



Tuality Healthcare
Building a healthier community.

**TUALITY HEALTHCARE
MEDICAL AND PRESCRIPTION DRUG PLANS
PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION**

Restated January 1, 2010

PLAN CONTACTS

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*The First Choice Health Network includes all chiropractors, mental health and chemical dependency providers covered by the Plan.

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INTRODUCTION

This document is a description of Tuality Healthcare's self insured Medical and Prescription Drug Plans (the Plan). This document will be the sole document used in determining benefits to which covered participants are entitled. No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain healthcare expenses.

The purpose of this document is to comply with the requirements for a written instrument under the Employee Requirement Income Security Act of 1974, as amended, hereinafter referred to as "ERISA", to set forth the provisions of the Plan which provide for medical and prescription drug benefits and to serve as the Plan document.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. Also the changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, copayments, maximums, exclusions, limitations, definitions, eligibility, and the like. The procedure to amend, suspend, or terminate the Plan is by a written amendment to be executed by an authorized fiduciary of the Plan, which is then attached to the document making the appropriate changes.

The Plan Administrator is required to provide Plan participants with a summary plan description within 90 days after the participant becomes covered under the Plan, and at times required by law thereafter. In addition, the Plan Administrator shall furnish participants with a summary of material reductions in covered services or benefits within 60 days after adoption of the reduction. The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of medical necessity, lack of timely filing of claims, or lack of coverage. These provisions are explained in this document additional information is available from the Plan Administrator at no extra cost.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to covered charges incurred before termination, amendment, or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Medical Management Services. Explains the methods used to curb unnecessary and excessive charges.

This part should be read carefully since each Participant is required to take action to assure that the maximum payment levels under the Plan are paid.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

Assistance: This booklet is an English language summary of your Plan rights and benefits under Tuality's Medical and Prescription Drug Plans. If you have difficulty understanding any part of this booklet, contact Tuality Healthcare's Human Resources Department at 6th Ave Plaza, Suite 100, 372 SE 6th Ave., Hillsboro, Oregon 97123. You may also call the Claims Administrator's office at (503) 844-8104 or (866) 575-8104 or via TTY at 1-800-735-2900.

Benefits described in this document are effective January 1, 2010.

OPEN ENROLLMENT

Every November, is the annual open enrollment period when eligible Employees and their eligible Dependents are able to change some of their benefit decisions based on which benefits and coverages are right for them. It is also the time when Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect until the next January 1 unless there is a change in family status during the year (birth, death, marriage, divorce, adoption or loss of coverage due to loss of a Spouse's employment.) To the extent previously satisfied, coverage Waiting Periods will be considered satisfied when changing from one plan to another plan.

Benefit choices for Late Enrollees made during the open enrollment period will become effective January 1.

A Plan Participant who fails to make an election during 2010 open enrollment will automatically lose his or her present coverages and will forfeit any cash options that are otherwise available.

Each year the Employer will provide Plan Participants with detailed information regarding open enrollment.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Participant should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test, or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Eligible Classes of Employees.

All Active benefit eligible employees who meet the eligibility requirements.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

- 1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she is budgeted to work at least 72 hours per pay period and is on the regular payroll of the Employer for that work.
- 2) is a Part-Time, Active Employee of the Employer. An Employee is considered to be Part-Time if he or she is budgeted to work at least 48 hours per pay period and is on the regular payroll of the Employer for that work.

NOTE: In order to be eligible for the Tuality Healthcare benefits program, employees must be budgeted to work at least 48 hours per pay period. "Grandfathered" employees who are budgeted to work 40-47 hours per pay period will still be eligible.

Proof of Dependent Eligibility

To be eligible for coverage under this plan, you are required to provide two (2) forms of documentation (financial and relationship) that proves your dependents meet the eligibility requirements of the plan. This applies to spouses, domestic partners and dependent children. To view a complete list of acceptable forms of relationship and financial documentation go to www.tuality.net or www.hrconnection.com.

Eligible Classes of Dependents.

A Dependent is any one of the following persons:

A covered Employee's lawful Spouse, domestic partner, and unmarried dependent children from birth to the limiting age or age 19. The limiting age can be extended to age 23 under the following conditions:

- 1) the child receives more than half of his or her support from the covered Employee or
- 2) they are full-time students at an accredited institution of higher learning, or
- 3) you are legally required to provide health coverage, or
- 4) they depend on you because of a physical or mental disability regardless of age. However, the disability must have existed before the child's 23rd birthday and the child must be unmarried and depend chiefly on you for support and maintenance. The Plan Administrator may require, at reasonable intervals during the two years following the Dependents reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

When a child reaches the limiting age, coverage will end on the last day of the child's birthday month.

If your full-time college student is unable to maintain their student status because of serious illness or injury, they can continue their coverage for up to one year on the same terms as if they were a full-time student. Proof of serious illness or injury is required.

The term "Spouse" shall mean a person recognized as the covered Employee's husband or wife or domestic partner under the laws of the state where the covered Employee lives.

The term "child" or "children" shall include natural children of the Employee, adopted children or children placed with a covered Employee in anticipation of adoption. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household. Children of domestic partners are also eligible to participate provided they meet the requirements in the Definition of Domestic Partner section of the document.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents.

The phrase "child placed with a covered Employee in anticipation of adoption" refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of twenty-three (23) as of the date of such placement for adoption. The term "placed" means the assumption and retention by such Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Grandchildren are only eligible if the covered Employee has legal guardianship or has adopted the grandchild.

When a Covered Person (Employee or Dependent) acts as a surrogate mother, the child born to the Covered Person who acts as a surrogate mother is not treated as a Dependent and is not eligible for coverage under this Plan. A surrogate mother is a woman who, pursuant to an agreement, carries a child on behalf of one or more other persons with the intention of giving that child up to the other person or persons once it is born. A surrogate mother is subject to this exclusion regardless of the method of impregnation.

It is the Employee's responsibility to maintain accurate dependent information and to contact the Human Resources Department to add or drop a dependent.

If you and your spouse (or domestic partner) are *both* eligible employees, you can cover any or all of your eligible family members (including your spouse or domestic partner) under your name, your spouse/domestic partner or both.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan with no Pre-existing Conditions provisions applied. A participant of the Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

Definition of Domestic Partner

Domestic partners of Tuality Healthcare employees may be eligible for medical and prescription drug benefits if the partnership meets the Employer's definition of domestic partnership. The partners must sign and submit a Tuality Healthcare Declaration of Domestic Partnership or submit proof to the employer of domestic partnership registration with the state of Oregon as well as provide documentation proving a financial relationship.

Domestic partners are defined by the Employer as persons who:

- Are same or opposite gender;
- Are in an exclusive committed relationship;
- Share a common residence and have lived together for a minimum of six months prior to enrollment;
- Are financially interdependent and jointly responsible for each other's basic living expenses;
- Are at least 18 years old and are capable of consenting to the partnership;
- Are not married or a member of another domestic partnership; and
- Are not related by blood in a way that would prevent them from being married in the state of Oregon.

Unmarried children of domestic partners from birth to the limiting age of 19, who depend upon the Employee for financial support, are eligible for coverage if the domestic partner is enrolled for coverage. The limiting age may be extended to age 23. See the Eligible Classes of Dependents section of this document for conditions for dependent child status.

Refer to the Tuality Healthcare Domestic Partner Benefits Guide for policies and procedures to enroll (or disenroll) your domestic partner and eligible dependents. This document can be obtained from Tuality's Human Resources Department or by accessing www.tuality.net or www.hrconnection.com. The IRS requires Tuality to tax you on the

fair market value of the Tuality paid portion of coverage for your domestic partner and their children. Fair market value is determined annually by Tuality based on the projected monthly cost of the Plan.

You are responsible for notifying Tuality Healthcare within 31 days if your domestic partnership ends.

Qualified Medical Child Support Order

Notwithstanding any Plan provision to the contrary, coverage will be provided in accordance with the terms of a qualified child support order (“QMCSO”).

A QMCSO is a judgment, decree or order issued by a court or agency of competent jurisdiction that creates or recognizes the right of an “Alternate Recipient” to receive benefits to which a participant or eligible dependent is entitled under this Plan. An “Alternate Recipient” is any child of a participant in this Plan who is recognized under the QMCSO as having a right to enrollment under this Plan.

A QMCSO must clearly specify (1) the name and last known mailing address of the participant and the name and mailing address of each “Alternate Recipient” covered by the order; (2) a reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined; (3) the period of coverage to which the order pertains; and (4) the name of the Plan. An order is not a QMCSO if it requires this Plan to provide any type or form of benefits not otherwise provided to participants and eligible dependents, except to the extent necessary to meet the requirements of any state law relating to medical child support orders.

If you are not enrolled for coverage, you will be required to enroll along with the child and your share of the cost of such coverage will be withheld from your pay.

The Plan Administrator follows procedures governing QMCSO determinations and will provide you with a copy of the procedures – without charge – upon request.

WHEN COVERAGE BEGINS

All eligible employees will receive medical benefit coverage on the first of the month following receipt of an Enrollment Form in the Human Resources Department. For coverage to be effective on that date, you must submit an Enrollment Form for yourself and any dependents you want covered within 31 days of the day you are hired or become eligible. If you don't enroll yourself and/or a dependent during the first 31 days of eligibility, you will not receive medical coverage and you will have to wait until the next open enrollment period to make your personal selection.

If you are not an active employee on your enrollment date, coverage will be deferred to the first of the month following your employment and upon submission of an enrollment form unless your enrollment or change replaced other group coverage.

Coverage will be effective for your spouse and eligible unmarried children under age 23 on the date your coverage begins, if you elect coverage for them. Two forms of documentation are required for your dependents to prove they meet the eligibility requirements of the plan: relationship and financial. All claims will be pended until required documentation has been received. To view a complete list of acceptable forms of relationship and financial documentation go to www.tuality.net or www.hrconnection.com.

Coverage selected cannot begin prior to receipt of your Enrollment Form due to IRS regulations.

The enrollment form for coverage includes payroll deduction authorization. All authorizations must be complete in order for the application to be considered received.

WHEN EMPLOYEE COVERAGE ENDS

Benefit coverage will end on the last day of the month during which any of the following happens.

- Your employment status changes from regular to temporary.

- Your regular work hours are reduced to less than 48 hours per pay period.
- You enter active full-time military service (Refer to USERRA for continuation rights).
- You terminate employment at Tuality Healthcare. The effective cancellation date will be the end of the month in which you last worked. *Benefits cannot be extended at termination by using Paid Leave Hours.* Your last day of work is considered your termination date.
- You discontinue payroll deductions or do not make a required premium payment.
- You fail to pay, or make arrangements to pay, the total payment due while on an authorized leave of absence.
- You are not actively at work due to strike or lockout.
- The plan terminates.
- The date you retire. Refer to the Continuation of Coverage section of this document for further information.
- The day you meet or exceed the lifetime maximum for benefits under the plan.

ENROLLMENT REQUIREMENT

If you fail to turn in a properly completed Enrollment Form within 31 days of hire (or of becoming eligible), you will not be enrolled in a benefit plan. It is important to return a completed Enrollment Form on time because the IRS tightly regulates your enrollment windows.

A Plan Participant who fails to make an election during open enrollment will lose his or her present coverages.

COVERAGES DURING PAID LEAVES OF ABSENCE

You continue to be eligible for benefits at any time you are eligible and use Paid Leave Hours and/or Extended Illness Hours for a Paid Leave of Absence. When PLH or EIH banks are depleted you may still be eligible for benefits. Refer to the Human Resource Department for details.

CHANGES IN BENEFIT SELECTIONS

You have the opportunity to change your benefit selections once each year during open enrollment as your needs and your circumstances change. See the Open Enrollment section for more detailed information concerning Open Enrollment dates and regulations. Sometimes those benefit needs can change *unexpectedly*. Depending on the nature of the change, you may be permitted to alter your coverage during the year, as permitted by IRS regulations, due to employment or qualified lifestyle status changes.

EMPLOYMENT AND QUALIFIED FAMILY STATUS CHANGES

Special Enrollment Periods. The following are situations which will enable you to make a change in your benefit selections at any time during the plan year. Coverage begins the first of the month after the notification is provided to Human Resources, except in the case of birth or adoption when coverage is immediate.

- Marriage, birth, adoption, divorce or death
- Termination of or change in spouse's employment
- Change in employment status of the employee or spouse from full-time or part-time
- Commencement of a leave of absence for employee or spouse
- Child is no longer eligible as a dependent
- A significant change in insurance coverage through your spouse's employer
- Qualification for premium assistance under the state's medical assistance program or CHIP
- Loss of health coverage under the state's medical assistance program or CHIP because you no longer qualify

Individuals losing other coverage. An Employee or dependent who is eligible, but not enrolled in this Plan, may enroll if any of the following conditions are met:

- The Employee or dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
- If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered, that the other health coverage was the reason for declining enrollment.
- The coverage of the Employee or dependent who had lost the coverage was under COBRA and the COBRA

coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility of the coverage or employer contributions towards the coverage were terminated.

- Loss of eligibility for coverage includes, but is not limited to the following: as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment, the plan no longer offering any benefits to a class of similarly situated individuals, an individual incurs a claim that is denied and coverage ceases due to meeting or exceeding the lifetime limit on all benefits, the plan does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual) and no other benefit packages are available to the individual.
- The Employee or dependent requests enrollment in this Plan no later than 31 days (60 days for dependents) after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above.

If the Employee or dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

When an employee and/or dependents are eligible for a special enrollment period (subject to plan eligibility rules and conditions), they must be treated the same as individuals who enroll when first eligible. Special enrollees must be offered medical benefit options available to similarly situated individuals who enroll when first eligible.

Benefit changes must be consistent with the change in family or employment status and must be made within 31 days (60 days for dependents) of the status change. Copies of documents verifying the status change are required.

The following paragraphs provide additional information needed for some of these situations.

Audit of Average Hours Worked by Employees. You will be assigned your benefit status when you are hired, promoted, transferred or have a change in scheduled hours. Because of fluctuating business needs, your scheduled work hours and actual work hours may differ. Your benefit status is initially set on scheduled work hours and is then based on actual work hours, paid time off hours, and low census hours.

Each month, a departmental report is generated, listing your benefit status along with the average hours paid (including low census) during the calendar quarter. Department Heads monitor your benefit status throughout the year, comparing the hours scheduled and may adjust your status to be consistent with your trend of hours worked.

In addition, at the end of each calendar quarter, you will be adjusted from one benefit status to another (full-time or part-time) if your average hours differ from the category to which you were assigned and it is expected that your average hours will continue to be unchanged. The cut-off for regular full time employees is an average of 72 hours per pay period. The cut-off point for regular part-time employees is an average of 48 hours per pay period. Anything less than this will be adjusted to the lower category. In this way, you are treated fairly in regards to your eligibility for benefits based on whether you are consistently paid more hours than regularly scheduled, consistently paid the hours originally scheduled, or consistently taking time off without pay and paid less hours than originally scheduled.

NOTE: Protected leaves of absence will not affect the average hours as they relate to category eligibility.

If You Have a Baby. If you deliver a baby while covered, the Plan automatically covers your newborn children for 31 days from the date of their birth. If you want that coverage to continue, you must submit a new Enrollment Form within 60 days of the birth listing the child as a dependent. Otherwise there will be no further payment from the Plan and the covered parent will be responsible for all costs. You must enroll the newborn by completing a new enrollment form even if this addition does not change your Family Coverage category. Otherwise you will not be able to obtain coverage for the child until the next open enrollment period.

To add a newly eligible child you must provide written notice to add the child and any additional premium or required contribution from the date of birth must be paid within 60 days of birth. All required documentation proving relationship and financial relationship must be submitted. If the required documentation is not submitted at the time of addition, all claims after 31 days will be pended until the documentation is received. To view a complete list of acceptable forms of relationship and financial documentation go to www.tuality.net or www.hrconnection.com.

If You Die. Coverage for your dependents will end on the last day of the month during which you die. Refer to the Continuation of Coverage section of this document for further information.

If You Retire. Your coverage ends on the last day of the month in which you retire. Refer to the Continuation of Coverage section of this document for further information.

Leaves of Absence. All benefits for you and/or your dependents are canceled the first of the month after you go into an unpaid status during a Leave of Absence with the exception of protected FMLA/OFLA Leaves, if your leave is not protected by FMLA/OFLA. You pay the total cost of any benefit options you have selected. For approved FMLA/OFLA Leaves you are only required to continue to pay your employee portion of the premiums. Payments will be made on an *after-tax* basis when you are in a protected unpaid status.

Coverage is then continued subject to the following rules:

- You pay the total cost of benefit options for yourself and your dependents in advance except for approved FMLA/OFLA leaves.
- If coverage is canceled or ends for non-payment, it cannot be reinstated until you return to work
- You may continue your coverage for the duration of your approved unpaid leave or a maximum of 6 months, whichever is less. Refer to the Continuation of Coverage Section of this Document for further information.
- If your leave is due to active military service refer to the USERRA provision listed below for details.
- For protected Family Medical or Parental leave, out of pocket costs remain the same for 12 weeks of the leave beginning with the first day of leave (paid or unpaid).

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Pre-Existing Conditions limitations and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her dependents when Plan coverage terminated.

Coverage under this provision will be continued only for the length of time the employee is away from work as provided under the FMLA. If the employee fails to return to work after a family or medical leave of absence, coverage will terminate on the last day of the last period for which the required premiums were paid. The Plan must be reimbursed for any claims paid for services received after the coverage termination date. If coverage is terminated and the employee later returns to work and applies for coverage, enrollment will be in accordance with the terms and provisions of the Plan at that time. An employee who must enroll again may be subject to new waiting periods for enrollment, if any.

It is the intent of the Plan to comply with all existing FMLA regulations. If for some reason the information presented in the Plan differs from actual FMLA regulations, the Plan reserves the right to administer the FMLA in accordance with such actual regulations.

Also, Oregon has a family leave law that has been revised to substantially parallel the federal FMLA law. However, there are a few provisions that differ between the Oregon Leave Law and the federal FMLA. Any family and medical leave that is covered by both state and federal law must be taken concurrently, not consecutively. Please contact the Human Resources Department for details on the policies and procedures of these laws and to obtain the required leave request forms.

Uniformed Services Employment And Reemployment Rights Act (USERRA). If you were covered under this Plan immediately prior to being called to active duty by any of the armed forces of the United States of America, coverage may continue for up to 24 months or the period of uniformed service leave, whichever is shortest, if you pay any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for active employees. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage. Coverage continued under this provision runs concurrently with coverage continued under Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).

Whether or not you elect COBRA coverage under the Uniformed Services Employment and Reemployment Rights Act, coverage will be reinstated on the first day you return to active employment with Tuality Healthcare.

- On the first full business day following completion of your military service for a leave of 30 days or less;
- within 14 days of completing your military service for a leave of 31 to 180 days; or
- within 90 days of completing your military service for a leave of more than 180 days (a reasonable amount of travel time or recovery time for an illness or injury determined by the Veterans Administration (VA) to be service connected will be allowed).

When coverage under the Plan is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied had you not taken military leave and your coverage had been continuous under this Plan. This waiver of limitations does not provide coverage for any Illness or Injury caused or aggravated by your military service, as determined by the VA. For complete information regarding your rights under the Uniformed Services Employment and Reemployment Rights Act, contact your Employer.

The Plan shall operate in conformance with USERRA and in the event that there is any inconsistency between that law and the terms of the Plan, the Plan shall be interpreted to conform with the requirements of USERRA. If this situation applies to you, please contact the Human Resources Department.

Rehiring a Terminated Employee. A terminated Employee who is rehired after 12 months from their last day of work will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

Coverage Following Return From Leave. If your benefit coverage is cancelled, or ends while on leave of absence, the coverage you had prior will be automatically reinstated the first of the month following your return to work as an eligible employee after you notify the Human Resources Department. If you had a status change while you were on leave, you may make related changes in your benefit elections. To do so, you must contact the Human Resources Department within 31 days of your return to work date. If you return from leave after the yearly open enrollment period has occurred, you may re-select your benefit coverage at that time.

Continuation Of Coverage. If you become ineligible for coverage based on a reduction in hours, or terminate employment from Tuality Healthcare, you may apply for COBRA continuation. This continuation privilege also applies to dependents who are no longer eligible for coverage due to divorce, attainment of age 23, marriage of a dependent child, or death of an employee. To apply, contact the COBRA Administrators. **Refer to the Continuation of Coverage section for more information on COBRA rights.**

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates: :

- 1) The date the Plan or Dependent coverage under the Plan is terminated.
- 2) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the continuation of coverage - COBRA section of the document.)
- 3) The date a covered Spouse or Domestic Partner loses coverage due to divorce, dissolution of the partnership or death of the employee. (See the continuation of coverage - COBRA section of this document)
- 4) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. If a dependent who loses coverage becomes eligible again, the Employee can reapply for coverage for that Dependent. This must be done within 60 days of when the Dependent becomes eligible, or wait until the next open enrollment period. (See the continuation of coverage - COBRA section of this document)
- 5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- 6) The date a Dependent meets or exceeds the lifetime maximum for benefits under the Plan.

Except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage at the time their coverage terminates. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the continuation of coverage – COBRA section outlined in this document.

Tuality Healthcare Schedule of Benefits Medical/Prescription Drug Benefit Plans

Effective January 1, 2010

The plan will provide the following coverage for medically necessary treatment of accidents and illnesses. Preventive and routine care will also be covered as noted. Benefits are paid based on eligible expenses. Please refer to the Plan Exclusions Section for services that are not covered. Following is a summary of your cost for covered services.

Plan Provisions and Services	Select Plus Plan	
	THA and OHSU Providers	First Choice Health Network Providers
Calendar Year Deductible		
Individual Deductible	\$300	\$500
Family Maximum	\$600	\$1,000
Individual Out of Pocket Maximum	\$2,300	\$3,500
Family Maximum	\$4,600	\$7,000
Medical Out-of-Pocket Excludes	Cost containment penalties, prescription out of pocket expenses and non-covered items	
Lifetime Maximum Benefit (Per Person)	\$2 million	
Pre-Existing Condition Limitations	No Limitations - see exclusions	
Physician's & Other Outpatient Services		
Primary Care Physician Office Visits (a)		
Diagnosis and treatment of illness or injury	\$15 copay (deductible waived)	30% coinsurance
Maternity office care (Employee and Spouse Only) (b)	\$50 copay per pregnancy (deductible waived)	30% coinsurance
Specialist Visit (a)		
Specialty care		
Diagnosis and treatment of illness or injury	\$25 copay (deductible waived)	30% coinsurance
Preventive Care		
Child Routine and Preventive Visits	Paid in full (deductible waived) for the first 2 years of life. Thereafter \$15 copay per visit (deductible waived)	
Immunizations		
Adult Routine and Preventive Visits	\$15 copay per office visit (deductible waived)	30% coinsurance (deductible waived)
Colonoscopy		
Mammography		
Well-women care		
Prostate Screening		
Bone Density	Paid in full (deductible waived)	

	Select Plus Plan	
	THA and OHSU Providers	First Choice Health Network Providers
Lab & X-Ray	Some tests require pre-certification	
Preventive Lab & X-ray	Paid in full (deductible waived)	30% coinsurance
Non- Preventive Lab & X-ray	20% coinsurance	30% coinsurance
Hearing Benefits		
Annual Hearing Exam (Adults & Children)	\$15 copay (deductible waived)	30% coinsurance (deductible waived)
Hearing Aids	20% (deductible waived) and limited to \$750 paid per ear every 3 years.	
Glasses or Contacts immediately following cataract surgery	20% coinsurance (limited to \$300 paid ever 5 years)	
Injections, Including Allergies and Contraceptives (c)	\$15 copay (deductible waived). Copay waived for allergy injections.	30% coinsurance
Emergency Room Care (a)		
Emergency Room Care for Medical Emergency (d)	\$100 copay (deductible waived for facility charges only.) Physician services and tests billed separately from the facility charges are subject to the deductible and 20% coinsurance.	\$100 copay (deductible waived for facility charges only.) Physician services and tests billed separately from the facility charges are subject to the deductible and 20% coinsurance.
Emergency Room Care for Non-Emergency (d)	\$100 copay (deductible waived), then you pay 20% for facility charges only. Physician services and tests billed separately from the facility charges are subject to the deductible and 20% coinsurance.	\$100 copay (deductible waived), then you pay 20% for facility charges only. Physician services and tests billed separately from the facility charges are subject to the deductible and 20% coinsurance.
Urgent Care Center (a) Services for immediate care when your physician is not available, or after normal office hours.	\$25 copay (deductible waived). Urgent care outside of the THA/OHSU Networks: \$50 copay per visit (deductible waived)	\$50 copay (deductible waived). Urgent Care outside the First Choice service areas: \$50 copay per visit (deductible waived).
Outpatient Surgery Use of operating room in hospital or authorized outpatient center (including birthing centers)	20% coinsurance (pre-certification required unless surgery is performed in the physician's office)	30% coinsurance (pre-certification is required unless the surgery is performed in the physician's office)
Outpatient Rehabilitation	Limit of 30 visits per calendar year (60 visits per calendar year for head and spinal cord injuries or for treatment of stroke)	
Short-term physical therapy (e)	20% coinsurance	30% coinsurance
Short-term occupational therapy		
Short-term speech therapy		
Chiropractic Maximum Benefit	\$25 copay (deductible waived). You must use First Choice Network Providers.	
Limitations	\$1,000 per calendar year	
Biofeedback Therapy	Limit of 30 visits per calendar year (60 visits per calendar year for head and spinal cord injuries or for treatment of stroke)	
	20% coinsurance	30% coinsurance
Outpatient Diabetic Instruction Services		
Health care professionals instruction services	Paid in Full (deductible waived)	Paid in Full (deductible waived)

	Select Plus Plan	
	THA and OHSU Providers	First Choice Health Network Providers
Hospital Services	Pre-certification required	
Hospital Care		
Room and board — semi-private	20% coinsurance	30% coinsurance
Maternity and routine nursery		
Intensive care		
Cardiac care		
Physician hospital visits		
Surgical services		
Anesthesiology fees		
Rehabilitative Therapy (e)	Limit of 30 visits per calendar year (60 visits per calendar year for head and spinal cord injuries or for treatment of stroke)	
	20% coinsurance	30% coinsurance
X-Ray and Lab Tests	20% coinsurance	30% coinsurance
Mental Health/Chemical Dependency	You must use First Choice Mental Health/Chemical Dependency Network providers	
Inpatient - Precertification required	20% coinsurance	20% coinsurance
Outpatient		
Residential - Precertification required		
Home Health Care - Pre-Certification Required (Limit 60 visits per calendar year)	\$15 copay per visit (deductible waived)	30% coinsurance
Bereavement Counseling	Administered as a Mental Health benefit, utilizing First Choice Health Network Providers	
	20% coinsurance	
Skilled Nursing Facility - Pre-Certification Required (Up to 100 days per calendar year)	20% coinsurance	30% coinsurance
Hospice Care - Pre-Certification Required	Paid in full, limited to 6 months (deductible waived)	30% coinsurance, limited to 6 months
Organ Transplants - Pre-Certification Required	20% coinsurance	30% coinsurance
Ambulance	\$100 copay (deductible waived)	
Anesthesiology Services-Outpatient fees	20% coinsurance	30% coinsurance
Dialysis Services-Professional services and center	20% coinsurance	30% coinsurance
Chemotherapy-Professional and facility services (f)	20% coinsurance	30% coinsurance
TMJ Services	50% coinsurance; benefit limited to \$1,000 per calendar year and \$5,000 lifetime	
Non Dental Oral Surgery	20% coinsurance	30% coinsurance
Durable Medical Equipment, Prosthetic Devices, and Supplies - Pre-Certification Required for DME over \$500 and for items for more than 3 months.	20% coinsurance	30% coinsurance
Family Planning Services	Additional Family Planning benefits can be found under Prescription Drug Benefits.	
Intrauterine Device	20% coinsurance	30% coinsurance
Vasectomy Employee & spouse only	20% coinsurance	30% coinsurance
Tubal ligation Employee & spouse only	20% coinsurance	30% coinsurance
Infertility Diagnosis	50% per procedure to a \$10,000 lifetime maximum benefit, see Plan Exclusions to related infertility treatments	
Voluntary interruption of pregnancy	50% coinsurance, per procedure	
Orthotics (\$200 calendar year maximum)	20% coinsurance	30% coinsurance

Prescription Drug Plan - CVS CAREMARK PBM - Managed Pharmacy (g)		
Retail Pharmacy - Up to 30-day Supply	CVS Caremark Pharmacy	Out of Network Pharmacy
Tier:		
1 Generic Drugs - Generics required see below	\$12 copay per prescription	If you use a non participating pharmacy, you will pay 100% of the prescription cost at the time of purchase. You must then file a paper claim form along with the original prescription receipt to CVS CAREMARK for covered medications. The out of network pharmacy cost will be paid at the same amounts as an in network pharmacy. The plan participant pays the difference.
2 Diabetic Medications (i)	\$12 copay per prescription	
3 Preferred Brand - Retail	20% copay per prescription , \$20 minimum and a \$70 maximum	
4 Non-Preferred Brand - Retail	35% copay per prescription, \$40 minimum and a \$90 maximum	
Out-of-Pocket Maximum	\$2,000 per individual - combined In-Network and Out-of-Network prescription drugs. Not including prescription drug copays or cost containment penalties.	
Mail Order Pharmacy - Up to 90-day Supply	CVS Caremark Mail Order Pharmacy	Out of Network Pharmacy
Tier:		
1 Generic Mail-Order 90 day supply (h)	\$30 copay per prescription	Not covered. Must use CVS CAREMARK mail order (see in-network).
2 Diabetic Medications (i)	\$30 copay per prescription	
3 Preferred Brand - Mail Order (h)	\$60 copay per prescription	
4 Non-Preferred Brand - Mail Order (h)	\$100 copay per prescription	
Generic Substitution	Mandatory Generic Requirement: All prescriptions filled under the retail or mail order prescription drug program will be automatically filled with the generic version of the medication (if one is available). Otherwise, you will be charged the difference in the price between the brand-name and generic version of that medication, <i>plus</i> the generic copay. A listing of preferred brand drugs can be obtained from CVS Caremark.	
<i>This benefit summary is intended to provide highlights of your medical and prescription drug options. If there is a discrepancy between this summary and the official plan document, the plan document will govern plan provisions and how benefits are paid.</i>		

(a) Depending on how services are billed, there may be additional costs to you if lab and x-ray services are ordered in conjunction with these services. Refer to the Lab and X-Ray Services for the coinsurance levels. Also, you may be subject to out-of-pocket expenses (copayment, coinsurance, and/or deductible, if applicable) if the lab or x-ray services are billed separately by the physician.

(b) Contact ICM to join the Healthy Mother Baby Program at no cost to you. You will receive a gift certificate from Tuality upon completion of this program.

(c) Chemotherapy injections are paid under the chemotherapy benefit.

(d) An emergency medical condition means a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.

(e) Participant may "self-refer" to Tuality HealthPlace Only for a Certified Athletic Trainer (Sports Medicine Specialists) for treatment of sports related injuries with no physician referral required.

(f) Chemotherapy injections received in the physician's office are paid under the chemotherapy benefit provision, not as a physician office visit.

(g) Some prescription drug medications require preauthorization or they may have internal plan limits. Please contact CVS CAREMARK regarding any limits or restrictions to the prescription drug program.

(h) By law, CVS CAREMARK must fill your prescription for the exact quantity of medication prescribed by your health care provider, up to the 90-day plan limit. "30 days plus 2 refills" does not equal one prescription written for "90 days." Be sure your health care provider writes the prescription accurately.

(i) Diabetic medications and supplies covered at the lower copay including insulin replacement and oral diabetic medications, syringes, pen needles, test strips and lancets.

SCHEDULE OF BENEFITS

Verification of Eligibility: (866) 575-8104 or (503) 844-8104.

Call this number to verify eligibility for Plan benefits **before** you have services or incur charges.

Precertification: Innovative Care Management (800) 862-3338 or (503) 654-9447.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described more fully later in this booklet. Coverage of a service or supply is based on the Plan Administrator's determination that care and treatment is Medically Necessary and is not Experimental and/or Investigational. Benefits paid will not exceed the contracted charges of the PPO.

Note: The following services must be pre-certified or reimbursement from the Plan may be reduced.

Hospitalizations

MRI/CAT/PET scans

Substance Abuse/Mental Disorder treatments (inpatient and residential)

Skilled Nursing Facility stays

Home Health Care

Hospice Care

Durable Medical Equipment (costs above \$500 or rental longer than 3 months)

Bone stimulators

Cardiac rehabilitation therapy

Surgical procedures (inpatient and outpatient) performed in a hospital or surgical center

Transplant services

Genetic testing and counseling

Dexa Scan (Bone Density) for those under age 65

Rapid Allergy Desensitization Treatment

TMJ treatment

NOTE: Chemotherapy Services do not require prior authorization but do require notification to ICM to verify that treatment is Medically Necessary and is not Experimental or Investigational.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Please see the Medical Management section in this booklet for details.

Each Covered Person will be given access to a list of Network Providers for the Plan. Under the Plan the highest level of coverage is for Tuality Health Alliance/Oregon Health Sciences University providers. Lesser benefits are available from a First Choice Health Network provider. There is no coverage for non-THA/OHSU or First Choice network providers unless the patient lives outside the service areas for both the THA/OHSU and First Choice networks.

Plan participants do not need to designate a primary care physician and have the freedom to change their primary care physician at any time. However, it is important to work closely with all attending physicians to ensure continuity of care. Use of the THA/OHSU Network Providers saves participants and the Plan money, so you are encouraged to select THA/OHSU providers whenever possible. The First Choice Health providers require a greater amount of cost sharing as well as larger deductibles and out-of-pocket maximums; unless the service is not available in the THA/OHSU Network and authorization is in place from ICM.

Covered services provided by a Non-network radiologist, anesthesiologist, pathologist, Emergency Room physician or hospitalist while hospital-confined in either a THA/OHSU or First Choice Network hospital will be covered at the Network level of benefits based on the network affiliation of the hospital.

If a Covered Person has a Medical Emergency and needs immediate medical care, this care will be covered at the rate shown in the Schedule of Benefits following:

Non-Participating emergency room hospital services rendered for a **medical emergency** will be covered at the THA/OHSU Network level of benefits **if the choice of hospital was beyond the control of the patient**. For services rendered in the Emergency Room that the Plan deems not emergent, benefit levels will be reduced to the non-emergency level.

Emergent services required while out-of-the service area: If services are non-life threatening, treatment in Oregon, Washington, Idaho and Alaska must be provided by a First Choice network provider.

Service Guidelines for out of network providers

- After approval by ICM, charges for services rendered by a provider whose specialty is not available in either the THA/OHSU or First Choice Network service area will be considered at the THA/OHSU Network provider level of benefits, subject to the deductible, copayment, and coinsurance (if applicable), out-of-pocket maximum amount, and benefit limitations.
- If a Plan participant is referred by Innovative Care Management to a First Choice Health Network Provider when services or access has not been available through the THA/OHSU network, those services shall be paid at the THA/OHSU Network benefit level.
- Chiropractic charges for services rendered by a provider who is in the First Choice preferred provider network will be covered as listed in the schedule of benefits. Members may access the network through the website at www.fchn.com. Chiropractic care provided by a non-First Choice provider will not be covered at any benefit level.
- Coverage for dependents (eligible spouse/domestic partner/children enrolled as out of area dependents) who reside out of the Select Plus Plan service area will be as follows

Services rendered by a THA/OHSU provider are paid at the THA/OHSU Network benefits level. Refer to the Schedule of Benefits for details on Covered Services.

If the dependent lives in Oregon, Washington, Idaho or Alaska, their care must be provided by a First Choice Health Network provider and benefits will be that of the First Choice Network provider. If the dependent lives in other states, coverage will be paid at the First Choice Network benefit level.

Deductibles/Copayments payable by Plan Participants. Deductibles/Copayments are dollar amounts that the Covered Person must pay before the Plan pays. A deductible is an amount of money that is paid once a Calendar Year per Covered Person. The deductible amount (if applicable) must be paid before any benefits are paid by the Plan for any covered services. Each January 1st, a new deductible amount (if applicable) is required. A copayment is paid each time a particular service is used.

Deductible Credit: If both husband and wife are employed by Tuality and make independent medical elections and one later leaves the employment of Tuality and becomes covered as a dependent spouse mid-plan year, any deductible amounts that were satisfied while covered as an employee under Tuality's medical plan will be credited toward their deductible as a dependent spouse. In other words, you will not be required to re-satisfy any deductible amounts that were previously satisfied while you were covered as an employee under Tuality's medical plan

MEDICAL BENEFITS

Medical Benefits apply when covered charges are incurred by a Covered Person for medically necessary care of an Injury or Illness and while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of covered charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year a Covered Person must meet the deductible shown in the Schedule of Benefits. Copayments do not apply to the deductible. THA/OHSU and First Choice Health Network plan deductibles do not cross-accumulate.

Family Deductible Limit. When the maximum amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year. As with the individual deductible, the family limits do not cross accumulate between the THA/OHSU and First Choice Networks.

Deductible For A Common Accident. This provision applies when two or more Covered Persons in a Family Unit are injured in the same accident. These persons need not meet separate deductibles for treatment of injuries incurred in this accident; instead, only one deductible for the Calendar Year in which the accident occurred will be required for them as a unit for expenses arising from the accident.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the covered charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under Reimbursement rate in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

In most instances, a Covered Person will receive greater benefits when THA/OHSU Network Providers are used. We encourage all Covered Persons to carefully review the Schedule of Benefits and Network Provider directories before making a choice of provider care.

COPAYMENT

Copayments are the first-dollar amounts you must pay for certain covered services under the Plan which are usually paid at the time the service is performed (i.e., physician office visits). These copayments do not apply to your annual deductible, but will apply to the annual out-of-pocket maximum. The copayment amounts are shown on the Schedule of Benefits.

OUT-OF-POCKET MAXIMUM

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket maximum shown in the Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket maximum, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

The out of pocket maximum includes the annual deductible and copayments.

BENEFIT MAXIMUMS

Total Plan payments for each Covered Person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to specific time period, such as per calendar year or per Lifetime. Whenever the word Lifetime appears in this Plan in reference to benefit maximums, it refers to the period of time you or your eligible dependents participate in any Plans sponsored by Tuahly Healthcare, regardless of your changes in plan selection.

The benefit maximums applicable to this Plan are shown on the Schedule of Benefits.

COVERED CHARGES

Covered charges are the charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished. Coverage is limited to medically necessary treatment of accidents and illnesses, and preventive care as outlined in this document.

1) Hospital Care. The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement. Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits.

Pre-certification is required for all non-maternity inpatient care, in or outpatient surgeries and tests as outlined under the Medical Management Services section.

Emergency Room Services. The charge for treatment in a Hospital emergency room. If the Covered Person is admitted as an inpatient directly from the emergency room, any copayment listed in the Schedule of Benefits for emergency room services will be waived and regular plan benefits will apply.

2) Coverage of Pregnancy. The care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse. Services for expenses incurred in connection with an Elective Abortion are covered as indicated in the Schedule of Benefits.

In accordance with Federal law, we will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. This does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Because of this, no pre-authorization is necessary for stays less than 48 hours (or 96 hours).

There is no coverage for Pregnancy for a Dependent child even if the pregnant child is covered under the Plan as an eligible Dependent.

3) Skilled Nursing Facility Care. The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when it directly follows a hospital stay and;

- a) the patient is confined as a bed patient in the facility;
- b) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
- c) the attending Physician completes a treatment plan, which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Pre-certification is required for all Skilled Nursing Facility care.

4) Physician Care. The professional services of a Physician for surgical or medical services, including, but not limited to:

Office visits
Hospital visits
Anesthesia
Surgery

- a) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:
 - i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the charge that is allowed for the primary procedures; 50% of the

charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

- ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the percentage allowed for that procedure; and
- iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's allowance.

For immediate care regarding your surgery when your physician is not available, or after normal office hours, services for immediate care at an **Urgent Care Center** are covered as indicated in the schedule of benefits.

- 5) **Injections.** Covered when provided in connection with a covered Illness or Injury and includes allergy injections, with the exception of Rapid Allergy Desensitization. Refer to the Schedule of Benefits for details.
- 6) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:
 - a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
 - b) **Outpatient Nursing Care.** Outpatient private duty nursing care is not covered.
- 7) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits. A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services. Pre-certification is required.

- 8) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as terminal and has placed the person under a Hospice Care Plan.. Terminal means the patient is not expected to live more than six months..

Covered charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits. Pre-certification is required.

Bereavement counseling is covered for services by a licensed social worker or other covered providers and is for the patient's immediate family (covered Spouse and/or covered Dependent Children). Bereavement services must be furnished within six months after the patient's death.

- 9) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

- a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
- b) **Anesthetic**; including oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
- c) **Biofeedback** therapy services that are part of a physician's treatment plan are limited to the treatment of tension or migraine headaches.
- d) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.
- e) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included. Pre-notification to the Medical Management Organization is required.
- f) Chiropractic Care services performed by a chiropractic physician in the First Choice Network. See Schedule of Benefits for details.
- g) Initial contact lenses or glasses required following cataract surgery. See Schedule of Benefits for details.
- h) Outpatient **Diabetic Instruction Services** provided by physicians, nurses, pharmacists and registered dietitians who are knowledgeable about the disease process of diabetes and treatment of a person with diabetes. See Schedule of Benefits for details.
- i) Rental of **durable medical or surgical equipment** if deemed Medically Necessary, and when preauthorized. See Utilization Review provision under the Medical Management Services section. These items may be bought rather than rented, with the cost not to exceed the fair market price of the equipment at the time the equipment is purchased, but only if agreed to in advance by the Plan Administrator. If the equipment is purchased, the purchase price will be prorated over a 12 months period, subject to benefits and eligibility. However, the 12-month prorated period stated above does not apply to bone stimulators. The entire covered benefit for bone stimulators will be paid to the service provider once the claim has been submitted and processed. **Pre-certification is required for bone stimulators and all durable medical equipment that exceeds \$500.** If the person purchased the equipment and the rental price would have been less or the necessary information was not provided, the Claims Administrator will only allow what would have been paid had the equipment been rented rather than purchased.
- j) Eating Disorders (Anorexia Nervosa and Bulimia). The Plan covers Medically Necessary therapy required for the treatment of eating disorders (Anorexia Nervosa and Bulimia) under the Mental Disorders provision of this document. This coverage does not include non-specific eating disorders nor does it include obesity or weight loss programs.
- k) **Family planning services.**
Employees and Spouses/Partners:
Covered family planning services for employees and spouses/partners include vasectomy, tubal ligation, and elective abortions. Benefits will be paid for outpatient or day surgery procedures only or, in the case of a female Covered Person, for sterilization procedure performed at the time of delivery. IUDs and other implantable devices, and injectible forms of birth control, are also covered under the medical plan. Additional contraceptives are included under the prescription drug benefits that are administered by CVS Caremark.

Family planning services **do not** include services and supplies related to the **reversal** of a sterilization procedure or in connection with in vitro fertilization, or embryo transfer procedures.

Dependent Children:

Covered family planning services for dependent children include IUDs and other implantable devices, and injectible forms of birth control, which are covered under the medical plan. Additional contraceptives are included under the prescription drug benefits that are administered by CVS Caremark. Vasectomies and tubal ligations are not covered for dependent children.

l) Medically Necessary services for care and treatment of **jaw joint conditions, including Temporomandibular Joint syndrome. Services are subject to the limits shown in the Schedule of Benefits.**

m) Laboratory and x-ray services. See Schedule of Benefits.

n) Medical supplies are covered when required by standard treatment practices for the treatment of an Illness or Injury.

o) Treatment of Mental Disorders and Substance Abuse

Psychiatrists (M.D.), psychologists (Ph.D.) or counselors (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

Pre-certification is required for inpatient or residential treatment of mental disorders or substance abuse.

p) Injury to or care of **mouth, teeth and gums. Charges for injury to or care of the mouth, teeth, gums and alveolar processes will be covered charges under Medical Benefits only if that care is for the following oral surgical procedures:**

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Emergency repair due to Injury to sound natural teeth. This repair must be made within 12 months from the date of an accident.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.
- Reduction of dislocations and excision of temporomandibular joints (TMJs).

No charge will be covered under Medical Benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

q) Occupational therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

r) Organ transplants. Charges for an organ or tissue transplant that is medically appropriate and

non-experimental or investigational as defined by the Plan. Pre-certification is required.

A transplant means a procedure or a series of procedures by which an organ or tissue is either: removed from the body of one person (called a donor) and implanted in the body of another person (called a recipient); or removed from and replaced in the same person's body (called a self-donor).

In treatment of cancer, the term transplant includes any chemotherapy and related course of treatment which the transplant supports. For purposes of this benefit, the term transplant does not include transplant of blood or blood derivatives (except hematopoietic stem cells), or cornea. These services are considered as non-transplant related and are covered elsewhere in the plan.

Donor costs mean the reasonable cost of: medical services required to remove the organ or tissue from either the donor's or the self-donor's body; preserving it; and transporting it to the site where the transplant is performed. Costs associated with locating an acceptable organ or tissue for transplant, and other administrative or program costs are not considered donor costs.

Facility transplant services means all medically necessary services and supplies provided by a health care facility in connection with a covered transplant except donor costs and anti-rejection medications.

Medically appropriate means the recipient or self-donor meets the criteria for transplant established by the Plan.

Professional provider transplant services means all medically necessary services and supplies provided by a professional provider in connection with a covered transplant except donor costs and anti-rejection medications.

Covered Organ Transplant Benefits are payable as follows:

- Facility Benefits - The Plan covers facility transplant services according to the benefit for Hospital Inpatient Services under the Plan.
- Professional Provider Benefits - The Plan covers professional provider transplant services according to the benefits for Physicians Services under the Plan.
- Donor Costs - If the recipient or self-donor is covered under this Plan, we cover donor costs incurred in connection with a covered transplant. If the donor is covered under this Plan and the recipient is not, we will not cover donor costs. Complications and unforeseen effects of the donation will be covered as any other illness under the terms of the Plan only if the donor or self-donor is covered under this Plan.
- Anti-rejection Medications – Anti-rejection medications following the covered transplant, will be covered according to the benefits for prescription medications, if any, under the Plan.

Pre-certification – All transplant procedures must be pre-certified for type of transplant and be medically appropriate and non-experimental or investigational according to the criteria established by the Plan. In addition, the procedure must be performed at an in-network facility or other facility approved by the Plan. Pre-certification is a part of the benefit administration of the Plan and is not a treatment recommendation. The actual course of medical treatment remains strictly a matter between the covered person and their physician.

Pre-certification Procedures - To pre-certify a transplant procedure, the covered person or their physician must contact the Medical Management Organization before the transplant admission. Pre-certification should be obtained as soon as possible after the covered person has been

identified as a possible transplant candidate. See the Medical Management Services section of this document for a description of the preauthorization process.

Only written approval from the Medical Management Organization on a proposed transplant will constitute pre-certification. If time is a factor, pre-certification will be made by telephone followed by written confirmation.

Transplant Exclusions - In addition to the exclusions listed in the PLAN EXCLUSIONS section, we will not pay for the following:

- any transplant procedure that has not been pre-certified;
- any donation-related services or supplies provided to an enrolled donor if the recipient is not covered under this Plan and eligible for transplant benefits.

This exclusion does not apply to:

- complication or unforeseen effects resulting from the donation of tissue; services or supplies for any transplant not specifically named as covered including the transplant of animal organs or artificial organs; and
- chemotherapy with autologous, allogeneic, or syngeneic hematopoietic stem cells transplanted for treatment of any type of cancer not specifically named as covered.

Refer to the Plan Exclusions section of this document for a list of all plan exclusions.

- s) The initial purchase, fitting and repair of **orthotic/orthopaedic appliances** such as braces, splints or other appliances, which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. The appliance or orthotic must be prescribed by a qualified provider. Podiatric orthotics required as result of surgery, congenital defect or diabetes are covered as outlined in the Schedule of Benefits. Covered services and expense does NOT include arch supports, insoles, heel wedges or lifts; orthopedic shoes; orthotics, except as provided above.
- t) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and to improve a body function. Plan Participants may "self-refer" to any THA/OHSU or FCHN Network Certified Athletic Trainer only (Sports Medicine Specialists) for outpatient treatment of sports related injuries (no physician referral required).
- u) **Prescription Drugs.** The prescription drug program is administered by CVS Caremark. Refer to the Prescription Drug Benefit section of this document for prescription drug benefits.
- v) **Routine Preventive Care.** Covered charges under Medical Benefits are payable for routine Preventive Care for adults and children as described in the Schedule of Benefits. Services are recommended in accordance with the following schedule:
- Well-baby-up to 8 visits during the first 24 months of life
 - Ages 2-6 – One exam per calendar year
 - Ages 7-18 – One exam every two calendar years
 - Ages 19-34 – One exam every four calendar years
 - Ages 35 and above – One exam every two calendar years or more frequently based on your physician recommendation and your family history.
 - Immunizations for plan participants over 18 as recommended by the American Academy of Family Physicians. Immunizations for hepatitis B are covered only for enrolled dependent children under age 19. Covered immunizations do not include immunizations for the sole purpose of travel, occupation, or residence in a foreign country. Immunization copay is waived if received in conjunction with an office visit where the \$15 copay is charged.
 - Age 50 and above: one colonoscopy every five years or more frequently or earlier than this schedule if recommended by your physician due to health status or family history.
 - Mammograms: age 35 to 40, one mammogram during this five-year period. Once the patient reaches age 40, mammograms are covered annually, Mammograms can be provided more

frequently or earlier than this schedule if recommended by your physician due to health status or family history.

- Shingles vaccine, for those over age 60
- One baseline DEXA Scan (bone density scans) is covered for women age 65 or older

- w) The initial purchase, fitting and repair of fitted **prosthetic devices**, which replace body parts. Pre-certification required.
- x) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered covered charges.

This mammoplasty coverage will include reimbursement for:

- i) all stages of reconstruction of the breast, on which a mastectomy has been performed,
- ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
- iii) coverage of prostheses and treatment of physical complications at all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient.

The same deductibles, copayments, coinsurance, and other limits and maximums apply to surgical reconstruction as to other surgery benefits under the Plan. The same deductibles, copayments, coinsurance, and other limits and maximums apply to breast prostheses as apply to other prostheses under the Plan.

- y) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy); (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder. Covered expenses also include developmental therapy.
- z) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.
- aa) Coverage of **Well Newborn Nursery/Physician Care/Circumcision**

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is covered under the Plan at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

The benefit is limited to billed charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the mother. If charges are not routine in nature then charges will be applied toward the Plan of the newborn child.

Circumcisions are covered as follows: (1) if the service is performed in the doctor's office, plan waives the co-pay and applies the deductibles and coinsurance to the surgery and professional fees or (2) if the service is done while inpatient, the hospital is still paid at the maternity case rate and the surgeon charge applies to the deductibles and coinsurance.

Charges for Routine Physician Care. The benefit is limited to the billed charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine Physician care will be applied toward the Plan of the newborn child.

Charges for nonprescription elemental enteral formula for home use when ordered by the patient's physician as long as:

- i) the formula is medically necessary for the treatment of severe intestinal malabsorption; and
- ii) the formula comprises the sole or an essential source of the patient's nutrition.

Medical foods, such a PKU formula, for treatment of inborn errors of metabolism that involve amino acid, carbohydrate, and fat metabolism and for which there exists medically standard methods of diagnosis, treatment, and monitoring. Medical foods means foods that are:

- i) formulated to be consumed or administered internally under the supervision of a physician;
- ii) specifically processed or formulated to be deficient in one or more of the nutrients present in typical nutritional counterparts;
- iii) for the medical and nutritional management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients, or have other specific nutrient requirements as established by medical evaluation; and
- iv) essential to optimize growth, health, and metabolic homeostasis.

Charges for diagnosis, treatment, and monitoring of the disorder requiring medical foods are covered elsewhere in the Plan.

- bb) **Supplies** for insulin pumps, ostomies, respiratory therapy devices and other prescribed devices are covered under the Medical Plan and not the Prescription Drug Plan.
- cc) Medically Necessary **genetic testing and counseling** services are covered provided pre-certification is obtained by the Medical Management organization. Experimental and/or Investigational genetic testing services are excluded.

MEDICAL MANAGEMENT SERVICES

Medical Management Services Phone Number

Innovative Care Management
(800) 862-3338 or (503) 654-9447

The attending Physician must call this number to receive certification of certain medical services. This call must be made at least 7 days in advance of services being rendered or within 48 hours after an emergency or Urgent Care (see item (b) below for definition of Urgent Care).

UTILIZATION REVIEW

Utilization review is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- a) Pre-certification is required to determine the Medical Necessity for the following non-emergency services before Medical and/or Surgical services are provided:
- Hospitalizations
 - MRI/CAT scans
 - Mental Health and Chemical Dependency (inpatient and residential)
 - Skilled Nursing Facility
 - Home Health Care
 - Hospice Care
 - Durable Medical Equipment (Costs above \$500 or rental longer than three months)
 - Cardiac rehabilitation therapy
 - Surgical procedures (inpatient and outpatient) performed in a hospital or surgical center
 - Transplant services
 - Genetic testing and counseling
 - DEXA Scan (Bone Density) for those under age 65
 - Rapid desensitization allergy therapy

NOTE: Chemotherapy Services do not require prior authorization but do require notification to ICM to verify that proposed treatment is Medically Necessary and is not Experimental or Investigational.

- b) If these services are provided on an urgent basis, then the review for medical necessity is performed retrospectively.

Urgent means any type of medical care or treatment that when using the Plan's timetable for making non-urgent decisions:

- 1) could seriously jeopardize the life or health of the Covered person; or
 - 2) could impair the ability of the Covered patient to regain maximum functions; or
 - 3) in the opinion of a Physician familiar with the Covered patient's medical condition, would subject the Covered patient to severe pain that could not be adequately managed without the care or treatment.
- c) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and
- d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine for the Plan the medical necessity of a desired service or supply. This program is not designed to be the practice of medicine or a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for reimbursement under the Plan.

The attending Physician does not have to obtain pre-certification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

Here's how the program works:

Pre-certification. Before a Covered Person enters a Medical Care Facility on a non-emergency or non-Urgent Care basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency or non-Urgent Care stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the attending Physician. Contact should be made with the utilization review administrator at the telephone number on your ID card **at least 7 days before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an **emergency or Urgent Care** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may deny reimbursement from the Plan.**

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services. They will coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the attending Physician must request the additional services or days.

SPECIAL NOTE

Pre-certification from Innovative Care Management does not guarantee eligibility nor does it guarantee that the service is covered under the Plan.

It is always up to you and your providers to decide what, if any, care you receive and to determine how long you stay in the hospital. Innovative Care Management does not provide medical advice; however, they do provide advice on the medical necessity and appropriateness of services provided.

HEALTHY MOTHER BABY PROGRAM

The Healthy Mother Baby Program is designed to answer your questions and support you through your pregnancy. This program is available at no cost to you. However, you will receive a gift certificate from Tuality Healthcare if you participate in this program. The program features include:

- Access to a prenatal nurse specialist,
- Educational information packets, a prenatal care book, and
- Videos and books for home viewing.

To join the Healthy Mother Baby Program, call Innovative Care Management (ICM) at 1-800-862-3338 or 503-654-9447.

CASE MANAGEMENT

When a catastrophic condition, such as a spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting--even to his or her home.

Case Management is a program whereby a case manager monitors these patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: 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 plan 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.

ALTERNATIVE BENEFITS

Alternative benefits means payment for those services or supplies which are not otherwise benefits of the Plan, but that the Plan believes to be Medically Necessary and cost effective. Payment for alternative benefits will not be made until the Plan has received specific approval from the Covered Person or the Covered Person's legal representative. The fact that alternative benefits for a Covered Person are paid under the Plan shall not obligate the Plan to pay such benefits for other Covered Persons, nor shall it obligate the Plan to pay continued or additional alternative benefits for the same Covered Person. Payments for alternative benefits are covered expenses for all purposes under the Plan.

APPEALING MEDICAL MANAGEMENT'S DECISION

If the patient or Physician does not agree with Medical Management's decision, it can be appealed by following the information provided under "**Request for Appeal**" and "**Filing Appeals and Notification Requirements**" as outlined under the section titled, "**HOW TO SUBMIT A CLAIM**".

CONFIDENTIALITY

The Claims Administrator and the Medical Management organization will not reveal to your employer individual patient identity regarding the type of services rendered.

You and your family are assured that both the Claims Administrator and the Medical Management organization will provide complete confidentiality with regards to treatment you or your covered dependents receive.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer performing the duties of his or her job with the Employer on a full-time or part-time basis. An Employee will be considered an "Active Employee" if he or she is absent from his or her job based on a health factor.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R. N.'s) and does not provide for overnight stays.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Birthing Center means any freestanding health facility, place, professional office or institution which 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.

The Birthing Center must provide 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 (R.N.) or a licensed nurse-midwife; and 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 January 1st through December 31st of the same year.

Claims Administrator is a party selected by the Plan Administrator to maintain Employee participation records and provides claims processing services for the Employer. Tuality Health Alliance is the Claims Administrator.

Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Covered Person is an Employee or Dependent who meets the eligibility requirements and is covered under this Plan.

Creditable Coverage includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare, coverage under a State Children's Health Insurance Program (SCHIP), a public health plan, and any health coverage under a plan

established or maintained by a foreign country or a political subdivision of a foreign country. Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication, which could normally be self-administered.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship and for whom the Employer pays payroll costs (FICA, FUI, SUI – employment taxes and Workers' Compensation).

Employer is Tuality Healthcare.

Enrollment Date is the first day of coverage.

ERISA is the Employee Retirement Income Security Act of 1974, as amended.

Experimental and/or Investigational means services, supplies, care and treatment which does not constitute accepted medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator will make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

- 1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- 2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- 3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- 4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Generic Drug means a Prescription Drug, which is equivalent to the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Home Health Care Agency is an organization whose main function is to provide Home Health Care Services and Supplies; is federally certified as a Home Health Care Agency; and is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days. It must state the diagnosis, certify that the Home Health Care is in place of Hospital confinement, and specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include:

- part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.);
- part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services);
- physical, occupational and speech therapy;
- medical supplies; and
- laboratory services.

Hospice Agency is an organization whose main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency, are part of a Hospice Care Plan, and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets the following standards:

- it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations;
- it is approved by Medicare as a Hospital;
- it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians;
- it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and
- it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" also includes the following:

- 1) A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- 2) A facility operating primarily for the treatment of Substance Abuse if it meets the following standards:

- maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients;
- has a Physician in regular attendance;
- continuously provides 24-hour a day nursing service by a registered nurse (R.N.);
- has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness includes Pregnancy, childbirth, miscarriage or Complications of Pregnancy.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit is defined as a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a “coronary care unit” or an “acute care unit.” It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 31-day period (60 days for newly eligible dependants) in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of the person, or a fetus in the case of a pregnant woman, in serious jeopardy.

Medically Necessary means those services and supplies that are required for diagnosis or treatment of **Illness** or **Injury** and which, in the **Plan’s** judgment, are:

- 1) appropriate by treatment setting and level of care, in amount, duration, and frequency of care and consistent with the symptoms or diagnosis and treatment of the covered person’s condition;
- 2) appropriate with regard to widely accepted standards of good medical practice;
- 3) not primarily for the convenience of the covered person or a provider of services or supplies; and
- 4) the least costly of the treatment settings, alternative supplies, or levels of service, which can be safely provided to the covered person. This means, for example, that care rendered in a **hospital** inpatient setting is not **medically necessary** if it could have been provided without harm to the covered person in a less expensive setting, such as a **skilled nursing facility**.

THE FACT THAT AN ELIGIBLE PROVIDER MAY PRESCRIBE, ORDER, RECOMMEND, OR APPROVE A SERVICE OR SUPPLY DOES NOT, OF ITSELF, MAKE A SERVICE OR SUPPLY MEDICALLY NECESSARY. THE CLAIMS ADMINISTRATOR DETERMINES

WHETHER THE SERVICES ARE NECESSARY IN CONSULTATION WITH PROFESSIONAL CONSULTANTS, PEER REVIEW COMMITTEES, OR OTHER APPROPRIATE SOURCES FOR THE RECOMMENDATIONS REGARDING THE NECESSITY OF THE SERVICES OR SUPPLIES RECEIVED BY ENROLLEES.

Medically necessary **care does not include** custodial care. Custodial care **refers to care that helps a person conduct activities of daily living and that can be provided by people without medical or paramedical skills such as help in bathing, eating, dressing, or getting in or out of bed. This also includes care that is primarily for the purpose of separating a covered person from others or preventing a patient from harming him or herself.**

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Network Providers means the following:

The medical Plan includes Network Providers which are a network of Physicians, Hospitals, and other health care providers that have entered into special contracts with THA/OHSU, First Choice Health Network and CVS Caremark to provide health care at a discount. The agreements are between the provider of care and each Network and providers of care have no contract with the Employer.

The Network Providers for the Select Plus Medical Plan are Tuality Health Alliance, Oregon Health Sciences University and First Choice Health Network for most covered health care services. Please refer to the Schedule of Benefits for coverage. First Choice Health Network also provides mental health and chemical dependency services as well as chiropractic care received by Select Plus Plan participants. CVS Caremark is the Network Provider for prescription drug services received under the Select Plus Plan

As the Plan participant, you will receive certain advantages by receiving care by a Network Provider. Some examples are as follows:

- 1) To receive the highest benefits you must use a THA/OHSU Provider, except where referred as indicated in the Schedule of Benefits Section under Medical Benefits.
- 2) When you use First Choice Health Network Providers, you will receive lesser benefits, except where referred as indicated in the Schedule of Benefits Section under Medical Benefits.
- 3) You will not be billed for the difference if a Network Provider's charge exceeds the Network's discounted charge.
- 4) The Network Provider will assist you through the pre-certification procedures that are required under the Medical Management Services Program.
- 5) The contract with Network Providers includes direct billing and payment. This means no claim form is required whenever you use a Network Provider.

Plan participants do not need to designate a primary care physician and have the freedom to change their primary care physician at any time. However, it is important to work closely with all attending physicians to ensure continuity of care. Use of the THA/OHSU Network Providers saves participants and the Plan money, so you are encouraged to select THA/OHSU providers whenever possible. The First Choice Health providers require a greater amount of cost sharing as well as larger deductibles and out-of-pocket maximums.

Covered services provided by an out-of-network radiologist, anesthesiologist, pathologist, Emergency Room physician or hospitalist while hospital-confined in either a THA/OHSU or First Choice Network hospital will be covered at the Network level of benefits based on the network affiliation of the hospital.

Services required while out of the service area of both the THA/OHSU and First Choice Networks : If a Covered Person has a true medical emergency that requires immediate medical care, this care will be covered at the THA/OHSU Network benefit levels provided that Innovative Care Management has authorized this treatment. If services are non-life threatening, treatment in Oregon, Washington, Idaho and Alaska must be provided by a First Choice network provider. If services are provided outside the First Choice service area, reimbursement will be at the First Choice network benefit.

Under the Plan the highest level of coverage is for Tuality Health Alliance/Oregon Health Sciences University providers. Lesser benefits are available from a First Choice Health Network provider. There is no coverage for non-THA/OHSU or First Choice network providers unless the covered person lives outside the service areas for both the THA/OHSU and First Choice networks.

Each Covered Person will be given access to a list of Network Providers for the Plan. The provider lists are updated periodically by the Network. To verify if your provider continues to be in the network call to confirm a current provider status. The Claims Administrator can be contacted to check Network Providers in Tuality Health Alliance and Oregon Health Sciences University. First Choice Health Network can be contacted to confirm their Network Providers. CVS Caremark can be contacted to confirm pharmacy Network Providers.

No-Fault Auto Insurance is the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient. It also includes services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Partial Hospitalization is an outpatient program specifically designed for the diagnosis or active treatment of a Mental Disorder or Substance Abuse when there is reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse. This program shall be administered in a psychiatric facility which is accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required, by the state in which the facility is providing these services. Partial hospitalization treatment lasts more than 4 but less than 24 hours, and no charge is made for room and board.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Certified Athletic Trainer (for outpatient rehabilitation treatment for sports related injuries only when provided by Tuality Healthplace), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Licensed Clinical Social Worker (L.C.S.W.), Licensed Social Worker (L.S.W.), Speech Language Pathologist and any other Mental Health practitioner who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license, unless specifically excluded in this Plan.

Plan means Tuality Healthcare Medical Select Plus Plan, which is a benefits Plan for certain employees of Tuality Healthcare and is described in this document.

Plan Administrator or Sponsor means Tuality Healthcare.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on January 1 and ending on December 31st of each year.

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following:

- a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription";
- injectable insulin; and contraceptives
- hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician.

All drugs must be Medically Necessary in the treatment of a Sickness or Injury

Sickness is:

For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its complications.

Skilled Nursing Facility is a facility that fully meets all of the following standards:

- 1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- 2) Its services are provided for compensation and under the full-time supervision of a Physician.
- 3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
- 4) It maintains a complete medical record on each patient.
- 5) It has an effective utilization review plan.
- 6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Disorders.
- 7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital or any other similar nomenclature.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: the complete inability as a result of Injury or Sickness to perform the normal activities of a person in good health of like age and sex.

Urgent Care Facility: A public or private facility, licensed and operated according to applicable state law, where ambulatory patients can receive immediate, non-emergency care for mild to moderate injuries and/or illnesses without scheduling an appointment.

PLAN EXCLUSIONS

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

Acupuncture. Charges for acupuncture or services of a certified Acupuncturist are not covered.

Complications of non-covered treatments. Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered.

Cosmetic Services. Care and treatment provided for cosmetic reasons. This exclusion will not apply if the care and treatment is for repair of damage from an accident that occurred while the person was covered under the Plan, or is for correction of abnormal congenital condition in a child. Reconstructive mammoplasty will be covered after a Medically Necessary mastectomy, providing the reconstruction is performed within five years of the mastectomy. In addition, reconstructive mammoplasty will be performed on either or both breasts to restore symmetrical appearance following mastectomy.

Custodial care. Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

Educational or vocational testing. Services for educational or vocational testing or training.

Excess charges. The part of an expense for care and treatment of an Injury or Sickness that is in excess of a Reasonable Charge.

Exercise programs. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

Experimental or not Medically Necessary. Care and treatment that is either Experimental/Investigational or not Medically Necessary.

Eye care. Radial keratotomy or other eye surgery to correct near-sightedness. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

Family Planning Services. Services and supplies related to the reversal of a sterilization procedure. Covered dependent children are not eligible for tubal ligations or vasectomies, or their reversal.

Foot care. Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).

Foreign travel. Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

Government coverage. Care, treatment or supplies furnished by a program or agency funded by any government (local, state or federal). This does not apply to Medicaid or when otherwise prohibited by law.

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

Hypnosis services are not covered, whether or not prescribed by a Physician.

Illegal acts. Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation. This includes committing or attempting to commit any crime, criminal act, assault or other felonious behavior, or participation in a riot or public disturbance.

Impotence or Erectile Dysfunction. Care, treatment, services or supplies in connection with treatment for impotence or erectile dysfunction.

Infertility. Treatment of infertility, including procedures, supplies and drugs for any assisted fertilization techniques, regardless of reason or origin of condition, including but not limited to, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT) and any direct or indirect complications thereof.

Massage or Massage Therapy. Charges for massage and/or massage therapy are not a covered expense, whether or not prescribed by a Physician.

Naturopathic Physician. Care, treatment, or services rendered by, or supplies or medication in connection with treatment by a Naturopathic Physician are not covered.

No charge. Care and treatment for which there would not have been a charge if no coverage had been in place.

No obligation to pay. Charges incurred for which the Plan or the patient has no legal obligation to pay.

No Physician recommendation. Care, treatment, services or supplies not recommended and approved by a Physician, and treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate for the Injury or Sickness.

Not specified as covered. Services, treatments and supplies which are not specified as covered under this Plan.

Nutritionist services. Service provided by a Nutritionist unless part of an approved course of diabetic instruction.

Occupational Accidents and Illnesses. Benefits are not available under this Plan for care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit including self-employment. This exclusion applies regardless of payment or coverage by Workers Compensation.

Personal comfort items. Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and non-hospital adjustable beds.

Plan exclusions. Charges excluded by the Plan design as mentioned in this document.

Pregnancy of daughter. Care and treatment of Pregnancy and Complications of Pregnancy for a dependent daughter.

Private duty nursing. Charges in connection with care, treatment or services of a private duty nurse.

Relative giving services. Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as self, spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

Replacement braces. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.

Services before or after coverage. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

Sex changes. Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

Sleep disorders. Care and treatment for sleep disorders unless deemed Medically Necessary.

Smoking cessation. Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma. Certain tobacco cessation drugs are covered through the Prescription Drug Benefit program.

Surgical sterilization reversal. Care and treatment for reversal of surgical sterilization.

Surrogate mothers. Any services or supplies rendered in connection with the Covered Person (Employee or Dependent) acting as, or utilizing the services of, a surrogate mother. Coverage is excluded both for the Employee or Dependent who acts as the surrogate mother and for the child born to the surrogate mother. For purposes of this exclusion, a surrogate mother is a woman who, pursuant to an agreement, carries a child on behalf of one or more other persons with the intention of giving that child up to the other person or persons once it is born. A surrogate mother is subject to this exclusion regardless of the method of impregnation. This exclusion does not apply to the child of a Covered Person who otherwise satisfies the Plan's Dependent eligibility requirements and is enrolled in the Plan, where a Covered Person utilizes the services of a surrogate mother but does not act as the surrogate mother.

Travel or accommodations. Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

Treatment for Obesity Or Weight Control. Surgery or treatment (including any later complications), even if you or your enrolled dependent has other medical conditions related to or caused by obesity. Specifically excluded are: gastric stapling or bypass procedures, lap banding, weight loss programs, counseling, hypnosis, biofeedback neurolinguistic programming, guided imagery, and other forms of relaxation training as well as subliminal suggestion used to modify eating behavior.

War. Any loss that is due to an act of war, whether declared or undeclared.

Note: Some exclusions may not apply if an injury results from a medical condition (including both physical and mental medical conditions) or an act of domestic violence, provided that the Plan generally provides benefits for the type of injury for which benefits are being claimed.

PRESCRIPTION DRUG BENEFITS

When you elect medical coverage, you also receive coverage for prescription drug benefits that are administered by CVS Caremark. There are two components to the prescription drug program:

- 1) Retail Pharmacies for short-term medications
- 2) Mail Order Service for long-term medications

There are four levels of coverage for prescription drugs purchased under the program:

- 1) A *generic drug* is one that is chemically equivalent to a brand name drug.
- 2) Diabetic medications for insulin replacement and oral anti-diabetic medications, including related syringes and blood glucose monitoring supplies.
- 3) A *preferred (formulary) brand name drug* is one that is on CVS Caremark's preferred drug list.

- 4) A non-preferred (*non-formulary*) *brand name drug* is one that is not on CVS Caremark's preferred drug list.

The specific price for each type of drug is based on whether you purchase the drug at a retail pharmacy or through the mail order program, as described in the following sections..

The prescription drug benefits are an independent program, separate from the medical plans, and administered by CVS Caremark. Tuahly Health Alliance does not administer the prescription drug program, so please direct prescription drug claims and questions to CVS Caremark. They can be reached at: **CVS CAREMARK: (800) 503-3241**

PARTICIPATING PHARMACIES

To locate a CVS Caremark participating pharmacy in your area, simply access their website: (www.Caremark.com) or call CVS Caremark's number listed above. You can also request a list of the participating pharmacy chains through the Human Resources Department or you can request it from CVS Caremark.

PREFERRED DRUG PROGRAM

Part of your prescription drug benefit includes a preferred drug (formulary) program. A formulary is a list of preferred brand prescription medications that have been chosen by CVS Caremark because of their clinical and cost effectiveness. Your participation in the preferred drug program is voluntary. However, it will cost you more to obtain a prescription drug not listed on the formulary program. A summary description of formulary medications is available through CVS Caremark's website at www.Caremark.com.

Periodic updates to the preferred drug list will occur. For the most current preferred drug information please call CVS Caremark at (800) 581-5300 or visit their website at www.Caremark.com.

PHARMACY DRUG CHARGE

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. CVS Caremark is the administrator of the pharmacy drug plan.

COST SAVING TIPS

- 1) Always ask your health care provider or pharmacist for generic drugs
- 2) Ask your healthcare provider for samples to make sure the medication works for you before you fill your prescription
- 3) Use the mail order drug benefit option for maintenance medications
- 4) Sign up for the Flexible Spending Account (FSA) program to cover the cost of copays and coinsurance

RETAIL PHARMACY BENEFIT OPTION

The copayment or coinsurance is applied to each covered retail pharmacy drug charge and is shown in the Schedule of Benefits. The copayment and/or coinsurance amount is not a covered charge under the Medical Plan. Any one prescription purchased from a retail pharmacy is limited to the greater of a 30-day supply or a 100-unit dose. The copayment or coinsurance does accumulate towards your pharmacy out of pocket maximum, which is separate from that of your medical plan.

If a drug is purchased from a non-participating pharmacy, or a participating pharmacy when the Covered Person's ID card is not used, the amount payable in excess of the copayment will be the ingredient cost and dispensing fee. In these instances, you are required to pay the full cost of the prescription at the time of purchase. You must file a claim form with CVS Caremark to be reimbursed for covered medications. You can obtain claim forms from the Human Resources Department.

Mandatory Generic Requirement: All prescriptions filled under the retail or mail order prescription drug program will be automatically filled with the generic version of the medication (if one is available). Otherwise, you will be

charged the difference in the price between the brand-name and generic version of that medication, **plus** the generic copay.

MAIL ORDER BENEFIT OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken regularly such as drugs prescribed for heart disease, high blood pressure, asthma, diabetes, thyroid, etc.). Because of volume buying, CVS Caremark's mail order pharmacy is able to offer Covered Persons significant savings on their prescriptions. You also have the convenience of having your prescriptions delivered to your home and refills are easy – just a phone call or on-line request to CVS Caremark.

You can obtain a Mail Service Prescription Enrollment Order Form (includes a postage paid envelope) from the Human Resources Department. The order form will guide you through the confidential and convenient process of obtaining prescription drugs delivered to your home.

Mandatory Generic Requirement: All prescriptions filled under the retail or mail order prescription drug program will be automatically filled with the generic version of the medication (if one is available). Otherwise, you will be charged the difference in the price between the brand-name and generic version of that medication, **plus** the generic copay

Mail Order Copayments

The copayment is applied to each covered mail order prescription charge as shown in the Schedule of Benefits. It is not a covered charge under the Medical Plan (prescription copayments do not accumulate toward the medical deductible or out-of-pocket limit). Any one prescription purchased at the mail order pharmacy is limited to the greater of a 90-day supply or a 300-unit dose. The copayment does accumulate towards your pharmacy out of pocket maximum, which is separate from that of your medical plan.

The law requires that pharmacies dispense the exact quantity prescribed by the Physician or practitioner. So if your Physician or practitioner authorizes the maximum order quantity, the prescription must be for a 90-day supply for you to receive that quantity. For example, if you take one tablet per day, your Physician or practitioner must write a prescription for 90 tablets. If you take two tablets per day, your Physician or practitioner must write a prescription for 180 tablets, etc. If your Physician or practitioner authorizes refills, these can be dispensed only when your initial order is nearly exhausted, so be sure to ask your Physician or practitioner to prescribe the normal supply, plus refills whenever appropriate.

Automatic Refill and Automatic Renewal Option

You have the option to enroll for automatic refills and prescription renewals under the mail order program.

Automatic prescription refill: When it's time for your mail order prescription to be filled, CVS Caremark will alert you by phone, email or text that your order will be processed. If you need to cancel the order you can do so. Otherwise, the order will automatically be refilled and sent to you.

Automatic prescription renewal: CVS Caremark will request a new prescription from your doctor when your prescription is about to expire, or when the last refill has been used. Before your doctor is contacted you will receive an alert that CVS Caremark will contact your doctor. If you need to cancel the order, you may do so.

To register for Automatic Prescription Refill and/or Renewal, go to www.Caremark.com and click on "Refill a Prescription," or call customer service at 1-800-503-3241.

PRESCRIPTION DRUG ANNUAL OUT-OF-POCKET MAXIMUM

The annual out-of-pocket maximum is the most you pay in copayments or coinsurance each calendar year for covered prescription drugs. It applies to the following covered prescriptions:

- 1) Retail and mail order prescriptions
- 2) Covered prescriptions received at participating and non-participating pharmacies

If your eligible out-of-pocket prescription expenses in a calendar year exceed the annual maximum, as shown in the Schedule of Benefits, the prescription drug plan pays 100% of covered prescriptions through the end of the calendar year. This is separate from your medical plan out-of-pocket maximum.

Non-participating pharmacy penalties **do not** apply to the prescription drug annual out-of-pocket maximum.

COVERED PRESCRIPTION DRUGS

- 1) 1) All drugs prescribed by a Physician that require a prescription either by federal or state law, except drugs not covered under this Plan (see prescription plan exclusions section).
- 2) 2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- 3) 3) Insulin when prescribed by a Physician.
- 4) Diabetic supplies including syringes, pen needles, test strips and lancets when prescribed by a physician.
- 5) Contraceptives prescribed by a Physician including oral contraceptives, DepoProvera, Lunelle, or other contraceptive injectables purchased at a retail pharmacy, and NuvaRing/Vaginal Ring.
- 6) Specific weight-loss medications with prior-authorization from CVS Caremark are covered. The requirement includes a morbid obesity diagnosis with appropriate BMI (body mass index) test results. The covered drugs include:
 - Xenical
 - Meridia
- 7) Prescription smoking cessation products (excluding-over-the-counter drugs) with a limit of three (3) cycles/lifetime. One cycle being a three-month period. The smoking cessation drugs covered by the Plan are as follows:
 - Nicotrol
 - Zyban
 - Chantix

PRESCRIPTION REFILLS

Covered refills for any one prescription will be limited to:

- 1) The number of refills as specified by your Physician.
- 2) Refills up to two years from the date of order by your Physician.

PRIOR AUTHORIZATION AND QUANTITY LIMITS

Prior authorization and quantity limits may apply to specific medications. Please contact CVS Caremark to determine if any of your prescribed medications require pre-authorization or have quantity restrictions.

PRESCRIPTION DRUG EXPENSES NOT COVERED

This benefit will not cover a charge for any of the following:

- 1) **Administration.** Any charge for the administration of a covered Prescription Drug.

- 2) **Appetite suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
- 3) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- 4) **Cosmetic drugs.** A charge for any drug prescribed for dermatological or cosmetic purposes or to promote hair growth (i.e., Rogaine, Minoxidil, Retin A for patients over age 24).
- 5) **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device. This does not apply to prescription contraceptive devices.
- 6) **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.
- 7) **FDA.** Any drug not approved by the Food and Drug Administration or off label use of medications that have been approved by the FDA.
- 8) **Immunization.** Immunization agents or biological sera.
- 9) **Implantable time-released medications** unless otherwise noted (Zoladex is a standard covered drug).
- 10) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- 11) **Medical exclusions.** A charge excluded under Medical Plan Exclusions
- 12) **No charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- 13) **No prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to insulin.
- 14) **Over the counter products** or over-the-counter equivalents and state restricted drugs (unless specifically included).
- 15) **Refills.** Any refill that is requested more than two years after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
- 16) **Smoking cessation.** A charge for Prescription Drugs for smoking cessation (i.e., nicotine gum) except as stated as a covered drug.
- 17) **Smoking deterrent patches.** A charge for smoking deterrent patches.

Note: Some exclusions may not apply if an injury results from a medical condition (including both physical and mental medical conditions) or an act of domestic violence, provided that the Plan generally provides benefits for the type of injury for which benefits are being claimed.

PRESCRIPTION DRUG APPEALS PROCESS

The Level 1 Appeal is a covered person's written request for a review of an adjudicated claim or related item. The following are rules that must be followed when submitting a Level 1 Appeal:

Rules for a Level 1 Appeal:

- 1) The appeal must be in writing. The letter does not have to say that this is an appeal. If the covered person is asking for a review, this can be responded to as a Level 1 Appeal. Covered persons should be directed to submit all appeals to:

CVS Caremark
Clinical Department – Appeals Process 1

620 Epsilon Drive
Pittsburgh, PA 15230-9949

- 2) The covered person may appeal a denial of any type, even if the service has not taken place. Some examples of appeal topics are:
 - Drug is experimental/investigational
 - Drug is not medically necessary
 - Lower reimbursement than expected
 - Non-compliance with Plan provisions
 - Overpayment
- 3) The covered person is the only one with the right to appeal. The covered person may assign this right to a designated representative. The covered person must notify CVS Caremark in writing of the appointment of the designated representative.
- 4) The deadline for filing an appeal is 180 days from the date the benefit or related item was denied.
- 5) For medical appeals (i.e. medical necessity, experimental drug, etc.), the covered person must include detailed written documentation from the member's physician.
- 6) CVS Caremark will complete its review and issue a written response to the covered person or designate within 30 days of receipt of the written appeal. If CVS Caremark requires additional time to complete the review, CVS Caremark will issue a written notice within that same 30 days stating the reason for the delay. All extended appeals will be completed within 60 days from receipt of the initial written appeal.
- 7) If the Level 1 reply is a denial, the letter will contain the following information:
 - Advisory that the letter is the response to a Level 1 Appeal.
 - The service in question, date of service and dollar amount if available and applicable.
 - The specific Plan provision(s) and reason(s) for the denial.
 - The last paragraph will contain an advisory on the availability of the Level 2 Appeal, and the time frame for filing the appeal.

If CVS Caremark's decision is to approve the appeal, the written notice will include the reason why the appeal was approved, the corrective action to be taken by CVS Caremark to remedy the situation, and a time frame for resolution.

Rules for a Level 2 Appeal:

- 1) The appeal must be in writing, and must indicate that the member is filing a Level 2 Appeal. The covered person should include any additional supporting documentation, along with a copy of the original Level 1 Appeal and the Level 1 decision. The written Level 2 Appeal should be sent to:

CVS Caremark
Clinical Department – Appeals Process 2
620 Epsilon Drive
Pittsburgh, PA 15230-9949
- 2) The covered person or the designate is permitted to file the appeal. If the member selects another designate, a written advisory by the member must accompany the appeal.
- 3) The written appeal must be filed within 180 days of receipt of the Level 1 decision. If an appeal is not filed in that 180-day time frame, no further action will be taken and the member cannot request an appeal at a later date. If the covered person wishes, they may request that his/her identity be withheld when the claim is presented to the Appeals Committee.

- 4) CVS Caremark will complete its review and issue a written response to the covered person or designate within 30 days of receipt of the written Level 2 Appeal. If CVS Caremark requires additional time to complete its review, CVS Caremark will issue a written notice within that same 30 days, stating the reason for the delay. All extended appeals will be completed within 60 days of receipt of the initial written Level 2 Appeal.
- 5) If the Level 2 reply is a denial, the letter, or an accompanying report, should contain the following information:
 - Advisory that the letter is the response to the Level 2 Appeal.
 - The service in question, date of service and dollar amount if available and applicable.
 - The specific Plan provision(s) and reason(s) for the denial.

If CVS Caremark's decision is to approve the appeal, the written notice will include the reason why the appeal was approved, the corrective action to be taken by CVS Caremark to remedy the situation, and a time frame for resolution.

- 6) The decision of the Appeals Committee shall be final and binding.

CVS Caremark will maintain a list of all Level 2 Appeals that are received. The list will include:

- Member's name
- Member's social security number
- Patient's name
- Date of Level 1 decision
- Date Level 2 Appeal letter received
- Level 2 Appeal decision – Upheld/Allowed
- Date of decision reply

HOW TO SUBMIT A MEDICAL CLAIM

Network Providers – Physicians and Hospitals

Be sure to present your identification card when receiving care or treatment. This card identifies you as a Tuality Healthcare participant and tells the provider where to send the bill for payment. You do not need to complete a claim form if you use a Network provider. The Physician or Hospital will submit the bill for you.

The Claims office will determine benefits and pay the provider directly, in accordance with your Plan provisions. You will receive an Explanation of Benefits which specifies what was paid by the Plan. If you should receive a bill from the provider, be sure to verify with the Physician or Hospital that they have billed the Claims Office.

If another benefit plan is primary, prior to processing your claim, the Claims Office will require an Explanation of Benefits indicating what the other plan paid.

Non-Network Providers (covered by this plan only in an emergency or if the patient lives outside the service area of both THA/OHSU and First Choice Health Network)

If you receive services from a non-network Physician or Hospital, follow these steps:

- 1) Obtain itemized Hospital and Physician bills listing all services and treatments you have received, and send them to the Claims Office.
- 2) Make sure the participating Employee's correct name and social security number is listed on the billings.
- 3) You must include the diagnosis, and accident information on the claim if due to an Injury.

- 4) Send the above to the Claims Administrator at this address:

Tuality Health Alliance
P.O. Box 925
Hillsboro, OR 97123
(866) 575-8104 or (503) 844-8104

If another benefit plan is primary, submit an Explanation of Benefits (EOB) from the other plan with your claim.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 120 days of the date charges for the service were incurred or date of primary Explanation of Benefits. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

- a) it's not reasonably possible to submit the claim in that time; and
- b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to require a Plan Participant seek a second medical opinion.

CLAIM AND APPEAL PROCEDURES

Introduction

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit made by a claimant, or by a representative of a claimant, that complies with the Plan's reasonable procedure for making benefit Claims. The timetables listed are maximum times only. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

The claims procedure has two levels: an initial claim decision and a review process. If you are not satisfied with an initial claims decision, you may use the claims review process. You must exhaust the claims review process before you can bring an action in court to recover benefits under the Plan.

There are different kinds of Claims and each one has a specific timetable for approval, payment, extension, request for further information, or denial of the Claim.

Types of Claims

Urgent Care Claim

An Urgent Care Claim means a claim for benefits provided in connection with Urgent Care services. **Urgent** means any type of medical care that if went untreated:

1. could seriously jeopardize the life or health of the Covered Person; or
2. could impair the ability of the Covered Person to regain maximum function; or
3. in the opinion of a Physician familiar with the Covered Person's medical condition, would subject the Covered Person to severe pain that could not be adequately managed without the care or treatment.

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan will only cover or pay for the benefit, in whole or in part, if the claimant receives Plan approval **before** obtaining medical care. For example, if the Plan reduces benefits if a claimant fails to obtain pre-certification of a procedure, the request for pre-certification would

be treated as a Pre-Service Claim. **Please see the COST MANAGEMENT SERVICES section of this booklet for further information about procedures for obtaining Pre-Certification, Utilization Review, and Second Opinion decisions.**

If services that require pre-approval have been provided and the only issue is what payment, if any, will be made, the claim will be processed as a post-service claim.

Post-Service Claim

A Post-Service Claim means that the claimant has already received the service at the time the Claim is filed. For example, if a Physician has performed a service for you, your Claim will be handled as a Post-Service Claim.

Deadlines for Initial Claim Decisions

Urgent Care Claims

In the case of an Urgent Care Claim, the following timetable applies:

Type of Service	Deadline for Providing Notice or Receiving Response
If your claim is incomplete, the Claim Administrator must notify you within:	24 hours
You must then provide completed claim information to the Claims Administrator within:	48 hours after receiving notice
If the Claims Administrator denies your initial claim, they must notify you of the denial:	
<ul style="list-style-type: none"> • If the initial claim is complete, within: • After receiving the completed claim (if the initial claim is incomplete), within: 	72 hours 48 hours
You must appeal the claim denial no later than:	180 days after receiving the denial
The Claims Administrator must notify you of the appeal decision within:	72 hours after receiving the appeal

You do not need to submit Urgent Care claim appeals in writing. You should call the Claims Administrator as soon as possible to appeal an Urgent Care claim.

Pre-Service Claims

In the case of a Non-Urgent Pre-Service Claim, the following timetable applies:

Type of Service	Deadline for Providing Notice or Receiving Response
Plan’s notification to claimant of benefit determination	Within 15 days from receipt of complete Claim, unless extension or additional information is needed
Extension of time to make initial decision due to matters beyond the control of the Plan:	
<ul style="list-style-type: none"> • Extension notice from Plan to claimant explaining circumstances requiring an extension and anticipated date of decision • Extension of time to make initial decision 	Within 15 days from receipt of claim Additional 15 days beyond original due date (to a total of 30 days)
Insufficient information on the Claim:	
<ul style="list-style-type: none"> • Plan’s notification to claimant describing needed information • Response by claimant 	Within 15 days from receipt of claim 45 days or less from receipt of deficiency notice
<ul style="list-style-type: none"> • Notification to claimant, orally or in writing, of failure to follow the Plan’s procedures for filing a Claim 	Within 5 days from receipt of Claim

Ongoing courses of treatment:	
<ul style="list-style-type: none"> • Notice from Plan to claimant of reduction or termination of the treatment 	Within 15 days before course of treatment terminates
<ul style="list-style-type: none"> • Claimant's request to extend course of treatment 	At least 15 days before scheduled end of course of treatment

Post Service Claim

In the case of a Post-Service Claim, the following timetable applies:

Type of Notice	Deadline for Providing Notice or Receiving Response
Notification to claimant of benefit determination	30 days from receipt of complete Claim, unless extension or additional information is needed
Extension due to matters beyond the control of the Plan:	
<ul style="list-style-type: none">Extension notice from Plan to claimant explaining circumstances requiring extension and anticipated date of decision	Within 30 days from receipt of claim
<ul style="list-style-type: none">Extension of time to make initial decision	Additional 15 days from original deadline (to a total of 45 days)
Insufficient information on the Claim:	
<ul style="list-style-type: none">Plan's deficiency notice to claimant describing information needed	Within 30 days from receipt of defective Claim
<ul style="list-style-type: none">Response by claimant to deficiency notice	45 days or less from receipt of deficiency notice

Content of Notice to Claimant of Initial Claim Decision

The Plan Administrator shall provide written notification of any adverse benefit determination (and the written notice may be provided electronically). The notice of an adverse benefit determination will state, in a manner calculated to be understood by the claimant:

- The specific reason or reasons for the adverse determination.
- Reference to the specific Plan provisions on which the determination was based.
- A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
- A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA if the adverse benefit determination is upheld on review.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.
- If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon written request.
- If the adverse benefit determination is based on the Medical Necessity or Experimental and/or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon written request.

Requests for Appeal

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. The request for an appeal must be in writing. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant submits a written request for documents, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

A document, record, or other information shall be considered relevant to a Claim if it:

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

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will take a fresh look at the Claim and will not assume that the initial benefit determination was correct. The review will be conducted by a fiduciary of the Plan who is neither the individual who made the initial adverse determination nor a subordinate of that individual.

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

Filing Appeals and Notification Requirements

Pre-Service and Post-Service Health Care Claims

If there is an adverse benefit determination on a Pre-Service or Post-Service Care Claim, a request for appeal may be submitted. The appeal must be submitted in writing by the claimant to the below address along with the name of the enrolled employee, the name of the claimant, group name, claim number and the reason(s) you disagree with the decision.

Tuality Healthcare
c/o Tuality Health Alliance
P.O. Box 925
Hillsboro, OR 97123

- The determination on review will be completed and notification provided within a reasonable period of time, but no later than 30 days after receipt of the appeal for non-urgent Pre-Service Care Claims; or
- 60 days after receipt of the appeal for Post-Service Care Claims.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Content of Appeal Decision

The decision on appeal will state, in a manner calculated to be understood by the claimant:

- The specific reason or reasons for the adverse determination.
- Reference to the specific Plan provisions on which the determination was based.
- A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

- If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon written request.
- If the adverse benefit determination is based on the Medical Necessity or Experimental and/or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon written request.
- A statement of the claimant's right to bring a civil action under section 502 of ERISA if the adverse benefit determination was upheld on review.

CONFIDENTIALITY

The Claims Administrator and Medical Management organization will not reveal to your Employer individual patient identity regarding the type of services rendered.

The Claims Administrator and Medical Management organization will use or disclose member health information only for the purpose of carrying out administrative functions for the THA-administered plans in a manner consistent with any applicable state or federal law. No confidential information shall be disclosed to any third party other than representatives who have a need to know such information, provided that such representatives are informed of the confidentiality provisions and agree to abide by them. All information must be maintained in strict confidence. In addition, each party will maintain the confidentiality of medical records and confidential patient information as required by law.

You and your family are assured that both the Claims Administrator and Medical Management organization will provide complete confidentiality with regards to treatment you or your Covered Dependents receive.

RESPONSIBILITY FOR THE QUALITY OF MEDICAL CARE

In all cases, you and your Covered Dependents have the exclusive right to choose your facility or professional provider. The Plan is not responsible for the quality of medical care you receive, since all those who provide care do so as independent contractors. The Employer, Claims Administrator, and Medical Management organization cannot be held liable for any claim or damages connected with injuries you or your Covered Dependent suffer while receiving medical services or supplies.

COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that the rules require to pay first will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

Benefit plan. The term benefit plan means this Plan or any one of the following plans:

- 1) Group or group-type plans, including franchise or blanket benefit plans.
- 2) Blue Cross and Blue Shield group plans.

- 3) Group practice and other group prepayment plans.
- 4) Federal government plans or programs including Medicare.
- 5) Other plans required or provided by law. This does not include Medicaid or any other like program.
- 6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other network plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same allowable charge, benefit payment will follow these rules.

- 1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
- 2) Plans with a coordination provision will pay their benefits in the following order:
 - a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

Special Rule. If (i) the person covered directly is a Medicare beneficiary, and (ii) Medicare is secondary to Plan B, and (iii) Medicare is primary to Plan A (for example, if the person is retired), THEN Plan B will pay before Plan A.
 - b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

- d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:
 - i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
- e) When a child's parents are divorced or legally separated, these rules will apply:
 - i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.
 - iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first.

- 3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
 - a) Federal Medicare Secondary Payer (MSP) rules require that individuals covered by Medicare and another health plan must use Medicare as a secondary payer. However, Medicare is considered primary in the following circumstances:
 - I. A Medicare-covered individual refuses coverage under a group health plan.
 - II. Medical services or supplies are not covered under a group health plan but are covered under Medicare.
 - III. A Medicare-covered individual has exhausted his/her coverage under Medicare
 - IV. A Medicare-covered individual experiences a COBRA qualifying event and elects COBRA continuation of their coverage.
 - V. An individual who was on COBRA coverage becomes entitled to Medicare, and his/her COBRA coverage ends.
- 4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
- 5) If an individual is covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and subsequent

amendments, and also under a new current employer's group plan, the following shall be the order of benefit determination:

- a) First, the coverage purchased under the Plan covering the person as a former Employee (or that Employee's Dependent) provided according to the provisions of COBRA; and
 - b) Second, the Plan covering the person as an Employee (or as that Employee's Dependent).
- 6) If an individual is covered under a COBRA continuation plan as a result of the purchase of coverage as provided under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and subsequent amendments, and also under Medicare, Medicare will be the primary payer and the COBRA plan will be the secondary payer.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY PROVISION

BENEFITS AVAILABLE FROM OTHER SOURCES

Situations may arise in which health care expenses are the responsibility of a source other than this Plan. Here are descriptions of the situations that may arise and how the Plan will deal with them:

***Third Party Liability.** There may be situations in which a Covered Person may have a legal right to recover the costs of health care from a third party who may be responsible for the Sickness or Injury. For example, if a Covered Person is injured by a defective product, the manufacturer of the product may be liable to the Covered Person. In situations where a Covered Person has a potential right of recovery for Sicknesses or Injuries for which a third party may have legal responsibility, the Plan will advance benefits while the third-party claim is being resolved as long as the Covered Person complies with (a) through (g) below. To the extent that the Plan does not advance or otherwise pay benefits because a third party is or may be responsible, the remaining benefits will be paid only after all claims against the third party have been fully and finally resolved, and only to the extent the Plan determines that the Covered Person has not been compensated for those expenses by the resolution of the third party claims.

- a) **Agreement and Enforcement of Plan Recovery Right.** By accepting or claiming benefits, the Covered Person
 - i) agrees that the Plan is entitled to recover from the first dollars received, by subrogation or other equitable or legal means, at the Plan's option, the full amount of benefits that the Plan has advanced;

- ii) grants to the Plan a first priority equitable lien that automatically attaches to any recovery;
- iii) agrees to hold the right to recovery, as well as any recovery itself, in trust for the benefit of this Plan, and to account to the Plan administrator for any amounts subject to this trust requirement;
- iv) agrees that payment shall be made to the Plan out of any settlement or recovery from any source, including any judgment, settlement, disputed claim settlement, uninsured motorist payment or other recovery related to the Sickness or Injury for which the Plan has provided benefits;
- v) agrees to instruct any party receiving any part of the recovery amount from a third party to hold that amount for the benefit of the Plan at least until the Plan's right to such recovery amount has been finally adjudicated; and
- vi) warrants and represents that no recovery or settlement of any kind has been obtained from or made with any third party, except as has been specifically disclosed to the Plan, and agrees to promptly notify the Plan if any such recovery or settlement is obtained or made.

The Plan shall be subrogated to all the rights, claims, interest, rights of action, judgments, and recoveries of the Covered Person against a third party to the extent of the full amount of benefits the Plan pays or may be obligated to pay, for any Sickness or Injury for which the third party is, or may be, responsible.

The Plan's recovery rights apply without reduction for or regard to any of the following:

- insufficient insurance or assets on the part of the third party resulting in an inability to fully compensate the Covered Person for losses caused by the third party;
- a characterization of the proceeds of the judgment or settlement as damages for emotional distress, lost wages, attorney fees, costs and expenses, medical expenses, or any other classification of damages;
- amounts payable to or for the Covered Person as attorney fees and recovery costs;
- taxes payable by the Covered Person; or any other factor that affects the amount of a judgment or settlement.

The Plan's right to full recovery, however, will not exceed the amount of recovery by or on behalf of the Covered Person from the third party.

- b) Rejection of the Make Whole and Pro Rata Doctrine.** This Plan has adopted the Plan Priority rule and expressly rejects the Pro Rata and Make Whole doctrines. Priority is given to this Plan for full recovery of benefits it has paid to or on behalf of a Covered Person for Sickness or Injury from any and all funds a Covered Person receives from a third party as a result of that Sickness or Injury. As used in this paragraph, the Pro Rata doctrine is a system by which a plan and covered person share ratably in the covered person's recovery from third parties. The Make Whole doctrine is an equitable principle of insurance law that generally means when a covered person suffers an injury or illness caused by a third party, the covered person is compensated for 100% of his or her losses and damages before the covered person's benefit plan is entitled to reimbursement from the covered person or subrogation to the covered person's rights against third parties. These doctrines are inapplicable to this Plan.
- c) Agreement.** As a condition precedent to receiving benefits advances under this Third Party Recovery Provision, a Covered Person must sign an Agreement, in the form specified by the Plan, setting forth the Covered Person's obligations and the Plan's recovery rights. If the Covered Person is a minor or otherwise legally incompetent, the Agreement shall be signed by a parent or legal guardian. If the Plan advances benefits without obtaining an Agreement, the Plan's right to full recovery under (a) shall not be impaired. If the Covered Person is represented by an attorney, the Plan may also require the attorney to sign the third-party recovery Agreement as a condition of advancing Plan benefits.
- d) Covered Person Duties.** The Covered Person agrees that he or she will do nothing to prejudice the Plan's recovery rights and will cooperate fully with the Plan, including signing any necessary

documents, providing prompt notice of any settlement and obtaining consent of the Plan Administrator before releasing any third party. The Covered Person acknowledges that the Plan is authorized to recover directly from any party liable to the Covered Person any benefits paid by the Plan. This direct recovery right is invoked by the Plan's mailing of written notice to the potential payor and Covered Person or his or her representative. The Covered Person agrees to instruct his or her attorney(s) to sign the third-party recovery Agreement and to pay over any recovery amount to the Plan in satisfaction of the Plan's recovery right.

- e) **Plan Not Responsible for Costs.** The Plan shall not be liable for any expenses or fees incurred by the Covered Person in connection with obtaining a recovery. If a Covered Person requests that the Plan pay a proportional share of attorney's fees and costs at the time of any settlement or recovery or to otherwise reduce the required Plan recovery amount to less than the full amount of benefits provided by the Plan, the Covered Person's attorney shall retain funds sufficient to satisfy the Plan's asserted lien for the full amount in a client trust account until such lien is satisfied or released.
- f) **Breach by Covered Person.** If a Covered Person or the Covered Person's representative fails to comply with (a) through (g) or fails to fully reimburse the Plan in accordance with (a) through (g), the Covered Person shall be liable to the Plan for all costs of enforcement and collection, including attorney and paralegal fees through and including any appeals. At the option of the Plan, the Plan may recover any such unreimbursed benefits and costs: (1) through legal action at law or in equity; or (2) by offset against any future Plan benefits, including benefits for unrelated Sicknesses and Injuries, that otherwise would be owing the Covered Person and all members of the Covered Person's Family Unit, regardless of whether the Covered Person continues to be eligible for coverage under the Plan.
- g) **Future Plan Benefits.** If a Covered Person continues to receive medical treatment for the Sickness or Injury after obtaining the settlement or recovery, the Plan will not pay benefits for the continuing treatment unless the Covered Person can prove that the total cost of treatment (including the cost of obtaining the settlement or recovery) is more than the amount he or she has recovered or expects to recover.
- h) **Interpretation.** The plan administrator has sole discretion to interpret and enforce these third-party recovery provisions, including the authority to determine whether all claims against third parties have been fully and finally resolved and how the proceeds of such claims are allocated to expenses for any Sickness or Injury that is the subject of the claims.

Please contact the claims administrator to obtain third-party reimbursement forms and to obtain additional information.

***Motor Vehicle or Other Insurance Coverage.** The Plan will not pay benefits for health care costs to the extent that you or a covered Dependent are covered by motor vehicle or other insurance. But the Plan will advance Covered Expenses over the amount covered by the insurance, subject to the Third Party Liability rules shown above. If the Plan has paid benefits first, the Plan is entitled to any recovery from the motor vehicle or other insurer.

You must give the Plan information about any insurance payments for medical expenses from other sources that are available to you or your covered Dependents.

CONTINUATION OF COVERAGE - COBRA

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you and/or your dependents may be eligible to continue medical coverage (called "COBRA coverage") at group rates. This COBRA coverage is available in certain instances, called "qualifying events," where coverage under the Tuality Healthcare Health Plan would otherwise end. You may elect to continue coverage at your own expense on an after-tax basis when the coverage that you have through the Tuality Healthcare Health Plan ends. The coverage described below may change

as permitted or required by changes in any applicable law.

The following information is intended to inform you of your rights and obligations under the continuation coverage provisions of COBRA. In some states, state law provisions may also apply to the insurers offering benefits under the Tuality Healthcare Health Plan. For more information, contact Tuality Healthcare's Human Resource Department at the address shown in the ERISA Information section of this document.

You don't have to show that you're insurable to choose COBRA coverage. However, COBRA coverage is provided subject to your eligibility for coverage as described below. Tuality Healthcare reserves the right to terminate your coverage retroactively if it's determined that you're ineligible under the terms of the Tuality Healthcare Health Plan.

You'll have to pay the entire cost of coverage – your share and Tuality Healthcare's – plus a 2% administrative fee. There's a grace period of 30 days for the payment of the regularly scheduled premium. A 45-day grace period applies for your first premium payment.

COBRA at a glance

The following table provides an overview of available COBRA coverage. See the sections following the table for more details.

Who Is Affected	Qualifying or Other Event	Who Is Eligible for COBRA Coverage	Duration of COBRA Coverage
You	You leave employment for reasons other than gross misconduct	You, your spouse/domestic partner and dependents (who lose coverage)	Up to 18 months
	You experience a reduction in hours below the level required for benefit eligibility	You, your spouse/domestic partner and dependents (who lose coverage)	Up to 18 months
	You are Social Security disabled when you become eligible for COBRA or within the first 60 days after an 18-month COBRA continuation coverage period begins	You, your spouse or domestic partner and dependents	Up to 29 months*
Your Spouse, Domestic partner or Dependent Child	You die	Your spouse/domestic partner and dependents (who lose coverage)	Up to 36 months
	You and your spouse become divorced or you and your domestic partnership terminates.	Your spouse/domestic partner and dependents if the decree causes them to lose coverage	Up to 36 months
	Your spouse/domestic partner, and/or dependent child is disabled when he/she becomes eligible for COBRA or within the first 60 days after an 18-month COBRA continuation coverage period begins	You, your spouse/domestic partner and dependents	29 months*
Your Dependent Child	Your dependent child is no longer an eligible dependent (for example, due to age limit)	Your dependent child (who loses coverage)	36 months

* You're required to provide proof of eligibility for Social Security disability benefits to be eligible for the additional 11 months of COBRA coverage.

Who is eligible for COBRA

If you're covered by the Tuality Healthcare Health Plan on the day before a qualifying event, you have the right to choose COBRA coverage if you lose that coverage because of a reduction in your hours of employment or the termination of your employment (unless you're terminated because of your gross misconduct).

If you're enrolled in the Tuality Healthcare Health Plan and don't return to work following a leave of absence qualifying under the Family and Medical Leave Act (FMLA), the event that will trigger COBRA coverage is the date that you indicate you won't be returning to work following the leave or the last day of the FMLA leave period, whichever is earlier.

If you're the spouse or domestic partner of an employee and you're covered by the Tuality Healthcare Health Plan on the day before the qualifying event, you're considered a qualified beneficiary. That means you have the right to choose COBRA coverage for yourself if you lose group health coverage under the Tuality Healthcare Health Plan for any of the following reasons:

- your spouse dies or domestic partner;
- your spouse's or domestic partner's employment is terminated (for reasons other than your spouse's gross misconduct) or your spouse's hours of employment are reduced; or
- you divorce your spouse or domestic partnership terminates.

If you're a dependent child of an employee and you're covered under the Tuality Healthcare Health Plan on the day before the qualifying event, you're also considered a qualified beneficiary. This means you have the right to COBRA coverage if your coverage under the Tuality Healthcare Health Plan is lost for any of the following reasons:

- the employee dies;
- the employee's employment is terminated (for reasons other than the employee's gross misconduct) or the employee's hours of employment are reduced;
- the employee divorces; or
- you cease to be a "dependent child" under the Tuality Healthcare Health Plan.

If the covered employee elects continuation coverage and then has a child (either by birth, adoption or placement for adoption) during that period of continuation coverage, the new child is a qualified beneficiary. In accordance with the terms of the Tuality Healthcare Health Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage by providing Tuality's Human Resource Department with a written notice of the new child's birth, adoption or placement for adoption at the address listed under the ERISA Information section in this document. This written notice should include information about the employee or qualified beneficiary receiving COBRA coverage and the new child who will be receiving COBRA coverage. Tuality Healthcare may ask you to provide documentation supporting the birth, adoption or placement for adoption of the new child.

If the covered employee fails to notify Tuality Healthcare in a timely fashion (in accordance with the terms of the Tuality Healthcare Health Plan), the covered employee won't be offered the option to elect COBRA coverage for the new child. Newly acquired eligible dependents (other than children born to, adopted by, or placed for adoption with the employee) won't be considered qualified beneficiaries but may be added to the employee's COBRA coverage as dependents by notifying Tuality Healthcare, according to the Tuality Healthcare Health Plan's rules that apply to active employees.

Tuality is not required by federal law to extend COBRA coverage to the employee's domestic partner and their eligible children. However, Tuality has elected to offer "COBRA Coverage Equivalent" continuation coverage to domestic partners and their children. Refer to the Domestic Partner Benefits Guide for complete details.

Your duties

Under the law, an active employee, a family member, or their representative must inform Tuality's Human Resource Department of a divorce, or child's loss of dependent status under the Tuality Healthcare Health Plan. This notice must be provided within 60 days from the latest of (1) the date of the divorce, or loss of dependent status, (2) the date coverage is lost because of the event, or (3) the date on which you were informed of the responsibility to provide the notice, and the Tuality Healthcare Health Plan's procedures for providing such notice to Tuality's Human Resource Department.

Notice must be provided to the Tuality's Human Resource Department on the appropriate form, which may be obtained

from the Human Resource Department. The form should be returned to Tuality's Human Resource Department at the address shown in the ERISA information section of this document.

The notice must include information about the employee or qualified beneficiary requesting COBRA coverage and the qualifying event that gave rise to the individual's right to COBRA coverage. In addition, the employee or qualified beneficiary must provide Tuality's Human Resource Department with documentation supporting the occurrence of the qualifying event. Acceptable documentation includes the documents listed below and any other supporting documentation approved by Tuality Healthcare:

- divorce – a copy of the divorce decree; and
- child no longer qualifying as a dependent – a copy of a driver's license or birth certificate showing the child's age (in the case of a child's becoming too old for coverage), a copy of the child's marriage certificate (in the case of the child's marriage)

If an active employee, family member, or personal representative fails to return the form and/or supporting documentation to Tuality's Human Resource Department during this 60-day period, any family member who loses coverage will lose the right to elect COBRA coverage.

When Tuality's Human Resource Department is notified that one of these events has happened, they in turn will notify you that you have the right to choose COBRA coverage.

Employer's duties

Qualified beneficiaries will be notified of the right to elect COBRA coverage (without any action required by the employee or a family member) if they lose coverage because of any of the following events:

- the employee dies;
- the employee's employment is terminated (for reasons other than the employee's gross misconduct) or the employee's hours of employment are reduced; or
- Tuality Healthcare experiences a bankruptcy.

Electing COBRA

To elect or inquire about COBRA coverage, contact Tuality's Human Resource Department.

Under the law, you have 60 days to elect COBRA coverage measured from the date you would lose your active coverage because of one of the events described earlier, or, if later, 60 days after you receive notice of your right to elect COBRA coverage. An employee or family member who doesn't choose COBRA coverage within the time period described above loses the right to elect COBRA coverage. The employee and family members will be required to reimburse the Tuality Healthcare Health Plan for any claims mistakenly paid after the date coverage would normally have ended.

If you choose COBRA coverage, your coverage will be the same coverage you had immediately before the event and the same coverage that is being provided to similarly situated beneficiaries. "Similarly situated" refers to a current employee or dependent who hasn't had a qualifying event. You'll have the same opportunity to change coverage as active employees have, e.g. at annual enrollment or if you gain a new dependent. This also means that if the coverage for similarly situated employees or family members is modified, your coverage will be modified in the same way. Your COBRA rights are provided as required by law. If the law changes, your rights will change accordingly.

Separate Elections

Each qualified beneficiary has the right to elect COBRA coverage. This means that a spouse or dependent child can elect COBRA coverage even if the covered employee chooses not to. However, an employee, or spouse may elect COBRA coverage on behalf of other qualified beneficiaries, and a parent or legal guardian may elect COBRA coverage on behalf of a minor child.

Length of COBRA Coverage

If elected, COBRA coverage begins on the date your coverage as an active employee ends. For dependents that no longer satisfy the requirements for dependent coverage, COBRA coverage begins on the date their dependent coverage ends. However, coverage won't take effect unless COBRA coverage is elected as described above and the required premium is received. The maximum duration of COBRA coverage depends on the reason you or your covered dependents are eligible for COBRA coverage.

If group health coverage ends because of your termination of employment or reduction in hours, COBRA coverage may continue for you and your covered spouse, and dependents for up to 18 months.

If your loss of coverage is due to termination of employment or reduction of hours and occurs within 18 months after becoming entitled to Medicare, your dependents COBRA coverage won't end before 36 months from the date of your Medicare entitlement.

COBRA coverage for your covered spouse and dependents may continue for up to 36 months if coverage would otherwise end because:

- you die;
- you divorce; or
- your dependent child loses eligibility for coverage.

Additional Qualifying Events

Your spouse, and dependents may have additional qualifying events while they are covered by COBRA. These events can extend their 18-month continuation period to 36 months, but in no event will they have more than 36 months of COBRA measured from the date of the loss of coverage that originally allowed them to elect coverage. This extension may be available to the spouse, and any dependent children receiving continuation coverage if the employee or former employee dies, or gets divorced, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the additional event would have caused the spouse, or dependent child to lose coverage under the Tuality Healthcare Health Plan had the first qualifying event not occurred

The law requires a qualified beneficiary to notify Tuality Healthcare if any of these additional qualifying events occur. This notice must be provided within 60 days from the latest of (1) the date of the second qualifying event, (2) the date coverage would have been lost because of the event, or (3) the date on which the qualified beneficiary is informed of the responsibility to provide the notice. The notice must include Tuality Healthcare Health Plan's procedures for providing such notice.

Notice of the additional qualifying event must be provided to Tuality Healthcare on the appropriate form, which may be obtained from Tuality Healthcare. The form should be returned to Tuality Healthcare at the address shown in ERISA Information section of this document.

The notice must include information about the qualified beneficiary requesting additional COBRA coverage and the qualifying event that gave rise to the individual's right to additional COBRA coverage. In addition, the qualified beneficiary must provide Tuality Healthcare with documentation supporting the occurrence of the qualifying event.

Acceptable documentation includes the documents listed below and any other supporting documentation approved by Tuality Healthcare:

- death – a copy of the death certificate;
- divorce – a copy of the divorce decree;

- child no longer qualifying as a dependent – a copy of a driver’s license or birth certificate showing the child’s age (in the case of a child’s becoming too old for coverage), a copy of the child’s marriage certificate (in the case of the child’s marriage).

If a qualified beneficiary (or their representative) fails to provide the appropriate notice and supporting documentation, if required, to Tuality Healthcare during the 60-day notice period, the qualified beneficiary won’t be entitled to extended COBRA coverage.

Special Rules for Disability

The 18 months of COBRA coverage may be extended to 29 months if an employee or covered family member is determined by the Social Security Administration to be disabled at any time during the first 60 days of an 18-month COBRA coverage period. This 11-month extension is available to all family members who have elected COBRA coverage due to the termination of employment or reduction in hours. It applies even to family members who aren’t disabled.

To benefit from the extension, the qualified beneficiary must provide Tuality Healthcare with the disability determination within 60 days after the later of (1) the Social Security Administration’s determination of disability, (2) the date on which a qualifying event occurs, (3) the date coverage is lost because of the qualifying event, or (4) the date on which the qualified beneficiary is informed of the responsibility to provide the notice, and the Tuality Healthcare Health Plan’s procedures for providing such notice to Tuality Healthcare. The notice of Social Security disability must be furnished to Tuality Healthcare before the end of the original 18-month COBRA coverage period.

If, during COBRA coverage, the Social Security Administration determines that the qualified beneficiary is no longer disabled, the Tuality Healthcare must be informed within 30 days of either the re-determination or the date on which the qualified beneficiary is informed of the responsibility to provide the notice and the procedures for providing such notice. This notice must be provided to Tuality Healthcare on the appropriate form, which may be obtained from Tuality Healthcare. The 11-month COBRA extension will end at the end of the month in which the notice is received. The notice must include information about the employee or covered family member requesting a disability COBRA coverage extension or notifying Tuality Healthcare that he/she is no longer disabled.

If a qualified beneficiary is receiving COBRA coverage under a disability extension and has another qualifying event during the 29-month continuation period, then the COBRA coverage period extends until 36 months after the date coverage was originally lost. The qualified beneficiary must provide the appropriate notice to Tuality Healthcare as described under the ERISA Information section of this document.

Trade Act of 2002

The Trade Act of 2002 created a second COBRA election for workers displaced by the impact of foreign trade and who are determined to be trade adjustment assistance (TAA) eligible individuals. TAA eligible individuals who declined COBRA when they were first eligible can elect COBRA within the 60-days of the first day of the month in which they become TAA eligible individuals. Nonetheless, this election may not be made more than six months after the date the TAA individual’s group health plan coverage ended.

TAA eligible individuals are also eligible for a health insurance tax credit of up to 65% of qualified health insurance premiums, including COBRA coverage. If you’re in this situation, you’ll be notified.

If you have questions about your extended ability to elect COBRA coverage or this new tax credit you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. More information about the Trade Act of 2002 is also available at www.doleta.gov/tradeact/2002act_index.asp.

Notice of Unavailability of COBRA Continuation Coverage

The Plan Administrator must provide a notice if the plan determines that the individual is not entitled to continuation coverage. If must include an explanation why the individual is not entitled to elect continuation coverage. The notice must also be sent no later than 14 days after receipt of a qualifying event notice.

Early Termination of COBRA Coverage

The law provides that your COBRA coverage may be cut short before the expiration of the 18-, 29- or 36-month period for any of the following reasons:

- Tuality Healthcare no longer provides group health coverage to any of its employees;
- the premium for COBRA coverage isn't paid on time (within the applicable grace period);
- the qualified beneficiary becomes covered – after the date COBRA coverage is elected – under another group health plan that doesn't contain any applicable exclusion or limitation for any pre-existing condition of the individual;
- the qualified beneficiary first becomes entitled to Medicare after the date COBRA coverage is elected; or
- a covered individual incurs a claim that is denied and coverage ceases due to meeting or exceeding the lifetime limit on all benefits for that plan;
- coverage has been extended for up to 29 months due to disability, and the Social Security Administration has made a final determination that the individual is no longer disabled.

If COBRA coverage terminates before the maximum available period the notice must indicate the reason for the date of termination, and any rights the qualified beneficiary may have under the plan to elect alternate coverage.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. If you become covered by another group health plan and that plan contains a pre-existing condition limitation that affects you, your COBRA coverage cannot be terminated early because of your participation in that other plan.

COBRA and FMLA

Taking an approved leave under the Family and Medical Leave Act (FMLA) isn't considered a qualifying event that would make you eligible for COBRA coverage. However, a COBRA qualifying event occurs if:

- you or your dependent is covered by the Tuality Healthcare Health Plan on the day before the leave begins (or you or your dependent becomes covered during the FMLA leave); and
- you don't return to employment at the end of the FMLA leave or you terminate employment during your leave.

Your COBRA coverage may begin on the earlier of the following:

- when you definitively inform Tuality Healthcare that you're not returning to work; or
- the end of the leave, if you don't return to work.

Cost of COBRA Coverage

Under the law, you may be required to pay up to 102% of the cost of COBRA coverage. If your coverage is extended from 18 months to 29 months for disability, you may be required to pay up to 150% of the cost of COBRA coverage beginning with the 19th month of coverage.

The cost of group health coverage periodically changes. If you elect COBRA coverage, Tuality Healthcare will notify you of any changes in the cost. Premiums are established in a 12-month determination period and will increase during that period if the Tuality Healthcare Health Plan has been charging less than the maximum permissible amount, if the qualified beneficiary changes coverage level, or in the case of a disability extension.

Payment for COBRA Continuation Coverage

Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments are then due on the first day of each month to continue coverage for that month. If a payment is not received and/or post-marked within 30 days of the due date, COBRA Continuation Coverage will be canceled and will

not be reinstated.

This Plan shall be in compliance with the American Recovery and Reinstatement Act of 2009 (ARRA), in effect as of the first period of COBRA Continuation Coverage starting on or after February 17, 2009 and as amended from time to time. ARRA may reduce the COBRA premium in some cases. You may qualify for a premium reduction. This premium reduction may only continue for a limited time and you may be subject to certain eligibility restrictions and obligations. You should consult either the Plan Administrator or the COBRA Administrator if you have questions or if you believe you are eligible for a premium reduction.

The Trade Act of 2002, as amended by ARRA, may affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a tax credit for premium paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA Continuation Coverage within the election period will be allowed an additional 60-day period to elect COBRA Continuation Coverage. If the Qualified Beneficiary elects COBRA Continuation Coverage during this second election period, the coverage period will run from the beginning date of the second election period. If you elect a tax credit under the Trade Act, you will not be eligible for other Federal COBRA premium subsidies which may be available. You should consult the Plan Administrator if you believe the Trade Act applies to you.

Contacting the COBRA Administrator

If you have any questions about COBRA coverage or the application of the law, contact the Tuality's Human Resource Department at the address listed below. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of regional and district EBSA offices are available through EBSA's website at www.dol.gov/ebsa.

Also, you must notify Tuality's Human Resource Department in writing immediately at the address listed below if:

- your marital status has changed;
- you, your spouse, or a dependent has changed address; or
- a dependent loses eligibility for dependent coverage under the terms of the Tuality Healthcare Health Plan.

All notices and other communications regarding COBRA coverage and the Tuality Healthcare Health Plan-sponsored group health plan should be directed to the Tuality Healthcare Human Resource Department at:

**Tuality Healthcare
Human Resource Department
6th Ave Plaza, Suite 100
372 SE 6th Ave.
Hillsboro, OR 97123**

You also may call 1-503-681-1158.

Coverage Certificate

When your COBRA coverage ends, you automatically receive a certificate of coverage that:

- confirms that you had whatever medical coverage you continued through COBRA; and
- states how long you were covered.

If you become eligible for other medical coverage that excludes or delays coverage for certain pre-existing conditions, you can use this certificate to receive credit – against the new plan's pre-existing condition limit – for the time you were covered by the Tuality Healthcare Health Plan.

In addition to the certificate you receive automatically, you also may request an additional certificate within 24 months after coverage ends. You may request a certificate of coverage by contacting the Tuality Healthcare Human Resource Department at:

**Tuality Healthcare
Human Resource Department
6th Ave Plaza, Suite 100
372 SE 6th Ave.
Hillsboro, OR 97123
503-681-1158
www.tuality.net/humanresources**

OREGON MEDICAL INSURANCE POOL (OMIP)

Eligible individuals residing in Oregon who lose self-insured group coverage, such as this medical plan, may purchase portability coverage through OMIP with no high-risk premium surcharge.

As mentioned above, the Tuality medical plan is self-insured. Therefore, this medical plan is not subject to insured group health plan rules that state a carrier must offer transition portability plans (similar to conversion plans) required of insured group health plans issued in the state of Oregon.

FAMILY AND MEDICAL LEAVE CONTINUATION

Coverage for Employees and dependents will be continued during a leave a absence taken in accordance with the federal Family and Medical Leave Act (FMLA). The following provisions apply:

1. The Plan Sponsor and Employee must continue to pay their respective shares of all required premiums on or before the date those premiums are due. Failure to make continued premium payments when due or before the end of the grace period allowed by the FMLA, will result in a lapse of coverage effective as of the last day of the last period for which premiums were paid.
2. The Plan Sponsor and Employee must follow all the requirements of the Plan during the period of continued coverage. The Employee must notify the Plan Sponsor of any new dependents within the period allowed or the dependent will be subject to the late enrollment rules.
3. When the Employee returns to active work at the end of a family or medical leave of absence, the Employee's coverage will resume as if there were no period away from work, provided that there was no lapse in coverage. If a lapse in coverage occurred, coverage will resume the first of the month following the date the Employee returns to work.
4. No new waiting periods or additional limitations, such as a new waiting period for pre-existing conditions, will be placed on the resumed coverage. This is true even if coverage lapsed during the family or medical leave of absence.

It is the intent of the Plan to comply with all existing FMLA regulations. If for some reason the information presented in the Plan differs from actual FMLA regulations, the Plan reserves the right to administer the FMLA in accordance with such actual regulations.

If covered by a state family leave law, participants will be eligible for the family leave that offers better coverage; any Family and Medical Leave that is covered by both state on federal law must be taken concurrently, not consecutively.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)– COVERAGE CERTIFICATES

A HIPAA certificate will be provided to each Employee and dependent whose coverage terminates under the group health Plan. These certificates will be used to reduce pre-existing condition exclusions under subsequent plan coverage. The certificates will describe coverage periods of up to 18 months.

Certifications must be provided automatically at both of the following times:

- When the Plan participant's (including covered dependents) active coverage ends under the group health Plan; and
- When a participant's (including covered dependents) claim is denied because coverage has ceased due to the operation of a lifetime limit on all benefits, and
- When the participant's (including covered dependents) COBRA coverage, if any, ends.

A Covered Person or his or her representative may also request a coverage certificate at any time within 24 months after coverage ends under the Plan by contacting the Plan Administrator. The certificate will include:

- Identity of the person covered (e.g., name, social security number);
- Period of prior coverage (with separate identification of COBRA and non-COBRA coverage periods); and
- Waiting period or affiliation period imposed by the Plan.

To request a HIPAA certificate, please contact the Human Resources Department at:

Tuality Healthcare
Human Resource Department
6th Ave Plaza, Suite 100
372 SE 6th Ave.
Hillsboro, OR 97123
503-681-1158
www.tuality.net/humanresources

The certification should indicate whether the individual was eligible for and has exhausted COBRA coverage. The coverage certification must generally reflect periods of prior coverage without regard to the specific benefits covered. However, if the subsequent plan or Covered Person requests, the entity that issued the certificate must provide additional information on the specific classes and categories of coverage (e.g., prescription drug coverage) available under the Plan. The entity can charge a reasonable charge for providing this additional information and may be able to satisfy the request by providing a copy of the summary plan description or benefit summary.

You should keep a copy of the coverage certification(s) you receive, as you may need to provide you had prior coverage when you join a new health plan. For example, if you obtain new employment and your new employer's plan has a pre-existing condition limitation (which delays coverage for conditions treated before you were eligible for the new plan), the employer may be required to reduce the duration of the limitation by one day for each day you had prior coverage (subject to certain requirements). If you are purchasing individual coverage, you may need to present the coverage certification to your insurer at that time as well.

The purpose of the certification is to limit a subsequent plan's ability to impose a pre-existing condition exclusion. HIPAA prohibits plans from imposing pre-existing condition exclusion (pregnancy is not considered a pre-existing condition) longer than 12 months (18 months for late enrollees).

HIPAA SPECIAL ENROLLMENTS — NOTICE OF EMPLOYEE'S RIGHTS

If you are declining coverage for yourself or your dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the Plan during the Special Enrollment Period, provided that you request enrollment within 31 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents during the Special Enrollment Period, provided that you request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

Special Enrollment Periods. The following are situations which will enable you to make a change in your benefit selections at any time during the plan year. Coverage begins the first of the month after the notification is provided to Human Resources, except in the case of birth or adoption when coverage is immediate if you are also covered on the date of birth or placement of adoption.

- Marriage, birth, adoption, divorce or death
- Termination of or change in spouse's employment
- Change in employment status of the employee or spouse from full-time or part-time
- Commencement of an unpaid leave of absence for employee or spouse
- Child is no longer eligible as a dependent
- A significant change in insurance coverage through your spouse's employer
- Qualification for premium assistance under the state's medical assistance program or CHIP
- Loss of health coverage under the state's medical assistance program or CHIP because you no longer qualify

RESPONSIBILITIES FOR PLAN SPONSOR

PLAN SPONSOR. Tuality Medical and Dental Trust is the benefit Plan of Tuality Healthcare, the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by Tuality Healthcare to be Plan Sponsor and serve at the convenience of the Employer. If the Plan Sponsor resigns, dies or is otherwise removed from the position, Tuality Healthcare shall appoint a new Plan Sponsor as soon as reasonably possible.

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

Service of legal process may be made upon the Plan Sponsor.

DUTIES OF THE PLAN SPONSOR.

- 1) To administer the Plan in accordance with its terms.
- 2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
- 3) To decide disputes which may arise relative to a Plan Participant's rights.
- 4) To prescribe procedures for filing a claim for benefits and to review claim denials.
- 5) To keep and maintain the Plan documents and all other records pertaining to the Plan.
- 6) To appoint a Claims Administrator to pay claims.
- 7) To perform all necessary reporting as required by ERISA.
- 8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
- 9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN SPONSOR COMPENSATION. The Plan Sponsor serves **without** compensation; however, all expenses for Plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

- 1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation; and
- 2) in accordance with the Plan documents to the extent that they agree with ERISA.

THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

- 1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
- 2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

GENERAL PLAN INFORMATION

Funding the Plan and Payment of Benefits

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Plan Participants.

The level of any Employee contributions will be set by the Plan Sponsor and is based on the claims experience of the Plan. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

Plan is not an Employment Contract

The Plan is not to be construed as a contract for or of employment.

Exclusive Benefit

The Plan Administrator intends that this Plan is maintained for the exclusive benefit of the Employees.

Clerical Error

Any clerical error by the Plan Sponsor or an agent of the Plan Sponsors 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 when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

Amending and Terminating the Plan

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right to amend, modify, reduce benefits or terminate the Plan at any time and for any reason and includes the following:

- Any Plan provisions governing the authority of the Plan Sponsors or others to terminate the Plan or amend or eliminate Plan benefits and the circumstances, if any, under which the Plan may be terminated or benefits may be amended or eliminated;
- Any Plan provisions governing the benefits, rights, and obligations of participants and beneficiaries when the Plan terminates or Plan benefits are amended or eliminated;
- Any Plan provisions governing the allocation and disposition of the Plan's assets on termination;
- Any Plan provisions governing subrogation, reimbursement, and other plan provisions that may eliminate, reduce, offset, or otherwise adversely affect the amount of benefits to which a participant or beneficiary is entitled; and
- Any Plan provisions that may result in the imposition of a fee or charge on a participant or beneficiary, or their individual account, as a condition to receiving a benefit if this may directly or indirectly reduce benefits the participant or beneficiary might otherwise reasonable expect to receive.

HIPAA PRIVACY AND SECURITY INFORMATION

Your Right to Privacy

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires employer health plans to maintain the privacy of your protected health information and to provide you with a notice of the plan's legal duties and privacy practices with respect to your health information. The notice describes how the plan may use or disclose your health information and under what circumstances they may share your health information without your authorization (generally, to carry out treatment, payment or health care operations). In addition, the notice describes your rights with respect to your health information.

Please refer to the Plan's privacy notice for more information. You can obtain a copy of the notice by contacting the Plan Administrator.

Disclosure of Protected Health Information to the Plan Sponsor

"Protected health information" (PHI) is individually identifiable health information that is not subject to specific exclusions, pursuant to 45 C.F.R § 164.501. "Electronic protected health information" (ePHI) means protected health information that is transmitted or maintained in any electronic media as set forth in 45 C.F.R § 160.103. Where this section references PHI it includes all forms of PHI, including ePHI.

A. Permitted and Required Uses and Disclosures of Protected Health Information

- 1) **Plan Administration Functions.** Subject to the conditions of disclosure described in (B) and (C) below, the Plan, or the Plan's business associate, may disclose PHI as defined in 45 C.F.R. § 164.501 to the plan sponsor for plan administration functions. Plan administration functions means administration functions performed by the plan sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions are limited to activities that would meet the definition of payment or health care operations, as defined in 45 C.F.R. § 164.501, but do not include functions to modify, amend, or terminate the Plan or solicit bids from prospective issuers. Plan administration functions do not include any employment-related functions or functions in connection with any other benefits or benefit plans. These permitted and required uses and disclosures may not be inconsistent with 45 C.F.R. Part 164, Subpart E.
- 2) **Enrollment and Disenrollment Information.** The Plan, or the Plan's business associate, may disclose to the plan sponsor information on whether the individual is participating in the Plan. Such disclosure is not subject to the conditions of disclosure described in (B) and (C) below.
- 3) **Summary Health Information.** The Plan, or the Plan's business associate, may disclose summary health information, as defined in 45 C.F.R. § 164.504(a), to the plan sponsor, provided the plan sponsor requests the summary health information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan or modifying, amending, or terminating the Plan. Such disclosure is not subject to the conditions of disclosure described in (B) and (C) below.

B. Conditions of Disclosure for Plan Administration Functions

Disclosure of PHI to the plan sponsor under A(1) above is permitted only upon receipt of a certification from the plan sponsor that the Plan has been amended and the plan sponsor has agreed to the following conditions regarding the use and disclosure of PHI. The plan sponsor will:

- 1) Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;
- 2) Ensure that any subcontractors or agents to whom the plan sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information. Effective April 21, 2005, ensure that any agents or subcontractor the Plan Sponsor provides participants' ePHI agrees to implement reasonable and appropriate security measures to protect such information;

- 3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the plan sponsor;
- 4) Report to the Plan any use or disclosure of PHI that is inconsistent with the uses and disclosures provided for in the Plan or under the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), of which it becomes aware. Effective April 21, 2005, report to the Plan any security incident, as defined in 45 C.F.R § 164.304, that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's electronic protected health information of which it becomes aware, within a reasonable time after becoming aware. Report to the Plan any other security incident on an aggregate basis every year, or more frequently upon the Plan's written request;
- 5) Make available PHI to comply with HIPAA's right to access in accordance with 45 C.F.R. § 164.524;
- 6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 C.F.R. § 164.526;
- 7) Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. § 164.528;
- 8) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the Department of Health and Human Services ("DHHS"), or any other officer or employee of DHHS to whom such authority has been delegated, for purposes of determining compliance by the Plan with 45 C.F.R., Part 164, Subpart E and 45 C.F.R., Parts 160, 162, and 164;
- 9) If feasible, return or destroy all PHI received from the Plan that the plan sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- 10) Ensure that adequate separation between the Plan and the plan sponsor, as required in 45 C.F.R. § 164.504(f)(2)(iii), has been established;
- 11) Effective April 21, 2005, implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic protected health information that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan as set forth in 45 C.F.R § 160, 162, and 164.

C. Adequate Separation Between Plan and Plan Sponsor

- 1) The benefits coordinator, the benefits assistant, and the plan administrator will have access to PHI under A(1) above. Such employees shall only have access to and use of PHI to the extent necessary to perform the plan administration functions that the plan sponsor performs for the Plan.
- 2) In the event that any of these specified employees uses or discloses PHI in a way prohibited by the Plan or HIPAA, the plan sponsor shall impose sanctions to ensure that no further non-compliance occurs. Such sanctions may include an oral warning, a written warning, time off without pay, or termination of employment. The plan sponsor shall determine the appropriate sanction based on the severity of the violation.

RIGHTS OF PLAN PARTICIPANTS

ERISA Plan Information

Special Disclosure and Additional Plan Information

As Required by the Employee Retirement Income Security Act of 1974 (ERISA)

Name of Plan	Tuality Medical and Dental Trust
Plan Sponsor/Employer	Tuality Healthcare 335 SE Eighth Avenue Hillsboro, OR 97123-4246 (503) 681-1158
Employer Tax Identification Number	93-0430029
Plan Number	505
Type of Plan	Employee Welfare Benefit Plans (Medical and Prescription Drugs)
Plan Administrator/Fiduciary	Tuality Healthcare 6th Ave Plaza, Suite 100 372 SE 6th Ave. Hillsboro, OR 97123 (503) 681-1158
Agent for Service of Legal Process	Director of Human Resources Human Resources Department Tuality Healthcare 6th Ave Plaza, Suite 100 372 SE 6th Ave. Hillsboro, OR 97123 (503) 681-1158 Service of process may also be made on the Plan Administrator at this address.
Type of Administration and Method of Funding Benefits	The Plan is a self-funded group health Plan and the administration is provided through a third party administrator. The funding for benefits is derived from the general assets of the Plan Sponsor and contributions made by covered participants. The Plan is not insured. The Plan Sponsor has purchased specific stop loss insurance coverage which is intended to reimburse the Plan Sponsor for certain losses incurred and paid under the Plan by the Plan Sponsor. The specific stop loss coverage is not a part of the Plan. Payments out of the Plan to health care providers on behalf of the Covered Person will be based on the provisions of the Plan.
Sources of Contributions	The cost of the Plan is paid with contributions from the Employer and Plan participants on an after-tax and pre-tax basis. Contributions are established each year and become effective January 1. The contribution will be communicated to each eligible Plan participant prior to the January 1 effective date each year.
Plan Year Ends On	December 31 each year

Normal Annual Open Enrollment Period	November of each year with coverage to become effective January 1.
Calendar Year	January 1 through December 31 of the same year.

Modification or Continuation of Plan	<p>Tuality Healthcare intends to continue this Plan indefinitely, but it reserves the right to discontinue or change the Plan at any time, without the consent of any participant. The Plan Administrator has the responsibility and authority to amend or terminate a Plan for any reason with written notice to all participants.</p> <p>If Tuality Healthcare discontinues this Plan for any reason and does not replace the coverages with comparable benefits, participants will receive ample written notice.</p> <p>If the Plan ends, claims for eligible coverages incurred before that date would still be paid, provided the benefits would have been payable before the Plan ended.</p>
Claims Procedures	<p>The procedures for claiming benefits and the appeal process for claims that are denied or partially denied are explained the How to Submit a Claim section of this document. Please contact the Human Resources Department if you have questions or problems with claiming benefits under your Plan.</p>
Special Note	<p>Every effort has been made to provide an accurate summary of the Plan described in this document. If questions arise about the Plan, final determination will be based on the official Plan document and agreements that govern the interpretation and administration of the Plan. You will not gain any new rights because of misstatement in or omission from this descriptive material, or by the operations of this Plan. The Plan documents are available for inspection during business hours at the Human Resources Department. Copies of these documents will be available from the Human Resources Department at the cost of reproduction.</p> <p>Your participation in this Plan does not guarantee your continued employment with the Employer. If you quit, are discharged or laid off, this Plan does not give you a right to any benefit or interest in the Plan except as specifically provided in the legal document and agreements.</p>

RIGHTS OF PLAN PARTICIPANTS UNDER ERISA

As a participant in the Health and Welfare Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health Plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation 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 of 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan document or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan’s decision or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that Plan fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if the court finds your claim is frivolous.

Assistance with Your Questions

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

BY THIS AGREEMENT, the Tuality Medical and Prescription Drug Plans Plan Document and Summary Plan Description is hereby restated effective January 1, 2010.

IN WITNESS WHEREOF, this instrument is executed for the Tuality Medical and Dental Trust on or as of the day and year first below written.

ADOPTED the _____ day of _____, 2010

Sign as Witness

Print Name

Print Title

Sign as Plan Sponsor

Print Name

Print Title

