

The FMLA gives employees on FMLA leave the same rights and privileges as active employees. The FMLA allows an eligible employee to take 12 weeks of leave each year (during a rolling backward calendar year).

If you are granted an authorized leave of absence from work, you will receive more information from Sedgwick CMS, the leave of absence service provider, regarding continuing coverage under this group health plan during the approved leave time as long as you pay your required contribution. Since continuation of coverage under this provision is not extended automatically, please contact Sedgwick CMS for more information. Any and all applicable monthly contributions must be paid in accordance with the agreement established before the leave.

If your leave is a paid leave, the contribution costs will continue to come out of your paycheck as a deduction. If your leave is unpaid, you are responsible for paying your share of contributions directly.

*Personal Leave of Absence*

Plan benefits will continue to the end of the month you receive pay from vacation accruals as long as you have vacation time remaining and are receiving a paycheck. Then, benefits will terminate at the end of the month for which you receive your last paycheck. (You’ll receive information about the option of continuing health benefits on a self-pay basis under COBRA.)

*Non-FMLA Medical Leaves of Absence*

Plan benefits will continue to the end of the month you receive pay from your sick and annual leave/vacation accruals. Once you exhaust all paid time (sick and vacation), benefits will terminate at the end of the month for which you receive your last paycheck. Eligible employees will receive information about the option of continuing health benefits on a self-pay basis under COBRA.

*Military Leave*

If you take a military leave, for active duty or training, you will be covered under the Plan’s health benefits as if you were an active employee, as long as you are in an active paid status. You will receive more information from Sedgwick CMS, the leave of absence service provider, regarding your options for continuing coverage while on your approved military leave.

*All Leave of Absences*

If your coverage has been terminated you may be eligible to re-enroll within 31 days of returning to work in a benefit-eligible status. There is no automatic re-enrollment process. Contact the HR Service Center at (888) 687-3753 if you have further questions.
Continuing Coverage for Domestic Partners

If you’re the domestic partner of an active employee and the active employee loses eligibility for coverage under this Plan due to a COBRA qualifying event, you will not be eligible for COBRA coverage independent of the employee. However, you may be eligible for continuation of the same group health plan coverage under a COBRA-like continuation. In this coverage, eligibility, notice and other rights consistent with COBRA requirements will be offered to a domestic partner, or a child of a domestic partner for up to 18 months from the termination of coverage date under your group health plan. Please contact the HR Service Center (888) 687-3753 for more information.

You must notify the HR Service Center within 31 days of a domestic partnership ending. You’re responsible to repay any Plan payments made for the domestic partner if you do not notify the Plan Administrator about the change in status within the 31 days.
Claim and Appeal Procedures

Claim

A claim means any request for a Plan benefit made by you (claimant) or your authorized representative (an individual acting on behalf of the claimant in obtaining or appealing a benefit claim). The authorized representative must be designated as such in writing with a form signed by the claimant (except for urgent care benefits or urgent care appeals). Once an authorized representative is selected, all information and notifications should be directed to that representative until the claimant states otherwise.

How to File a Claim for Plan Benefits

In most cases, network providers, hospitals and licensed vision providers submit claims for you, and there are no claim forms for you to complete. If you do receive a bill for services from a provider, write your name, participant ID number and group number on the bill and send a copy to the claim address on your ID card. (Your group number can also be found on your ID card.) Any bill you submit must contain:

- Provider name
- Provider tax ID information
- Specific dates of service
- Diagnosis codes (ICD-9 codes) or description of the symptoms or a diagnosis
- Specific procedure codes (CPT codes) or description of the medical service or procedure.
- Specific procedure codes (CDT codes) or description of the dental service or procedure.

Claims should be submitted to First Choice Health Administrators (FCHA ) for medical benefits and MedImpact Healthcare Systems for pharmacy benefits. It is best to submit charges as soon as possible. However, claims must be received within 12 months from the date the service or supply was rendered or received. Claims will not be considered for benefits if received after this timeframe. (See your ID card for the FCHA claim address.) Contact the HR Service Center (888) 687-3753 or submit an AskHR ticket after logging into Lawson Employee Self Service) regarding claim forms.

Claim Types

- Pre-service claim means any claim for which the Plan requires approval before medical care is obtained.
- Concurrent claim means any claim reconsidered after initial approval for an ongoing course of treatment which results in a reduced or terminated benefit.
- Post-service claim means any claim for a Plan benefit that is not a pre-service claim and is a request for payment or reimbursement for covered services already received.
- Urgent-care claim means a claim for medical care or treatment that, would in the opinion of a physician with knowledge of the claimant’s medical condition:
  - Seriously jeopardize the claimant’s life, health or ability to regain maximum function
  - Subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested.
Claim Procedure

The Plan Sponsor has final authority over appeals as the appropriate named fiduciary, however the Plan delegates to First Choice Health Administrators (FCHA) and MedImpact Healthcare Systems, as it relates to benefits issues, the authority, responsibility and discretion to:

- Interpret and construe Plan provisions, as necessary
- Reach factually supported conclusions
- Make a full and fair review of each denied claim under ERISA requirements, as amended.

Benefit issues include questions regarding medical necessity, health care setting, level of care, experimental or investigational treatment, cost-sharing requirements or other limits on otherwise covered benefits.

All claims for benefits are subject to a full and fair review within a reasonable time appropriate to the medical circumstances. Payment of any benefits will be subject to the applicable deductibles, coinsurance, co-pays and benefit maximums. FCHA or MedImpact Healthcare Systems will notify the claimant in writing of the decision of claim review.

It is important to note the Plan Administrator (Providence Health & Services through a Shared Services Agreement with Swedish Health Services, the Plan Sponsor) holds the authority, responsibility and discretion to deny claims based on administrative issues such as questions of eligibility status for you, your spouse and your dependents; change in status; special enrollment; termination and continuation of coverage; and qualified medical child support orders. The same appeal process (an ERISA mandated process) described below applies to administrative issues, however such appeals are handled by the Plan Administrator, not FCHA or MedImpact Healthcare Systems.

Adverse Benefit Determination

An adverse benefit determination means a denial, decrease or termination of a benefit. This includes a failure to provide or make payment — in whole or in part — for a benefit based on:

- A determination that a benefit is not covered by the Plan;
- A determination based on an individual’s eligibility to participate in the Plan, or to receive plan benefits at the time of service. (These appeals are considered administrative and handled by the Plan Administrator, see Claim Procedure above.);
- A determination that a service is experimental, investigational or not medically necessary; and/or
- A rescission of coverage. (These appeals are considered administrative and handled by the Plan Administrator.)
The different claim types have specific times for approval, payment, request for information or denial, as shown below:

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Notice of Incorrectly Filed Claim – Notice to Claimant</th>
<th>Notice of Incomplete Claim – Notice to Claimant</th>
<th>Initial Benefit Determination by FCHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Claim</td>
<td>5 days</td>
<td>Not required (may be part of extension notice)</td>
<td>Reasonable period = 15 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>15-day extension with notice to claimant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reasonable period suspended up to 45 days on incomplete claim</td>
</tr>
<tr>
<td>Concurrent Claim</td>
<td>n/a</td>
<td>n/a</td>
<td>In time to permit appeal and determination before treatment ends or is reduced</td>
</tr>
<tr>
<td>Post-Service Claim</td>
<td>n/a</td>
<td>Not required (may be part of extension notice)</td>
<td>Reasonable period = 30 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>15-day extension with notice to claimant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reasonable period suspended up to 45 days on incomplete claim</td>
</tr>
<tr>
<td>Urgent Care Claim</td>
<td>24 hours</td>
<td>24 hours</td>
<td>As soon as possible, taking into account the medical exigencies, but not later than 72 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No extensions from claimant</td>
</tr>
</tbody>
</table>

If your claim is denied wholly or in part, you will receive a written notice of adverse benefit determination. For a denial of a pre-service claim such notice will be in the form of a letter from FCHA explaining the denial. For a post-service claim your Explanation of Benefits (EOB) will serve as your notice of adverse benefit determination. Both will include information necessary to identify the claim, such as the date of service, provider name, amount billed, and a statement describing the availability, upon request, of the diagnosis and treatment codes (along with the corresponding meanings of those codes), as well as the reason for the denial(s), which will include:

1. For pre-service claims, the standards for medical necessity relied upon in making the adverse benefit determination (denial). (for example, an explanation of the scientific or clinical judgment used in making the decision) if applicable;

2. Reference to the specific Plan provisions on which the determination is based;

3. Reference to any internal Plan rule, guideline, protocol or similar criterion relied upon in making the decision, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request.
In addition to the above information, the notice of adverse benefit determination will also include:

1. A description of any additional material or information needed to support your claim and an explanation of why it is needed;

2. A description of the available internal and external review processes (as also outlined below), including information about how to initiate the appeal process;

3. A statement that you have the right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the claim;

4. A statement of your right to bring a civil action under Section 502(a) of ERISA following a final denial by the Plan;

5. In the case of a denial of an urgent care claim, a description of the expedited appeal procedures applicable to such claims; and

6. Contact information for the Employee Benefits Security Administration toll-free at (866) 444-EBSA (3272).

**Appeal Procedure**

First Choice Health Administrators (FCHA) performs functions associated with the internal review of medical appeals for this Plan. Pharmacy appeals are handled by MedImpact Healthcare Systems, Inc. Providence Health & Services, through a Shared Services Agreement with Swedish Health Services has final authority over appeals as the appropriate named fiduciary.

If your claim is denied wholly or in part, you have the right to request an internal review of an adverse benefit determination (commonly referred to as an appeal). Upon request, you may obtain free of charge reasonable access to, and copies of, all documents, records and information relevant to your claim for benefits, and relied upon in making the adverse benefit determination. You may also request the name of the health care expert who reviewed your claim for medical necessity or experimental or investigational care or treatment.

If your situation is urgent you may call the FCHA Appeals Coordinator at (877) 749-2031. An urgent care situation is one in which, in the opinion of a physician with knowledge of the claimant's medical condition, the application of the time periods for making non-urgent care determinations could seriously jeopardize the claimant's life, health, or ability to regain maximum function; or would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

For all other appeals you may submit them in writing to the following addresses:

**Medical Appeals:**

First Choice Health Administrators  
Attn: Appeals Coordinator  
600 University Street, #1400  
Seattle, WA 98101  
Fax: (206) 258-2920

**Pharmacy Appeals:**

MedImpact Healthcare Systems, Inc.  
Attention: Appeals Department  
10680 Treena St., Stop 5  
San Diego, CA 92131
Internal Review

You, or your authorized representative, must file your appeal within 180 days of the date you receive the adverse benefit determination or else you lose the right of appeal. The appeal must be in writing and sent to the address noted above.

The appeal should include comments, documents, records and/or other information noting the reason you feel your claim should have been approved. FCHA will send a letter acknowledging receipt of your appeal within five calendar days.

FCHA’s designated Appeals Coordinator will prepare your documents and any applicable documentation from the Summary Plan Document for review and discussion by the FCHA Appeals Committee or Medical Director (the individual who made the original adverse benefit determination will not be involved in the internal appeal process).

FCHA will provide you with any new or additional evidence or rationale and any other information and documents used in the appeal review of your claim without regard to whether such information was considered in the initial determination. Any such new or additional evidence or rationale and information will be provided to you sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond.

The committee or Medical Director will review the information and make a recommendation to either uphold or overturn the original adverse benefit determination, and such recommendation will be sent to the Plan Administrator for a final decision. FCHA will notify you in writing of the decision to either uphold the original denial or overturn it within 30 calendar days of pre-service claims or 60 calendar days if your appeal involved a post-service claim. If the determination is to uphold the original denial, the letter will also include information on how to initiate the next level of appeal (External Review) if the determination is based on medical judgment.

If the determination is not based on medical judgment, the letter will advise you of your right to file a civil action for benefits under ERISA §502(a)(1)(b).

Note: a decision regarding an urgent care claim will be made as soon as possible, but not later than 72 hours after receipt of a request for internal review if a delay would jeopardize the member’s or their dependent’s health.

External Review

For standard internal appeals, you have the right to request external review (for appeal denials based on medical judgment) after you have completed the required internal appeals process and you have received a final appeal denial. For expedited internal appeals, you may request external review simultaneously with your request for an expedited internal appeal. The Independent Review Organization (IRO) will determine whether or not your request is appropriate for expedited external review or if the expedited internal appeals process must be completed before external review may be requested.

External review may not be requested for a claim denial involving a post-service claim until the internal appeals process has been exhausted. You will be deemed to have exhausted the internal appeals process and may request external review if FCHA waives the internal appeals process or FCHA has failed to comply with the internal claims and appeals process. External review may only be requested for post-service claim denials that are based on medical judgment.

Standard External Review

The Plan offers an external review, if the FCHA Appeals Committee decides to uphold the original denial, and such denial involves a rescission of coverage or is based on medical judgment. Denials that do not involve medical judgment (i.e., denials that involve only contractual or legal interpretation without any use of medical judgment) are not eligible for external review.
You must first submit your claim for internal review, and receive a final internal adverse benefit determination before you may request external review. The request for external review must be received within 125 calendar days of receipt of the final internal adverse benefit determination.

Within five calendar days of the receipt of a request for external review, FCHA will conduct a preliminary review to determine whether the claim is eligible for external review, and will send you notification of its decision within one business day thereafter. This notice will include the following:

- If your request is found ineligible for external review, the reason for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number (866) 444-EBSA (3272))
- If your request is eligible for external review but not complete, a description of any additional information or materials required to complete your request
- If your request is complete and eligible for external review, contact information for the Independent Review Organization (IRO) assigned by FCHA, and details about your right to provide additional information.

If eligible for external review, FCHA will forward your appeal (including all information and documentation considered in both the original denial and the internal review, as well as any additional documentation you submit) to an Independent Review Organization (IRO). The IRO consists of independent physicians or other specialists that are not associated with FCHA or Swedish Health Services. If applicable, they will also possess medical training specific to the appeal.

The IRO will notify you that your appeal has been received, and will allow you at least 10 business days to submit any additional information to the IRO that you wish to be considered in reviewing your appeal. The IRO will review all information submitted, make a determination, and notify both you and FCHA of the results within 45 calendar days.

**Expedited External Review**

You will be entitled to request an expedited external review if you receive either of the following:

- An adverse benefit determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the claimant’s life or health or would jeopardize the claimant’s ability to regain maximum function, provided that he/she has already filed a request for an expedited internal appeal.
- An appeal denial that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize the claimant’s life or health or would jeopardize his/her ability to regain maximum function, or if the appeal denial concerns an admission, availability of care, continued stay, or health care item or service for which he/she received emergency services, but have not been discharged from a facility.

Immediately upon the receipt of a request for an expedited external review, FCHA will conduct a preliminary review to determine whether the claim is eligible for expedited external review, and will immediately send you notification of its decision that includes the information described in Standard External Review above.

If eligible for expedited external review, FCHA will forward your appeal (including all information and documentation considered in both the original denial and the internal review, as applicable, as well as any additional documentation you submit), to an IRO. The IRO will review all information submitted, make a determination, and notify both you (or your authorized representative) and FCHA of the decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to you and FCHA.
Exhaustion

You have a right to file a civil action for benefits under ERISA §502(a)(1)(b) after you exhaust these claim procedures; the civil action must be filed within 180 days from your receipt of the Plan’s final determination regarding your claim.
Coordination of Benefits

This section describes how benefits are paid when you or a dependent are covered by more than one plan. Coordination of Benefits (COB) means that one plan pays its benefits first (the Primary Plan), and the other plan pays second (the Secondary Plan). If a third plan is involved (a Tertiary Plan) that plan would pay after both the primary and secondary plans have paid.

Coordination of Benefits ensures that you do not receive more in benefits than what you would otherwise be responsible to pay for the care or treatment you receive.

Calculation of Benefit Payments

The Primary Plan always pays its benefits as if you were not covered under any other plan.

The Secondary Plan pays its benefits taking into account what the Primary Plan has already paid. Similarly, a Tertiary Plan pays benefits after taking into account what the primary and secondary plans have paid. When this Plan is secondary to another plan, benefits will be calculated according to the following steps:

1. This Plan will calculate the amount it would have paid if it were your Primary Plan.

2. Next, any payment made by your Primary Plan will be subtracted from this amount. The difference remaining (if any) will be the secondary payment available from this Plan.

**Example 1**

<table>
<thead>
<tr>
<th>Allowed Amount</th>
<th>$150</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount this Plan would pay if Primary</td>
<td>$135</td>
</tr>
<tr>
<td>- (minus) amount paid by Primary Plan</td>
<td>$100</td>
</tr>
<tr>
<td>= (equals)</td>
<td>$35 (this Plan’s secondary payment)</td>
</tr>
</tbody>
</table>

**Example 2**

<table>
<thead>
<tr>
<th>Allowed Amount</th>
<th>$200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount this Plan would pay if Primary</td>
<td>$155</td>
</tr>
<tr>
<td>- (minus) amount paid by Primary Plan</td>
<td>$185</td>
</tr>
<tr>
<td>= (equals)</td>
<td>(-$30) (no payment is made by this Plan)</td>
</tr>
</tbody>
</table>

*Important note: in these examples, and in most other claim situations using this calculation method, there is still a balance owed to the provider. This balance is your responsibility.*

There are different ways in which a plan may calculate its benefit payment when it is the Secondary Plan. If this Plan is your Primary Plan (as determined by the rules in the following paragraphs), refer to your Secondary Plan’s Coordination of Benefits rules to find out how its benefits are calculated when secondary.
How Do I Know Which Plan is my Primary Plan?

The rules in this section determine the order in which your plans pay benefits (i.e., which plan is your Primary Plan, and which is your Secondary Plan, also known as the order of benefits). If you have Medicare coverage in addition to coverage under this Plan, refer to the What if I’m Covered by Medicare? section for more information.

These rules are intended to be applied in the order in which they are listed (i.e., if the order of benefits can be determined by Rule 1, but Rule 3 also speaks to your situation, Rule 1 will determine the order of benefits). If you are covered by more than one secondary plan, these rules also determine the order in which the secondary plans’ benefits are determined in relation to each other.

1. **Dependent or non-dependent:**

   A plan covering a person an active employee, retiree, member or subscriber pays before a plan covering a person as a dependent.

   If you are a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as an active employee, retiree, member or subscriber (according the rules under What if I’m Covered by Medicare?) then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is secondary to the plan covering the person as a dependent.

2. **Child covered under more than one plan:**

   A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      1) The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

      2) If both parents have the same birthday, the plan that has covered the parent longest is the Primary Plan.

   B. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

      1) If a court decree states that one of the parents is responsible for the dependent child’s health care expenses or health care coverage, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child’s health care expenses, but that parent's spouse does, that parent's spouse’s plan is the primary plan. This does not apply to any Plan year during which benefits are paid or provided before the plan has actual knowledge of the court decree provision.

      2) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary.

      3) If a court decree states that both parents are responsible for the child’s health care expenses or health care coverage, or that the parents have joint custody without mentioning financial responsibility or responsibility for health care expenses, the birthday rule of the policy holders determines the order of benefits.

      4) If there is no court decree allocating responsibility for the child’s health care expenses or health care coverage, the plans covering the child pay in the following order:

         a. The plan covering the custodial parent
b. The plan covering the custodial parent’s spouse

c. The plan covering the non-custodial parent

d. The plan covering the non-custodial parent’s spouse

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits is determined as if those individuals were parents of the child.

5) If there is no court decree that allocates responsibility for the child’s health care expenses or that specifies a custody arrangement (for example, if the child is over 18), the birthday rule of the policy holders will determine the order of benefits.

3. **Active or inactive:**

A plan covering a person as an active employee or dependent of an active employee pays before a plan covering a person as a retiree, laid-off or inactive employee or dependent of a retiree, laid-off or inactive employee.

This rule does not apply if Rule 1 can determine the order of benefits.

4. **COBRA or State Continuation Coverage:**

If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

This rule does not apply if Rule 1 can determine the order of benefits.

5. **Length of coverage:**

If none of the preceding rules establish which plan pays first, the plan that has covered the person the longest is primary. To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended. The start of a new plan does not include:

A. A change in the amount or scope of a plan’s benefits;

B. A change in the entity that pays, provides or administers the plan’s benefits; or

C. A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

A person’s length of time covered under a plan is measured from the person’s first date of coverage under that plan. If that date is not readily available, the date the person first became a member of the group must be used as the date to determine the length of time the person’s coverage under the present plan has been in force.

**Note:** This Plan is always primary to TRICARE CHAMPVA state Medicaid programs and the Indian Health Service (IHS).
What if I’m Covered by Medicare?

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan that covers a person as an active employee or dependent of an active employee. Medicare is primary in most other circumstances.

• **Age** — If you are covered under this Plan as an active employee or a dependent of an active employee (excluding domestic partners) and you become entitled to Medicare because of reaching age 65, this Plan will be primary. If you are covered under this Plan after your sixth month of receiving disability benefits, as a domestic partner or as a COBRA qualified beneficiary (i.e., not as an “active” employee for Medicare purposes or a federally-recognized spouse of an active employee) and are also entitled to Medicare based on age, Medicare is primary.

• **Disability** — If you are covered under this Plan as an active employee or dependent of an active employee (including domestic partners) and become entitled to Medicare due to disability, this Plan will be primary. Once you or your dependent is declared disabled by Social Security, the disabled individual should apply for coverage under Medicare Parts A and B. If you are covered under this Plan after your sixth month of receiving disability benefits or as a COBRA qualified beneficiary (i.e., not as an “active” employee for Medicare purposes) and are also entitled to Medicare based on disability, Medicare is primary.

• **End Stage Renal Disease (ESRD)** — If you become entitled to Medicare on the basis of ESRD, this Plan will pay primary during the initial coordination period (refer to the Medicare Secondary Payer Manual at www.cms.gov/manuals/downloads/msp105c02.pdf for more information regarding the initial coordination period). After this initial coordination period, this Plan will pay secondary to Medicare. This is true even if you are covered under this Plan as a domestic partner or COBRA qualified beneficiary.

  **Important note:** this Plan will not pay benefits for dialysis services normally allowed under Medicare Part B when, by law, Medicare Part B would be primary and you are eligible for, but not enrolled in, Medicare Part B coverage.

In all cases, this Plan will act in accordance with federal law when determining its status as either primary or secondary when Medicare is the other plan. Please visit the website of the Centers for Medicare and Medicaid Services at www.cms.gov for more information.

Pre-authorization when this Plan is Secondary

With the exception of transplant services (which always require pre-authorization), pre-authorization is not required if this Plan is your secondary plan. First Choice Health will honor a determination of medical necessity made by your primary plan. This means that if your primary plan determines a service to be medically necessary, this Plan will apply its normal benefit, subject to all other Plan provisions and exclusions. If your primary plan determines a service to be not medically necessary, coverage under this Plan will be denied. Benefits which are excluded by your primary plan but payable under this Plan are subject to medical review by First Choice Health Administrators or MedImpact Healthcare Systems, Inc.

Meaning of Plan for COB

For COB purposes, the term “Plan” means any agreement for benefits or services from any of the following sources for medical or other covered health care services:

• This Swedish Health Services medical plan (the Plan with a capital “P”)
• Group and non-group insurance contracts and subscriber contracts
• Uninsured arrangements of group or group-type coverage
• Group and non-group coverage through closed panel plans
• Group-type contracts ("group-type contract" means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. It does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.)
• The medical care components of long-term care contracts, such as skilled nursing care
• The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts
• Medicare or other governmental benefits, as permitted by law "Plan" does not include:
• Hospital indemnity coverage benefits or other fixed indemnity coverage
• Accident only coverage
• Specified disease or specified accident coverage
• School accident type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a to-and-from-school basis
• Benefits provided in long-term care insurance policies for non-medical service, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services
• Medicare supplemental policies
• A state plan under Medicaid
• A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

If in any situation the rules contained in this section cannot determine the order of benefits, this Plan will follow the NAIC Model COB Regulation as its basis for determining the order of benefits in these extenuating circumstances.

Claim Determination Period

The claim determination period used when applying this COB provision is the Plan year, January 1 through December 31.

Right of Recovery

If the Plan pays in excess of the maximum under the COB provision, the Plan will exercise the right to recover the excess payments from any person(s), insurer(s) or other organizations, as the Plan deems appropriate.

This Plan will not seek to recover funds on any claim with a date of service that is more than 365 days prior to the date on which the Plan receives (receipt date) information regarding a participant’s other coverage.
Facility of Payment

When another plan makes payments that should have been made under this Plan and in accordance with this provision, the Plan may, at its sole discretion, elect to reimburse to the other plan the amount necessary to satisfy the intent of this COB provision. Any amount paid under this subsection will be considered benefits paid under this agreement, and the Plan will be fully discharged from liability under this agreement to the extent of those payments.

This Plan will not make any additional payment on a claim with a date of service that is more than 365 days prior to the date on which the Plan receives (receipt date) information regarding a participant’s other coverage.

Right to Receive and Release Information

The Plan Administrator and FCHA may, with consent as required by law, receive or release to another insurer or organization any information concerning the participant and covered benefits deemed necessary to implement and determine the applicability of this COB provision.

The Plan Administrator and FCHA have the right to require the participant to complete and return a Multiple Coverage Inquiry when primary liability is not clearly established or to verify that multiple coverage information on hand is accurate. Claim payment will be withheld until the Multiple Coverage Inquiry is complete and received by FCHA.
Subrogation

Liable Third Parties and Insurers

If the Plan makes payments on your behalf for injury or illness another party is liable for, or injury or illness covered by uninsured/underinsured motorists (UIM) or personal injury protection (PIP) insurance, the Plan is entitled to be repaid for those payments out of any recovery from that liable party. (The liable party is also known as a third party because it is a party other than you or the Plan, including your UIM and PIP carriers because they represent a third party and because the Plan excludes coverage for such benefits.)

Subrogation means the Plan can collect directly from third parties, to the extent the Plan has paid for illness or injury caused by the third party, to recover those expenses.

To the fullest extent permitted by law, the Plan is entitled to the proceeds of any settlements or judgments that result in the recovery from a first or third party, up to the amount of benefit paid by the Plan for the condition, whether or not you have been made whole by such settlement. In recovering those amounts, the Plan Administrator, Plan Sponsor and/or FCHA may either hire their own attorney or be represented by your attorney. If the Plan chooses to be represented by your attorney, the Plan will pay, on a contingent basis, a reasonable portion of the attorney’s fees necessary for asserting right of recovery in the case. This portion will not exceed 20% of the amount the Plan seeks to recover, unless in the Plan Administrator’s sole discretion, determines not sharing a larger portion of the fees would be inequitable given the facts of a particular case. The Plan will not pay for any legal costs incurred by or for you, and you won’t be required to pay any portion of the costs incurred by or for the Plan.

Before accepting any settlement on your claim against a third party, you must notify FCHA’s Subrogation Department in writing of any terms or conditions offered in a settlement, and you must notify the third party of the Plan’s interest in the settlement (established by this provision). You must also cooperate with the Plan in recovering amounts paid on your behalf. If you retain an attorney or other agent to represent you in the matter, you must require your attorney or agent to reimburse the Plan directly from the settlement or recovery proceeds.

To the maximum permitted by federal law, the Plan has the right to:

• Sue the third party in your name
• Have a security interest in and a lien on any recovery up to the amount paid by the Plan and for its expenses in obtaining a recovery
• Recover benefits directly from the third party.

However claims, recoveries, etc. are classified or characterized by the parties, the courts or any other entity will not affect your responsibilities described above or the Plan’s entitlement to first dollar recovery, regardless of whether you are made whole.

Uninsured/Underinsured Motorist Coverage

If the Plan pays for services also covered by uninsured/underinsured motorist coverage, despite the exclusion above, the Plan has the right to be reimbursed for benefits provided from any proceeds of that UIM or PIP coverage.
Venue

All suits or legal proceedings (including arbitration proceedings) brought against the Plan by a participant or anyone claiming any right under this contract, and all suits or legal proceedings brought by the Plan against a participant or other party, will be filed within the appropriate statutory period of limitation. In all suits or legal proceedings brought by the Plan or brought against the Plan, venue may lie, at the Plan’s option, in King County, state of Washington.

Subrogation Forms

The participant will be required to complete a Subrogation Questionnaire, a Subrogation Agreement form and Authorization for Release of Information when details of the injury or condition do not clearly indicate if there is third party liability. Claims are denied 30 days after the forms have been mailed if they are not both completed and returned in their entirety, and until the Incident Response Questionnaire and Subrogation Agreement forms are completed and returned.
Health Insurance Portability and Accountability Act of 1996

Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides you certain rights with respect to the use and disclosure of your protected health information. Below is a copy of the Swedish Health Services HIPAA Privacy Notice.

NOTICE OF PRIVACY PRACTICES THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

The Health Plans

This Notice describes the privacy practices of the following health benefits programs offered by Swedish Health Services and its participating affiliates (collectively referred to as the “Health Plans”):

- Medical, dental, vision and employee assistance program (EAP) benefits offered by Swedish Health Services Employee Benefit Plan;
- Health care flexible spending account benefits provided under the Swedish Health Services Cafeteria Plan (a component benefit under the Swedish Health Services Employee Benefit Plan); and
- These Health Plans provide health benefit to eligible Swedish employees and their eligible dependents.

If you have any questions about this Notice, please contact:

Privacy Contact
Program Director, Benefits Compliance
Providence Health & Services
2001 Lind Avenue SW, Suite 500
Renton, Washington 98057
Contact through the HR Service Center: (888) 687-3753

Privacy Officer
Compliance Privacy Manager
Swedish Health Services
747 Broadway
Seattle, WA 98122
Contact through Integrity Line: (888) 294-8455 or use Web-based reporting tool, Integrity Online

As required by the Health Insurance Portability and Accountability Act of 1996, as amended by the Health Information Technology for Economic and Clinical Health Act (“HITECH”) and the Modifications to the HIPAA Privacy, Security, Enforcement, and Breach Notification Rules under the Health Information Technology for Economic and Clinical Health Act and the Genetic Information Nondiscrimination Act; Other Modifications to the HIPAA Rules (collectively “HIPAA”), this Notice describes the legal obligations of Swedish Health Services and the Swedish Health Services medical plan (the Plan) regarding your protected health information (“PHI”) held by the Plan.

“We” as referenced in this section, may refer to the Plan, the Plan Administrator and/or FCHA.
Among other things, this Notice describes how your PHI may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

PHI means any information, including demographic information, that is created or received by a covered entity or an employer and relates to:

- The past, present, or future physical or mental health or condition of an individual;
- The provision of health care to an individual; or
- The past, present, or future payment for the provision of health care to an individual; and
- That identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information concerning persons living or deceased and may be written, oral, or electronic.

We understand that your PHI is personal. We are committed to protecting your PHI. We create a record of the health care claims reimbursed under the Plan for Plan administrative purposes.

This Notice applies to all of the medical records we maintain in connection with the Plan’s group health plan benefits. Your personal doctor or health care provider may have different policies or notices regarding the doctor’s use and disclosure of your PHI created in the doctor’s office or clinic. An insurer that insures group health plan benefits of the Plan may have different policies or notices regarding the insurer’s use and disclosure of your PHI created by the insurer.

This Notice tells you about the ways in which we may use and disclose your PHI. It also describes our obligations and your rights regarding the use and disclosure of your PHI.

Our Responsibilities

We are required by law to:

- Maintain the privacy of your PHI;
- Provide you with certain rights with respect to your PHI;
- Provide you with this Notice of our legal duties and privacy practices with respect to your PHI; and
- Follow the terms of the Plan’s Notice of Privacy Practices that are currently in effect.

How We May Use and Disclose Your PHI

The following categories describe different ways that we use and disclose PHI. For each category of uses or disclosures we explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

For Treatment (as described in the Privacy Regulations). We may use or disclose your PHI to facilitate medical treatment or services by providers. We may disclose your PHI to providers, including doctors, nurses, technicians, medical students, or other hospital personnel, who are involved in taking care of you.

For Payment (as described in the Privacy Regulations). We may use and disclose your PHI to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. Likewise, we may share your PHI with another entity to assist with the adjudication or subrogation of health claims or to another plan to coordinate benefit payments.
For Health Care Operations (as described in the Privacy Regulations). We may use and disclose your PHI for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use your PHI in connection with:

- Conducting quality assessment and improvement activities;
- Underwriting, premium rating, and other activities relating to Plan coverage;
- Submitting claims for stop-loss (or excess loss) coverage;
- Conducting or arranging for medical review,
- Legal services, audit services, and fraud abuse detection programs;
- Business planning and development such as cost management; and business management and general Plan administrative activities.

The Plan may not use or disclose PHI that constitutes genetic information for underwriting purposes.

Plan Administrator — For purposes of administering the Plan, through a Shared Services Agreement with the Plan Sponsor, the Plan may disclose your PHI to certain employees of Providence Health & Services. However, those employees will only use or disclose that information to perform Plan administration functions, including payment and health care operations, or as otherwise required by HIPAA or state law, unless you have authorized further disclosures. Your PHI cannot be used for employment purposes without your specific authorization. For a more detailed explanation of the limited ways that we may use or disclose your PHI, please refer to the Plan document and/or any applicable amendments.

Business Associates — We contract with service providers — called business associates — to perform various functions on its behalf. For example, the Plan contracts with a service provider (FCHA) to perform the administrative functions necessary to pay your claims for medical benefits. To perform these functions or to provide the services, business associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the business associate agree in writing to contract terms requiring the business associate to appropriately safeguard your PHI. The Plan will comply with requirements of HIPAA and its requirements to provide notification to affected individuals, the Department of Health & Human Services, and the media (when required) if the Plan or one of its business associates discovers a breach, as defined under HIPAA, of unsecured PHI.

Organized Health Care Arrangement — Swedish Health Services and its affiliates and the insurers, if any, of benefits provided under the group health plans are an organized health care arrangement within the meaning of the Privacy Regulations. As such, members of the organized health care arrangement may share your protected health information with each other to carry out payment and health care activities on behalf of the group health plans.

Other Covered Entities — We may use or disclose your PHI to assist health care providers in connection with their treatment or payment activities, or to assist other covered entities in connection with certain health care operations. For example, the Plan may disclose your PHI to a health care provider when needed by the provider to render treatment to you. The Plan may disclose PHI to another covered entity to conduct health care operations in the areas of quality assurance and improvement activities, or accreditation, certification, licensing, or credentialing. This also means that the Plan may disclose or share your PHI with other health care programs or insurance carriers in order to coordinate benefits, if you or your family members have other health insurance or coverage.

As Required by Law — We will disclose your PHI when required to do so by federal, state, or local law. For example, we may disclose your PHI when required by a court order in a litigation proceeding such as a malpractice action.
To Avert a Serious Threat to Health or Safety – We may use and disclose your PHI when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would only be to someone able to help prevent the threat. For example, we may disclose your PHI in a proceeding regarding the licensure of a physician.

Disclosures to Your Personal Representative and Family Members

Your Personal Representative — The Plan will disclose your PHI to an individual who has been designated by you as your personal representative and who has qualified for such designation in accordance with relevant law. Prior to such a disclosure, however, the Plan must be given written documentation that supports and establishes the basis for the personal representation. The Plan may elect not to treat the person as your personal representative if it has a reasonable belief that you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; treating such person as your personal representative could endanger you; or the Plan determines, in the exercise of its professional judgment, that it is not in your best interest to treat the person as your personal representative.

Others Involved in Your Care — The Plan may disclose your PHI to a friend or family member who is involved in your health care, unless you object or request a restriction (as provided below). The Plan also may also disclose your information to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. If you are not present or able to agree to these disclosures of your PHI, then using professional judgment, the Plan may determine whether the disclosure is in your best interest.

Mail to Employee — With only limited exceptions, we will send all mail to the employee. This includes mail relating to the employee’s spouse and other family members who are covered under the Plan, and it also includes mail with information on the use of Plan benefits by the employee’s spouse and other family members and information on the denial of any Plan benefits to the employee’s spouse and other family members. If a person covered under the Plan has requested restrictions or confidential communications (as provided below), and if we have agreed to the request, we will send mail as provided by the request.

Special Situations When We May Use or Disclose Your Protected Health Care Information

Organ and Tissue Donation – If you are an organ donor, we may release your PHI to organizations that handle organ procurement or organ, eye, or tissue procurement or transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans – If you are a member of the armed forces, we may release your PHI as required by military command authorities. We may also release PHI about foreign military personnel to the appropriate foreign military authority.

Workers Compensation – We may release your PHI for workers compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks – We may disclose your PHI for public health activities. These activities generally include the following:

• To prevent or control disease, injury or disability;
• To report births and deaths;
• To report child abuse or neglect;
• To report reactions to medications or problems with products;
• To notify people of recalls of products they may be using;
• To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
• To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence.

We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities – We may disclose health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes – If you are involved in a lawsuit or a dispute, we may disclose your PHI in response to a court administrative order. We may also disclose your PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement – We may release your PHI if asked to do so by a law enforcement official:
• In response to a court order, subpoena, warrant, summons, or similar process;
• To identify or locate a suspect, fugitive, material witness, or missing person;
• If it pertains to the victim of a crime if, under certain limited circumstances, we are unable to obtain the person’s agreement;
• If it pertains to a death we believe may be the result of criminal conduct;
• If it pertains to criminal conduct at a hospital, clinic, or treatment facility;
• In emergency circumstances to report a crime;
• The location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors – We may release your PHI to a coroner or medical examiner. This may be necessary to identify a deceased person or determine the cause of death. We may also release your PHI to funeral directors as necessary to carry out their duties.

National Security and Intelligence Activities – We may release your PHI to authorized federal officials for intelligence, counterintelligence, or other national security activities authorized by law, and for the protection of the President, other authorized persons, or heads of state.

Inmates – If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.

Required Disclosures

Disclosures to the Secretary of the U.S. Department of Health and Human Services – The Plan is required to disclose your PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan’s compliance with the Privacy Regulations.

Disclosures to You – The Plan is required to disclose to you or your personal representative most of your PHI when you request access to this information.
Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you:

Right to Inspect and Copy – You have the right to inspect and copy PHI that may be used to make decisions about your Plan benefits. To inspect and copy PHI that may be used to make decisions about you, you must submit your request in writing to the privacy contact. To the extent that PHI is maintained in an electronic health record, you may request that the Plan provide a copy to you or to a person or entity designated by you in an electronic format. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to PHI, you may request that the denial be reviewed.

Right to Request Amendment – If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

To request an amendment, your request must be made in writing and submitted to the Privacy Contact. To the extent that PHI is maintained in an electronic health record, you may request that the Plan provide a copy to you or to a person or entity designated by you in an electronic format. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason that supports the request. In addition, we may deny your request if you ask us to amend information that:

• Is not part of the medical information kept by or for the Plan;
• Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
• Is not part of the information which you would be permitted to inspect or copy; or
• Is accurate and complete.

Right to an Accounting of Disclosures – You have the right to request an accounting of certain disclosures the Plan has made of your PHI. To request an accounting of disclosures, you must submit your request in writing to the Privacy Officer. Your request must state the time period, which may not be longer than six years and may not include disclosures made before April 14, 2003. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a twelve month period will be free. For additional accountings, we may charge you for the costs of providing the accountings. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions – You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose PHI for payment or health care operations purposes for a surgery you had where the surgery costs have been paid out-of-pocket in full by you (in other words, the Plan is not required to pay for any part of the item or service). Other than where the Plan is not required to pay for the medical services you receive, we are not required to agree to your request. To request restrictions, you must make your request in writing to the Regional Privacy Officer. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

Right to Request Confidential Communications – You have the right to request that we communicate with you about medical matters in a certain way or a certain location. For example, you can ask that we only contact you at work or by mail.
To request confidential communications, you must make your request in writing to the Privacy Contact. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how and where you wish to be contacted.

**Right to a Paper Copy of This Notice** – You have the right to a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice. To obtain a paper copy of this Notice, you must request it in writing from the HR Service Center.

**Changes to This Notice** – We reserve the right to change this Notice. We reserve the right to make the revised or changed notice effective for PHI we already have about you as well as any information we receive in the future.

**Complaints** – If you believe your privacy rights have been violated, there are several ways by which you may lodge a complaint. You may call and make a report using the Swedish Health Services’ Integrity Line at (888) 294-8455, submit an electronic complaint by logging on to Swedish Health Services’ Integrity web-site, contact the Privacy Contact at the above-address and telephone number, or file a complaint with the Secretary of the Department of Health & Human Services. You will not be penalized or retaliated against for filing a complaint.

**Questions**

If you have questions about this notice, please contact the HR Service Center at (888) 687-3753 or submit an AskHR ticket after logging into Lawson Employee Self Service. Your inquiry will be forward to the Program Director, Benefits Compliance.

**Other Uses of PHI**

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us with an authorization to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your PHI for the reason covered by your initial written authorization. We are unable to take back any disclosures we have already made with your permission. We are required to retain our records of the care that we provided to you. The Plan must always obtain an authorization for use and disclosure of psychotherapy notes, marketing and sale of PHI as added by the 2013 final regulations in 45 CFR Section 164.520(b)(1)(ii)(E).

**Keep the Plan Informed of Address Changes**

You should keep the Plan informed of any changes in your address. In the event that your PHI has been breached, the Plan will notify you at your address on record in accordance with the Plan’s health information privacy policy.

**Effective Date**

This Notice of Privacy Practices becomes effective on September 23, 2013.
Separation of Providence Health & Services and the Group Health Plan

The following classes of employees or other persons under the control of Providence Health & Services as the Plan Administrator through a Shared Services Agreement with Swedish Health Services, the Plan Sponsor, shall be given access to protected health information:

- VP, Chief Human Resources Operating Officer
- Administrative Assistant to the CHROO
- Senior Director, Benefits, PH&S
- Senior Benefits Coordinator, PH&S, or successor Administrative Assistant position to Senior Director, Benefits
- Director, Health and Welfare Benefits, PH&S
- Program Director, Benefit Compliance/ Communication, PH&S
- Director, Wellness & Absence Management, PH&S
- Manager Benefits, PH&S
- Senior Benefits Analyst, PH&S
- Benefits Analyst, PH&S
- Senior Manager HRSC Operations
- Manager HRSC Operations
- HRSC Consultant
- Senior HR Specialist, Customer Service Specialist and Electronic Files Specialists within the HRSC limited to and pursuant with receiving information from employees
- Regional and PSMS Privacy Officers
- Internal Auditors
- Department of Legal Affairs attorneys
- Risk Management, PSMS

Providence Health & Services shall restrict the access to and use of protected health information by such employees and other persons described above to the Plan administration functions that Providence Health & Services performs for the Plan under a Shared Services Agreement with Swedish Health Services, including payment and health care operations.
Plan Benefit Information

Benefits, Contributions and Funding

This Plan provides eligible employees and dependents with medical and pharmacy benefits. This Plan is an employer-sponsored self-funded group health plan with administration provided through the third party administrator (TPA), FCHA. The benefits will be funded in part by the Plan Sponsor’s general assets and contributions made by Plan participants. The Plan will determine, and periodically communicate, your share of the cost for benefits under each component benefit plan, and may change that determination at any time.

The Plan will make employer contributions in an amount that, at the Plan’s sole discretion, is at least sufficient to fund the benefits or a portion of the benefits not otherwise funded by employee contributions, then use these contributions to pay benefits directly to or for participants from the Plan’s general assets. Employee contributions will be used in their entirety before using the Plan’s contributions to pay for the cost of such benefit.

The Plan will provide benefits in accordance with the requirements of all applicable laws, including but not limited to, the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns’ and Mothers’ Health Protection Act of 1996, the Women’s Health and Cancer Rights Act of 1998, the Mental Health Parity and Addiction Equity Act of 2008, and the Patient Protection and Affordable Care Act of 2010 (PPACA).

Plan Administrator’s Power of Authority

The Plan Administrator role for this Plan has been delegated by Swedish Health Services as Plan Sponsor to the Benefits department of Providence Health & Services through a Shared Services Agreement. The Plan Administrator is responsible for:

• Determining eligibility for and the amount of any benefits payable under the Plan, and
• Prescribing procedures to be followed and forms to be used by participants in this Plan.

The Plan Administrator may delegate any of these administrative duties among one or more entities, in writing. The written delegation must 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 proper administration of the Plan.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices and procedures.

The Plan Sponsor may appoint a Plan Administrator. If a Plan Administrator resigns, dies or is otherwise removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

Discretionary Authority

The Plan Administrator or its delegate has the discretionary authority to interpret the Plan and to resolve any ambiguities under the Plan.
The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive benefits under this Plan and to decide questions of Plan interpretation and of fact relating to the Plan. Plan Administrator decisions will be final and binding on all interested parties.

**Collective Bargaining Agreements**

You may contact the Plan Administrator to determine where the Plan is maintained under one or more collective bargaining agreements. A copy is available from the Plan Administrator, upon written request.

**Clerical Error**

Any clerical error by the Plan Administrator, or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made if the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains the contractual right to reimbursement for the overpayment. The person or institution receiving the overpayment will be required to return the overpaid amount to the Plan through FCHA. In the case of a Plan participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.
Statement of ERISA Rights

As a participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants will be entitled to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor (DOL) and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly Pension and Welfare Benefits Administration).
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and an updated plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan’s annual financial report, if any is required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

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 Plan fiduciaries, who are responsible for your Plan, have a duty to do so prudently and in the interest of Plan participants and beneficiaries. No one, including Swedish Health Services 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 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 obtain 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 materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator’s control. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or 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 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 frivolous.

Continue Group Health Coverage/Certificate of Creditable Coverage

You may 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 may have to pay for such coverage. Review this Summary Plan Document and the documents governing your COBRA continuation coverage rights.
You are entitled to a reduction or elimination in any coverage exclusion periods for pre-existing conditions under your health plan if you have creditable coverage from another plan. You should receive a certificate of creditable coverage, free of charge, from the Plan Administrator when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months after your enrollment date in your new coverage.

**Assistance with Your Questions**

If you have questions about your Plan, contact the HR Service Center.

HR Service Center  
Human Resources, Suite 500  
2001 Lind Ave. SW  
Renton, WA 98057  
(888) 687-3753

If you have any questions about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in your phone directory or:

The Division of Technical Assistance and Inquiries  
Employee Benefits Security Administration, US Department of Labor  
200 Constitution Avenue NW Washington DC 20210  

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.
## Summary Plan Description and General Information

<table>
<thead>
<tr>
<th>Plan Name:</th>
<th>Swedish Health Services Employee Benefit Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plan Year:</td>
<td>January 1 through December 31</td>
</tr>
<tr>
<td>Original Effective Date:</td>
<td>January 1, 2001</td>
</tr>
<tr>
<td>Type of Plan:</td>
<td>Group health plan (a type of welfare benefit plan subject to ERISA provisions)</td>
</tr>
<tr>
<td>Plan Number:</td>
<td>519</td>
</tr>
<tr>
<td>Funding Medium:</td>
<td>Claims are paid directly out of the general assets of the Company. Employee contributions are placed in the general assets of the company and accounted for separately in the accounting records of the Company. Employee contributions shall only be used to pay medical claims.</td>
</tr>
<tr>
<td>Source of Contributions:</td>
<td>The company bears the entire cost of this benefit Plan, minus the participants’ contribution.</td>
</tr>
<tr>
<td>Plan Sponsor:</td>
<td>Swedish Health Services</td>
</tr>
<tr>
<td></td>
<td>747 Broadway</td>
</tr>
<tr>
<td></td>
<td>Seattle, WA 98122</td>
</tr>
<tr>
<td>Plan Sponsor’s Employer Identification Number:</td>
<td>91-0433740</td>
</tr>
<tr>
<td>Named Fiduciary:</td>
<td>Swedish Health Services</td>
</tr>
<tr>
<td>Plan Administrator:</td>
<td>Swedish Health Services designated to Providence Health Services under the Shared Services Agreement Benefits Department 2001 Lind Ave SW Renton, WA 98057</td>
</tr>
<tr>
<td>Third Party Administrator:</td>
<td>First Choice Health Network, Inc. d.b.a. First Choice Health Administrators 600 University Street, Suite 1400 Seattle, WA 98101 (800) 430-3818/Local (206) 268-2360 <a href="http://www.myFirstChoice.fchn.com">www.myFirstChoice.fchn.com</a></td>
</tr>
<tr>
<td>Pharmacy Benefit Manager:</td>
<td>MedImpact Healthcare Systems, Inc. 10680 Treena St. San Diego, CA 92131 (888) 678-7779 <a href="http://www.medimpact.com">www.medimpact.com</a></td>
</tr>
</tbody>
</table>
| **Agent for Service of Legal Process** | Swedish Health Services:  
Business Filings Incorporated  
1801 West Bay Drive NW, Suite 206  
Olympia WA 98502  
(800) 981-7183  
  
FCHA:  
Ken Hamm, President & CEO  
First Choice Health Network, Inc.  
600 Union Street, Suite 1400  
Seattle WA 98101 |
| **Plan Description:** | The written Plan Description for the medical plan required by ERISA §402 consists of this entire document plus provider directories for the Plan. |
| **Type of Administration:** | Contract administration with First Choice Health Administrators as the claims administrator/third party administrator. |
Plan Definitions

Accidental injury means physical harm caused by a sudden and unforeseen event at a specific time and place.

Active employee is an employee who is on the regular payroll of Swedish Health Services and is scheduled to perform job duties either at the employer’s place of business or at some location to which the employee is required to travel for the employer’s business. An employee shall be considered “active” if absent due to illness or any other health-related factor.

Adverse benefit determination means 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. A rescission of coverage is also an adverse benefit determination, except when related to non-payment of premium contribution.

Allowed amount means the maximum amount considered for payment by the Plan for a medically necessary covered service. Generally, this amount is equal to the following:

- The contracted amount agreed to by FCHN participating providers (in Washington, Oregon, Alaska, Idaho, Montana, Wyoming, North Dakota, and South Dakota), and First Health participating providers (in all other states not served by FCHN).
- For services received from non-network providers outside Washington State (except emergency services), the Usual, Customary and Reasonable (UCR) rate (see related definition).
- For services received from non-network providers inside Washington State (except emergency services), the Allowed Amount is based on a FCHN fee schedule,
- For non-network emergency services, the Allowed Amount is determined annually by FCHA based on federal guidelines stating the Allowed Amount must be equal to the greatest of the following amounts: 1) the median of the contracted amounts described above; 2) the Usual, Customary and Reasonable (UCR) amount (see related definition); or 3) the Medicare amount.

For services received from non-network providers, you are responsible to pay the difference between the Allowed Amount and the provider’s actual charges.

Authorized representative means an individual acting on behalf of the participant or beneficiary claimant in obtaining or appealing a benefit claim. The authorized representative must have a signed form (specified by the Plan) by the claimant except for urgent care benefits or appeals. Once an authorized representative is selected, all information and notifications should be directed to that representative until the claimant states otherwise.

Birthing center means any freestanding licensed health facility, place, professional office or institution, that is not a hospital or in a hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located. It must:

- Have facilities for obstetrical delivery and short-term recovery after delivery
- Provide care under the full-time supervision of a physician and either a registered nurse or a licensed nurse-midwife
- Have a written agreement with a hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar year means the 12-month period beginning January 1 and ending December 31 of the same year.
Certificate of creditable coverage means a certificate issued by a group health plan that 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).

Charitable activity status means a Swedish Health Services employee or their dependent who is on a certain defined charitable activity. Examples of charitable activity status include but may not be limited to the Peace Corps or church missions. Please contact the Plan Administrator — the Benefits Department — for more information.

Chemical dependency condition means a condition characterized by a physiological or psychological abuse/dependency of a controlled substance and/or alcohol that impairs or endangers the participant’s or beneficiary’s health. It must be listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. The following conditions are either not considered Chemical Dependency Conditions or are covered under other benefits offered by this Plan (subject to all terms, limitations and exclusions):

- Conditions related to Mental Health (see Mental Health Condition definition)
- Nicotine Related Disorders (see Tobacco Cessation, if applicable to this Plan)
- Non-substance related disorders

Claim means any request for a Plan benefit made by you or your authorized representative. A participant making a claim for benefits is a claimant.

Coinsurance means a cost-sharing requirement that requires a participant to pay a specific percentage of the cost for certain covered services.

Concurrent claim means any claim that is reconsidered after an initial approval for ongoing treatment and results in a reduced or terminated benefit.

Copay/copayment means the amount a participant pays at the time of service. Copayments are paid in addition to any employee contribution.

Custodial care is care designed primarily to assist in activities of daily living, including institutional care that serves primarily to support self-care and provide room and board. Custodial care includes, but is not limited to, bathing, dressing, walking assistance, help with getting in and out of bed, feeding, preparing special diets and supervising medications that are ordinarily self-administered.

Developmental disability means a condition that meets all of the following:

- Is defined as mental retardation, cerebral palsy, epilepsy, autism or other neurological or other condition
- Originates before the individual reaches age 18
- Is expected to continue indefinitely
- Results in a substantial handicap.

Domestic partners mean two individuals, either opposite or same sex, who meet all the following criteria:

- Must be 18 or older
- Must have an intimate, committed relationship of mutual caring that has existed for at least 12 months
- Must be financially interdependent and share the same residence
- Neither partner can be married or legally separated from any other person or involved in another domestic partner relationship
- Partners must not be blood relatives of a degree of closeness that would prohibit marriage
• The partners must complete during the enrollment process the Affidavit of Domestic Partnership (and be responsible for keeping a copy of the original and providing copies when requested by the Plan Administrator).

**Emergency** means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent person acting reasonably to believe a health condition exists that requires immediate medical attention, and that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person’s health in serious jeopardy.

**Employee contribution** is the employee portion of the costs for a benefit plan.

**ERISA** is the federal Employee Retirement Income Security Act of 1974, as amended, which governs plan administration, supervision and management.

**Experimental, investigational and unproven procedures** mean services determined to be either:

• Not in general use in the medical community,
• Not proven safe and effective or to show a demonstrable benefit for a particular illness or disease,
• Under continued scientific testing and research,
• 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.

**First Choice Health Administrators (FCHA)** is the Third Party Administrator for this group health plan.

**First Choice Health Network, Inc. (FCHN)** is the network of providers that is used by FCHA and defines the service area.

**Fiduciary means, under ERISA**, a person who exercises discretionary authority or control over the management of an ERISA plan or its assets or has discretionary authority or responsibility in Plan administration.

**Levels of Care** related to Mental Health and Chemical Dependency Conditions:

• **Intensive Outpatient Programs** provide services for mental health or chemical dependency conditions on an outpatient basis through planned, structured services available at least two hours per day and three days per week. Services include group, individual and when indicated family or multi-family group treatment. Medical monitoring, evaluation and adjunctive services are available. Treatment must follow a written plan of care.

• **Partial Hospitalization Programs** provide multi-disciplinary care for mental health or chemical dependency condition at least six hours a day, five days a week, and schedule at least three distinct services per day. Services include individual and group therapy, medication evaluation and management, family therapy, activity therapy, occupational therapy, and education training directed at treating the Condition. Services for mental health conditions must include evaluation by a psychiatrist within 48 hours and weekly thereafter. All programs must include a substance abuse evaluation. Treatment must follow a written plan of care.

• **Residential Treatment Programs** provide a 24-hour level of care seven days a week for patients with long-term or severe mental health or chemical dependency conditions. Care is medically monitored, with 24-hour medical and nursing availability. Services include treatment with a range of diagnostic and therapeutic behavioral health services that cannot be adequately provided through existing community programs. Residential care also includes family involvement in assessment, treatment and discharge planning, and offers training in the basic skills of living as determined necessary for each patient. Treatment must follow a written plan of care.
• **Chemical Dependency Rehabilitation Programs** provide 24-hour rehabilitation treatment seven days a week for substance related conditions. Services include group, individual and when indicated family or multi-family group. The facility must offer sufficient availability of medical and nursing services to manage ancillary detoxification needs. Treatment must follow a written plan of care.

**Lifetime** is a reference to benefit maximums and limitations, understood to mean while covered under this Plan. Under no circumstances does lifetime mean during the lifetime of the participant.

**Medical group** means a group or association of providers, including hospital(s), listed in the provider directory.

**Medically necessary** is a medical service or supply that meets all the following criteria:

• 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
• It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the patient.

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.

**Mental Health Condition** means a mental disorder listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. The following conditions are either not considered Mental Health Conditions or are covered under other benefits offered by this Plan (subject to all terms, limitations and exclusions):

• Conditions related to Substance Related and Addictive Disorders (see Chemical Dependency definition)
• Developmental Delays/Learning Disorders (see Neurodevelopmental Therapy benefit)
• Relational, family, and lifestyle stressors absent a primary psychiatric diagnosis
• Sexual dysfunctions, gender dysphoria, personality disorders, paraphilic disorders

**Network provider** means a contracted FCHN provider in Washington, Idaho, Montana, Oregon, Alaska, Wyoming, North Dakota, and South Dakota that is listed in the provider directory. Outside these states, participants must use the First Health Network for network providers.

**Non-network provider** means a provider who delivers or furnishes health care services but is not a contracted FCHN provider in Washington, Idaho, Montana, Oregon, Alaska, Wyoming, North Dakota, or South Dakota. Outside these states a non-network provider means a provider who delivers or furnishes health care services but is not a contracted First Health Network provider.

**Out of area/out of the service area** means outside the FCHA service area as described under network provider and non-network provider.

**Open enrollment period** is a defined time when you are allowed to enroll yourself and/or your dependents for benefit coverage.

**Participant** means any eligible employee or other eligible individual enrolled in the Plan.

**Plan Administrator** means the department designated by an employer group to administer a plan on behalf of participants. The Plan Administrator is Providence Health & Services through a Shared Services Agreement.
The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of eligible participants and beneficiaries, without discrimination. The Plan Administrator has the power and exclusive authority necessary, at its discretion, to:

- Interpret the Plan document and to decide all questions of eligibility and participation,
- Make all findings of fact for Plan administration, including payment of reimbursements,
- Prescribe procedures to be followed and forms to be used by participants and beneficiaries,
- Request and receive from all employees the information necessary for proper Plan administration, and,
- Appoint and employ the individuals or entities to assist in Plan administration as necessary or advisable, including benefit consultants and legal counsel.

**Plan Document** means the document that describes requirements for eligibility and enrollment, covered services, limitations and exclusions, and other terms and conditions that apply to participation in this Plan.

**Plan Year** means the twelve (12) month period beginning January 1 and ending December 31.

**Post-service claim** means any claim for a Plan benefit that is not a pre-service claim and is a request for payment or reimbursement for covered services already received.

**Pre-authorization** is the process of obtaining coverage determination from FCHA before receiving inpatient and certain outpatient services, as specified in the benefit description booklets.

**Pre-service claim** means any claim for a Plan benefit for which the Plan requires approval before medical care is obtained.

**Primary Care Provider (PCP)** means a general practitioner, internist, family practitioner, general pediatrician, OB-GYN or Advanced Registered Nurse Practitioner (ARNP) chosen by a participant to coordinate all health care needs.

**Provider** means any person, organization, health facility or institution licensed to deliver or furnish health care services.

**Provider directory** is the listing of the network providers, hospitals, and other facilities that have agreed to provide covered services to participants or dependents of Plans contracted with First Choice Health Network (FCHN) and First Choice Health Administrators (FCHA).

**Qualifying event** means, under COBRA, the triggering event that causes a loss of coverage under a group health plan, including termination of employment, reduction in hours, death or divorce. (See the COBRA section for more details.)

**Recognized Providers** are providers acting within the scope of his/her license but for whom:

1. FCHN does not offer agreements to his/her category of providers, or
2. Agreements are offered but covered participant choice is not provided.

Examples of both types are outlined below:

- Ambulance services
- Anesthesiologists
- Assistant surgeon
- Blood banks
- Dental services covered by the Plan; provider types may include:
  - Dentist
— Oral and Maxillofacial Surgeon
— Otolaryngologist (Ear, Nose & Throat specialist, or ENT)

• Non-contracted laboratories used by FCHN referring provider
• Ocular prosthetics (if covered by the Plan)
• PKU formula
• Services of non-contracted providers when rendering care within a network facility, except a primary surgeon for a non-emergent admission
• Suppliers of wigs (if covered by the Plan)
• TMJ providers (if covered by the Plan)

Regular employee means a person appointed by Swedish Health Services to work in a position for an undetermined period of time; (i.e., for a period of time not specifically limited in duration). Regular employees do not include leased, seasonal or temporary employees, except where required by law.

Special enrollment means, under HIPAA, special enrollment rights that group health plans must offer to certain employees and dependents not enrolled in the plan who experience a loss of other coverage or when there is a birth, adoption or marriage that takes place during the Plan year, after the annual enrollment period. Becoming ineligible for Medicaid or CHIP (children’s health insurance program) is also a special enrollment event as is becoming eligible for CHIP or a premium subsidy through Medicaid. Special enrollees may enroll eligible dependents and have the option to select from any available plans.

Telemedicine means the use of medical information exchanged from one site to another via both synchronous and asynchronous electronic communications.

• Synchronous communication includes the use of audio and video equipment permitting two-way, real time interactive communication between the patient and provider at a distant site (example: videoconference).
• Asynchronous (or “store and forward”) communication includes the use of audio and video equipment that records and stores information to be sent to a provider at a distant site to be interpreted at a later time.

Temporomandibular Joint (TMJ) Disorders mean disorders that have one or more of the following characteristics:

• Pain in the musculature associated with the temporomandibular joint
• Internal derangement of the temporomandibular joint
• Arthritic problems with the temporomandibular joint
• An abnormal range of motion or limited motion of the temporomandibular joint.

Third Party Administrator (TPA) is the organization providing services to this Plan’s Administrator and Sponsor, including processing and payment of claims. First Choice Health Administrators (FCHA) is the Third Party Administrator for this Plan.

Urgent care means services that are medically necessary and immediately required as a result of an unforeseen illness, injury or condition that is not an emergency, but it was not reasonable given the circumstances to wait for a routine appointment.

Urgent care claim means a claim for medical care or treatment that:

• Would seriously jeopardize the claimant’s life, health or ability to regain maximum function
• In the opinion of a physician with knowledge of the claimant’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 (UCR) is the 90th percentile of cost data for a given geographic area. This data is obtained from an independent, nationally recognized vendor.

Vision provider means a provider licensed to dispense optical care and services who practices within the standards and scope of accepted vision and optometry care and service.