



NORTHWEST HOSPITAL  
& MEDICAL CENTER

UW Medicine

## Northwest Hospital & Medical Center

# Health and Welfare Plan Summary Plan Description

January 1, 2011

[www.myFirstChoice.fchn.com](http://www.myFirstChoice.fchn.com)

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

# Table of Contents

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Highlights.....	1
Contacting First Choice Health Administrators.....	2
Eligibility and Enrollment .....	3
• Eligible Classes of Employees .....	3
• Waiting Period .....	3
• How to Enroll.....	3
• Open Enrollment .....	3
• Special Enrollment Periods .....	4
• Late Enrollment .....	5
• Effective Date .....	5
• Special Rule .....	6
• Waiver of Group Health Plan Benefits.....	6
Dependents .....	7
• Dependent Eligibility.....	7
• Dependents Acquired Through Marriage/Domestic Partnership.....	8
• Dependent Children .....	8
• Dependent Children Out of Area .....	9
• Continued Eligibility for a Disabled Child.....	9
• Qualified Medical Child Support Orders .....	10
Termination of Coverage .....	12
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).....	14
• Who Is a COBRA Qualified Beneficiary?.....	14
• Qualifying Events and Continuation Periods.....	15
• When COBRA Coverage Ends.....	15
• Contribution Payment Requirements .....	16
• Election Requirements .....	16
• What Coverage Must Be Offered When Electing COBRA? .....	17
Other Continuation of Coverage.....	18
• Leaves of Absence .....	18
Claim and Appeal Procedures .....	20
• Claim .....	20
• How to File a Claim for Plan Benefits.....	20
• Claim Types.....	20
• Claim Procedure.....	21

• Adverse Benefit Determination.....	21
• Appeal Procedure.....	22
<b>Coordination of Benefits .....</b>	<b>25</b>
• Calculation of Benefit Payments .....	25
• How Do I Know Which Plan is my Primary Plan? .....	26
• What if I'm Covered by Medicare? .....	27
• Meaning of Plan for COB .....	28
• Claim Determination Period .....	29
• Right of Recovery.....	29
• Facility of Payment.....	30
• Right to Receive and Release Information.....	30
<b>Subrogation .....</b>	<b>31</b>
• Liable Third Parties and Insurers .....	31
• Uninsured/Underinsured Motorist Coverage.....	32
• Venue .....	32
• Subrogation Forms.....	32
<b>Health Insurance Portability and Accountability Act of 1996 .....</b>	<b>33</b>
• Privacy Notice .....	33
<b>Plan Administration Information.....</b>	<b>36</b>
• Benefits, Contributions and Funding .....	36
• Plan Administrator's Power of Authority .....	36
• Discretionary Authority .....	37
• Collective Bargaining Agreements .....	37
• Clerical Error .....	37
<b>Statement of ERISA Rights .....</b>	<b>38</b>
• Prudent Actions by Plan Fiduciaries.....	38
• Enforce Your Rights.....	38
• Continue Group Health Coverage/Certificate of Creditable Coverage.....	39
• Assistance with Your Questions .....	39
<b>Summary Plan Description and General Information .....</b>	<b>40</b>
<b>Plan Definitions.....</b>	<b>41</b>

# Highlights

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This Group Health Summary Plan Description provides you important information about the Northwest Hospital and Medical Center Employee Benefit Plan including benefits, administration, eligibility, enrollment, continuation of coverage, coordination of benefits, subrogation, claim and appeal procedures and other legally required material.

Northwest Hospital and Medical Center (herein after referred to as “NWHMC” or the “Plan”), the employer, Plan Administrator and Plan Sponsor of this self-funded Plan, delegates certain Plan services to First Choice Health Administrators (FCHA – a division of First Choice Health Network, Inc.) as Third Party Administrator (TPA). NWHMC delegates to FCHA the authority to make decisions on benefit coverage, medical management, claim payment and certain other administrative services according to NWHMC’s policies and procedures. However, NWHMC maintains the ultimate fiduciary authority, responsibility and control over Plan assets, management and administration.

Please review this booklet carefully and share it with your family. If you have questions, contact the Plan Administrator (NWHMC’s Benefits Department) or FCHA.

*Coverage under the Plan will take effect for eligible employees and dependents when all eligibility requirements are satisfied. Northwest Hospital and Medical Center fully intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue or amend the Plan at any time, for any reason. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, co-pays, exclusions, limitations, definitions, eligibility and the like.*

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

*This document is a summary description of the overall Northwest Hospital and Medical Center medical benefits, herein after referred to as ‘Plan.’ No oral interpretations can change this Plan. This booklet, combined with the Medical and Pharmacy Benefit Plan Document booklet and the applicable provider directories, comprise the Plan document and summary plan description for the Northwest Hospital and Medical Center Employee Benefit Plan.*

# Contacting First Choice Health Administrators

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

First Choice Health Administrators  
Customer Service Department  
PO Box 12659  
Seattle, WA 98111-4659  
(800) 395-0212  
Local: (206) 268-2360  
Fax: (888) 206-3092  
Medical pre-authorization: (800) 808-0450  
Mental health/chemical dependency pre-authorization: (800) 640-7682  
TTY: (866) 876-5924  
[www.myFirstChoice.fchn.com](http://www.myFirstChoice.fchn.com)

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

You can access benefit information or your specific claim and enrollment status anytime at [www.myFirstChoice.fchn.com](http://www.myFirstChoice.fchn.com) or by calling FCHA Customer Service's automated voice response system at (800) 305-0849.

# Eligibility and Enrollment

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## Eligible Classes of Employees

If you are classified as a 0.4 FTE through 1.0 FTE and are in a paid status, you are eligible to enroll in one of the medical plans. Retirees with fifteen (15) or more years of service with NWHMC and who are at least 60 years old, but under 65, are also eligible to enroll.

Examples of employees that are considered non-eligible are those classified on NWHMC's books or records as:

- Leased, temporary or reserve employees
- One that is enrolled as a dependent on another NWHMC employee's plan

## Waiting Period

If you are a newly hired employee, your eligibility date for coverage under the Plan is the first day of the calendar month following 90 days of continuous service. If you become eligible because your employment status changes, for example from temporary status to a 0.4 FTE, your service as a temporary employee will be credited to the 90 day waiting period.

## How to Enroll

The Plan Administrator (Human Resources) will contact you prior to the end of your 90 day waiting period (see above). You will be provided with the necessary paperwork to enroll. This paperwork *must* be returned prior to the end of the 90 day period. If the necessary paperwork is not received by this time, you will automatically be enrolled in the Preferred Plan with Employee Only coverage. You will not be able to enroll your dependents until the next group open enrollment.

Discovery of false or misrepresented information will result in the complete nullification of coverage and you will be held financially responsible for any benefits paid. It is your responsibility to notify the Plan Administrator of all dependent eligibility changes.

## Open Enrollment

Open enrollment is a defined period when you, if an eligible employee, are allowed to enroll or make changes to your health care benefit coverage. Open enrollment occurs once each Plan year. Under no circumstances will you be able to change the medical plan outside of open enrollment.

## Special Enrollment Periods

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you special enrollment rights as described within this section.

### Change in Status

If you decline Plan group health coverage and later acquire a new dependent by marriage, birth, adoption or placement, you may be eligible to enroll yourself and your dependents into the group health plan if you request enrollment within 30 days after the marriage or 60 days after the birth, adoption or placement (See also Dependents). If you decline Plan group health coverage and later experience a change in status (as described below) and become eligible to participate in a premium assistance program under Medicaid or the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 you have 60 days to enroll in the Plan.

In addition, a special enrollment period is available if a change of status occurs.

A change in status includes:

- Marriage, divorce or legal separation
- Death of your spouse or dependent
- Birth, adoption, or placement for adoption of child
- A change in employment status, such as a switch between part-time and full-time
- Changes in your dependent's age status or other factor affecting his or her eligibility
- Change in your eligibility to participate in a premium assistance program under Medicaid or CHIP

Any changes made in elections must be consistent with the change in status.

### Involuntary Loss of Other Coverage

You may enroll for coverage under this Plan outside of open enrollment when all of the following requirements are met:

- You waived coverage under this Plan at the time this coverage was previously offered because you were already covered under another plan (A waiver of group health plan benefits is required at open enrollment or when you become eligible for enrollment in the benefit Plan; forms are available from the Plan Administrator)
- Your coverage under the other health care plan was terminated as a result of:
  - Loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or the reduction in the number of hours of employment)
  - Termination of employer contributions toward such coverage
- You were covered under COBRA at the time coverage under this Plan was previously offered and your COBRA coverage has been exhausted
- You, or your dependent(s), were covered under Medicaid or CHIP but have since lost eligibility for either program

The Plan Administrator must receive a completed enrollment form within 30 days of the date your prior coverage ended. Coverage under this Plan will become effective on the first of the month following loss of coverage.

## Late Enrollment

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

## Effective Date

### Effective Date of Coverage for You

The employee's coverage will become effective on the first day of the calendar month following the date that the employee has satisfied: 1) the eligibility requirement noted under *Eligible Classes of Employees* described above, 2) the waiting period, as described above, and 3) the Plan is in receipt of the completed enrollment form.

### Effective Date of Coverage for Your Dependents

If you have one or more eligible dependents on the date that you become covered under this Plan and you elect to insure them, they will be covered on the date your coverage becomes effective. Only dependents for which you have submitted an enrollment form and paid any required premiums will be covered. Your dependent will be considered a late enrollee if we do not receive the enrollment form and premium payment within 30 days (60 days in the case of birth, adoption or placement for adoption) of the date he or she is eligible for coverage. **Late enrollments are not accepted.**

### Deferred Effective Date of Your Coverage or an Increase in Coverage

If you are not at work on a full-time basis on the effective date of insurance or any increase in benefits, for any reason other than a vacation day, work holiday, or scheduled non-work day, your coverage or any increase in benefits will not become effective until the date you return to full-time basis.

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

### Effective Date for Adding Dependents (Other than Newborn, Adopted Children, those under Legal Guardianship or a QMCSO)

Any dependents added after your effective date of coverage will be covered on the date they become eligible. You must submit an enrollment form to us for any such dependent and pay any required premiums. The Plan Administrator must receive the form within 30 days of the date the dependent becomes eligible for coverage. If you do not notify us within 30 days, the dependent will be considered a late enrollee. **Late enrollments are not accepted.**

## Special Rule

If an employee and spouse/domestic partner are each employees of NWHMC and are eligible for benefits, employees may not “double” cover each other as dependents.

If two NWHMC employees are married or in a domestic partnership, one may enroll as the dependent on their spouse’s or domestic partner’s employee coverage. In such a case, the employee spouse/domestic partner enrolled as a dependent would not be eligible for employee only coverage in addition to their dependent coverage. Also, s/he would not be eligible to take advantage of the *Waiver of Group Health Benefits* cash-out option mentioned below.

Children whose parents are both NWHMC employees may enroll under only one parent.

If you are covered under a family member employed by NWHMC and become eligible for benefits due to your own employment status, your family member must contact the Plan Administrator to cancel your coverage within 31 days.

## Waiver of Group Health Plan Benefits

As an eligible employee, you may elect to waive participation in the group health plan by completing the enrollment form, stating you choose to waive coverage and providing proof of other coverage. If you waive coverage, you may not enroll your dependents – a dependent is not eligible for coverage without the eligible employee also enrolled.

NWHMC provides a cash-out benefit of \$50 (taxable income) a month to employees who opt to waive benefits. If two NWHMC employees are married, and one opts to enroll as a dependent on their spouse’s employee coverage, this cash-out option is not available.

# Dependents

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## Dependent Eligibility

Dependents become eligible for group health plan benefits on either the day you become eligible or the day you acquire your first dependent, whichever is later. Dependents can be enrolled in the group health plan only if you also are enrolled. Dependents include:

- Lawful spouse
- Washington State-registered domestic partner (a Washington State-registered domestic partner can be either a same-sex partner if at least one of the partners is at least age 62, or opposite-sex partner of any age)
- Natural child, adopted child, child placed with you for legal adoption, stepchild, or other legally designated ward up to age 26 (through their 25th birthday) (the Limiting Dependent Child Age)
- Natural child, adopted child, child placed with you for legal adoption, stepchild, dependent child or other legally designated ward that a health care professional determines is not capable of self-sustaining employment due to a physical handicap or developmental disability (see *Continued Eligibility for a Disabled Child* below)
- Child named in a Qualified Medical Child Support Order (QMCSO) as defined under federal law and authorized by the Plan (see *Qualified Medical Child Support Orders* below).

A child who loses dependent status for coverage eligibility under this provision may be eligible for continuation of coverage under COBRA (See *COBRA* section). You are responsible for paying the contribution for your dependent's group health plan benefits.

Dependents do not include:

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

## Dependents Acquired Through Marriage/Domestic Partnership

If you acquire a new dependent through marriage, the Plan Administrator must receive the completed enrollment application and a copy of the marriage certificate/Washington State certification of domestic partnership within 30 days after the marriage or start of the domestic partnership for coverage to be effective, or your new dependent will not be able to enroll until the next open enrollment.

Coverage for your new dependent will become effective on the first of the month following the date of lawful marriage/start of the domestic partnership.

## Dependent Children

An enrollment form is required to enroll any dependent child. Your dependent will not be denied based on health status. The Plan Administrator may ask for added information to establish a dependent child's eligibility. Children whose parents are both NWHMC employees may enroll under only one (1) parent (see *Special Rule in Enrollment and Eligibility* section).

## Natural Newborn Children

If you acquire a new dependent through birth, the Plan Administrator must receive the enrollment form within 60 days from the date of birth. The child will be covered for the first three weeks of life. For coverage to continue after the third week, an enrollment form must be received within the noted timeframe.

## Adopted Children Acquired

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

If the enrollment form, with documentation to support legal guardianship, is received within 60 days of placement, coverage becomes effective on the date of placement. The Plan Administrator may request added information.

## Children Acquired Through Legal Guardianship

If the enrollment form, with documentation to support legal guardianship, is received within 60 days of obtaining legal guardianship, dependent coverage becomes effective on the date of the order. The Plan Administrator may request added information.

## Children Covered Under Qualified Medical Child Support Orders

Dependents named in a Qualified Medical Child Support Order (QMCSO) will begin on the first day of the calendar month following receipt of the order, but only after the order has been determined to be a QMCSO. (See *Qualified Medical Child Support Orders* below.)

## Dependent Children Out of Area

To receive the network level of coverage, medically necessary care for covered services must be provided by First Choice Health Network (FCHN) providers within Washington, Oregon, Alaska, Montana and Idaho.

FCHN providers include providers contracting with HealthInfoNet in Montana. Beech Street Network is available for network benefits to:

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

(A full description of the provider networks is in your Medical, Vision and Pharmacy Benefits booklets for each medical plan, under *How to Obtain Health Services*.)

## Continued Eligibility for a Disabled Child

Coverage may be extended beyond the dependent child limiting age if the child is incapable of self-sustaining employment due to mental or physical handicap, and depends primarily on you for support. Such disability must occur prior to age 26. An enrollment form must be received 30 days prior to the date the child reaches the maximum dependent child age (26) for dependent coverage. Thereafter, employees are required to resubmit proof of continued disability annually.

Proof may be defined as a copy of the State Disability check for the current month. If a copy of the State Disability check for the current month is not available, the provider of care must complete a physician statement to confirm the following:

- Name of dependent child
- Dependent child's date of birth
- Dependent child's Plan ID number
- Date of onset of disabling condition
- Description of disabling condition and functional limitations
- Expected duration of disabling condition and prognosis
- Signature of provider

The participant must also submit the following:

- Signed statement that the participant provides total support for this child
- Participant social security number
- Date information provided

A disabled child will continue to be eligible for coverage until the employee participant fails to submit proof of dependence due to disability or physical handicap, or if coverage terminates for the employee or the dependent due to any of the reasons noted under *Termination of Coverage*.

## Qualified Medical Child Support Orders

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

A medical child support order:

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

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

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

If the medical child support order is a QMCSO:

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

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

The enrollment form with the notification of the medical child support order needs to be received within 30 days of the order in order for coverage to become effective on the date of the order. If the enrollment information is received after 30 days of the order, coverage will become effective on the first of the month following the date we receive the enrollment information for coverage.

# Termination of Coverage

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## **For participating employees, coverage ends at these events:**

- Non-payment of a contribution that is your responsibility
- You no longer meet eligibility requirements for coverage; coverage ends the last day of the month after the date you are no longer in a class of eligible or active employees
- The date you cancel coverage under the Plan
- The employee or any participant performs an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this policy
- The policy is materially breached
- The Plan Sponsor ceases to offer coverage in the group market under which this coverage is issued

## **For participating dependents, coverage ends at these events:**

- The date the participant's coverage ends for any reason
- The date the participating employee or participating dependent terminates coverage
- The last day for which any required Plan contributions are paid
- The participant dies
- The participating employee and spouse legally divorce (the Plan Administrator must receive a copy of the decree)
- The date a dependent child exceeds the dependent child limiting age, unless disabled (see Continued Eligibility for a Disabled Child)

## **Related details follow:**

- Coverage is automatically extended through the last day of the month of the termination, provided the applicable contribution for the coverage period has been paid. Participants receive a Certificate of Creditable Coverage that shows the coverage period under this Plan. (Contact the Plan Administrator for more information.)
- If the Plan terminates or is cancelled, the Plan will continue to cover any participants who are hospital inpatients on the date the plan terminates, or is cancelled. Coverage will end on the first of these dates:
  - Date of discharge
  - When you reach the Plan maximums
  - FCHA's Medical Director determines inpatient care is no longer medically necessary, or
  - Three consecutive months have elapsed
- Enrollment into this Plan is a 1 year commitment. Under Internal Revenue Code §125 regulations, you can opt out of the Plan mid year only if you have a Qualifying Event (see *Plan Definitions*).

- NWHMC requires 30 days written notice for dependent coverage termination.
- A terminated employee who is rehired within 90 days of his/her termination date will become eligible for benefits the first of the month following their rehire date. A terminated employee who is rehired more than 90 days from his/her termination date will be treated as a new hire for benefit purposes and be required to satisfy all eligibility and enrollment requirements.

If you or your dependents lose coverage under this Plan, you may be eligible to continue coverage. For more information, read the COBRA section or ask your Plan Administrator.

# Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

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If your coverage terminates under this group health plan, you may be eligible under COBRA to continue the same coverage you had when coverage ended, on a temporary self-pay basis. COBRA requires this continuation of coverage be made available to covered persons – called qualified beneficiaries under COBRA – on the occurrence of a qualifying event, described below.

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

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

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

## Who Is a COBRA Qualified Beneficiary?

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

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

***Domestic Partnerships are not recognized by the federal government and therefore not eligible for COBRA as such. Northwest Hospital, however, will offer COBRA-like continuation of coverage to domestic partners as would be available to spouses through COBRA. Contact the Plan Administrator for more details.***

A qualified beneficiary may choose to continue any one benefit, or all of the benefits that s/he was enrolled in prior to the qualifying event.

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

## Qualifying Events and Continuation Periods

Qualifying events and continuation periods are explained below:

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

## When COBRA Coverage Ends

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

- The Plan no longer provides group health coverage to any employees
- The COBRA coverage premium is not paid within 31 days of the due date (the initial grace period is 45 days after the first COBRA election)

- The qualified beneficiary becomes covered under another group health plan with no applicable pre-existing condition exclusion or limit
- The qualified beneficiary enrolls in Medicare
- If an extension from 18 to 29 months was granted due to a disability and the individual receives a final determination from the Social Security Administration stating the individual is no longer disabled the individual must notify the plan administrator within 31 days after the date of that determination. Coverage ends on the last day of the month through which contribution payments have been received, so long as that date is within the first month that begins within 31 days after the final determination date, and after the initial 18-month COBRA coverage period
- If retiree medical coverage is lost due to NWHMC filing a proceeding in bankruptcy under Title 11 of the United States Code, the retiree's COBRA continuation coverage, generally, can last indefinitely. The COBRA continuation of coverage for your spouse will also generally continue indefinitely; however, upon your death, your surviving spouse will be eligible for up to 36 months of COBRA continuation coverage from the date of your death

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

## Contribution Payment Requirements

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

If you are eligible and receive a disability extension under Title II or XVI of the Social Security Act, your contribution will also be 102% of the full cost of coverage.

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

Failure to make payments within the designated time frame will result in automatic termination of coverage to the last day of the month for which a complete payment was made. Payments need to be sent directly to FCHA, One Union Square, 600 University St., Suite 1400, Seattle, WA 98101. If you have COBRA related questions you may call (206) 268-2400 if you are local, or toll-free (888) 782-7771 and ask to be transferred to the COBRA representative.

## Election Requirements

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

In the case of divorce, legal separation or the ineligibility of a dependent, the employee or qualified beneficiary is responsible for notifying the Plan Administrator within 61 days of the divorce, legal separation or ineligibility of a dependent. The Plan is not obligated to offer COBRA benefits to beneficiaries if this notification is not received within the 61 days.

## What Coverage Must Be Offered When Electing COBRA?

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

- **Identical coverage** – the qualified beneficiary must be offered the opportunity to continue the coverage received immediately before the qualifying event
- **Independent rights** – once a qualifying event occurs each qualified beneficiary has an independent right to elect continuation coverage. For example, if an employee and family are offered COBRA coverage, each individual can make an election. Although an active employee must be covered to cover a dependent, it is possible to have COBRA coverage for a dependent when the former employee does not elect to continue coverage
- **Open enrollment** – qualified beneficiaries must be notified of any benefit or carrier changes at open enrollment and be given the opportunity to change coverage just like active employees. Qualified beneficiaries have the same rights as active employees during open enrollment to add or drop family members, change coverages and change carriers, if available. However, if a qualified beneficiary adds a family member during open enrollment who was not previously covered, that added family member does not become a qualified beneficiary
- **Modification of coverage** – if an employer modifies coverage for similarly situated active employees; the coverage for qualified beneficiaries must be modified similarly. Some examples of modifications include benefit enhancements, elimination of coverage and changes in carriers

# Other Continuation of Coverage

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## Leaves of Absence

### FMLA Leaves

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

- The birth or adoption of the employee's child
- Placement of a foster child in the employee's care
- To care for the employee's spouse, parent or child if suffering from a serious health condition
- An employee's own disabling serious health condition
- For qualifying exigencies arising out of the fact that the employee's spouse, parent or child is on active duty with the Armed Forces, including the National Guard or Reserves (Examples of "qualifying exigencies" include, but may not be limited to, short-notice deployment, military events and related activities, certain childcare and related activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities and/or any other event that the employer and employee agree constitute a qualifying exigency)

The FMLA also allows an eligible employee to take 26 weeks of leave each year (during a rolling backward calendar year) for the following reasons:

- For military caregiver leave, an employee may be allowed for up to 26 weeks of leave, per service member, per injury, to care for a family member who (1) is an current member of the Armed Forces, Guard or Reserves; (2) who suffered a serious illness or injury or whose pre-existing illness or injury was aggravated in the line of duty while on active duty; and (3) is undergoing medical treatment, recuperation, therapy, outpatient care, or has been placed on the temporary disability retirement list by the military (Please note the Department of Labor (DOL) has established an order of familial priority for family members seeking this leave; your employer is within its rights to request information seeking proof and/or clarification of your relationship to the service member)

If you are granted an authorized leave of absence from work, you may choose to continue coverage under this group health plan during the approved leave time as long as you pay your required contribution. Since continuation of coverage under this provision is not extended automatically, please contact your Plan Administrator for more information. Any and all applicable monthly contributions must be paid directly to the Plan in accordance with the agreement established before the leave. Failure to make the established monthly contribution may result in the termination of group health benefits. Eligible employees will receive information about the option of continuing their health benefits on a self-pay basis under COBRA.

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

If you lose coverage during your leave because you did not make the required contributions, you may enroll again within 31 days of returning to work. Your coverage will start on the first day of the month after you return to work and make any required contributions.

## Military Leave

If you take a military leave, for active duty or training, you will be covered under NWHMC group plan as if you were an active employee, as long as you are in an active paid status.

If your uniformed service (Armed Forces, Army National Guard, Air National Guard) lasts beyond your paid time or 31 days, whichever is longer, you may continue coverage under the self-pay option for approved leaves (as described in the COBRA section) according to your rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA). While continued, coverage will be what was in force on the last day you worked as an active employee. However, if benefits decrease for others in the class, yours will also decrease.

If you return to active employment promptly after your military leave, in accordance with federal law, your medical and pharmacy coverage will be reinstated on the date you return to the active payroll. You must submit a written request for reinstatement within 90 days of your discharge from active military service, or one year following a hospitalization which continues after you are discharged from active military service.

# Claim and Appeal Procedures

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## Claim

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

## How to File a Claim for Plan Benefits

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

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

It is best to submit charges as soon as possible. However, charges for covered services submitted to FCHA must be received within 12 months from the date the service or supply was rendered or received. Claims will *not* be considered for benefits if received after this timeframe. (See your ID card for the FCHA claim address.) Claim forms are available from your Plan Administrator.

## Claim Types

- **Pre-service claim** means any claim for a Plan benefit for which the Plan requires approval before medical care is obtained.
- **Concurrent claim** means any claim reconsidered after initial approval for an ongoing course of treatment which results in a reduced or terminated benefit.
- **Post-service claim** means any claim for a Plan benefit that is not a pre-service claim and is a request for payment or reimbursement for covered services already received.

- **Urgent care claim** means a claim for medical care or treatment that, if normal pre-service standards are applied:
  - Would seriously jeopardize the claimant's life, health or ability to regain maximum function
  - In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested.

## Claim Procedure

NWHMC delegates to FCHA the authority, responsibility and discretion to:

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

FCHA will notify the claimant in writing of its decision on review.

All claims for benefits are subject to a full and fair review within a reasonable time appropriate to the medical circumstances. Payment of any benefits will be subject to the applicable deductibles, coinsurance, co-pays and benefit maximums.

## Adverse Benefit Determination

An adverse benefit determination means a denial, decrease or ending of a benefit. This includes a failure to provide or make payment (in whole or in part) for a benefit including claims based on medical necessity or experimental and investigational exclusions.

The different claim types listed in the preceding subsection have specific times for approval, payment, request for information or denial, as shown below:

Time Table for Adverse Benefit Determinations for Claim Procedures			
Type of Review	FCHA Notice of Incorrectly Filed Claim – Notice to Claimant	FCHA Notice of Incomplete Claim – Notice to Claimant	Initial Benefit Determination by FCHA
Pre-Service Claim	5 days	Not required (may be part of extension notice)	Reasonable period = 15 days 15-day extension with notice to claimant Reasonable period suspended up to 45 days on incomplete claim
Concurrent Claim	N/A	N/A	In time to permit appeal and determination before treatment ends or is reduced

Time Table for Adverse Benefit Determinations for Claim Procedures			
Type of Review	FCHA Notice of Incorrectly Filed Claim – Notice to Claimant	FCHA Notice of Incomplete Claim – Notice to Claimant	Initial Benefit Determination by FCHA
Post-Service Claim	N/A	Not required (may be part of extension notice)	Reasonable period = 30 days 15-day extension with notice to claimant Reasonable period suspended up to 45 days on incomplete claim
Urgent Care Claim	24 hours	24 hours	72 hours No extensions from claimant

If your claim is denied wholly or in part, you will receive a written adverse benefit determination notice that includes:

1. The specific reason or reasons for the adverse benefit determination (denial);
2. Reference to the specific Plan provisions on which the determination is based; and,
3. Reference to any internal Plan rule, guideline, protocol or similar criterion relied upon in making the decision.

If the denial is based on medical necessity, experimental or investigational treatment or other similar exclusion or limit, the following will be provided:

- Explanation of the scientific or clinical judgment used in making the decision;
- Statement that an explanation will be provided free, upon request;
- A description of any additional material or information needed to support your claim and an explanation of why it is needed; and,
- Appropriate information on steps to take if you want to submit the claim for appeal review.

## Appeal Procedure

This Plan offers a two-step appeals procedure. NWHMC Benefits Committee performs all functions related to Pharmacy appeals. FCHA performs functions associated with the first step of the medical appeals process. A second, optional, appeal level is handled by the NWHMC Benefits Committee. Regardless of appeal level, Step 1 or Step 2, NWHMC has final authority over appeals as the appropriate named fiduciary.

### Step 1 – Standard Appeal

If your claim is denied wholly or in part, you have the right to appeal this adverse benefit determination in writing by following the appeal procedure listed below:

1. You, or your authorized representative, must file your appeal within 180 days of the date you receive the adverse benefit determination or else you lose the right of appeal.

2. You may submit written comments or questions, documents, records and other information including the reason you feel your claim should not have been denied.
3. On request, you may obtain reasonable access to and copies of all documents, records and information relevant to your claim for benefits, free of charge.
4. You may request the name of the health care expert who reviewed your claim for medical necessity or experimental or investigational care or treatment.
5. You must exhaust these claim procedures before filing a civil action for benefits under ERISA §502(a)(1)(b); the civil action must be filed within 180 days from your receipt of the Plan's final determination regarding your claim.

A time table for processing and notification of appeal procedures for each claim type follows:

<b>Time Table for Processing and Notification of Appeal Procedures</b>	
<b>Type of Review</b>	<b>Appeal (Benefit Determination on Review and Notification to Claimant)</b>
Pre-Service Claim	Reasonable period = 30 days No extension from claimant
Concurrent Claim	Before treatment ends or is reduced
Post-Service Claim	Reasonable period = 60 days No extension from claimant
Urgent Care Claim	72 hours No extension from claimant

*Urgent care appeals will be expedited within 72 hours of receiving the appeal. The appeal may be oral or written.*

The appeal process will take into account all comments, documents, records and other information offered that relates to the claim, which may include information not offered previously. The standard appeal review will be a fresh look at your claim without considering the initial denial. The appeal review is conducted by persons who are neither involved in the initial decision nor assistants to the person who made the initial decision.

If the decision is to uphold the denial of your claim, you will receive a written notice of adverse benefit determination containing:

- The specific reason or reasons for the adverse benefit determination (denial);
- Reference to the specific Plan provisions on which the determination is based; and,
- Reference to any internal rule, guideline, protocol or similar criterion relied upon in making the decision.

On request you may obtain reasonable access to and copies of all documents, records and information relevant to your claim for benefits, free of charge.

If the denial is based on medical necessity, experimental or investigational treatment or other similar exclusion or limit, the following will be provided:

- Explanation of the scientific or clinical judgment used in making the decision
- Statement that an explanation will be provided free, upon request.

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

## Step 2 – Optional Appeal

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

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

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

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

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

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

## Appeal Submittal

For urgent care medical appeals, you may call the Appeals Specialist at (800) 808-0450. For all others, please use the appropriate address below to submit your written appeals:

**Medical Appeals:**

First Choice Health Administrators  
Attn: Appeals Specialist  
600 University Street, #1400  
Seattle, WA 98101

**Pharmacy Appeals:**

Northwest Hospital &  
Medical Center Benefits Committee  
1550 N 115th Street, MS P1  
Seattle, WA 98133

# Coordination of Benefits

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

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

## Calculation of Benefit Payments

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

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

1. This Plan will calculate the amount it would have paid if it were your Primary Plan.
2. Next, any payment made by your Primary Plan will be subtracted from this amount. The difference remaining (if any) will be the secondary payment made by this Plan.

### Example 1

<b>Allowed Amount</b>	<b>\$150</b>
Amount this Plan would pay if primary	\$135
- (minus) amount paid by Primary Plan	\$100
= (equals)	\$35 (this Plan's secondary payment)

### Example 2

<b>Allowed Amount</b>	<b>\$200</b>
Amount this Plan would pay if primary	\$155
- (minus) amount paid by Primary Plan	\$185
= (equals)	<b>(-\$30)</b> (no payment is made by this Plan)

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

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

# How Do I Know Which Plan is my Primary Plan?

The rules in this section determine the order in which your plans pay benefits (i.e. which plan is your Primary Plan, and which is your Secondary Plan, also known as the order of benefits). **If you have Medicare coverage in addition to coverage under this Plan, refer to *What if I'm Covered by Medicare?* for more information.** These rules are intended to be applied in the order in which they are listed (i.e., if the order of benefits can be determined by Rule 1, but Rule 3 also speaks to your situation, Rule 1 will determine the order of benefits). If you are covered by more than one secondary plan, these rules also determine the order in which the secondary plans' benefits are determined in relation to each other.

- 1. Dependent or non-dependent:** A plan covering a person as other than a dependent (i.e., as an active employee, retiree, member or subscriber) pays before a plan covering a person as a dependent.

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

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

- A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
  - 1) The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
  - 2) If both parents have the same birthday, the plan that has covered the parent longest is the Primary Plan.
- B. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
  - 1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This does not apply to any plan year during which benefits are paid or provided before the plan has actual knowledge of the court decree provision.
  - 2) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary
  - 3) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, or that the parents have joint custody without mentioning financial responsibility or responsibility for health care expenses, the birthday rule of the policy holders determines the order of benefits.
  - 4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the plans covering the child pay in the following order:
    - a. The plan covering the custodial parent
    - b. The plan covering the custodial parent's spouse

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

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

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

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

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

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

- A. A change in the amount or scope of a plan's benefits;
- B. A change in the entity that pays, provides or administers the plan's benefits; or
- C. A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

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

*Note: this Plan is always primary to TRICARE, CHAMPVA, state Medicaid programs and the Indian Health Service (IHS). Continuation of coverage under COBRA is always secondary to other coverage, except as required by law.*

## What if I'm Covered by Medicare?

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan that covers a person as an active employee or dependent of an active employee. Medicare is primary in most other circumstances. Additionally, Federal law does not recognize domestic partnerships, therefore if you are covered under this Plan as a domestic partner, Medicare will be primary (regardless of the reason for your Medicare entitlement).

If your Medicare entitlement is due to:

- **Age:**

If you are covered under this Plan as an active employee or a dependent of an active employee and you become entitled to Medicare because of reaching age 65, this Plan will be primary.

If you are covered under this Plan as a COBRA qualified beneficiary and are also entitled to Medicare based on age, Medicare is primary

- **Disability:**

If you are covered under this Plan as an active employee or dependent of an active employee and become entitled to Medicare due to disability, this Plan will be primary. Once you or your dependent is declared disabled by Social Security, the disabled individual should apply for coverage under Medicare Parts A and B.

If you are covered under this Plan as a COBRA qualified beneficiary and are also entitled to Medicare based on disability, Medicare is primary

- **End Stage Renal Disease (ESRD):**

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

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

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

## Meaning of Plan for COB

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

- This NWHMC Plan (the Plan with a capital “P”) whether the Basic, Preferred or Preferred Plus Plans
- Group and non-group insurance contracts and subscriber contracts
- Uninsured arrangements of group or group-type coverage
- Group and non-group coverage through closed panel plans
- Group-type contracts (“group-type contract” means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. It does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

- The medical care components of long-term care contracts, such as skilled nursing care
- The medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts
- Medicare or other governmental benefits, as permitted by law

“Plan” does not include:

- Hospital indemnity coverage benefits or other fixed indemnity coverage
- Accident only coverage
- Specified disease or specified accident coverage
- School accident type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a “to and from school” basis
- Benefits provided in long-term care insurance policies for non-medical service, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services
- Medicare supplemental policies
- A state plan under Medicaid
- A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

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

## Claim Determination Period

The claim determination period used when applying this COB provision is the Plan year, January 1 through December 31. For new participants, the claim determination period begins on the effective date of coverage and ends on December 31. When you terminate coverage before December 31, your termination date would be the end of the determination period.

## Right of Recovery

This provision does not reduce the benefits allowed under this agreement when this Plan is the primary plan. However, if the Plan pays in excess of the maximum necessary at the time to satisfy the intent of this COB provision, the Plan will exercise the right to recover the excess payments from any person(s), insurer(s) or other organizations, as the Plan deems appropriate.

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

## Facility of Payment

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

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

## Right to Receive and Release Information

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

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

# Subrogation

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## Liable Third Parties and Insurers

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

To the fullest extent permitted by law, the Plan is entitled to the proceeds of any settlements or judgments that result in the recovery from a first or third party, up to the amount of benefit paid by the Plan for the condition. In recovering those amounts, the Plan Administrator (Benefits Department), Plan Sponsor (NWHMC) and/or FCHA may either hire their own attorney or be represented by your attorney. If the Plan chooses to be represented by your attorney, the Plan will pay, on a contingent basis, a reasonable portion of the attorney's fees necessary for asserting right of recovery in the case. This portion will not exceed 20% of the amount the Plan seeks to recover. The Plan will not pay for any legal costs incurred by or for you, and you won't be required to pay any portion of the costs incurred by or for the Plan.

Before accepting any settlement on your claim against a third party, you must notify FCHA's Subrogation Department in writing of any terms or conditions offered in a settlement, and you must notify the third party of the Plan's interest in the settlement (established by this provision). You must also cooperate with the Plan in recovering amounts paid on your behalf. If you retain an attorney or other agent to represent you in the matter, you must require your attorney or agent to reimburse the Plan directly from the settlement or recovery proceeds. Notify the FCHA Subrogation Department at PO Box 12659, Seattle WA 98111-4659 ((800) 395-0212, local: (206) 268-2360, fax: (888) 206-3092).

To the maximum permitted by law, the Plan is subrogated to your rights against any third party responsible for the condition, meaning the Plan has the right to:

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

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

## **Uninsured/Underinsured Motorist Coverage**

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

## **Venue**

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

## **Subrogation Forms**

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

# Health Insurance Portability and Accountability Act of 1996

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## Privacy Notice

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

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

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

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

## Permitted Disclosure of Enrollment/Disenrollment Information

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

## Permitted Uses and Disclosure of Summary Health Information

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

Summary Health Information means information:

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

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

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

Plan Administration Purposes means administration functions performed by the Plan Sponsor on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. It does not include functions performed by the Plan Sponsor in connection with any other benefit or benefit plans of the Plan sponsor, and they do not include any employment related functions. Notwithstanding the provision of the Plan to the contrary, in no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR § 164.504(f).

### Conditions for Disclosure for Plan Administration Purposes

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

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

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

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

## Adequate Separation between the Plan and the Plan Sponsor

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

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

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

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

## Certification

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

# Plan Administration Information

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## Benefits, Contributions and Funding

This Plan, an employer-sponsored self-funded group health plan with administration provided through FCHA, provides eligible employees and dependents with medical and pharmacy benefit plans. The cost of benefits provided through the component benefit plans will be funded in part by NWHMC's general assets and in part by employee contributions. NWHMC will determine, and periodically communicate, your share of the cost for benefits under each component benefit plan, and may change that determination at any time.

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

FCHA and Navitus pay claims on behalf of NWHMC however; they do not insure or guarantee that claims will be paid. FCHA and Navitus rely on NWHMC to provide funding to pay claims and cannot do so if NWHMC does not provide the funds.

The Plan will provide benefits in accordance with the requirements of all applicable laws, such as Employee Retirement Income Security Act of 1974 (ERISA), Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), Health Insurance Portability and Accountability Act of 1996 (HIPAA), Newborns' and Mothers' Health Protection Act of 1996 (see below) and Women's Health and Cancer Rights Act of 1998 (see below) and Mental Health Parity and Addiction Equity Act of 2008.

## Plan Administrator's Power of Authority

The Plan Administrator role for this Plan rests with NWHMC's Human Resources Department. The Plan Administrator is responsible for:

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

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

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

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

An individual, or individuals, may be appointed by the Plan Sponsor to serve as Plan Administrator at the convenience of the Plan Sponsor. If a Plan Administrator resigns, dies or is otherwise removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

## **Discretionary Authority**

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

## **Collective Bargaining Agreements**

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

## **Clerical Error**

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

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

# Statement of ERISA Rights

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

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

## Prudent Actions by Plan Fiduciaries

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

## Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to obtain any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

## **Continue Group Health Coverage/Certificate of Creditable Coverage**

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Group Health Summary Plan Document and the documents governing your COBRA continuation coverage rights.

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

## **Assistance with Your Questions**

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

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

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

# Summary Plan Description and General Information

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<b>Plan Name:</b>	Health Resources Northwest Employee Benefit Plan – Medical Plan
<b>Plan Year:</b>	January 1 – December 31
<b>Type of Plan:</b>	Group health plan (a type of welfare benefit plan subject to ERISA provisions)
<b>Plan Number:</b>	501
<b>Plan Funding:</b>	The Plan is funded through a combination of employee pre-tax contributions and Northwest Hospital and Medical Center general assets.
<b>Plan Sponsor:</b>	Northwest Hospital and Medical Center
<b>Plan Sponsor’s Employer Identification Number:</b>	91-0637400
<b>Named Fiduciary:</b>	Northwest Hospital and Medical Center
<b>Plan Administrator:</b>	Northwest Hospital and Medical Center
<b>Third Party Administrator:</b>	First Choice Health Network, Inc. d.b.a. First Choice Health Administrators 600 University Street, Suite 1400 Seattle WA 98101 (800) 430-3818/Local: (206) 268-2360 <a href="http://www.myFirstChoice.fchn.com">www.myFirstChoice.fchn.com</a>
<b>Agent for Service of Legal Process:</b>	Northwest Hospital and Medical Center 9709 Third Ave NE Suite 509 Seattle, WA 98115 (206) 368-1106
<b>Plan Description:</b>	The written Summary Plan Description required by ERISA §402 consists of this entire document plus benefit summary booklets and provider directories.

# Plan Definitions

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**Adverse benefit determination** means a denial, decrease or ending of a benefit. This includes a failure to provide or make payment (in whole or in part) for a benefit including claims based on medical necessity or experimental and investigational exclusions.

**Allowed amount** means the maximum amount paid by the Plan for a medically necessary covered service. Generally, this is a contracted amount agreed to by FCHN participating providers (known as the First Choice Health Network). The allowed amount paid by the Plan for services from non-network providers and for out-of-area providers is based on usual, customary and reasonable (UCR) rates.

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

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

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

**Calendar year** means the 12-month period beginning January 1 and ending December 31 of the same year.

**Certificate of creditable coverage** means a certificate issued by a group health plan that describes a person's prior period(s) of creditable health care coverage as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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

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

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

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

**Copay** is the fixed amount you pay at the time you receive certain covered services.

**Coinsurance** is the amount you and the Plan share toward covered expenses. For example, if the Plan pays 90% coinsurance for the care you receive, your coinsurance is 10%.

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

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

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

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

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

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

- Not in general use in the medical community,
- Not proven safe and effective or to show a demonstrable benefit for a particular illness or disease,
- Under continued scientific testing and research,
- A significant risk to the health or safety of the patient, or,
- Not proven to result in greater benefits for a particular illness or disease than other generally available services.

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

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

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

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

- **Intensive Outpatient Programs** provide services for Mental Health or Chemical Dependency Conditions on an outpatient basis through planned, structured services available at least two hours per day and three days per week. Services include group, individual and when indicated family or multi-family group treatment. Medical monitoring, evaluation and adjunctive services are available. Treatment must follow a written plan of care.
- **Partial Hospitalization Programs** provide multi-disciplinary care for Mental Health or Chemical Dependency Condition at least 6 hours a day, 5 days a week, and schedule at least three distinct services per day. Services include individual and group therapy, medication evaluation and management, family therapy, activity therapy, occupational therapy, and education training directed at treating the Condition. Services for Mental Health Conditions must include evaluation by a psychiatrist within 48 hours and weekly thereafter. All programs must include a substance abuse evaluation. Treatment must follow a written plan of care.
- **Residential Treatment Programs** provide a 24-hour level of care 7 days a week for patients with long-term or severe Mental Health or Chemical Dependency Conditions. Care is medically monitored, with 24-hour medical and nursing availability. Services include treatment with a range of diagnostic and therapeutic behavioral health services that cannot be adequately provided through existing community programs. Residential care also includes family involvement in assessment, treatment and discharge planning, and offers training in the basic skills of living as determined necessary for each patient. Treatment must follow a written plan of care.
- **Chemical Dependency Rehabilitation Programs** provide 24-hour rehabilitation treatment 7 days a week for Substance Abuse Conditions. Services include group, individual and when indicated family or multi-family group. The facility must offer sufficient availability of medical and nursing services to manage ancillary detoxification needs. Treatment must follow a written plan of care.

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

**Limiting Dependent Child Age** for this plan is 23, meaning, a dependent can remain on your plan if enrolled in an accredited educational institution through the age of 23.

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

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

- It is required for the treatment or diagnosis of a covered medical condition
- It is the most appropriate supply or level of service that is essential for the diagnosis or treatment of the patient's covered medical condition
- It is known to be effective in improving health outcomes for the patient's medical condition in accordance with sufficient scientific evidence and professionally recognized standards
- It is not furnished primarily for the convenience of the patient or provider of services
- It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the patient.

The fact that a service or supply is furnished, prescribed or recommended by a physician or other provider does not, of itself, make it medically necessary. A service or supply may be medically necessary in part only.

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

- Conditions related to Substance Disorders (see *Chemical Dependency* definition)
- Developmental Delays/Learning Disorders (see *Neurodevelopmental Therapy* benefit)
- Relational or behavioral issues (specifically those claims submitted with DSM V code as a primary diagnosis)
- Sexual and gender identity disorders (specifically DSM codes 302.0-302.9)

**Network provider** means a contracted FCHN provider in Washington, Idaho, Montana, Oregon and Alaska that is listed in the provider directory. Outside these states, participants must use the Beech Street Network for network providers. Contracted FCHN providers include providers contracting with Healthcare Direct (a wholly owned subsidiary of FCHN) in Oregon and Idaho, and HealthInfoNet in Montana.

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

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

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

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

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

- Construe and interpret the Plan document and to decide all questions of eligibility and participation,
- Make all findings of fact for Plan administration, including payment of reimbursements,
- Prescribe procedures to be followed and forms to be used by participants and beneficiaries,

- Request and receive from all employees the information necessary for proper Plan administration, and,
- Appoint and employ the individuals or entities to assist in Plan administration as necessary or advisable, including benefit consultants and legal counsel.

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

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

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

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

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

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

**Provider directory** is the listing of the network providers, hospitals, and other facilities that have agreed to provide covered services to participants or dependents of Plans contracted with FCHN and FCHA for PPO and TPA services.

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

**Recognized Providers** are providers acting within the scope of his/her license but for whom: 1) FCHN does not offer agreements to his/her category of providers, or 2) agreements are offered but covered participant choice is not provided. Examples of both types are outlined below:

- Ambulance services
- Anesthesiologists
- Assistant surgeon
- Blood banks
- Dental providers (only when services provided are covered by the Plan, such as Dental Trauma services)
- Non-contracted laboratories used by FCHN referring provider
- Ocular prosthetics (if covered by the Plan)
- PKU formula
- Services of non-contracted providers when rendering care within a network facility

- Suppliers of wigs (if covered by the Plan)
- TMJ providers (if covered by the Plan)

**Special enrollment** means, under HIPAA, special mid-year enrollment rights that group health plans must offer to certain unenrolled employees and dependents who experience a mid-year loss of other coverage or when there is a mid-year birth, adoption or marriage.

**Spouse** means one person of the opposite gender who is the lawful spouse as recognized by federal laws.

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

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

**Third Party Administrator (TPA)** is the organization providing services to this Plan's Administrator and Sponsor, including processing and payment of claims. FCHA is the Third Party Administrator for this Plan.

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

**Urgent care claim** means a claim for medical care or treatment that, if normal pre-service standards are applied:

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

**Usual, Customary and Reasonable (UCR)** is the allowed amount paid by FCHA for services received from non-network providers. This amount is determined at FCHN's discretion based on various, yet consistently applied criteria such as the state in which the provider practices and geographic cost data obtained from an independent entity.