



**NORTHWEST HOSPITAL
& MEDICAL CENTER**

SUMMARY PLAN DESCRIPTION

Vision Plan Summary

Vision Service Plan

Revised & Restated
2007

BENEFITS DIRECTORY

Call ...	For Questions About ...
<p>Vision Service Plan at (800) 877-7195 vsp.com</p>	<ul style="list-style-type: none">• Plan benefit details (covered expenses, limitations, exclusions)• Low-vision benefit authorization• VSP doctors• Claims processing
<p>Benefits Department at (206) 368-1106 http://nwhweb/hr/benefits/</p>	<ul style="list-style-type: none">• Northwest Hospital & Medical Center's benefit program• Eligibility• Cost• When coverage begins• Enrollment• Qualifying change in family status

HOW TO USE THIS BOOKLET

This booklet is the Summary Plan Description of the vision coverage available to you and your family members through the Vision Service Plan (VSP) if you are an eligible Northwest Hospital & Medical Center employee. It summarizes the coverage, describes when coverage begins and explains how to use the plan. See your enrollment materials for information on enrollment procedures and deadlines, coverage options and required payroll deductions.

This booklet uses a number of technical terms you will need to know to understand your benefits. For reference, we've defined many unfamiliar terms in "Definitions" starting on page 38.

Keep this booklet and refer to it whenever you have a question about your vision coverage. If you still have questions, contact VSP toll free at (800) 877-7195. You may also contact the Benefits Department in Human Resources at (206) 368-1106.

Although this booklet includes certain key features and brief summaries of Northwest Hospital & Medical Center's vision coverage through the Vision Service Plan, it does not provide detailed descriptions. If you have questions about specific plan details, contact VSP, or the Benefits Department.

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

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

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

LEARN MORE ABOUT...**ON PAGE...**

HIGHLIGHTS	1
WHO'S ELIGIBLE	1
PREMIUMS	2
COST	2
ENROLLING IN THE PLANS	2
WHEN COVERAGE BEGINS	4
FALSE STATEMENTS, FRAUDULENT ACTS and MATERIAL MISREPRESENTATIONS	5
HOW THE VISION PLAN WORKS	6
NETWORK PROVIDERS AND ACCESSING CARE	7
PRIOR AUTHORIZATION	7
COVERED EXPENSES	8
EXPENSES NOT COVERED	9
SPECIAL SITUATIONS	10
HOW TO SUBMIT A CLAIM	11
CLAIMS PROCEDURE	12
APPEALING A CLAIM	13
PRIVACY AND SECURITY OF YOUR PROTECTED HEALTH INFORMATION	14
QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)	17
COORDINATION OF BENEFITS (COB)	18
WHEN COVERAGE ENDS	20
CERTIFICATE OF COVERAGE	20
CONTINUATION OF COVERAGE UNDER COBRA	21
USERRA NOTICE	30

ASSIGNMENT OF BENEFITS	32
THIRD PARTY CLAIMS	33
RECOVERY OF OVERPAYMENTS.....	33
PAYMENT OF VISION BENEFITS.....	34
TERMINATION AND AMENDMENT OF THE PLAN	34
YOUR ERISA RIGHTS	34
PLAN ADMINISTRATION	36
FOR MORE INFORMATION	37
DEFINITIONS	38
NOTES.....	40

HIGHLIGHTS

This plan covers eye exams, prescription lenses and frames for you and your family members.

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

- You can use any provider you wish; plan benefits apply if you see a VSP doctor or an out-of-network provider.
- Benefits are higher if you use a VSP doctor.

Claim processing is provided by VSP, an organization that has contracted with thousands of quality eye care doctors (optometrists and ophthalmologists) throughout the country.

WHO'S ELIGIBLE

Employees

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

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

Family Members of Employees

The following family members are eligible for medical coverage:

- Your spouse, unless legally separated or divorced. The term Spouse means one person of the opposite gender who is the lawful spouse as recognized by Federal laws.
- Unmarried children who are:
 - Younger than age 19 and primarily dependent on you for support, or
 - Younger than age 24 if they rely on you for half of their financial support and are a full time student enrolled in an accredited educational institution
Beginning with your child's 19th birthday, First Choice Health Administrators will verify, on a semi-annual basis, their full time student status.
 - Incapacitated due to developmental or physical disability and chiefly dependent on you for support. You must submit proof of your child's disability at the time coverage is extended and annually thereafter unless otherwise requested by the Plan. The child must have become incapacitated while covered by one of these plans and before age 19 (or before age 24 if a full time student).
 - Named in a Qualified Medical Child Support Order (QMCSO) as defined under federal law and authorized by the Plan. See page 17 for details.

Eligible children include unmarried:

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

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

PREMIUMS

Employees who are classified as a 0.6 FTE or greater, who are eligible participants, contribute a flat dollar amount of the premiums to provide spouse and/or dependent coverage. Employee coverage under the plan is paid 100% by Northwest Hospital & Medical Center.

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

COST

When you receive vision benefits, you pay:

- Required co-pays, paid at the time of the service
- Expenses for services or supplies not covered by the Plan

If you see a VSP doctor, you pay the co-payments directly to the doctor; if you see an out-of-network provider, you will be required to pay the provider in full at the time of service. The co-payments will be deducted from the amount the plan reimburses you.

See "Vision Plan Summary" on page 6 for plan benefits and covered expenses.

ENROLLING IN THE PLANS

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

Making Changes

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

Qualifying Change in Family Status

If you have a qualifying change in status as defined by the Internal Revenue Service that affects your eligibility, or your dependent's eligibility, you may drop or add family members' coverage during the plan year. Examples of qualifying changes (events) include:

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

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

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

Special Enrollment Rules

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

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

Loss of other coverage means:

- You or your family member(s) were covered under other health insurance or group health plan at the time coverage under this Plan was previously offered to the individual; and
- The other coverage was lost due to one of the following reasons:
 - The other coverage was under COBRA and the COBRA coverage has been exhausted, or
 - The other coverage was not under COBRA and employer contributions toward the other coverage was terminated; or
 - The other coverage was not under COBRA and the other coverage was terminated as a result of loss of eligibility for the other coverage. Loss of eligibility includes:
 - Loss of eligibility due to divorce, legal separation, death, cessation of dependent status, termination of employment, or reduction in the number of hours of employment
 - Loss of eligibility due to the other coverage no longer offering any benefits to a class of similarly situated individuals

- Loss of eligibility on the earliest date the individual incurs a claim that reaches or exceeds the lifetime maximum benefit under the other coverage
 - Loss of eligibility when coverage is offered through an HMO (or other arrangement) in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual)
 - Loss of eligibility when coverage is offered through an HMO (or other arrangement) in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual) and no other benefit package is available to the individual.
- **Newly Acquired Family Member:** If you have a new family member as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your family members.

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

WHEN COVERAGE BEGINS

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

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

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

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

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

FALSE STATEMENTS, FRAUDULENT ACTS and MATERIAL MISREPRESENTATIONS

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

HOW THE VISION PLAN WORKS

Vision Plan Summary

The following table summarizes covered eye care services and eyewear under this plan and identifies related maximums and limitations. Please refer to “Covered Expenses” on page 8 and “Expenses Not Covered” on page 9 for more information on your vision benefits.

Benefits are available once every plan year beginning on January 1st.

Benefit	If you see a VSP doctor	If you see an out-of-network provider
Co-payments – \$10 for eye exam – \$25 for eyewear (applied to lenses and frame)	You pay your co-payments to the doctor and the plan pays...	You pay the bill in full and the plan pays the following amount minus your co-pays...
Exams	Covered in full	Reimbursed up to \$50 allowance
Lenses – Single vision – Lined bifocal – Lined trifocal – Lenticular	Covered in full Covered in full Covered in full Covered in full	Reimbursed up to \$40 Reimbursed up to \$50 Reimbursed up to \$60 Reimbursed up to \$125
Frames¹	Covered up to \$120 allowance ²	Reimbursed up to \$50 allowance
Lens Options - Tinted/Photochromic lenses	Covered in full	up to \$5
Contacts - per pair (once every 12 months instead of eyeglass lenses and frames) – Cosmetic – Visually Necessary	100%, up to \$120 ³ 100% (subject to co-payment)	up to \$80 up to \$ 210 (subject to co-payment)
Low Vision Benefit⁴ - Supplementary Testing - Supplemental Care Aids (maximum benefit available is \$1,000 every two years)	Covered in full 75% of cost	up to \$125 75% of cost

¹ Lenses and frames include such professional services as are necessary, which shall include: prescribing and ordering proper lenses; assisting in the selection of frames; verifying the accuracy of the finished lenses; proper fitting and adjustment of frames; subsequent adjustments of frames to maintain comfort and efficiency; progress or follow-up work as necessary.

² VSP covers a wide selection of frames, but not all frames. If you choose a frame valued at more than your allowance, you'll be responsible for the extra cost. You'll save 20% on your out-of-pocket costs for frames from your VSP doctor. Your VSP doctor can tell you which frames are fully covered by the plan.

³ Your allowance applies to the cost of your contact lens exam and your contact lenses. You'll receive a 15% discount off the cost of your contact lens exam from a VSP doctor.

⁴ The Low Vision Benefit is available to covered persons who have severe visual problems that are not correctable with regular lenses and is subject to prior approval by VSP consultants.

NETWORK PROVIDERS AND ACCESSING CARE

VSP has an extensive nationwide network of doctors who agree to provide quality vision care and eyewear to plan members. Finding a VSP doctor is easy – to obtain a complete directory or details about VSP doctors, call VSP's Member Services Department at (800) 877-7195, or visit VSP's website at vsp.com.

Using your VSP benefit is easy:

- There are no cards and no claim forms.
- You make an appointment with your VSP doctor. Be sure to identify yourself as a VSP member and give your identification number; this is typically your Social Security number, but may be any other unique identifying number. The VSP doctor will notify you if any services you are requesting are not covered and will explain when those services will be available, if at all.
- You pay a \$10 exam co-payment when you meet with the doctor.
- You pay an additional \$25 co-payment if you select lenses and/or frames.
- The plan covers in full most eye care services and eyewear.

To receive out-of-network provider benefits:

- You make an appointment with any licensed eye care provider. If you want to verify that the care you'll receive is covered, call VSP's Member Services Department at (800) 877-7195.
- You pay the provider in full at the time of service. Be aware that out-of-network benefits do not guarantee full payment.
- Submit a claim to VSP for Reimbursement as shown in "Filing a Claim".
- The plan reimburses you up to the level of benefits shown in "Vision Plan Summary" minus the applicable co-payments.

PRIOR AUTHORIZATION

Certain Plan benefits require prior authorization from VSP before those plan benefits will be covered. VSP's prior authorization determinations are based upon criteria developed by optometric and ophthalmic consultants and approved by VSP's Utilization Management Committee and Board of Directors.

Initial Determination

VSP will approve or deny requests for prior authorization of services within fifteen (15) calendar days of receipt of the request from the covered individual's doctor. In the event that a prior authorization cannot be resolved within the time indicated, VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days.

Appeals

If VSP denies the doctor's request for prior authorization, the doctor, covered individual or the covered individual's representative may request an appeal of the denial. Please refer to the section on Claim Appeals, beginning on page 13, for details on how to request an appeal. VSP shall provide the requestor with a final review determination

within thirty (30) calendar days from the date the request is received. A second level appeal, and other remedies as described below, is also available. VSP shall resolve any second level appeal within thirty (30) calendar days. A covered individual may designate any person, including the provider, as the covered individual's authorized representative.

For more information regarding VSP's criteria for authorizing or denying plan benefits, contact the VSP Member Services Department at (800) 877-7195.

COVERED EXPENSES

This section describes the vision care services and vision care materials to which you are entitled, subject to any co-payments and other conditions, limitations and/or exclusions stated below.

When plan benefits are received by VSP doctors, benefits are generally covered in full after any applicable co-payment.

When plan benefits are available and received by from non-VSP doctors, you are reimbursed for such benefits according to the schedule described in the "Vision Plan Summary" on page 6.

Vision Care Services

- Eye Examination - Complete initial vision analysis which includes an appropriate examination of visual functions, including the prescription of corrective eyewear where indicated.

Vision Care Materials

- Lenses
- Frames
- Contacts – Contact lenses are available in lieu of all other lens and frame benefits available. When contact lenses are obtained, you are not eligible for lenses and frames again until the next plan year.
- Visually necessary contact lenses – Visually necessary contact lenses are generally recommend for the following conditions:
 - Cataract surgery
 - Extreme visual acuity problems that cannot be corrected with eyeglasses
 - Conditions of anisometropia
 - Keratoconus

Low Vision Benefit

If you have severe visual problems that are not correctable with regular lenses, you may be eligible for the low vision benefit. To receive this benefit, you must:

- Obtain authorization from VSP before you receive services

- See a VSP doctor or an out-of network provider

The following low vision benefits are covered:

- Supplementary Testing – Analysis and diagnosis including a comprehensive exam of visual functions, with a prescription for corrective eyewear or vision aids where indicated.
- Supplemental Aids

The maximum low vision benefit available is \$1,000.00, excluding any applicable co-pays, every two years.

Additional Discounts

In addition to the benefits describe above, VSP doctors offer the following discounts if you want another pair of glasses or contacts:

- You may purchase an additional pair of frames and prescriptions lenses from your VSP doctor at a 20% discount. To receive this discount, you must make the additional purchase within 12 month of your initial exam and from the same VSP doctor.
- You'll receive a 15% discount toward the cost of your contact lens exam (evaluation and fitting).
- Lens options, which can enhance the appearance, durability and function of your glasses, are available to you at VSP's member preferred pricing. Ask your doctor for details.
- VSP also offers valuable savings on annual supplies of certain brands of contacts. You can receive these VSP member preferred prices, even if you use your VSP coverage for glasses. Ask your doctor for details.
- VSP has contracted with many of the nation's finest laser surgery facilities and doctors, offering you a discount off PRK and LASIK surgeries, available through contracted laser centers. Visit VSP's website at vsp.com to learn more about this exciting program.

EXPENSES NOT COVERED

The following expenses are not covered under the Vision Plan:

- Blended lenses
- Coated lenses
- Costs that exceed plan allowances
- Exams or eyewear required as a condition of employment

- Extra cost items – The plan is designed to pay the cost of visual rather than cosmetic needs. You pay the extra cost for:
 - Amounts over the low-vision benefit maximum
 - Cost for frames above the plan allowance
 - Optional cosmetic services, procedures and supplies
 - UV protected lenses
- Laminated lenses
- Medical or surgical treatment of the eye. See the Medical Plan Summary Plan Description for information on covered expenses.
- Orthoptics or vision training and any associated supplemental testing
- Oversized lenses (61mm or larger)
- Plain (nonprescription) lenses
- Progressive multifocal lenses
- Replacement of lenses and frames that are lost or broken, except at normal intervals – once every 12 months, beginning January 1st for lenses and frames
- Services or eyewear provided as a result of Workers' Compensation law or similar legislation, or obtained through or required by any government agency or program
- Two pair of glasses in place of bifocals

SPECIAL SITUATIONS

If You Need Care While Traveling

See "Accessing Care" on page 7 for details.

If Your Family Member Lives Away From Home

See "Accessing Care" on page 7 for details.

If You Take a Leave of Absence

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

If You Take a Leave of Absence to Perform Military Service

Please see section "USERRA Notice" beginning on page 30.

If You Enter Into a Labor Dispute

If your pay is suspended directly or indirectly as a result of a strike, lockout, or other labor dispute, you may continue vision coverage for up to 6 months for yourself and your eligible family members if you pay the full cost of coverage directly to the Benefits Department in Human Resources. At the end of 6 months, you may be eligible for up to 18 months more coverage under COBRA; see “Continuation of Coverage under COBRA” starting on page 21 for details.

If You Are Laid Off

If you are laid off while a plan participant, coverage for you and your eligible family members may continue for a limited time if you, or your eligible family members, pay the full cost of coverage under COBRA. See “Continuation of Coverage under COBRA” starting on page 21 for details.

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

If You Die

If you die while a plan participant, coverage for your eligible family members may continue for a limited time if they pay the full cost of coverage under COBRA. See “Continuation of Coverage under COBRA” starting on page 21 for details.

If You Become Disabled

If you become disabled, you may be eligible to continue coverage under COBRA. See “Continuation of Coverage under COBRA” starting on page 21 for details.

If You Retire

If you retire, you may be eligible to continue your coverage under COBRA. See “Continuation of Coverage under COBRA” starting on page 21 for details.

HOW TO SUBMIT A CLAIM

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

Your VSP doctor, typically, will be able to submit claims for you directly to VSP. In the event you obtain covered services or eyewear from an out-of-network provider, you must pay the provider in full at the time of service, and then submit a claim and an itemized receipt to VSP. The plan reimburses you up to the amount identified in “Vision Plan Summary” on page 6.

All claims must be filed within 6 months of the date services are completed.

To ensure a timely reimbursement, log on to VSP's website and access the claim form.

Simply:

- Sign on to vsp.com
- Click “Members & Consumers”
- Under “About VSP Coverage”, click “View frequently asked questions”
- In the section “VSP Network Doctor Questions”, click “How do I submit an out-of-network claim for reimbursement”

If you do not have internet access, you must send to VSP:

- An itemized receipt listing the services you received
- The name, address and phone number of the non-VSP provider
- The employee’s Social Security number, or other identification number
- The employee’s name, phone number and address
- The name of the group that provides coverage. This is Northwest Hospital & Medical Center
- The patient’s name, date of birth, phone number and address
- The patient’s relation to the employee, such as “self”, “spouse” or “child”

You should keep a copy of the information and mail the originals to:

VSP
Attn: Out-of-Network Claims
PO Box 997105
Sacramento, CA 95899-7105

CLAIMS PROCEDURE

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

The timeframes listed below are maximum times only.

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

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

“Days” mean calendar days.

Claim Determination

VSP will pay or deny claims within thirty (30) days of the receipt of the claim from the covered individual, or their authorized representative.

In the event that a claim cannot be resolved within the time indicated VSP may, if necessary, extend the time for decision by no more that fifteen (15) days.

APPEALING A CLAIM

You have the right to appeal any adverse benefit determination, or any claim decision made by VSP to deny, modify, reduce or terminate payment, coverage, authorization, and/or any provision of vision care services or benefits.

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

To file an appeal, contact VSP at:

VSP
Member Appeals
3333 Quality Drive
Rancho, Cordova, CA 95670
(800) 877-7195

The Plan offers a two-step appeals procedure.

Step 1

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

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

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

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

VSP will make an appeal determination, including specific reasons for the decision and will communicate their decision to the covered individual within thirty (30) days.

Step 2

If, after completing Step 1, VSP affirms its original benefits determination, you may, if you choose, request a second level appeal within sixty (60) days from the date of the determination. VSP shall communicate its final determination to the covered person in compliance with all applicable state and federal laws and regulations and shall include the specific reasons for this determination.

When a covered individual has completed all appeals mandated by ERISA, additional voluntary alternative dispute resolution options may be available, including mediation and arbitration. Covered individuals should contact the U.S. Department of Labor or the State insurance regulatory agency for details. Additionally, under ERISA § 502(a)(1)(B), a covered individual has the right to bring a civil (court) action when all available levels of reviews of denied claims, including the appeal process, have been completed, the claims were not approved in whole or in part, and the covered individual disagrees with the outcome.

PRIVACY AND SECURITY OF YOUR PROTECTED HEALTH INFORMATION

Northwest Hospital & Medical Center (“Plan Sponsor”) sponsors the Health Resources Northwest Employee Benefit Vision 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 non-compliance pursuant to the Plan Sponsor's corrective action policies and procedures.

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

Certification

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

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

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

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

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

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

If the medical child support order is a QMCSO:

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

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

COORDINATION OF BENEFITS (COB)

Benefits Subject to this Provision

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

Allowable Expense

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

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

Plan

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

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

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

Claim Determination Period

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

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

Effect on Benefits

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

Right of Recovery

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

Facility of Payment

Whenever another plan makes payments that should have been provided under the Plan and in accordance with this COB provision, VSP may, at its sole discretion, reimburse to the plan making the other payments any amount necessary to satisfy the intent of this COB provision. Any amount paid under this subsection is considered to be benefits paid under vision coverage, and VSP will be fully discharged from liability to the extent of these payments.

Determination of Plan Priority

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

- The plan covering the individual as an employee rather than the dependent is primary.
- When a participant is covered as a dependent under more than one plan, the plan of the parent whose date of birth occurs earlier in a calendar year is the primary plan. However, in the absence of a court decree to the contrary, the following rules apply to dependents of legally separated or divorced parents:
 - The plan of the custodial parent is primary, provided the custodial parent has not remarried
 - If the custodial parent has remarried, the plan of the custodial parent is primary to a plan covering the child as a dependent of a stepparent, or
 - The plan of a stepparent is primary to the plan of the non-custodial parent
- If none of the above rules applies, the plan that has covered the participant the longest is the primary plan.

Right to Receive and Release Information

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

WHEN COVERAGE ENDS

Employees

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

- You are no longer eligible as defined on page 1
- You resign, retire or are terminated
- You don't pay your premiums/payroll deductions

Your vision coverage also ends

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

Family Members

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

- Your coverage ends
- Your family member is no longer eligible as defined on page 1

Your family member's vision coverage also ends:

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

CERTIFICATE OF COVERAGE

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

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

CONTINUATION OF COVERAGE UNDER COBRA

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

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

What is COBRA Coverage?

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

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

Who is Entitled to Elect COBRA?

Qualifying Events for the Covered Employee

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

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

Qualifying Events for the Covered Spouse

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

- Your spouse dies
- Your spouse's hours of employment are reduced
- Your spouse's employment ends for any reason other than his or her gross misconduct
- You become divorced or legally separated from your spouse. Also, if your spouse reduces or eliminates your group health coverage in anticipation of a

divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for you even though your coverage was reduced or eliminated before the divorce or separation, or

- Your spouse becomes entitled to Medicare

Qualifying Events for Dependent Children

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

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

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

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

When is COBRA Coverage Available

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

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

For the other qualifying events, divorce or legal separation of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child, a COBRA election will be available to you only if you notify the Benefits Department in Human Resources in writing within 60 days after the later of (1) the date of the qualifying event; and (2) the date on which the qualified beneficiary loses, or would lose, coverage under the terms of the Plan as a result of the qualifying event.

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

In providing this notice, you must follow the notice procedures specified in the section below entitled "Notice Procedures". If these procedures are not followed or if the notice

is not provided during the 60-day period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.

Electing COBRA Coverage

How to Elect COBRA

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

Deadline for COBRA Election

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

Independent Election Rights

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

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

Special Considerations in Deciding Whether to Elect COBRA

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

Length of COBRA Coverage

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

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

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

When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, the covered employee's entitlement to Medicare, or a

dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months.

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

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

Termination of employment or reduction of hours

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

Extension of Maximum Coverage Period

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

Disability extension of COBRA coverage

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

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

Health Administrators in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

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

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

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

Second qualifying event extension of COBRA coverage

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months, or in the case of a disability extension, the 29 months following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, the employee's entitlement to Medicare, divorce or legal separation from the covered employee, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred.

You must notify First Choice Health Administrators of a second qualifying event by this deadline. This extension due to a second qualifying event is available only if you notify First Choice Health Administrators in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event, if it had occurred while the qualified beneficiary was still covered under the Plan.

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

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

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

- Any required premium is not paid in full on time
- A qualified beneficiary becomes covered, after electing COBRA, under another group health plan, but only after any exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied
- A qualified beneficiary becomes entitled to Medicare benefits under Part A, Part B, or both, after electing COBRA
- Northwest Hospital & Medical Center ceases to provide any group health plan for its employees; or
- During a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled, COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate. For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period"

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

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

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

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

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

Cost of COBRA Coverage

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

Payment for COBRA Coverage

How premium payments must be made

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

When premium payments are considered to be made

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

First payment for COBRA coverage

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

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

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

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

Monthly payments for COBRA coverage

After you make your first payment for COBRA coverage, you will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that

month's COBRA coverage. If you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without a break. It is your responsibility to pay your COBRA premiums on time.

Grace periods for monthly COBRA premium payments

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

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

More Information About Individuals Who May Be Qualified Beneficiaries

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

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

Alternate recipients under QMCSO's

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

NOTICE PROCEDURES

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

Notices Must Be Written

Any notice that you provide must be in writing.

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

How, When, and Where to Send Notices

You must mail or hand deliver your notice to:

COBRA Administrator
First Choice Health Administrators

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

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

However, if a different address for notices to the Plan appears in the Plan's most recent summary plan description, you must mail or hand deliver your notice to that address. If you do not have a copy of the Plan's most recent summary plan description, you may request one from the Benefits Department in Human Resources.

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

Information Required for All Notices

Any notice you provide must include:

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

Additional Information Required for Notice of Qualifying Event

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

Health Administrators that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Additional Information Required for Notice of Disability

Any notice of disability that you provide must include:

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

Additional Information Required for Notice of Second Qualifying Event

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

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

Who May Provide Notices

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

USERRA NOTICE

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

You Have Rights Under Both COBRA and USERRA

Your rights under COBRA and USERRA are similar but not identical. Any election that you make pursuant to COBRA will also be an election under USERRA, and COBRA and USERRA will both apply with respect to the continuation coverage elected. If COBRA and USERRA give you, or your covered spouse or dependent children, different rights or protections, the law that provides the greater benefit will apply. The administrative policies and procedures described for COBRA above (for example, the procedures for

how to elect COBRA coverage and paying premiums for COBRA coverage) also apply to USERRA coverage, unless compliance with the procedures is precluded by military necessity or is otherwise impossible or unreasonable under the circumstances.

Definitions

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

“Service in the uniformed services” or “service” – means the performance of duty on a voluntary or involuntary basis in the uniformed services under competent authority, including active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, a period for which a person is absent from employment for an examination to determine his or her fitness to perform any of these duties, and a period for which a person is absent from employment to perform certain funeral honors duty. It also includes certain service by intermittent disaster response personnel of the National Disaster Medical System.

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

Duration of USERRA Coverage

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

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

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

Period of Service	Return-to-Work Requirement
Less than 31 days	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible.
More than 30 days but less than 181 days	Within 14 days after completion of your service or, if that is unreasonable or impossible through no fault of your own, the first day on which it is possible to do so.
More than 180 days	Within 90 days after completion of your service.
Any period if for purposes of an examination for fitness to perform uniformed service	The beginning of the first regularly scheduled work period on the day following the completion of your service, after allowing for safe travel home and an eight-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as is possible.
Any period if you were hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service	Same as above (depending on length of service period) except that time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. Maximum period for recovering is limited to two years, but the two-year period may be extended if circumstances beyond your control make it impossible or unreasonable for you to report to work within the above time periods.

COBRA and USERRA coverage are concurrent.

Premium Payments for USERRA Continuation Coverage

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

ASSIGNMENT OF BENEFITS

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

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

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

THIRD PARTY CLAIMS

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

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

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

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

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

RECOVERY OF OVERPAYMENTS

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

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

PAYMENT OF VISION BENEFITS

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

TERMINATION AND AMENDMENT OF THE PLAN

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

YOUR ERISA RIGHTS

This plan was established or sponsored by Northwest Hospital & Medical Center for the exclusive benefit of Plan Participants.

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents have

to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rule governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance with Your Questions

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

PLAN ADMINISTRATION

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

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

The Plan is maintained and administered by:

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

Employer Identification Number

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

Plan Year

January 1 – December 31.

Plan Name

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

Plan Number

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

Plan Type

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

Plan Funding

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

Plan Administration

The Plan is a self-funded health plan and certain administrative services are provided through Vision Service Plan.

Power of Authority of Plan Administrator

The Plan Administrator is responsible for:

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

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

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

Discretionary Authority

The Plan Administrator has the authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive benefits under the Plan.

Claim Administration

Vision claims are administered by:

Vision Service Plan
PO Box 997105
Sacramento, CA 95899-7105
(800) 877-7195

FOR MORE INFORMATION

In addition to the information in this booklet, you may contact VSP for:

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

DEFINITIONS

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

Blended Lenses	A bifocal lens that has invisible segment lines in the reading area.
Certificate of Creditable Coverage	A certificate issued by a health plan which describes a person's prior period(s) of creditable health care coverage as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
Claim	Any request for a plan benefit, made by your or your authorized representative. A covered individual making a claim for benefits is a "claimant" under ERISA regulations.
Co-pay	The amount you pay once during each plan year before the plan pays benefits.
Eligibility Date	The first day of the calendar month following 90 days of continuous service in which you meet the hourly requirement.
Full Time Student	A full time student is an eligible dependent, under the age of 24, who is enrolled with at least 12 credit hours a quarter or semester, at an accredited educational institution.
Legally Designated Ward	A person, especially a child or an individual unable to care for him or herself, placed by a court under the care of a legal guardian.
Non-VSP Provider	A provider who does not have a contract with VSP.
Open Enrollment	The annual period in which eligible Northwest Hospital & Medical Center employees may join, drop or change plans and add or drop family members' coverage.
Plan Document	The instrument or instruments that set forth and govern the duties of the Plan Sponsor and eligibility and benefit provisions of the Plan which provide for the payment or reimbursement of covered services.
Plan Year	The twelve (12) month period beginning January 1 and ending December 31 of the same year.
Progressive Multifocal Lenses	A multifocal lens that has invisible segment lines in the reading area. The process by which technicians make the lenses will distinguish the progressive multifocal lenses from the blended lenses.

Provider	Optometrists, ophthalmologists or dispensing opticians.
Vision Service Plan (VSP)	VSP is an organization that has contracted with optometrists and ophthalmologists to provide professional vision care and materials at a uniform cost.
VSP Provider	A provider who has a contract with VSP (optometrists or ophthalmologists).

NOTES