TO OUR VALUED EMPLOYEES

Welcome to the Yakima Valley Memorial Hospital Employee Health Care Plan!

We are pleased to provide you with this comprehensive program of medical and dental coverage.

The standard benefit level of the medical plan is 80% after deductible. However, this plan also offers financial incentives to use Yakima Valley Memorial Hospital for services that are available here, as well as financial penalties on benefits when services are received from another provider, if the service could have been provided by Yakima Valley Memorial Hospital.

With the exception of very large medical claims from which the Plan is protected by insurance, all Plan expenses are directly paid by the Yakima Valley Memorial Hospital Employee Health Care Plan. The major portion of the Plan cost is provided by your employer and is supplemented by the contributions you make to participate. This means that through careful use of the Plan, you, as a consumer of health care, can have a direct impact on the cost of our Plan that will benefit both you and the Company by allowing us to continue to provide this high quality level of benefits.

Please read this booklet carefully and particularly note the special requirements you must follow prior to being admitted to a medical facility - this is explained in the IMPORTANT INFORMATION section.

If you have any questions regarding either your Plan's benefits or the procedures necessary to receive these benefits, please call:

- Healthcare Management Administrators, Inc. at 509/574-8462 or toll free at 877/581-9109.
- Washington Dental Service at 206/522-2300 or toll free at 800/554-1907.

We wish you the best of health.

Yakima Valley Memorial Hospital Employee Health Care Plan

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This booklet is the Master Plan Document and has been prepared in accordance with Public Law 93-406, the Employee Retirement Income Security Act of 1974 (ERISA). This booklet and any amendments constitute the plan document for this benefit plan. This Plan is maintained for the exclusive benefit of the Plan Employees and each Participant's rights under this Plan are legally enforceable.

The Plan Administrator has the right to amend this Plan at any time. The Plan Administrator will make a good faith effort to communicate to the Plan participants all Plan amendments on a timely basis. For further information, see the section titled Amendment of Plan Document located in the General Provisions section of this booklet.

ELIGIBILITY AND ENROLLMENT PROVISIONS

ELIGIBILITY

Employee Eligibility

Employees eligible for coverage under this plan are:

- Active full- and part-time employees of Yakima Valley Memorial Hospital who are regularly scheduled to work 20 hours or more per week are eligible for coverage under this Plan.

- An employee is defined as: an individual directly involved in the regular business of and compensated for services by YVMH, who is regularly scheduled to work as indicated above.

Dependent Eligibility

Dependents eligible for coverage under this plan are:

- An employee's legally married spouse (who is neither divorced nor legally separated from the employee.)

- An employee's unmarried dependent child(ren) under age 19.

- An employee's unmarried child to age 19 and up to age 24 if that child is enrolled as a full-time student (as defined by the school being attended) in an accredited school, college, university, vocational school, or educational institution, and who qualify for tax deduction according to the Internal Revenue Service.

  Cessation of full-time school attendance shall terminate dependent status EXCEPT that:

  – If cessation is due to summer school vacation, dependent status shall terminate on the date the school reconvenes if attendance does not resume.

  – If cessation is due to disability that prevents full-time school attendance, dependent status shall terminate on the first day of the following quarter/semester in which the student is no longer disabled.

  – A dependent child may re-enroll in the Plan effective the first of the month following or coinciding with regaining full-time student status as long as an enrollment form is submitted to the Plan within 31 days. The dependent child may also be re-enrolled at the annual Open Enrollment period.

- An employee's unmarried dependent child(ren) who is incapable of self-support because of mental retardation, mental illness, or physical incapacity that began prior to the date on which the child's eligibility would have terminated due to age. Proof of incapacity must be received within 120 days after the date on which the maximum age is attained. Subsequent evidence of disability or dependency may be required as often as is reasonably needed to verify continued eligibility for benefits.

- An employee's unmarried dependent child(ren) whose coverage is required pursuant to a valid court or administrative order, or Qualified Medical Child Support Order (QMCSO).

- Adopted children are eligible under the same terms and conditions that apply to dependent, natural children of parents covered under this Plan.

Any individual who is covered as an employee cannot also be covered as a dependent. No dependent can be covered as a dependent of more than one employee.

The term "dependent children" means any of the employee's natural children, legally adopted children, or children who have been placed for adoption with the employee prior to the age of 18, or step-children who depend on the employee for support, or children who have been placed under the legal guardianship of the employee or the employee's spouse by a court decree or placement by a State agency. Placement for adoption is defined as the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption irrespective of whether the adoption has become final. The child's eligibility terminates upon termination of the legal obligation.

ENROLLMENT

Regular Enrollment

To apply for coverage under this plan, the employee must complete and submit an enrollment form within 31 days of the date the individual first becomes eligible for coverage. The completed enrollment form should list all eligible dependents to be covered. Individuals who do not enroll when first eligible will not later be allowed to enroll, unless they become eligible for Special Enrollment or during the annual Open Enrollment period.

When the employee acquires a new eligible dependent through birth, adoption or placement for adoption, the dependents must be enrolled within 60 days of the date they first became eligible for coverage. When the employee acquires new eligible dependents through marriage, the dependents must be enrolled within 31 days of the date they first became eligible for coverage.

Special Enrollment for Loss of Other Coverage

A special enrollment period is available for current employees and their dependents who lose coverage under another group health plan or had other health insurance coverage if the following conditions are met:

- The employee or dependent is eligible for coverage under the terms of the Plan, but not enrolled.

- Enrollment in the Plan was previously offered to the employee.

- The employee declines the coverage under the Plan because, at the time, the employee and/or dependent was covered by another group health plan or other health insurance coverage.

- The employee has declared in writing that the reason for the declination was the other coverage.

The current employee or dependent may request the special enrollment within 31 days of loss of other health coverage under the following circumstances.

- If the other group coverage is not COBRA continuation coverage, special enrollment can only be requested after losing eligibility for the other coverage due to a COBRA qualifying event or after cessation of employer contributions for the other coverage. Loss of eligibility of other coverage does not include a loss due to failure to pay premiums on a timely basis or termination of coverage for cause. COBRA continuation does not have to be elected in order to preserve the right to a special enrollment.

- If the other group coverage is COBRA continuation coverage, the special enrollment can only be requested after exhausting COBRA continuation coverage.

- If the other individual or group coverage does not provide benefits to individuals who no longer reside, live, or work in a service area, and in the case of group coverage, no other benefit packages are available.

- If the other plan no longer offers any benefits to the class of similarly situated individuals.

Effective date of coverage will be the first of the month following or coinciding with the date the request is received by the Plan Administrator.

Special Enrollment for Loss of Eligibility Due to Reaching Lifetime Maximum Benefits Under Another Plan

A special enrollment period is available for current employees and their dependents, if an individual incurs a claim that causes the individual to meet or exceed a lifetime maximum on all benefits. The current employee or dependent may request the special enrollment within 31 days from the date that the claim putting the individual over the lifetime maximum has been denied.

If the other coverage is COBRA continuation coverage, meeting or exceeding a lifetime maximum on all benefits, shall also result in the exhaustion of COBRA continuation coverage. Special enrollment must be requested within 31 days from the date the claim putting the individual over the lifetime maximum has been incurred.

Effective date of coverage will be the first of the month following or coinciding with the date the request is received by the Plan Administrator.

Special Enrollment for New Dependents

A special enrollment period is available for current employees who acquire a new dependent by birth, marriage, adoption, or placement for adoption. This special enrollment applies to the following events:

- When an employee marries, a Special Enrollment period is available for the employee and spouse. The effective date will be the first of the month following or coinciding with the date the completed enrollment material is received by the Plan Administrator, provided the forms are returned within 31 days of the date of marriage.

- When an employee or spouse acquires a child through birth, adoption or placement for adoption, a Special Enrollment period is available for the employee, the spouse and the dependent. As long as the proper enrollment material is received by the Plan within the 60 day enrollment period, the effective date of coverage will be the date of the birth, adoption or placement of adoption.

Special Enrollment for New Dependents through Qualified Medical Child Support Order

Section 609(a) of ERISA requires medical benefit plans to honor the terms of a Qualified Medical Child Support Order (QMCSO). The order must be a judgment, order of decree or a divorce settlement agreement related to a child support, alimony, or the division of marital property, issued pursuant to state law. Agreements made by the parties, but not formally approved by the court are not acceptable. If the child is enrolled within 31 days of the court or state agency order, the waiting period and pre-existing conditions exclusion period does not apply.

Open Enrollment

An open enrollment period is held once every 12 months to allow eligible employees to change their participation in the Plan. The Open Enrollment period will be the month of December for an effective date of January 1.

The waiting period for coverage of pre-existing conditions for participants enrolling at the Open Enrollment period will start on the date coverage becomes effective. The pre-existing conditions limitation for eligible employees enrolling during Open Enrollment will be 6 months from the date coverage begins, less any period of creditable coverage.

MILITARY LEAVE OF ABSENCE

Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994. These rights apply only to eligible employees and eligible dependents covered under the Plan before leaving for military service.

The maximum period of coverage of a person under such an election shall be the lesser of:

a. For elections made before December 10, 2004, the 18 month period beginning on the date that Uniformed Service leave commences; or

b. For elections made on or after December 10, 2004, the 24 month period beginning on the date that Uniformed Service leave commences; or

c. The period beginning on the date that Uniformed Service leave commences and ending on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

A person who elects to continue Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the employee's share, if any, for the coverage.

A preexisting condition exclusion may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, Plan exclusions and waiting periods may be imposed for any sickness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during military service.

Please contact the Group's Human Resources Department for information concerning your eligibility for USERRA and any requirements of the Plan.

EFFECTIVE DATE OF COVERAGE

Employee Effective Date

The effective date of coverage for eligible employees is the first of the month following or coinciding with completion of the probationary period. The probationary period is the period that must pass before coverage for an employee or dependent that is otherwise eligible to enroll under the terms of Plan can become effective. Periods of employment in an ineligible classification are not part of a probationary period.

Management's effective date of coverage is the date of hire; there is no probationary period.

The effective date of coverage for other eligible employees is the first of the month following or coinciding with completion of three months from your date of hire (which is your probationary period), or after you have completed three months at an eligible status.

Dependent Effective Date

If the employee elects coverage for dependents during the first 31 days of eligibility, the dependents' effective date will be the same as the employee's effective date.

Newly acquired dependents must be enrolled within 31 days of the date of marriage, the date the valid court or administrative order takes effect, or the date of eligibility; or within 60 days of the date of birth, date of adoption, or the date of placement for adoption. The effective date of coverage will be the date of birth, date of adoption, date of placement for adoption, or the first of the month following or coinciding with the date of marriage; provided the enrollment forms are received within the required time frame.

TERMINATION OF COVERAGE

Except as provided in the Plan's Continuation of Coverage provisions, coverage will terminate on the earliest of the following occurrences:

Management

Management's coverage shall terminate on the date of termination.

Managers who have been covered under this Plan under the management class for five or more years and coverage terminates due to disability and are not covered under any other group plan or Medicare, may remain covered for Medical benefits until the earlier of the following:

- They become eligible to be covered under any other group plan.
- They become eligible to be covered under Medicare.
- They are no longer disabled.

All dependents of managers covered on that date of termination may remain covered as long as they are eligible under the dependent definition of the Plan, or;

- Until they become eligible to be covered under any other group plan;
- Until they become eligible to be covered by Medicare;

- Until children reach age 19, or age 24 if a full-time student;
- Until the employee expires.

Other Employees (Non-Management)

- The last day of the month in which the employee ceases to meet the eligibility requirements of the Plan.
- The last day of the month in which the employee terminates employment.
- The last day of the month in which the employee begins active service in the armed forces.
- The first day of the month in which the employee fails to make any required contribution when coverage is contributory.
- The last day of the month in which an employee fails to return to work following an approved leave of absence.
- The last day of the month in which the employee retires.
- The last day of the month in which the Employer terminates the Plan and offers no other group health plan.

Dependent(s) of Other Employees (Non-Management)

- The last day of the month in which the employee's coverage terminates.
- The last day of the month in which such individual ceases to meet the eligibility requirements of the Plan.
- The last day of the month in which the dependent becomes eligible as an employee.
- The last day of the month in which contributions have been made on their behalf.
- The last day of the month in which the dependent begins active service in the armed forces of any country.
- The last day of the month in which dependent coverage is discontinued under the Plan.
- The last day of the month in which the Employer terminates the Plan and offers no other group health plan.

APPROVED FAMILY AND MEDICAL LEAVE

If an employee is eligible for a Family/Medical leave and is absent from work because of an approved leave of absence under the provisions of the Family and Medical Leave Act of 1993, coverage under the Plan may be continued for the employee and covered dependents for up to 12 weeks during any 12 month period, provided the employee makes any required contributions. YVMH may require employees who fail to return from Family and Medical Leave to repay any health plan premiums paid on their behalf during that leave unless the employee's failure to return from leave is related to a serious health condition or events beyond the employee's control. If the employee's leave extends more than 12 weeks, the employee will be eligible to continue coverage under the (COBRA) Continuation of Coverage provision of the plan.

Please contact YVMH's Human Resources Department for information on how to qualify for a Family/Medical Leave of Absence.

REINSTATEMENT OF COVERAGE

If an employee or dependent who was covered under this Plan terminates employment or loses eligibility for coverage and is rehired or again becomes eligible for coverage within six months of the date of termination, the probationary period will be waived. Credit will be given toward the deductible and out-of-pocket for amounts satisfied within the current calendar year (fourth quarter deductible carryover will also credit if applicable). Credit will also be applied to the pre-existing condition waiting period (including any creditable coverage acquired during the absence) for the time previously covered under this Plan if reinstated within six months. An employee (and their dependents) will be eligible for reinstatement of coverage on the first of the month following or coinciding with the date the employee returns to work. Individuals continuously covered under the COBRA Continuation of Coverage Provision of this Plan will be given credit for the time covered under this Plan toward meeting the pre-existing condition requirement. Individuals not reinstated on the Plan within six months and not continuously covered under the COBRA Continuation of Coverage Provision of this Plan will be treated as a new hire.

CERTIFICATES OF CREDITABLE COVERAGE

Under the Health Insurance Portability and Accountability Act of 1996, former Plan participants and their eligible dependents have the right to request and receive a Certificate of Creditable Coverage for any coverage, including COBRA coverage that was in effect June 1, 1996 or after. The right to receive this certificate continues for 24 months following the date of the termination of coverage under this Plan.

When enrolling in this Plan, you must provide a Certificate of Creditable Coverage in order to receive credit toward the pre-existing condition waiting period.

COBRA

CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

Yakima Valley Memorial Hospital Employee Health Care Plan (the Plan)

The following information about your right to continue your health care coverage in the Plan is important. Please read it very carefully.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to you when you would otherwise lose your group health coverage under the Plan. It can also become available to your spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan.

The following paragraphs generally explain 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.

In general, COBRA requires that a "qualified beneficiary" covered under the Employer's group health plan who experiences a "qualifying event" be allowed to elect to continue that health coverage for a period of time. ***Qualified beneficiaries are employees and dependents who were covered by the Plan on the day before the qualifying event occurred.*** Coverage is elected on the election form provided by the Plan Administrator. Both employees and dependents should take the time to read the Continuation of Coverage Rights provisions.

The Plan has multiple group health components and you may be enrolled in one or more of these components. COBRA (and the description of COBRA coverage contained in this SPD) applies only to the group health plan benefits offered under the Plan and not to any other benefits offered under the Plan or by Yakima Valley Memorial Hospital (such as life insurance, disability, or accidental death or dismemberment benefits). 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.

The Plan Administrator is:

Yakima Valley Memorial Hospital
2811 Tieton Drive
Yakima, WA 98902
509/575-8085

The party responsible for administering COBRA continuation coverage ("COBRA Administrator") is:

Yakima Valley Memorial Hospital
2811 Tieton Drive
Yakima, WA 98902
509/575-8085

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 section entitled "Who Is Entitled to Elect COBRA?"

After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, 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 QMCSOs may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

We use the pronoun "you" in the following paragraphs regarding COBRA to refer to each person covered under the Plan who is or may become a qualified beneficiary.

COBRA coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the component or components of the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect
COBRA must pay for COBRA coverage.

Additional information about the components of the Plan is available in other portions of this SPD.

WHO IS ENTITLED TO ELECT COBRA

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.

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; or
- you become divorced or legally separated from your spouse. Also, if your spouse (the employee) 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.

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;
- you stop being eligible for coverage under the Plan as a "dependent child."

If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee's spouse and dependent children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage within 18 months because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section below entitled "Length of COBRA Coverage.")

Special COBRA rights apply to certain employees and former employees who are eligible for federal trade adjustment assistance (TAA) or alternative trade adjustment assistance (ATAA). These individuals are entitled to a second opportunity to elect COBRA for themselves and certain family members (if they did not already elect COBRA) during a special second election period. This special second election period lasts for 60 days or less. It is the 60-day period beginning on the first day of the month in which an eligible employee or former employee becomes eligible for TAA or ATAA, but only if the election is made within the six months immediately after the individual's group health plan coverage ended. If you are an employee or former employee and you qualify or may qualify for TAA or ATAA, contact the Plan Administrator using the Plan contact information provided below. **CONTACT THE PLAN ADMINISTRATOR PROMPTLY AFTER QUALIFYING FOR TAA OR ATAA OR YOU WILL LOSE THE RIGHT TO ELECT COBRA DURING A SPECIAL SECOND ELECTION PERIOD**.

WHEN IS COBRA COVERAGE AVAILABLE

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. You need not notify the Plan Administrator of any of these three qualifying events.

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 Plan Administrator 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.

In providing this notice, you must use the Plan's form entitled "Notice of Qualifying Event (Form & Notice Procedures)," and you must follow the procedures specified in the section below entitled "Notice Procedures for Notice of Qualifying Event." If these procedures are not followed, or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA. **(You may obtain a copy of the Notice of Qualifying Event (Form & Notice Procedures)** from the Plan Administrator**.)**

ELECTING COBRA COVERAGE

To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and submit it to Plan Administrator (An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from the Plan Administrator.)

Under federal law, you must have 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event to decide whether you want to elect COBRA under the Plan. Mail or hand-deliver the completed Election Form to:

Human Resources
Yakima Valley Memorial Hospital
2811 Tieton Drive
Yakima, WA 98902
509/575-8085

The Election Form must be completed in writing and mailed or hand delivered to the individual and address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage; and electronic communications, including e-mail and faxed communications.

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

If you reject COBRA before the due date, you may change your mind as long as you furnish a completed Election Form before the due date.

You do not have to send any payment with your Election Form when you elect COBRA. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA. For example, the employee's spouse may elect COBRA even if the employee does not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. **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.**

When you complete the Election Form, you must notify the COBRA Administrator if any qualified beneficiary has become entitled to Medicare (Part A, Part B, or both) and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the Election Form, immediately notify the COBRA Administrator of the date of your Medicare entitlement at the address specified above for delivery of the Election Form.

Qualified beneficiaries may be enrolled in one or more group health components of the Plan at the time of a qualifying event. If a qualified beneficiary is entitled to a COBRA election as the result of a qualifying event, he or she may elect COBRA under any or all of the group health components of the Plan under which he or she was covered on the day before the qualifying event.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied). See the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period."

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 will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get COBRA coverage for the maximum time available to you. Finally, 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 ends 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."

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

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 his employment terminates, COBRA coverage under the Plan for his spouse and children who lost coverage as a result of 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.

Otherwise, 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 for only 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 the COBRA Administrator 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.

If a qualified beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator 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 61st day after the later of the covered employee's termination of employment or reduction of hours or the date coverage is lost due to the qualifying event 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.

The disability extension is available only if you notify the COBRA Administrator 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.

You must also 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.

In providing this notice, you must use the Plan's form entitled "Notice of Disability (Form & Notice Procedures)," and you must follow the procedures specified in the section below entitled "Notice Procedures for Notice of Disability." If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator 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. (You may obtain a copy of the Notice of Disability (Form & Notice Procedures) from the COBRA Administrator.)

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, 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. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare.)

This extension due to a second qualifying event is available only if you notify the COBRA Administrator 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).

In providing this notice, you must use the Plan's form entitled "Notice of Second Qualifying Event (Form & Notice Procedures)," and you must follow the procedures specified in the section below entitled "Notice Procedures for Notice of Second Qualifying Event." If these procedures are not followed or if the notice is not provided in writing to the COBRA Administrator during the 60-day notice period, THEN THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT. (You may obtain a copy of the Notice of Second Qualifying Event (Form & Notice Procedures) from the COBRA Administrator.)

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 preexisting condition 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;
- the employer 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. 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 the COBRA Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare (Part A, Part B, or both) or becomes covered under other group health plan coverage (but only after any preexisting condition exclusions of that other plan for a preexisting condition of the qualified beneficiary have been exhausted or satisfied). You must use the Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures)," and you must follow the procedures specified below in the section entitled "Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability." (You may obtain a copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures) from the COBRA Administrator.)

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary). The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the COBRA Administrator of Medicare entitlement or other group health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, you must notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination. You must use the Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures)," and you must follow the procedures specified below in the section entitled "Notice Procedures for Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability." (You may obtain a copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures) from the COBRA Administrator.)

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the COBRA Administrator that the disabled qualified beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period.")

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.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (eligible individuals). Under the new tax provisions, eligible individuals can take a tax credit equal to 65% of premiums paid for qualified health insurance, including COBRA coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact/2002act_index.asp.

PAYMENT FOR COBRA COVERAGE

All COBRA premiums must be paid by check.

Your first payment and all monthly payments for COBRA coverage must be mailed or hand-delivered to:

Human Resources
Yakima Valley Memorial Hospital
2811 Tieton Drive
Yakima, WA 98902
509/575-8085

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 above. 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.

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, Sue’s employment terminates on September 30, and she loses coverage on September 30. Sue 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 the COBRA Administrator 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.

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 any break. The COBRA Administrator will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill to you for your COBRA coverage—it is your responsibility to pay your COBRA premiums on time).

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 (going back to the first day of the month) when the monthly payment is received. This means that any claim 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

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 (for example, regarding age).

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

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan and COBRA Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan and COBRA Administrator.

PLAN CONTACT INFORMATION

You may obtain information about the Plan and COBRA coverage on request from:

Human Resources
Yakima Valley Memorial Hospital
2811 Tieton Drive
Yakima, WA 98902
509/575-8085

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent SPD (if you are not sure whether this is the Plan's most recent SPD, you may request the most recent one from Plan Administrator).

NOTICE PROCEDURES

Notice Procedures For Notice Of Qualifying Event

The deadline for providing this notice is 60 days after the later of (1) the qualifying event (i.e., a divorce or legal separation or a child's loss of dependent status); or (2) the date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the qualifying event.

You must mail or hand-deliver this notice to:

Human Resources
Yakima Valley Memorial Hospital
2811 Tieton Drive
Yakima, WA 98902
509/575-8085

Your notice must be in writing (using the Plan's form described below) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline described above.

You must use the Plan's form entitled "Notice of Qualifying Event (Form & Notice Procedures)" to notify the Plan Administrator of a qualifying event (i.e., a divorce or legal separation or a child's loss of dependent status), and all of the applicable items on the form must be completed. (You may obtain a copy of the Notice of Qualifying Event (Form & Notice Procedures) from the Plan Administrator.

Your notice must contain the following information:

- the name of the Plan (Yakima Valley Memorial Hospital Employee Health Care Plan);
- the name and address of the employee or former employee who is or was covered under the Plan;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the qualifying event (divorce, legal separation, or child's loss of dependent status);
- the qualifying event (divorce, legal separation, or child's loss of dependent status);
- the date that the divorce, legal separation, or child's loss of dependent status happened; and
- the signature, name, and contact information of the individual sending the notice.

If you are notifying the Plan Administrator of a 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 you are notifying the Plan Administrator that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, you must provide notice within 60 days of the divorce or legal separation in accordance with these Notice Procedures for Notice of Qualifying Event and must in addition provide evidence satisfactory to the Plan Administrator that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

If you provide a written notice that does not contain all of the information and documentation required by these Notice Procedures for Notice of Qualifying Event, such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- the notice is mailed or hand-delivered to the individual and address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan;
- from the written notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies), the qualifying event (the divorce, legal separation, or child's loss of dependent status), and the date on which the qualifying event occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Qualifying Event) within 15 business days after a written or oral request from the Plan Administrator for more information (or, if later, by the deadline for the Notice of Qualifying Event described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be offered. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. 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.

If your notice was regarding a child's loss of dependent status, you must, if the Plan Administrator requests it, provide documentation of the date of the qualifying event that is satisfactory to the Plan Administrator (for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution). This will allow the Plan Administrator to determine if you gave timely notice of the qualifying event and were consequently entitled to elect COBRA. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the Plan Administrator that the child ceased to be a dependent on the date specified in your Notice of Qualifying Event, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have started. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

Notice Procedures For Notice Of Disability

The deadline for providing this notice is 60 days after the latest of (1) the date of the Social Security Administration's disability determination; (2) the date of the covered employee's termination of employment or reduction of hours; and (3) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the termination of employment or reduction of hours. Your Notice of Disability must also be provided within 18 months after the covered employee's termination of employment or reduction of hours.

You must mail or hand-deliver this notice to:

Human Resources
Yakima Valley Memorial Hospital
2811 Tieton Drive
Yakima, WA 98902
509/575-8085

Your notice must be in writing (using the Plan's form described below) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline described above.

You must use the Plan's form entitled "Notice of Disability (Form & Notice Procedures)" to notify the Plan Administrator of a qualified beneficiary's disability, and all of the applicable items on the form must be completed. (You may obtain a copy of the Notice of Disability (Form & Notice Procedures) from the Plan Administrator.)

Your notice must contain the following information:

- the name of the Plan (Yakima Valley Memorial Hospital Employee Health Care Plan);
- the name and address of the employee or former employee who is or was covered under the Plan;

- the initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction of hours);
- the date that the covered employee's termination of employment or reduction of hours happened;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;
- the name and address of the disabled qualified beneficiary;
- the date that the qualified beneficiary became disabled;
- the date that the Social Security Administration made its determination of disability;
- a statement as to whether or not the Social Security Administration has subsequently determined that the qualified beneficiary is no longer disabled; and
- the signature, name, and contact information of the individual sending the notice.

Your Notice of Disability must include a copy of the Social Security Administration's determination of disability.

If you provide a written notice to the Plan Administrator that does not contain all of the information and documentation required by these Notice Procedures for Notice of Disability, such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- the notice is mailed or hand-delivered to the individual and address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, the Plan Administrator is able to determine that the notice relates to the Plan and a qualified beneficiary's disability;
- from the written notice provided, the Plan Administrator is able to identify the covered employee and qualified beneficiary(ies) and the date on which the covered employee's termination of employment or reduction of hours occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Disability) within 15 business days after a written or oral request from the Plan Administrator for more information (or, if later, by the deadline for the Notice of Disability described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

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 covered employee's termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the disability reported in the notice.

Notice Procedures For Notice Of Second Qualifying Event

The deadline for providing this notice is 60 days after the later of (1) the date of the second qualifying event (i.e., a divorce or legal separation, the covered employee's death, or a child's loss of dependent status); and (2) the date on which the covered spouse or dependent child would lose coverage under the terms of the Plan as a result of the second qualifying event (if this event had occurred while the qualified beneficiary was still covered under the Plan).

You must mail or hand-deliver this notice to the COBRA Administrator at:

Human Resources
Yakima Valley Memorial Hospital
2811 Tieton Drive
Yakima, WA 98902
509/575-8085

Your notice must be in writing (using the Plan's form described below) and must be mailed or hand-delivered. Oral notice, including notice by telephone, is not acceptable. Electronic (including e-mailed or faxed) notices are not acceptable. If mailed, your notice must be postmarked no later than the deadline described above. If hand-delivered, your notice must be received by the individual at the address specified above no later than the deadline described above.

You must use the Plan's form entitled "Notice of Second Qualifying Event (Form & Notice Procedures)" to notify the COBRA Administrator of a second qualifying event (i.e., a divorce or legal separation, the covered employee's death, or a child's loss of dependent status), and all of the applicable items on the form must be completed. (You may obtain a copy of the Notice of Second Qualifying Event (Form & Notice Procedures) from the COBRA Administrator).

Your notice must contain the following information:

- the name of the Plan (Yakima Valley Memorial Hospital Employee Health Care Plan);
- the name and address of the employee or former employee who is or was covered under the Plan;
- the initial qualifying event that started your COBRA coverage (the covered employee's termination of employment or reduction of hours);
- the date that the covered employee's termination of employment or reduction of hours happened;
- the name(s) and address(es) of all qualified beneficiary(ies) who lost coverage due to the termination or reduction of hours and who are receiving COBRA coverage at the time of the notice;
- the second qualifying event (a divorce or legal separation, the covered employee's death, or a child's loss of dependent status);
- the date that the divorce or legal separation, the covered employee's death, or a child's loss of dependent status happened; and
- the signature, name, and contact information of the individual sending the notice.

If you are notifying the COBRA Administrator of a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation.

If you provide a written notice to the COBRA Administrator that does not contain all of the information and documentation required by these Notice Procedures for Notice Second Qualifying Event, such a notice will nevertheless be considered timely **if all of the following conditions are met:**

- the notice is mailed or hand-delivered to the individual and address specified above;
- the notice is provided by the deadline described above;
- from the written notice provided, the COBRA Administrator is able to determine that the notice relates to the Plan;
- from the written notice provided, the COBRA Administrator is able to identify the covered employee and qualified beneficiary(ies), the first qualifying event (the covered employee's termination of employment or reduction of hours), the date on which the first qualifying event occurred, the second qualifying event, and the date on which the second qualifying event occurred; and
- the notice is supplemented in writing with the additional information and documentation necessary to meet the Plan's requirements (as described in these Notice Procedures for Notice of Second Qualifying Event) within 15 business days after a written or oral request from the COBRA Administrator for more information (or, if later, by the deadline for this Notice of Second Qualifying Event described above).

If any of these conditions is not met, the incomplete notice will be rejected and COBRA will not be extended. If all of these conditions are met, the Plan will treat the notice as having been provided on the date that the Plan receives all of the required information and documentation but will accept the notice as timely.

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 covered employee's termination or reduction of hours and is still receiving COBRA coverage, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who may be entitled to an extension of the maximum COBRA coverage period due to the second qualifying event reported in the notice.

If your notice was regarding a child's loss of dependent status, you must, if the COBRA Administrator requests it, provide documentation of the date of the qualifying event that is satisfactory to the COBRA Administrator (for example, a birth certificate to establish the date that a child reached the limiting age, a marriage certificate to establish the date that a child married, or a transcript showing the last date of enrollment in an educational institution). This will allow the COBRA Administrator to determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the COBRA Administrator that the child ceased to be a dependent on the date specified in your Notice of Second Qualifying Event, his or her COBRA coverage may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to loss of dependent status. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

If your notice was regarding the death of the covered employee, you must, if the COBRA Administrator requests it, provide documentation of the date of death that is satisfactory to the COBRA Administrator (for example, a death certificate or published obituary). This will allow the COBRA Administrator to determine if you gave timely notice of the second qualifying event and were consequently entitled to an extension of COBRA coverage. If you do not provide satisfactory evidence within 15 business days after a written or oral request from the COBRA Administrator that the date of death was the date specified in your Notice of Second Qualifying Event, the COBRA coverage of all qualified beneficiaries receiving an extension of COBRA coverage as a result of the covered employee's death may be terminated (retroactively if applicable) as of the date that COBRA coverage would have ended without an extension due to the covered employee's death. The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date.

Notice Procedures For Notice Of Other Coverage, Medicare Entitlement, Or Cessation Of Disability

If you are providing a Notice of Other Coverage (a notice that a qualified beneficiary has become covered, after electing COBRA, under other group health plan coverage), the deadline for this notice is 30 days after the other coverage becomes effective or, if later, 30 days after exhaustion or satisfaction of any preexisting condition exclusions for a preexisting condition of the qualified beneficiary.

If you are providing a Notice of Medicare Entitlement (a notice that a qualified beneficiary has become entitled, after electing COBRA, to Medicare Part A, Part B, or both), the deadline for this notice is 30 days after the beginning of Medicare entitlement (as shown on the Medicare card).

If you are providing a Notice of Cessation of Disability (a notice that a disabled qualified beneficiary whose disability resulted in an extended COBRA coverage period is determined by the Social Security Administration to be no longer disabled), the deadline for this notice is 30 days after the date of the Social Security Administration's determination.

You must mail or hand-deliver this notice to the COBRA Administrator at:

Human Resources
Yakima Valley Memorial Hospital
2811 Tieton Drive
Yakima, WA 98902
509/575-8085

Your notice must be provided no later than the deadline described above.

You should use the Plan's form entitled "Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures)" to notify the COBRA Administrator of any of these events, and all of the applicable items on the form should be completed. (You may obtain a copy of the Notice of Other Coverage, Medicare Entitlement, or Cessation of Disability (Form & Notice Procedures) from the COBRA Administrator.)

Your notice should contain the following information:

- the name of the Plan (Yakima Valley Memorial Hospital Employee Health Care Plan);
- the name and address of the employee or former employee who is or was covered under the Plan;

- the name(s) and address(es) of all qualified beneficiary(ies);
- the qualifying event that started your COBRA coverage;
- the date that the qualifying event happened; and
- the signature, name, and contact information of the individual sending the notice.

If you are providing a Notice of Other Coverage, your notice should include the name and address of the qualified beneficiary who obtained other coverage, the date that the other coverage became effective (and, if there were any preexisting condition exclusions applicable to the qualified beneficiary, the date that these were exhausted or satisfied), and evidence of the effective date of the other coverage (such as a copy of the insurance card or application for coverage).

If you are providing a Notice of Medicare Entitlement, your notice should include the name and address of the qualified beneficiary who became entitled to Medicare, the date that Medicare entitlement occurred, and a copy of the Medicare card showing the date of Medicare entitlement. If you are providing a Notice of Cessation of Disability, your notice must include the name and address of the disabled qualified beneficiary, the date of the Social Security Administration's determination that he or she is no longer disabled, and a copy of the Social Security Administration's determination.

The covered employee (i.e., the employee or former employee who is or was covered under the Plan), a qualified beneficiary with respect to the qualifying event, or a representative acting on behalf of either may provide the notice. A notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all related qualified beneficiaries with respect to the other coverage, Medicare entitlement, or cessation of disability reported in the notice.

If a qualified beneficiary first becomes covered by other group health plan coverage after electing COBRA, that qualified beneficiary's COBRA coverage will terminate (retroactively if applicable) as described above in the section entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period," regardless of whether or when a Notice of Other Coverage is provided.

If a qualified beneficiary first becomes entitled to Medicare Part A, Part B, or both after electing COBRA, that qualified beneficiary's COBRA coverage will terminate (retroactively if applicable) as described above in the section entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period," regardless of whether or when a Notice of Medicare Entitlement is provided.

If a disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled, COBRA coverage for all qualified beneficiaries whose COBRA coverage is extended due to the disability will terminate (retroactively if applicable) as described above in the section entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period," regardless of whether or when a Notice of Cessation of Disability is provided.

MEDICAL BENEFITS

HEALTHCARE MANAGEMENT ADMINISTRATORS (HMA) PREFERRED PPO

Medical Coverage: This plan utilizes the HMA Preferred PPO, which consists of Regence BlueShield Preferred and Participating providers, as well as Asuris Northwest Health Preferred providers. You can help reduce your out-of-pocket expense by using services of a contracted Preferred (PPO) or Participating (PAR) provider. Benefits will be paid as outlined in the Schedule of Benefits. Regence and Asuris PPO or PAR providers have agreed to accept the Plan's allowance as their charge, and will not balance bill for amounts which exceed the Plan's allowance. Based on the allowed amount, where applicable, your share of the expense or your out-of-pocket amount may now be lower. You may contact HMA Preferred at 1-800-869-7093 or www.wa.regence.com.

SCHEDULE OF MEDICAL BENEFITS

Major Medical benefits using any eligible provider or Preferred Benefits using Yakima Valley Memorial Hospital (YVMH)

This Schedule of Benefits is a summary of the benefits provided under this Plan. Please read the entire booklet for details on specific benefit limitations and maximums, waiting periods and exclusions.

The level of benefits received is based upon the participant's decision at the time treatment is needed to access care through either YVMH or another medical facility or provider. Benefits are payable at the identified higher level by accessing your care through YVMH.

PRE-AUTHORIZATION FOR INPATIENT MEDICAL FACILITY ADMISSIONS is required for services not scheduled at YVMH. Failure to pre-authorize will result in a penalty, which will not apply toward the deductible or out-of-pocket maximum. The pre-authorization requirements are outlined on pages 39-40.

NOTE: If services are accessed through other medical facilities when the service could be provided by YVMH, the benefit is reduced to a constant 60% level and will not apply to the out-of-pocket maximum, with the following exceptions which will be paid at 80% after deductible regardless of whether or not YVMH can provide the service:

- Ambulatory/outpatient surgical suites or centers at another medical facility.
- Services performed at Westside Medi-Center and Valley Medi-Center.

If YVMH is unable to perform a service, charges will be reimbursed at the 80% level after deductible and will apply toward the out-of-pocket maximum. Tertiary care needs will also be taken into consideration when determining whether or not a service is considered to be available at YVMH.

Outpatient services provided at YVMH to employees and enrolled dependents will be covered in full (with the Major Medical deductible waived); EXCEPT that the following outpatient services will not be subject to this benefit:

- Emergency department fees.
- Emergency department physician fees.
- Mental health services.

Diagnostic Testing, Laboratory, Magnetic Resonance Imaging (MRI), Stereotactic Mammotomy and X-Rays are paid at 100% with deductible waived for both the service and the reading of the result if initially provided by YVMH or Valley Imaging Partners (VIP) or Yakima Gastroenterology Associates (YGA). If services are provided by a facility other than as stated, then benefits are payable at 80% after deductible.

SKILLED NURSING FACILITY CARE

Any services at YVMH-owned Skilled Nursing Facilities are paid at the preferred level – 80%. In addition, if beds at a YVMH Skilled Nursing Facility (SNF), including Garden Village and Heritage Grove, are not available at the time the patient is first confined to the SNF, the service will be considered as not available at YVMH with the preferred level of benefits payable. If the patient is temporarily admitted to a hospital and returns to the same non-YVMH SNF, benefits will continue under the same basis, subject to all other plan provisions and limitations. As long as Medical Facility Admission Pre-Authorization is complied with, the 20% coinsurance in these instances shall apply to the out-of-pocket maximum.

OUT OF AREA & EMERGENCY SERVICES

As long as Medical Facility Admission Pre-Authorization is complied with, the 20% coinsurance (or 50% coinsurance for Skilled Nursing Facility Care), in the instances below shall apply to the out-of-pocket maximum.

For Emergency Services Only

- While traveling or residing more than 25 miles from YVMH, treatment received at a non-YVMH facility for life threatening or other medical emergency services shall be paid at 80% for both inpatient and outpatient care. Medical Facility Admission Pre-Authorization must be complied with to avoid a reduction in this benefit.

- If within 25 miles from YVMH, treatment received at a non-YVMH facility for life threatening or other emergency medical services due to trauma center designation, or for reasons beyond control of the patient, shall be paid at 80% for both inpatient and outpatient care. Medical Facility Admission Pre-Authorization must be complied with to avoid a reduction in this benefit.

For Non-Emergency Services

- If residing more than 75 miles from YVMH, treatment received from a non-YVMH facility for non-emergency medical services will be covered at standard plan benefit levels of 80% after deductible (50% Skilled Nursing Facility); subject to all other provisions and limitations of this plan. Medical Facility Admission Pre-Authorization must be complied with to avoid a reduction in this benefit.

DEDUCTIBLE
Per individual, per calendar year. $300

OUT-OF-POCKET MAXIMUM
Individual $1,000
Family $2,000
Per calendar year, includes deductible.

The deductible, out-of-pocket limit and maximums are combined for both the YVMH and Other Medical Facility / Provider expenses.

After the deductible has been satisfied, the Plan pays the coinsurance amount listed for eligible expenses incurred, by an individual in a calendar year, until the out-of-pocket maximum is reached. Once the out-of-pocket maximum is reached, expenses are paid at 100% of allowable charges for the remainder of the calendar year. The following expenses do not apply to the out-of-pocket maximum and are not payable at the 100% coinsurance rate: 1) Penalties and penalty coinsurance; 2) Ineligible charges; 3) Chemical Dependency Treatment; 4) Mental and Nervous Treatment; 5) Pharmacy copays; 6) Services received from a facility other than a YVMH owned and operated facility, when the service could have been provided by a YVMH owned and operated facility; and 7) Amounts in excess of Regence or Asuris allowances or UCR, as applicable.

	YVMH	Other Medical Facilities/Provider
ALLERGY INJECTIONS/TESTING	N/A	80%
AMBULANCE (AIR AND GROUND)	N/A	80%
AMBULATORY SURGICAL CENTERS	100% Deductible waived	80%
ANESTHESIOLOGIST	N/A	80%
ASSISTANT SURGEON Limited to 20% of surgeon's allowable charge.	N/A	80%
BIOFEEDBACK	N/A	80%
BIRTH CONTROL DEVICES		
Diaphrams and Patches	Rx Copay	60%
Other Devices	N/A	80%
CHEMICAL DEPENDENCY TREATMENT Limited to $3,000 per calendar year. Lifetime maximum of $9,000.	N/A	80%*
CHEMOTHERAPY		
Inpatient	80%	60%
Outpatient	100% Deductible Waived	60%

	YVMH	Other Medical Facilities/Provider
CHIROPRACTIC CARE Limited to $500 per calendar year.	N/A	80%
COLONOSCOPIES	100% Deductible Waived	80%
DIABETIC EDUCATION AND COUNSELING Lifetime maximum of $500.	100% Deductible waived	Not Covered
DIAGNOSTIC X-RAY AND LABORATORY Services provided by VIP and YGA also Paid @ 100% and Deductible waived.	100% Deductible waived	80%
DURABLE MEDICAL EQUIPMENT	N/A	80%
EMERGENCY ROOM	80%	60%
HEARING BENEFIT		
Hearing Aids / Hardware Limited to $750 every three calendar years.	N/A	80%
Hearing Impairment Services Limited to 5 office visits per calendar year.	N/A	80%
HOME HEALTH CARE Limited to $10,000 per calendar year.	80%	60%
HOSPICE CARE Lifetime maximum of six months (additional benefits upon approval – see Hospice Care under Comprehensive Major Medical Benefits).	80%	60%
Respite Care 240 hours maximum. (included in 6-month lifetime maximum)	80%	60%
INFUSION THERAPY		
Inpatient	80%	60%
Outpatient	100% Deductible waived	60%
INPATIENT PHYSICIAN VISIT	N/A	80%
KIDNEY DIALYSIS	N/A	80%
MAMMOGRAMS	100% Deductible waived	60%

	YVMH	Other Medical Facilities/Provider
MATERNITY CARE		
Facility	80%	60%
Professional/Physician	80%	80%
MEDICAL FACILITY SERVICES/HOSPITAL		
Inpatient	80%	60%
Outpatient		
Ambulatory/Surgical Facility	100% Deductible waived	80%
Miscellaneous Services (excluding Emergency Department, Emergency Room Physician fees, and Outpatient Mental Health)	100% Deductible waived	60%
MEDICAL SUPPLIES	N/A	80%
MENTAL NERVOUS TREATMENT		
Inpatient		
Limited to 15 days per calendar year.		
Age 18+	80%*	60%*
Under Age 18	80%*	80%*
Outpatient	80%*	80%*
Limited to 25 visits per calendar year.		
MAGNETIC RESONANCE IMAGING (MRI)	100% Deductible waived	60%
Services provided by VIP also paid @ 100% and Deductible waived.		
NEURODEVELOPMENTAL THERAPY	100% Deductible waived	60%
Limited to $2,000 per calendar year.		
NEWBORN CARE		
Facility	80%	60%
Professional/Physician (Inpatient Care or Outpatient Follow-up care)	80%	80%
OFFICE VISIT	N/A	80%
PRE-ADMISSION TESTING	100% Deductible waived	60%
PRESCRIPTION DRUGS		
Inpatient	80%	60%
Outpatient	Copay as determined by YVMH and posted at YVMH Pharmacy	60%

	YVMH	Other Medical Facilities/Provider
PREVENTIVE CARE Limited to $200 per calendar year.	100% Deductible waived	100% Deductible waived
PROSTHETICS	N/A	80%
RADIATION THERAPY		
Inpatient	80%	60%
Outpatient	100% Deductible waived	60%
REHABILITATION SERVICES		
Inpatient Limited to $50,000 per calendar year.	80%	80%
Outpatient	100% Deductible waived	60%
SECOND SURGICAL OPINION - OPTIONAL Required for Organ Transplants.	N/A	100% Deductible waived
SKILLED NURSING FACILITY CARE Limited to $10,000 per calendar year.	80%	50%*
STEREOTACTIC MAMMOTOMY Services provided by VIP also paid @ 100% and Deductible waived.	100% Deductible waived	60%
SURGEON	N/A	80%
TRANSPLANTS	80%	60%
Donor Benefit Limited to $5,000 per transplant (recipient must be covered by this plan).	80%	60%
OTHER MISCELLANEOUS ELIGIBLE CHARGES		
Available at YVMH	80%	60%
Other Services not Available at YVMH	N/A	80%

***Remains at a constant coinsurance level and does not apply to the out-of-pocket maximum.**

LIFETIME MAXIMUM BENEFITS

Major Medical	$1,000,000
Chemical Dependency	$9,000
Diabetic Education and Counseling	$500
Hospice Care	6 months

NOTE: N/A means not applicable or the service is not available at YVMH at the time of this booklet printing.

NOTE: All benefits are subject to Regence or Asuris PPO or Participating Provider allowances where applicable, or subject to UCR as determined by the Plan.

Important Information - Please Read

When contacting Healthcare Management Administrators, Inc. (HMA), answers for benefits and eligibility will be provided to any participant and to providers of service, subject to all Federal and State privacy requirements. The benefits quoted by HMA are not a guarantee of claim payment, since claim payment will be dependent upon eligibility at the time of service and all terms and conditions of the Plan. This disclaimer will be provided to the caller when benefits are quoted over the telephone.

For a written pre-estimate of benefits, a provider of service must submit to the Plan Supervisor their proposed course of treatment, including diagnosis, procedure codes, place of service and proposed cost of treatment. In some cases, medical records or additional information may be necessary to complete the pre-estimate.

MEDICAL FACILITY ADMISSION PRE-AUTHORIZATION

This plan requires pre-authorization of all inpatient hospital and medical facility admissions to facilities other than Yakima Valley Memorial Hospital (YVMH). To avoid a penalty, pre-authorization is required for all scheduled admissions. Failure to obtain authorization five business days **prior** to an admission into a non-YVMH facility (or as soon as surgery or procedure is scheduled if within less than 5 days) or, in the case of an emergency admission, failure to obtain authorization either within 48 hours after the emergency admission or on the next business day, if later, will result in the following reductions and losses:

- The benefit will be reduced by a $500 penalty.
- The penalty will not apply toward either the calendar year deductible or the out-of-pocket maximum.

Pre-authorization will not be required for normal vaginal deliveries where the length of stay is 48 hours or less and cesarean section deliveries where the length of stay is 96 hours or less.

Pre-authorization does not guarantee payment of benefits. The Utilization Review (UR) Coordinator should be contacted at the following numbers:

HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
425/462-1000 - SEATTLE
800/700-7153 - OTHER AREAS NATIONWIDE

STEPS TO TAKE

When an inpatient admission is recommended at a facility other than YVMH, the patient, the physician or a family member must call the UR Coordinator at least five business days prior to the admission to obtain authorization. If an emergency admission occurs, the patient or a family member should contact the UR Coordinator within 48 hours of admission, or by the next business day, if later. It is the employee's responsibility to make sure the pre-authorization is done. Please be prepared to give the UR Coordinator the following information when you make the call to pre-authorize:

- Name and age of patient.
- Employee's Identification Number as found on the insurance card.

- Group Number (GM048).
- Medical Facility name and address.
- Name and phone number of admitting physician.
- Admission date.
- Diagnosis and purpose for admission.

If an inpatient stay is extended, a hospital transfer is needed or the patient is admitted after outpatient surgery due to complications, the facility, patient or family member should inform the UR Coordinator of the change in circumstances. However, if this fails to happen, a $500 penalty will not apply.

CASE MANAGEMENT/ALTERNATE TREATMENT

In cases where the Covered participant's condition is expected to be or is of a serious nature, the Employer may arrange for review and/or case management services from a professional qualified to perform such services. The UR Coordinator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost-effective result without a sacrifice to the quality of a patient's care.

Alternate care will be determined on the merits of each individual case and any care or treatment provided will not be considered setting any precedent or creating any future liability, with respect to that covered participant or any other covered participant.

HOW TO FILE A MEDICAL CLAIM

- All medical claims/bills should be sent to:

Healthcare Management Administrators, Inc.
PO Box 85008
Bellevue, WA 98015-5008

- In order for providers to submit claims on your behalf, you must give the provider of service the information listed on the back of your medical identification card. The provider must attach itemized bills to a claim form. An itemized bill is one that contains the patient's name, subscriber ID# including the 9HP prefix, date of service, type of service rendered including CPT code, charge for each service, provider's name, address and Federal Tax ID Number and the nature of the accident or illness being treated.

Regence and Asuris Preferred (PPO) or Participating (PAR) providers will submit claims on your behalf; Non-PPO and Non-PAR providers are not required to do so. If you need to file a claim yourself, include the same itemized billing information noted above with a claim form and mail to the claims address above.

All claims for reimbursement must be submitted within one year of the date incurred.

CONTINUATION OF COVERAGE PROVISIONS (COBRA)

Both employees and dependents should take the time to read the Continuation of Coverage Provisions. Under certain circumstances, participants may be eligible for a temporary extension of health coverage, at group rates, where coverage under the plan would otherwise end. The information in this section is intended to inform you, in a summary fashion, of your rights and obligations under the Continuation of Coverage provisions. To find out more about your Continuation of Coverage rights refer to the COBRA Section of this booklet.

CONTACT FOR QUESTIONS ABOUT THE MEDICAL PLAN BENEFITS

You are encouraged to contact Healthcare Management Administrators, Inc. (HMA) with questions that you have regarding this Plan. HMA is available to answer questions about claims and how your benefits work. You may contact HMA at:

Healthcare Management Administrators, Inc.
Larson Building
6 S. 2nd Street, Suite 210
Yakima, WA 98901
509/574-8462
Toll Free 877/581-9109

If a claim is paid in error which was related to a pre-existing condition, the payment will not constitute a waiver of this exclusion for that claim or any subsequent claim if it is later determined that the condition was pre-existing.

When this Plan replaces another group health coverage program previously held by the Employer, the waiting periods will be credited for the time those employees and their eligible dependents were enrolled under the prior coverage.

PRE-EXISTING CONDITIONS

A pre-existing condition, whether physical or mental, and regardless of the cause of the condition, is a condition for which medical advice, diagnosis, care, or treatment has been recommended or received within the three month period prior to the enrollment date. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under State law and who operates within the scope of practice authorized by the State law.

PRE-EXISTING CONDITIONS EXCLUSION

The exclusion period for pre-existing conditions starts on your enrollment date and will be six consecutive months, less any period of prior creditable coverage. For employees enrolling late during the Open Enrollment period or through the Special Enrollment provision, the exclusion period will also be 6 consecutive months, less any period of creditable coverage.

The term "enrollment date" is defined as the first day of coverage or, if there is a probationary period for coverage to begin under the Plan, the first day of the probationary period. The term "probationary period" refers to the period that must pass before coverage for an employee or dependent that is otherwise eligible to enroll under the terms of the plan can become effective. For a person who is a late enrollee or who enrolls on a special enrollment date, the "enrollment date" will be the first date of actual coverage. If an individual receiving benefits under a group health plan changes benefit packages, or if the Plan changes group health insurance issuers, the individual's enrollment date does not change.

Pregnancy and genetic pre-existing conditions are not subject to this pre-existing conditions exclusion.

NEWBORNS AND ADOPTED CHILDREN

If a newborn child of a covered employee, a child under the age of 18 years of age who is placed for adoption with the covered employee, or a child who is actually adopted by a covered employee, is enrolled in the Plan within 60 days of birth, placement of adoption, or the date of actual adoption, the pre-existing conditions exclusion period of the Plan will not apply. If the child was continuously covered under another Plan from birth, placement of adoption, or actual adoption prior to being covered under this Plan and such child becomes covered under this Plan without a break in coverage of 63 days or more, the pre-existing conditions exclusion period of the Plan will not apply.

MEDICAL PLAN PAYMENT PROVISIONS

DEDUCTIBLES

Individual

The deductible is the amount of eligible medical expenses an employee or dependent must incur each calendar year before any benefits are payable by the Plan. The individual deductible amount is listed in the Schedule of Benefits.

Family Accident

If two or more family members are injured in the same accident, only one deductible will be required during that calendar year and the next calendar year as a result of the accident. This deductible waiver applies only to medical bills incurred as a result of the accident. For services not related to the accident, the regular deductible amount per individual would apply.

DEDUCTIBLE CARRYOVER

Although a new medical deductible will apply each calendar year, expenses incurred during October, November and December which are applied against that year's deductible will also be applied toward the deductible for the next year (unless the full deductible had been met and benefits were paid) and thus reduce or eliminate the next year's deductible.

AMOUNTS NOT CREDITED TOWARD THE DEDUCTIBLE

The following expenses will not be considered in satisfying the deductible requirement:

- Expenses for services or supplies not covered by this Plan.
- Amounts in excess of the Regence BlueShield or Asuris Northwest Health Preferred or Participating provider allowances, where applicable.
- Amounts in excess of usual, customary and reasonable (UCR) charges, where applicable.
- Pharmacy Copays (the amount paid by you each time an outpatient prescription is filled at the YVMH Pharmacy.)
- Penalties.

COINSURANCE PERCENTAGE

Coinsurance is the percentage that the plan will pay on eligible expenses. Where applicable with Regence BlueShield or Asuris Northwest Health Preferred (PPO) or Participating (PAR) providers, this is a percentage of the Plan's allowed amount. When NonPPO or NonPAR providers are used, the coinsurance is a percentage of the Usual, Customary, and Reasonable (UCR) charge as determined by the Plan.

Once the deductible is satisfied, the Plan shall pay benefits for covered expenses at the applicable coinsurance level specified in the Schedule of Benefits. The participant is responsible for paying the remaining percentage, which is your out-of-pocket, plus amounts exceeding UCR where applicable. When a Regence or Asuris PPO or PAR provider is used, participants are not responsible for paying amounts exceeding the Regence or Asuris allowance.

OUT-OF-POCKET MAXIMUM

The amount of the coinsurance that is your responsibility is called your out-of-pocket. When you (or your family's) out-of-pocket total reaches the out-of-pocket maximum amount shown in the Schedule of Benefits during one calendar year, the Plan will pay 100% of allowable charges of the participant's eligible medical expenses for the remainder of the calendar year. Benefits stated at a constant coinsurance level do not apply toward the out-of-pocket and are not payable at 100% when the out-of-pocket maximum is reached.

The following expenses are not applied to the out-of-pocket:

- Expenses for services or supplies not covered under this Plan.
- Amounts in excess of the Regence BlueShield or Asuris Northwest Health PPO or Participating provider allowances, where applicable.
- Amounts in excess of usual, customary and reasonable charges, where applicable.
- Pharmacy copays.
- Mental and Nervous or Chemical Dependency expenses.
- Services received from a facility other than YVMH, when the service could have been provided by YVMH.
- Penalties and penalty coinsurance.

MAJOR MEDICAL LIFETIME MAXIMUM BENEFIT

The Major Medical Lifetime Maximum Benefit per participant covered under the Yakima Valley Memorial Hospital Employee Health Care Plan is $1,000,000.

REINSTATEMENT OF LIFETIME MAXIMUM

The total benefits paid by this Plan for any participant for all illnesses, accidental injuries, and physical disabilities combined during the participant's lifetime shall not exceed a cumulative maximum of $1,000,000. However, on January 1 of each calendar year, benefits received by the participant under this Plan and charges against the participant's lifetime maximum shall automatically be forgiven up to the amount of $2,000.

ELIGIBLE EXPENSES

When medically necessary for the diagnosis or treatment of an illness, injury or an accident, the following services are eligible expenses for participants covered under this Plan. Eligible expenses are payable as shown in the Schedule of Benefits and are limited by certain provisions listed in the General Exclusions. Major Medical expenses are subject to all Plan conditions, limitations and exclusions.

ALLERGY INJECTIONS/TESTING

Eligible charges for the injections, testing, syringes and medication will be payable as shown in the Schedule of Benefits.

AMBULANCE (AIR AND GROUND)

Services of a licensed ambulance company for transportation to the nearest medical facility where the required service is available, if other transportation would endanger the patient's health and the purpose of the transportation is not for personal or convenience reasons.

AMBULATORY SURGICAL CENTERS

An ambulatory surgical center refers to a lawfully operated facility that is established, equipped and operated to perform surgical procedures. Services rendered by an ambulatory surgical center are covered as outlined in the Schedule of Benefits when performed in connection with a covered surgery.

BIOFEEDBACK

Biofeedback therapy is an electronic method which allows the patient to monitor the functioning of the body’s autonomic systems (e.g. body temperature, heart rate, etc.) and is payable under this Plan only when medically necessary.

BIRTH CONTROL DEVICES

Birth control devices such as, but not limited to, IUD's and diaphragms are covered as shown in the Schedule of Benefits.

CHEMICAL DEPENDENCY

Benefits will be provided for services of a physician and/or an approved chemical dependency treatment facility for medically necessary inpatient and outpatient treatment of chemical dependency, including detoxification and supportive services. Chemical dependency is defined as physical and/or emotional dependence on drugs, narcotics, alcohol, or other addictive substances to a debilitating degree. Eligible expenses for treatment of chemical dependency shall be paid according to the limitations shown in the Schedule of Benefits. Inpatient and outpatient treatment expenses are not applied to the out-of-pocket maximum. The coinsurance level for these services remains constant and does not increase to 100% when the out-of-pocket maximum is reached.

Treatment for chemical dependency includes:

- Medical and psychiatric evaluations.
- Inpatient room and board (including detoxification).
- Psychotherapy (individual and group), counseling (individual and group), and behavior therapy for the covered participants.
- Prescription drugs prescribed by and administered while in an approved treatment facility.
- Supplies prescribed by an approved treatment facility, except for personal items.

Chemical dependency treatment does not include:

- Personal items.
- Items or treatment not necessary for the care or recovery of the patient.
- Custodial care
- Education or training.
- Treatment for the addiction of tobacco.

Inpatient Treatment

When inpatient chemical dependency treatment is recommended, the participant must first pre-authorize the admission. In addition to pre-authorization the following is required:

- Treatment must be ordered in writing by a physician for the entire length of time the participant is confined.
- Under extenuating circumstances, such as emergency inpatient chemical dependency treatment, you must notify the Plan Supervisor within 48 hours of admission, or by the next business day. Written explanation of the extenuating circumstances should be submitted to support the need for the emergency admission.
- The patient must complete the approved course of treatment in a hospital or an approved alcoholism or drug treatment facility as defined by the Plan.

Outpatient Treatment

If treatment is provided on an outpatient basis, then treatment must be provided by a physician as defined under this Plan.

No benefits will be provided for information and referral services, information schools, Alcoholics Anonymous and similar chemical dependency programs, long-term care or custodial care and tobacco cessation programs.

CHIROPRACTIC CARE

Covered chiropractic services include spinal manipulation, adjunctive therapy, vertebral alignment, subluxation, spinal column adjustments and other chiropractic treatment of the spinal column, neck, extremities or other joints, provided for as defined under the definition of physician. Examinations, x-rays and supplies (such as cervical collar, pillow, back brace, etc.) in connection with chiropractic care are subject to the chiropractic limit shown in the Schedule of Benefits.

COSMETIC RECONSTRUCTIVE SURGERY

Coverage for cosmetic reconstructive surgery, or related medical facility admission, is limited to:

- Treatment of an illness or injury.
- Except as specifically excluded by this plan, for correction of congenital deformity. To be covered, the surgery must be done within 18 years of the date of birth.
  - The Plan does not cover congenital reconstructive or cosmetic upper or lower jaw augmentation or reduction procedures (orthognathic surgery).
- A member receiving benefits for a medically necessary mastectomy who elects breast reconstruction after the mastectomy, will also receive coverage for:
  - Reconstruction of the breast on which the mastectomy has been performed.
  - Surgery and reconstruction of the other breast to produce a symmetrical appearance.
  - Prostheses.
  - Treatment of physical complications of all stages of mastectomy, including lymphedemas.

This coverage will be provided in consultation with the attending physician and the patient, and will be subject to the same annual deductibles and coinsurance provisions that apply for the mastectomy.

DENTAL SERVICES

Dental services provided by a dentist, oral surgeon, denturist, or physician, including all related medical facility inpatient or outpatient charges are subject to the medical plan deductible and are covered only for the following:

- Treatment for accidental injuries to natural teeth provided that the injury occurred while covered under this Plan. Treatment for up to six months from the date of the accident for accidental injuries is provided under this Plan. Injuries caused by biting or chewing are not covered under the medical plan.

- Inpatient or outpatient hospital services will be covered under the Plan if the participant has an underlying documented medical condition that requires hospitalization, subject to approval of the Plan Supervisor.

DIAGNOSTIC X-RAY AND LABORATORY

Covered charges are as follows and are payable as shown in the Schedule of Benefits.

- Diagnostic x-ray and laboratory services (not including dental x-rays).

- Charges made by a blood bank for processing of blood and its derivatives, cross-matching, and other blood bank services.

- Charges made for whole blood, blood components, and blood derivatives to the extent not replaced by volunteer donors.

DIABETIC EDUCATION AND COUNSELING

Diabetic education and counseling is a covered benefit. In order to be considered an eligible charge, services must be provided by a YVMH sponsored program. No benefit is available through any other source.

DURABLE MEDICAL EQUIPMENT

Benefits are provided for rental or purchase (if more economical in the judgment of the Plan Supervisor) of medically necessary durable medical equipment. Durable medical equipment is equipment able to withstand repeated use, is primarily and customarily used to serve a medical purpose, and is not generally used in the absence of illness or injury. The durable medical equipment must be prescribed by a physician for therapeutic use, and include the length of time needed, the cost of rental and cost of purchase prior to any benefits being paid. Examples include the following: crutches; wheelchairs; kidney dialysis equipment; hospital beds; traction equipment; and equipment for administration of oxygen. Repairs or replacement of eligible equipment shall be covered when necessary to meet the medical needs of the covered patient.

Benefits are **not** provided for certain equipment including, but not limited to: Air conditioners, dehumidifiers, purifiers, heating pads, enuresis (bed-wetting) training equipment, exercise equipment, whirlpool baths, weights, or hot tubs.

HEARING BENEFIT

The Plan will pay as outlined in the Schedule of Benefits for a hearing aid device and hearing impairment services.

In order to receive services through this hearing benefit, examination by a licensed physician, as defined under the definition of physician, must be obtained before a hearing aid is received.

Services will be provided for:

- Otologic (ear) examination by a physician.
- Audiologic (hearing) examination and hearing evaluation by a certified or licensed audiologist, including a follow-up consultation.
- The hearing aid (monoaural or binaural) prescribed as a result of the examinations.
- Ear mold(s).
- The hearing aid instrument.
- The initial batteries, cords and other necessary ancillary equipment.
- A follow-up consultation within 30 days following delivery of the hearing aid with either the prescribing physician or audiologist.
- Repairs, servicing, and alteration of hearing aid equipment.

INFUSION THERAPY

Inpatient and outpatient services and supplies for infusion therapy are provided at the coinsurance level and calendar year maximum as shown in the Schedule of Benefits. The attending physician must submit and periodically review a written treatment plan that specifically describes the infusion therapy services and supplies to be provided. If home infusion therapy is required, the treatment plan must outline the medical necessity for such and will be subject to approval by the Plan Supervisor. The treatment plan must be approved in advance by the Plan Supervisor. Drugs and supplies used in conjunction with infusion therapy will be provided only under this benefit.

MATERNITY SERVICES

Benefits for maternity care and services are available to a covered employee or spouse. Benefits are not available for dependent children. Pregnancy and complications of pregnancy will be covered as any other medical condition. Inpatient stays for a normal delivery at a facility other than YVMH must be pre-authorized. Medical facility, surgical and medical benefits are available on an inpatient or outpatient basis for the following maternity services:

- Normal delivery.
- Cesarean delivery.
- Routine prenatal and postnatal care.
- Treatment for complications of pregnancy.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

The Plan will at all times comply with the terms of the Newborns' and Mothers' Health Protection Act of 1996. The Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or to less than 96 hours following a cesarean section, or require that a provider obtain authorization from the Plan for prescribing a length of stay for the mother or newborn child not in excess of the above periods.

MEDICAL FACILITY SERVICES

Inpatient Care

All inpatient admissions to facilities other than YVMH must be pre-authorized as outlined in the Medical Facility Admission Pre-Authorization section described on pages 39-40.

The following benefits will be provided for inpatient care in an accredited hospital or medical facility when the patient is under the care of a physician:

- Room and board in a semi-private room.
- Intensive care, cardiac care, isolation or other special care unit.
- Private room accommodations, if medically necessary.
- Nursing care services.
- Prescribed drugs and medications administered in the hospital or the medical facility.
- Anesthesia and its administration.
- Oxygen and its administration.
- Dressings, supplies, casts and splints.
- Diagnostic services.
- The use of durable medical equipment.

Outpatient Care

Benefits will be provided as outlined in the Schedule of Benefits for minor surgery and for emergency room treatment of an accidental injury or a medical emergency, outpatient lab, x-ray and physical therapy.

Miscellaneous

All other charges made by a hospital or the medical facility during an inpatient confinement are eligible, exclusive of: personal items; services not necessary for the treatment of an illness or injury; or services specifically excluded by the plan.

ALTERNATIVES TO INPATIENT ADMISSIONS - SPECIAL PROVISIONS

Home Health Care, Hospice Care, Skilled Nursing Facility, and Rehabilitation are provided in lieu of and as an alternative to inpatient admissions.

Alternate care will be determined on the merits of each individual case and any care or treatment provided will not be considered setting any precedent or creating any future liability, with respect to that covered participant or any other covered participant.

- They are subject to the concurrent opinion of the attending physician and the Plan Supervisor that they will be less costly than an inpatient confinement that would otherwise have been required.

- Services are outlined in a written treatment plan.

- The treatment plan is to be developed and reviewed periodically by the attending physician.

- The treatment plan should include an estimate of the cost of services, length of stay and treatment, and supplies to be rendered.

- In cases where the covered participant's condition is expected to be or is of a serious nature, the Employer may utilize case management services from a professional qualified to perform such services. The UR Coordinator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of patient's care.

Home Health Care

Charges made by a home health care agency (approved by Medicare or state certified) for the following services and supplies furnished to a participant in their home for care in accordance with a home health care plan are included as covered medical expenses. Charges for home health care services described below will be applied to the home health care benefit and subject to the home health care maximum as shown in the Schedule of Benefits. This benefit is not intended to provide custodial care but is provided for care in lieu of inpatient hospital, medical facility or skilled nursing facility care for patients who are homebound.

The following services will be considered eligible expenses:

- Part-time or intermittent nursing care by a registered nurse, a licensed vocational nurse or by a licensed practical nurse.

- Physical therapy by a licensed, registered or certified physical therapist.

- Speech therapy services by a licensed, registered or certified speech therapist.

- Occupational therapy services by a registered, certified or licensed occupational therapist.

- Nutritional guidance by a registered dietitian.

- Nutritional supplements such as diet substitutes administered intravenously or by enteral feeding.

- Services of a certified or registered respiratory therapist.

- Home health aide services by an aide who is providing intermittent care under the supervision of a registered nurse, physical therapist, occupational therapist or speech therapist. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in your condition and needs, completing appropriate records.

- Medical supplies, drugs and medicines prescribed by a physician, and laboratory services normally used by a patient in a skilled nursing facility, medical facility or hospital, but only to the extent that they would have been covered under this Plan if the participant had remained in the hospital or medical facility.

Hospice Care

If a participant is terminally ill, the services of an approved hospice will be covered for medically necessary treatment or palliative care (medical relief of pain and other symptoms) for the terminally ill participant, subject to the conditions and limitations specified below. Services and supplies furnished by a licensed hospice (Medicare approved or state certified) for necessary treatment of the participant, pursuant to a written treatment plan furnished by the attending physician, will be eligible for payment as shown in the Schedule of Benefits. The following services will be considered eligible expenses:

- Confinement in a hospice facility or at home.

- Ancillary charges furnished by the hospice while the participant is confined.

- Medical supplies and drugs prescribed by the attending physician, but only to the extent such items are necessary for pain control and management of the terminal condition.

- Physician services and/or nursing care by a registered nurse, licensed practical nurse, master in social work, or a licensed vocational nurse.

- Home health aide services and home health care.

- Nutritional guidance by a registered dietitian, nutritional supplements, such as diet substitutes, administered intravenously or through hyperalimentation.

- Physical therapy, speech therapy, occupational therapy, respiratory therapy.

- Respite care up to a maximum of 240 hours per calendar year, subject to the lifetime maximum as shown in the Schedule of Benefits, to relieve anyone who lives with and cares for the terminally ill participant.

If the covered participant requires end of life care beyond six months, the Plan will approve additional hospice care benefits on receipt of a plan of care documenting the continued need for the services.

With respect to hospice care, a treatment plan must include:

- A description of the medically necessary palliative care, to be provided to a terminally ill patient or medically necessary treatment of an illness or injury, but not for curative care.

- A provision, that care will be reviewed and approved by the physician at least every 60 days.

- A prognosis of six months or less to live.

- The concurrent opinion of the physician and Plan Supervisor that hospice care will cost less in total than alternate treatment.

Exclusions to Home Health Care and Hospice Care

- Non-medical or custodial services except as specifically included as an eligible expense.

- Meals on Wheels or similar home delivered food services.

- Services performed by a member of the patient's family or household.

- Services not included in the approved treatment plan.

- Supportive environmental materials such as handrails, ramps, telephones, air conditioners or similar appliances or devices.

- Hospice bereavement.

Skilled Nursing Facility Care

This Plan will pay benefits for confinement in a Medicare approved or state certified skilled nursing facility, as specified in the Schedule of Benefits, provided such confinement:

- Is for necessary recuperative care that would otherwise require hospitalization;

- Is for required 24 hour care and the patient is under continuous care of the attending physician;

- Is not for Custodial Care.

Eligible expenses are:

- Room, board and other services and supplies furnished by the facility for necessary care (other than personal items and professional services).

- Use of special treatment rooms.

- X-ray and laboratory examinations.

- Occupational, physical and speech therapy.

- Oxygen and other gas therapy.

Rehabilitation Benefit

Rehabilitative services are provided when medically necessary to restore and improve bodily function previously normal, but lost due to illness or injury, including function lost as a result of congenital anomalies.

The services specified below will be provided as long as continuing measurable progress is demonstrated at regular intervals.

Occupational, physical and speech therapy in the office, medical facility or hospital will be paid under the rehabilitation benefit as shown in the Schedule of Benefits.

Occupational Therapy - Charges of a registered, certified or licensed occupational therapist are covered when necessary to restore a bodily function lost or impeded due to illness or injury. A treatment plan must be submitted and approved in advance by the Plan Supervisor or UR Coordinator for any Inpatient Rehabilitative Care provided at other than YVMH.

Physical Therapy - Charges of a registered, certified or licensed physical therapist are covered when necessary to restore a bodily function lost or impeded due to illness or injury. A treatment plan must be submitted and approved in advance by the Plan Supervisor or UR Coordinator for any Inpatient Rehabilitative Care provided at other than YVMH.

Speech Therapy - Charges of a licensed speech pathologist or speech therapist are covered when prescribed by a Physician and when necessary to restore a bodily function lost or impeded due to illness or injury. A treatment plan must be submitted and approved in advance by the Plan Supervisor or UR Coordinator for any Inpatient Rehabilitative Care provided at other than YVMH. Excluded are speech therapy services that are only educational in nature.

> **NOTE:** No benefits will be provided for custodial care; maintenance, non-medical self-help, recreational, educational or vocational therapy; psychiatric care; learning disabilities or developmental delay; chemical dependency rehabilitative treatment; gym or swim therapy; any services not meeting medically necessary standards.

MAMMOGRAMS

Mammograms are covered when recommended by a physician. Mammograms may be done as often as medically necessary to treat or diagnose an illness. This benefit will be paid as shown in the Schedule of Benefits.

MEDICAL SUPPLIES

When prescribed by a physician and medically necessary, the following medical supplies are covered including but not limited to: braces; surgical and orthopedic appliances; colostomy bags and supplies required for their use; catheters; syringes and needles necessary for diabetes or allergic conditions; dressings for surgical wounds, cancer, burns, or diabetic ulcers; oxygen; back brace; and cervical collars.

MENTAL NERVOUS TREATMENT

Benefits will be provided for mental health care when treatment is rendered by the following: physicians; licensed clinical psychologist; accredited hospitals; state mental hospitals; or mental health agencies licensed by the state as defined herein. Mental and nervous is defined as and includes (whether organic or non-organic, whether of biological, non-biological, chemical or non-chemical origin and irrespective of cause, basis or inducement) mental disorders, mental illnesses, psychiatric illnesses, mental conditions and psychiatric conditions. This includes but is not limited to the following conditions: psychoses, neurotic disorders, schizophrenic disorders, affective disorders, personality disorders, attention deficit or attention deficit hyperactivity disorders, and psychological or behavioral abnormalities associated with transient or permanent dysfunction of the brain or related neurohormonal systems. Expenses for mental

nervous treatment are not applied toward the out-of-pocket maximum. The coinsurance level remains constant and will not increase to 100% when the out-of-pocket maximum is reached. Benefits are subject to the limits as shown in the Schedule of Benefits.

Inpatient Treatment

When inpatient mental nervous treatment is recommended, the patient must first pre-authorize the admission if at a facility other than YVMH. In addition to pre-authorization the following are required:

- Treatment must be ordered in writing, by a physician, for the entire length of time the patient is confined.

- Under extenuating circumstances, such as emergency inpatient mental nervous treatment, you must notify the Plan Supervisor within 48 hours of admission, or by the next business day (or when mentally capable). A written explanation of the extenuating circumstances should be submitted to support the need for the emergency admission.

- The patient must complete the approved course of treatment in a hospital or medical facility as defined by the Plan.

Outpatient Treatment

If treatment is provided on an outpatient basis, then treatment must be provided by a physician; licensed clinical psychologist, accredited hospital; state mental hospital; or mental health agency licensed by the state, as defined under this Plan.

NEURODEVELOPMENTAL THERAPY SERVICES

Benefits will be provided for medically necessary neurodevelopmental therapy treatment to restore and improve bodily function for children age six and under. This benefit includes maintenance services where significant deterioration of the patient's condition would result without the service. Neurodevelopmental therapy means therapy designed to treat structural or functional abnormalities of the central or peripheral nervous system. Its purpose is to restore, maintain or develop age appropriate functions in a child.

Such therapy includes occupational therapy, physical therapy and speech therapy. The services of a physician, physical therapist, speech therapist, or occupational therapist will be provided in the office, medical facility, or hospital outpatient department. Inpatient hospital, medical facility or skilled nursing facility expenses will be eligible when care cannot be safely provided on an outpatient basis. The physician must submit a treatment plan to the Plan Supervisor for prior approval and must periodically review the treatment plan.

Benefits are payable at the coinsurance level indicated in the Schedule of Benefits. Benefits for rehabilitative services or other treatment programs will not be available for the same condition.

NEWBORN CARE

Benefits are available for hospital and associated professional care for a covered newborn dependent child during the first three weeks from birth. Newborn care includes:

Hospital Care

Hospital nursery services as determined necessary by the physician, in consultation with the mother, based on accepted medical practice. Also covered is any required readmission to a hospital, and outpatient or emergency room services for medically necessary treatment of an illness or injury.

Professional Care

- Inpatient newborn-care.
- Follow-up care consistent with accepted medical practice that is ordered by the physician, in consultation with the mother. Follow-up care includes services of the physician, a home health agency and/or a registered nurse.
- Circumcision (for up to six months following birth).
- Hearing screenings.

Benefits for a newly born child are provided only when the child meets the dependent eligibility and enrollment requirements. Benefits are subject to the child's own deductible and coinsurance requirements. Benefits for a covered ill newborn will continue beyond the three-week period following birth.

PHENYLKETONURIA (PKU) DIETARY FORMULA

Dietary formula that is medically necessary for the treatment of phenylketonuria is covered.

PHYSICIAN SERVICES

Physician's fees for medically necessary medical and surgical services are covered.

PRE-ADMISSION TESTING

Charges for laboratory and x-ray examinations to determine if the participant is suitable for surgery prior to admission are covered.

PRESCRIPTION DRUGS

Inpatient and Outpatient Prescription drugs are covered when prescribed for treatment of a covered illness or accident. Prescription drugs will be paid as shown in the Schedule of Benefits and are subject to the deductible. However, outpatient drugs filled at YVMH's pharmacy are not subject to the deductible, but rather are subject to only a copay. The copay will not apply toward the Major Medical deductible or out-of-pocket. **Further procedures for obtaining prescription drugs are published by the YVMH Pharmacy.** Prescription drugs covered are: Legend drugs (those which cannot be purchased without a prescription written by a physician or dentist); insulin, prenatal vitamins and oral contraceptive medications. Generic products will be used when an acceptable generic medication is available at a lower cost.

Prescription drugs for treatment of dental conditions are reimbursed under Medical coverage as shown in the Schedule of Benefits. There is no prescription drug benefit under the Dental Plan.

PREVENTIVE MEDICAL CARE

The Preventive Medical Care Benefit provides coverage for the following routine and preventive services performed on an outpatient basis and furnished by a covered provider. This benefit is payable as shown in the Schedule of Benefits. Covered services are:

- Routine physicals (including routine gynecological exams, and exams with a birth control diagnosis) and well-baby examinations (beyond the three-week period specified under "Newborn Care"), and laboratory and x-ray services performed in connection with such examinations.
- Immunizations.

In addition to “General Exclusions to the Medical Plan”, benefits are not provided for:

- Services not named above as covered.
- Routine vision examinations.
- Routine and diagnostic screening mammography services, routine hearing examinations, and contraceptive devices. Benefits for such services are provided as stated under the Major Medical provisions of this Plan.
- Preventive services provided by a naturopathic physician.

Charges for preventive medical care services or supplies that exceed what is covered under this benefit are not covered under other benefits of this Plan.

PROSTHETIC APPLIANCES

Benefits are provided for artificial limbs and eyes. Benefits will also be payable for an external and the first permanent internal breast prosthesis following a mastectomy. External breast prostheses are limited to one replacement every three calendar years. A prosthesis ordered before your effective date of coverage will not be covered. A prosthesis ordered while your coverage is in effect and delivered within 30 days after termination of coverage will be covered. Repair or replacement of prostheses due to normal use or growth of a child will be covered. Benefits are not provided for cosmetic prostheses.

RADIATION THERAPY AND CHEMOTHERAPY

X-ray, radium, radioactive isotope therapy, and chemotherapy are covered expenses under this Plan and are payable as shown in the Schedule of Benefits.

SECOND SURGICAL OPINION

A second surgical opinion is required for organ transplant procedures. It is optional for other surgical procedures. This benefit is paid as shown in the Schedule of Benefits.

When requested, the Plan will pay the usual, customary and reasonable charges for a second surgical opinion, and for a third and final opinion in case of conflict between the first two opinions.

Second or Third Opinion: Must be an opinion of an independent second or third surgeon acting on a consulting basis. A surgeon in association or practice with a prior surgical consultant will not be accepted.

STERILIZATION - ELECTIVE

The Plan pays for elective sterilization procedures such as tubal ligations and vasectomies. These procedures shall be paid under the Major Medical benefits for covered employees and spouses.

Eligible expenses under this Plan shall not include reversal or attempted reversal of these procedures.

SURGERY AND RELATED SERVICES

Benefits are provided for the following inpatient or outpatient services:

- Surgeon's charges
- Assistant surgeon's charges (not to exceed 20% of surgeon's allowable charge).
- Anesthesia

If two or more surgical procedures are performed through the same incision during an operation, full benefits are only provided for the primary procedure and one half for the lesser procedure.

TAXES

Charges for surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) will be considered covered expenses.

Local, State and Federal taxes, associated with supplies or services covered under this Plan, will also be considered covered expenses.

TRANSPLANTS

Benefits are payable for charges for organ or tissue transplant services which are incurred while the recipient is covered by this Plan. Such covered charges must be due to an accidental injury or sickness covered by this Plan.

A second opinion is required for all transplant surgeries. Eligibility for benefits relating to a transplant is subject to the pre-existing conditions exclusion under this Plan.

You must contact the Plan Supervisor's Medical Management Department prior to any testing that may occur to determine whether you are a transplant candidate. A written treatment plan must be submitted in order to obtain pre-authorization.

Also remember pre-authorization is required before admission to any medical facility other than YVMH. See the Medical Facility Admission Pre-Authorization requirements in the Important Information Section at the beginning of this Booklet.

Organ or tissue transplant services include the following medically necessary services and supplies:

- Compatibility testing undertaken prior to procurement is covered if medically necessary. This includes costs related to the search for, typing and testing, and identification of a bone marrow or stem cell donor for allogeneic transplant up to the maximum amount shown in the Schedule of Benefits. These expenses will be charged against the transplant benefit maximum as shown in the Schedule of Benefits.

- Organ or tissue procurement. These consist of removing, preserving and transporting the donated part.

- Medical facility or Hospital room and board, and medical supplies.

- Diagnosis, treatment and surgery by a doctor.

- Private nursing care by a Registered Nurse (R.N.) or a Licensed Practical Nurse (L.P.N.).

- The rental of wheelchairs, hospital-type beds and mechanical equipment required to treat respiratory impairment.

- Local ambulance services, medications, x-rays and other diagnostic services, laboratory tests, and oxygen.

- Rehabilitative therapy consisting of: speech therapy (not for voice training or lisp), audio therapy, visual therapy, occupational therapy, and physiotherapy. Any of these must be in direct respect to rehabilitation from the covered transplant procedure.

- Surgical dressing and supplies.

- Other services approved by the Plan Supervisor's Medical Management Department.

Benefits for a donor are payable only in the absence of other coverage and shall not exceed the benefit limitation as shown in the Schedule of Benefits. Donor expenses are payable only when the organ recipient is covered under this Plan and are considered expenses of the recipient.

No benefits will be provided for the following:

- Any procedure that has not been proven effective or is experimental or investigational or does not meet generally accepted medical practices at that time. (See definition of Experimental and Investigational.)

- When donor benefits are available through other group coverage.

- When government funding of any kind is available.

- When the recipient is not covered under this Plan.

- Transportation, lodging and meals.

GENERAL EXCLUSIONS TO THE MEDICAL PLAN

This section of your booklet explains the circumstances in which all the medical benefits of this Plan are limited or in which no benefits are provided. Benefits may also be affected by the Utilization Review provisions of the plan, your eligibility and expenses are subject to all Plan conditions, exclusions and limitations, including medical necessity. In addition, some benefits have their own limitations.

1. Services and supplies not medically necessary (as defined in the Definition Section) for the diagnosis or treatment of an illness or injury, unless otherwise listed as covered.

2. Services covered by or for which the employee is entitled to benefits under any Worker's Compensation or similar law.

3. Charges by a medical facility owned or operated by the United States or any state or local government unless the participant is legally obligated to pay. This does not apply to covered expenses rendered by a medical facility owned or operated by the United States Veteran's Administration when the services are provided to a participant for a non-service related illness or injury. This exclusion also does not apply to covered expenses rendered by a United States military medical facility to participants who are not on active military duty.

4. Charges that the employee is not legally required to pay for; or for charges which would not have been made in the absence of this coverage.

5. Charges that are in excess of contractual provider allowances where applicable, usual, customary and reasonable (UCR) fees; or that are not generally accepted medical procedures for the treatment of the diagnosed illness or injury.

6. Charges that are reimbursed or eligible to be reimbursed by any public program except as otherwise required by law.

7. Charges for the treatment of a condition resulting from or made necessary by war or an act of war, declared or undeclared, or an injury sustained or illness contracted while on duty with any military service for any country. An act of terrorism will not be considered an act of war, declared or undeclared.

8. Licensed/Certified – Any services outside the scope of the provider's license, registration, or certification, or that is furnished by a provider that is not licensed, registered, or certified to provide the service or supply by the State in which the services or supplies are furnished. Treatment or services provided by anyone other than a physician operating within the scope of their license, as defined herein.

9. Services considered to be experimental, investigational or generally non-accepted medical practices at the time they are rendered.

10. Charges in connection with any injury or illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

11. Charges incurred for treatment or care by any provider if he or she is a relative, or treatment or care provided by any individual who ordinarily resides with the participant.

12. Charges for expenses payable under the terms of any automobile, medical, no fault, or similar contract of insurance.

13. Pre-existing conditions except as provided herein.

14. Medical facility services performed in a facility other than as defined herein.

15. Charges for any illegal treatment or treatment listed by the American Medical Association (AMA) as having no medical value.

16. Missed or canceled appointments or for telephone consultations.

17. Personal comfort or service items while confined in a medical facility, such as, but not limited to: radio, television, telephone and guest meals.

18. Mailing and/or shipping and handling expenses.

19. Insurance exams.

20. Expenses for preparing medical reports, itemized bills or claim forms.

21. Hospital or Medical Facility admission for inpatient diagnostic studies or routine testing.

22. Except as provided under the Chemical Dependency Treatment benefit, any medical treatment required because of the use of narcotics or the use of hallucinogens in any form unless the drug is prescribed by a physician.

23. Court Ordered – Court Services and supplies that are court-ordered or are related to deferred prosecution, deferred or suspended sentencing, or driving rights, if those services are not deemed medically necessary under the Plan.

24. Charges that are a result of any injury or illness sustained as a result of participating in the commission of a felony.

25. Charges for any injury to a participant sustained while under the influence of alcohol or illegal drugs.

26. Over-the-Counter – Over the counter drugs, supplies, food supplements, infant formulas, and vitamins.

27. Drugs Used for Cosmetic Purposes including, but not limited to Botox.

28. Cosmetic surgery or related medical facility admission, except as noted under Cosmetic Reconstructive Surgery.

29. Rest Home – Any services rendered by an institution, which is primarily a place of rest, a place for the aged, a nursing home, sanitarium, or a convalescent home.

30. Custodial care, except as specifically provided herein. Custodial care is care whose primary purpose is to meet personal rather than medical needs. (Plan Supervisor or the Case Manager will determine if care is custodial.) Such care includes, but is not limited to: helping a patient walk, getting in or out of bed, and taking normally self-administered medicine.

31. Habilitative, Education, or Training Services – Habiliative, education, or training services or supplies for dyslexia, for attention deficit disorders, and for disorders or delays in the development of a child's language, cognitive, motor, or social skills, including evaluations therefore, except as provided herein under the Neurodevelopmental Therapy and Mental Health benefits.

32. Hospital admission primarily for rehabilitative care including, but not limited to: speech and occupational therapy except as provided under the Major Medical Plan. Further, when the type of care rendered during a continuous period of hospital confinement develops into primarily rehabilitative care, that portion of the stay primarily for rehabilitative care is covered under this Plan as provided under the rehabilitation provisions in the Major Medical Plan.

33. Travel, whether or not recommended by a physician, except as provided herein under the Ambulance Benefit.

34. Transportation by private automobiles or taxi service or other ground transportation, except as specifically provided herein.

35. Routine Foot Care – Services for routine or palliative foot care, including hygienic care; impression casting for prosthetics or appliances and prescriptions thereof; fallen arches, flat feet, care of corns, bunions (except when medically necessary for treatment of diabetes and for bone surgery), and other asymptomatic complaints of the foot. This includes foot-support supplies, devices, and shoes.

36. Charges for orthopedic shoes, orthotics or other supportive devices for the feet.

37. Charges for reversal or attempted reversal of sterilization.

38. Charges for gender change or for procedures to change one's physical characteristics to those of the opposite gender.

39. Charges for breast or penile implants except as provided herein.

40. Impotency – Charges associated with impotency and erectile dysfunction, and procedures to restore potency, including but not limited to: corrective or reconstructive surgery; hormone injections; penile implants; or impotency drugs whether or not they are the consequence of an illness or injury.

41. Fertility and Infertility – Charges in association with infertility, and procedures to restore fertility or to induce pregnancy, including but not limited to: corrective or reconstructive surgery; hormone injections; in-vitro fertilization; embryo transfer; artificial insemination; gamma intra-fallopian transfer (G.I.F.T.); fertility drugs (including but not limited to Clomid, Pergonal or Serophene); or any other artificial means of conception.

42. Services for pregnancy or complications of pregnancy for dependent children.

43. Voluntary termination of pregnancy.

44. Services or supplies that are primarily educational in nature other than as defined herein.

45. Services or supplies for learning disabilities, job training or other education or training services except as provided herein.

46. Services or supplies for, marital, sexual or family counseling outreach.

47. Milieu therapy (a treatment designed to provide a change in environment or a controlled environment).

48. Self-Help Programs – Non-medical, self-help programs such as "Outward Bound" or "Wilderness Survival", recreational or educational therapy.

49. Adoption Expenses – Adoption expenses or any expense related to surrogate parenting.

50. Treatment for obesity (excessive weight) including surgery or complications of such surgery, wiring of the jaw or procedures of similar nature, except as provided herein.

51. Acupuncture treatment unless provided by a physician as defined by this Plan.

52. Treatment or classes to stop smoking.

53. Charges for or in connection with the treatment of the teeth, periodontium, periodontal disease, periapical disease or any condition (other than a malignant tumor) involving the teeth, surrounding tissue or structure, except for oral surgery for repair of accidental injury to sound, natural teeth while covered under this Plan, or as otherwise provided herein.

54. Eyeglasses, contact lenses, eye refractions or examinations for prescriptions or fitting of eyeglasses, contact lenses or charges for radial keratotomy or other similar corrective surgeries.

55. Charges for vision analysis, therapy or training relating to muscular imbalance of the eye; orthoptics.

56. Massage therapy, unless provided as part of a physical rehabilitation program performed by, or under the direction of, a Physical Therapist.

57. Non-Covered Services – Services or supplies directly related to any condition, service or supply that are not covered by this Plan. This includes any complications arising from any treatment, services or supplies not covered by this Plan.

58. Third Party Liability – Benefits payable under the terms of any automobile medical, personal injury protection, automobile no fault, homeowner, commercial premises or similar contract or insurance when such contract or insurance is issued to, or makes benefits available to, the covered participant. This also includes treatment of illness or injury for which the third party is liable.

Upon termination of this Plan, all expenses incurred prior to the termination date of this Plan, but not submitted to the Plan Supervisor within 75 days of the effective date of termination of this Plan, will be excluded from any benefit consideration.

GENERAL MEDICAL DEFINITIONS

ACCIDENT/ACCIDENTAL INJURY - A personal bodily injury due solely to external violent and unintentional means. All injuries sustained in connection with one accident will be considered one Accidental Injury. Accidental Injury does not include ptomaine poisoning, disease or infection (except pyogenic infection occurring through an accidental cut or wound).

ALLOWABLE CHARGES – When Regence BlueShield or Asuris Northwest Health Preferred (PPO) or Participating (PAR) providers are used, eligible expenses covered by the Medical Plan are subject to the Regence or Asuris allowed amount. When NonPPO or NonPAR providers are used, expenses are subject to usual, customary and reasonable (UCR) allowances.

APPROVED CHEMICAL DEPENDENCY TREATMENT FACILITY - For the purpose of treatment of chemical dependency, the definition of the term facility includes any public or private treatment facility providing services for the treatment of chemical dependency that has been licensed or approved as a chemical dependency treatment facility by the State in which it is located.

APPROVED TREATMENT PLAN - A written outline of proposed treatment that is submitted by the attending physician to the Plan Supervisor for review and approval.

BIOFEEDBACK THERAPY - Biofeedback therapy is an electronic method which allows the patient to monitor the functioning of the body's autonomic systems (e.g., body temperature, heart rate) that were previously thought to be involuntary.

CALENDAR YEAR - The 12 months beginning January 1 and ending December 31 of the same year.

CONTRIBUTORY OR CONTRIBUTION - The employee is required to pay a portion of the cost for enrolling in the Plan.

COORDINATION OF BENEFITS / ORDER OF BENEFITS DETERMINATION - The method for ascertaining the order in which the Plan renders payment when a Participant is covered by more than one plan. The principle applies when another plan has a Coordination of Benefits provision.

COVERED INDIVIDUAL OR PARTICIPANT - An employee, spouse or child who is eligible for benefits under this Plan and is enrolled.

CREDITABLE COVERAGE - The period of prior medical coverage that an individual had from any of the following sources, and that is not followed by a Significant Break in Coverage: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the uniformed services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan (meaning any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan), a health benefit plan under the Peace Corps Act, or a State Children's Health Insurance Program. Creditable Coverage does not include coverage for liability, dental, vision, specified disease and/or other supplemental-type benefits.

CUSTODIAL CARE - Care or service which is not medically necessary, and is designed essentially to assist a participant in the activities of daily living. Such care includes, but is not limited to: bathing, feeding, preparation of special diets, assistance in walking, dressing, getting into or out of bed and supervision over taking of medication which can normally be self-administered.

DEDUCTIBLE - The amount of eligible expenses that an employee or dependent must incur each calendar year before any benefits are payable by the Plan. The individual deductible amount is listed in the Schedule of Benefits.

DENTIST - A doctor of dentistry and/or doctor of dental surgery practicing within licensed authority, or a legally qualified Physician authorized by license to perform the particular dental service rendered.

DENTURIST - A person who is licensed to make, fit and repair dentures and who is practicing within the scope of his/her license.

DEPENDENT –Any individual who is or may be eligible for coverage according to Plan terms due to relationship to a participant.

DISABILITY - See Total Disability.

DONOR - A donor is the individual who provides the organ for the recipient in connection with organ transplant surgery. A donor may or may not be an employee or covered under the provisions of this Plan.

DURABLE MEDICAL EQUIPMENT - Equipment prescribed by the attending Physician which meets all of the following requirements:

- Is medically necessary;
- Is designed for prolonged and repeated use;
- Is for a specific purpose in the treatment of an Illness or Injury;
- Would have been covered if provided in a medical facility;
- Is appropriate for use in the home; and
- Not generally used in the absence of Illness or Injury.

EFFECTIVE DATE - The effective date of the Plan shall mean the first day this Plan was in effect as shown in the Plan Specifications. As to the participant, it is the first day the benefits under this Plan would be in effect, after satisfaction of any applicable waiting period and any other provisions or limitations contained herein.

ELECTIVE SURGICAL PROCEDURE - A surgical procedure that need not be performed on an emergency basis because reasonable delay will not cause life endangering complications.

ENROLLMENT DATE - The first day of coverage or, if there is a probationary period for coverage to begin under the Plan, the first day of the probationary period. The term "probationary period" refers to the period that must pass before coverage for an employee or dependent that is otherwise eligible to enroll under the terms of the plan can become effective. For a person who is a late enrollee or who enrolls on a special enrollment date, the "enrollment date" will be the first date of actual coverage. If an individual receiving benefits under a group health plan changes benefit packages, or if the Plan changes group health insurance issuers, the individual's enrollment date does not change.

ERISA - The Employee Retirement Income Security Act of 1974 and its amendments.

EXPERIMENTAL OR INVESTIGATIONAL - Any treatment, procedure, facility, equipment, drug, drug usage, device or supply which, at the time rendered, does not meet the criteria listed below:

- Approval has been granted by the Federal Food and Drug Administration (FDA), or by another United States governmental agency, for general public use for treatment of a condition.

- It has been scientifically demonstrated by the medical profession to have efficacy in terms of:

  - When the prognosis for the patient's condition is terminal, that the treatment substantially extends the probabilities of the participant's survival.

  - When deterioration of a body system is progressive and reasonably certain to or has, disabled or incapacitated the patient, and the treatment can be substantially expected to improve the probabilities of arresting the condition's progress for five or more years.

  - When the body function has been lost by the patient, that the treatment has been shown to restore the body function to usefulness at least sixty percent of the time treatment has been utilized.

- Treatment must be ordered by an institution or provider within the United States that has scientifically demonstrated proficiency in such treatment. All services directly connected with a non-approved experimental or investigational procedure are not covered.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (FMLA) - A leave of absence granted to an eligible participant by the Employer in accordance with Public Law 103-3 for the birth or adoption of the participant's child, placement in the participant's care of a foster child, the serious health condition of the participant's spouse, child or parent, and the participant's own disabling serious health condition.

GENERAL ANESTHESIA - A drug/gas which produces unconsciousness and insensitivity to pain.

HIPAA – Health Insurance Portability and Accountability Act. This plan is subject to and complies with HIPAA rules and regulations.

HOMEBOUND - A patient is homebound when leaving the home could be harmful, involves a considerable and taxing effort, and the patient is unable to use transportation without the assistance of another.

ILLNESS – A sickness, disease, medical condition, complication of pregnancy or pregnancy of a subscriber or spouse. However, "illness" does not mean a dependent child's pregnancy.

INCURRED CHARGE - The charge for a service or supply is considered to be incurred on the date it is furnished or delivered. In the absence of due proof to the contrary, when a single charge is made for a series of services, each service will be considered to bear a pro rata share of the charge.

INELIGIBLE CHARGES – Those charges which are excluded, limited, above usual, customary, reasonable (UCR), etc.

INJURY - The term injury shall mean only bodily injury caused by an accident and which requires treatment by a physician.

INPATIENT - Anyone treated as a registered bed patient in a medical facility or other institutional facility.

LIFE THREATENING CONDITION - An accident or illness which requires immediate medical attention, without which death or serious impairment to a participant's bodily functions could occur.

LIFETIME - While covered under this Plan or any other YVMH plan. Under no circumstances does lifetime mean during the lifetime of the covered person.

MEDICAL EMERGENCY - An illness or injury which is life threatening or one that must be treated promptly to avoid serious adverse health consequences to the participant.

MEDICAL FACILITY (HOSPITAL) - An accredited institution which receives compensation from its patients for services rendered. On an inpatient basis, it is primarily engaged in providing the following:

- Diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and ill participants.

- Services performed by or under the supervision of a staff of physicians who are duly licensed to practice medicine.

- Continuous 24 hours a day nursing services by registered graduate nurses.

It is not, other than incidentally, a place for rest, or for the aged.

For the services covered under this Plan and for no other purpose, inpatient treatment of mental nervous conditions or chemical dependency, provided by any psychiatric medical facility licensed by the State Board of Health or the Department of Mental Health, will be considered services rendered in a medical facility as defined subject to the limitations shown in this booklet.

MEDICALLY NECESSARY - Medical services and/or supplies which are absolutely needed and essential to diagnose or treat an illness or injury of a covered employee or dependent. The following criteria must be met. The treatment must be:

Consistent with the symptoms or diagnosis and treatment of the participant's condition.

- Appropriate with regard to standards of good medical practice.

- Not solely for the convenience of the participant, family members or a provider of services or supplies.

- The least costly of the alternative supplies or levels of service which can be safely provided to the participant. When specifically applied to inpatient care, it further means that the service or supplies cannot be safely provided in an outpatient setting without adversely affecting the participant's condition or the quality of medical care rendered.

MEDICARE - The programs established by Title XVIII of the U.S. Social Security Act as amended and as may be amended, entitled Health Insurance for the Aged Act, and which includes Part A - Hospital Insurance Benefits for the Aged; Part B - Supplementary Medical Insurance Benefits for the Aged.

NON-EMERGENCY MEDICAL FACILITY ADMISSIONS - A medical facility admission (including normal childbirth) which may be scheduled at the convenience of a participant without endangering such participant's life or without causing serious impairment to that participant's bodily functions.

OPEN ENROLLMENT – The period held once every year to allow eligible employees to change their participation in the Plan. The Open Enrollment period will be the month of December for an effective date of January first.

ORTHOTICS/ORTHOSIS - An orthopedic appliance or apparatus used to support, align, prevent or correct deformities or to improve function of movable parts of the body.

OUTPATIENT SURGICAL FACILITY - A licensed surgical facility, surgical suite or medical facility surgical center in which a surgery is performed and the patient is not admitted for an overnight stay.

PARTICIPANT – Any employee or former employee who is or may become eligible to receive a benefit under the Plan.

PHYSICIAN - The term physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.) or a Physician's Assistant (P.A.) who is legally qualified and licensed without limitation to practice medicine, surgery, or obstetrics at the time and place service is rendered. For services covered by this Plan and for no other purpose, Doctors of dental surgery, Doctors of dental medicine, Doctors of podiatry, optometrists, chiropractors and licensed health service providers in psychology are deemed to be physicians when acting within the scope of their license for services covered by this Plan.

Registered Physical Therapists, Licensed Speech Therapists, Certified-Occupational Therapists, who are registered, licensed, or certified by the state, acting within the scope of their license.

Registered Nurses (R.N.), Licensed Vocational Nurses (L.V.N.) and Licensed Practical Nurses (L.P.N.) will be covered under this definition, acting within the scope of their license.

A Licensed Masters in Social Work (M.S.W.), Licensed Masters of Arts (M.A.), Licensed Masters of Education (M.Ed.), and Licensed Masters of Counseling (M.C.) who are licensed or certified by the state, and operating under the direct supervision of an M.D. or Ph.D., and acting within the scope of their license.

A Licensed Midwife or Nurse Practitioner who is licensed by the state to perform services for which benefits are provided under the Plan, and who acts within the scope of such license is included in the term physician.

PLAN - Shall mean the Benefits described in the Plan Document. The Plan is the Covered Entity as defined in HIPAA (§ 160.103).

PLAN ADMINISTRATOR/PLAN SPONSOR - The individual, group or organization responsible for the day-to-day functions and management of the Plan. The Plan Administrator/Plan Sponsor may employ individuals or firms to process claims and perform other Plan connected services. The Plan Administrator/Plan Sponsor is as shown in the Plan Specifications.

PLAN DOCUMENT - The term Plan Document whenever used herein shall, without qualification, mean the document and any amendments containing the complete details of the benefits provided by this Plan. The Plan Document is kept on file at the office of the Plan Administrator.

PLAN SUPERVISOR - The individual or group providing administrative services to the Plan Administrator in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it by the Plan Administrator.

PLAN YEAR - An annual period beginning on the effective date of this Plan and ending twelve (12) calendar months thereafter or upon termination of the Plan, whichever occurs earliest.

PRE-EXISTING CONDITION - A pre-existing condition, whether physical or mental, and regardless of the cause of the condition, is a condition for which medical advice, diagnosis, care, or treatment has been recommended or received within the three month period prior to the enrollment date. In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under State law and who operates within the scope of practice authorized by the State law.

PROBATIONARY PERIOD – The period that must pass before coverage for an employee or dependent that is otherwise eligible to enroll under the terms of the plan can become effective. Periods of employment in an ineligible classification are not part of a probationary period.

PROTECTED HEALTH INFORMATION (PHI) – Individually identifiable information (as provided for in the privacy rules of HIPAA), whether it is in electronic, paper or oral form that is created or received by or on behalf of the Plan Sponsor or the Plan Supervisor.

RECIPIENT - The recipient is the participant who receives the organ for transplant from the organ donor. The recipient must be an employee or dependent covered under this Plan.

RELATIVE - A husband, wife, son, daughter, mother, father, sister or brother of the employee or any covered dependent.

ROOM AND BOARD CHARGES - The medical facility charges for room and board and its charges for other necessary services and supplies, made regularly at a daily or weekly rate as a condition of occupancy of the type of accommodations occupied.

SEMI-PRIVATE RATE - The daily room and board charge which a medical facility applies to the greatest number of beds in its semi-private rooms containing two or more beds. If the medical facility has no semi-private rooms, the semi-private rate will be the daily room and board rate most commonly charged for semi-private rooms with two or more beds by similar medical facilities in the area. The term "area" means a city, a county, or any greater area necessary to obtain a representative cross section of similar medical facilities.

SIGNIFICANT BREAK IN COVERAGE - Any period of 63 days or more without Creditable Coverage. Periods of no coverage during an HMO affiliation period, a waiting period, or for an individual who elects COBRA continuation coverage during the second election period provided under the Trade Act of 2002, the days between the date the individual lost group health plan coverage and the first day of the second COBRA election period, shall not be taken into account for purposes of determining whether a Significant Break in Coverage has occurred..

SKILLED NURSING/REHABILITATION FACILITY - An institution, or a distinct part of an institution meeting all of the following tests:

- It is licensed to provide and is engaged in providing, on an inpatient basis, for participants convalescing from injury or illness, professional nursing services rendered by a Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse, physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.

- Its services are provided for compensation from its patients and patients are under the full-time supervision of a physician or Registered Nurse (R.N.).

- It provides 24 hours per day nursing services by a licensed nurse, under the direction of a full-time Registered Nurse (R.N.).

- It maintains a complete medical record on each patient.

- It has an effective utilization review plan.

- It is not, other than incidentally, a place for rest for the aged, drug addicts, alcoholics, the mentally handicapped, custodial or educational care, or care of mental disorders.

SPOUSE - The man or woman to whom the employee is legally married, not including a common-law marriage.

SUMMARY PLAN DESCRIPTION - The document required by ERISA, containing a summary of the benefits provided under the Plan. In the event of a discrepancy between the summary and the Plan Document, the provisions stated in the Plan Document will supersede.

SURGICAL PROCEDURE - A surgical procedure is defined as the following, but not limited to:

- A cutting operation.
- Treatment of a fracture.
- Reduction of a dislocation
- Radiotherapy if used in lieu of a cutting operation for removal of a tumor.
- Electrocauterization.
- Diagnostic and therapeutic endoscopic procedures.
- Injection treatment of hemorrhoids and varicose veins.

TEMPOROMANDIBULAR JOINT - The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

TOTAL DISABILITY AND DISABLED - The terms total disability and disabled mean for the:

- Employee - the inability to engage, as a result of accident or illness, in their normal occupation with YVMH on a full time basis;
- Dependent - the inability to perform the usual and customary duties or activities of a participant in good health and of similar age.

TREATMENT - Any service or supply used to evaluate, diagnose or remedy a condition of a participant or their covered dependents.

USUAL, CUSTOMARY AND REASONABLE (UCR) - A reasonable fee that is commonly accepted as payment for a given service by physicians or suppliers of services in a geographical area. The Plan will consider the actual charge billed if it is less than the Usual, Customary and Reasonable Charge.

UTILIZATION REVIEW COORDINATOR - The individual or organization designated by the Plan Administrator to authorize medical facility admissions and surgeries and to determine the medical necessity of treatment for which Plan benefits are claimed.

WAITING PERIOD – The period that must pass before coverage for an employee or dependent that is otherwise eligible to enroll under the terms of the Plan can become effective. Periods of employment in an ineligible classification are not part of a waiting period.

APPEALING A CLAIM

Post-Service Claim:

If your claim is denied in whole or in part, you will receive an Explanation of Benefits showing the calculation of the total amount payable, charges not payable, the reason for the determination, and if applicable, a description of any additional information needed. If additional information is needed, you may be requested to provide the information prior to payment of your claim.

First Level: You may request a review **within 180 days** by filing a written appeal with the Plan Supervisor. The written appeal must clearly state that it is an appeal, and clearly state the reason for appeal. You must supply any additional information to support your appeal reason. The Plan Supervisor will make a decision **within 30 days**. This decision will be delivered to you in writing setting forth specific references to the pertinent Plan provision rule, protocol or guidelines upon which the decision is based. You will also be given a description of any additional information needed to overturn the decision.

Second Level: You may request a review **within 180 days** by filing a written appeal with the Plan Supervisor. The written appeal must clearly state that it is an appeal, and clearly state the reason for appeal. You must supply any additional information to support your appeal reason. The Plan Supervisor will make a decision **within 30 days.** This decision will be delivered to you in writing setting forth specific references to the pertinent Plan provision rule, protocol or guidelines upon which the decision is based. You will also be given a description of any additional information needed to overturn the decision.

Subsequent Action: Upon exhaustion of the full member appeals process, you may have a right to pursue voluntary appeals procedures, and for most group coverage, may bring action under section 502(a) of ERISA.

Pre-Service Claim:

If your Pre-Service claim (or Pre-Authorization) is denied in whole or in part, you will receive written notification of the decision, and the reason for the determination, and if applicable, a description of any additional information needed. If additional information is needed, you may be requested to provide the information prior to payment of your claim.

First Level: You may request a review **within 180 days** by filing a written appeal with the Plan Supervisor. The written appeal must clearly state that it is an appeal, and clearly state the reason for appeal. You must supply any additional information to support your appeal reason. The Plan Supervisor will make a decision **within 15 days**. This decision will be delivered to you in writing setting forth specific references to the pertinent Plan provision rule, protocol or guidelines upon which the decision is based. You will also be given a description of any additional information needed to overturn the decision.

Second Level: You may request a review **within 180 days** by filing a written appeal with the Plan Supervisor. The written appeal must clearly state that it is an appeal, and clearly state the reason for appeal. You must supply any additional information to support your appeal reason. The Plan Supervisor will make a decision **within 15 days.** This decision will be delivered to you in writing setting forth specific references to the pertinent Plan provision rule, protocol or guidelines upon which the decision is based. You will also be given a description of any additional information needed to overturn the decision.

Subsequent Action: Upon exhaustion of the full member appeals process, you may have a right to pursue voluntary appeals procedures, and for most group coverage, may bring action under section 502(a) of ERISA.

Urgent Pre-Service Claim: Urgent Care Claims are defined as claims that involve a decision that, if treated as non-urgent, could seriously jeopardize the claimant's life, health or ability to regain maximum function; or would, according to a physician, subject the claimant to severe pain. If your Urgent Pre-Service claim (or Pre-Authorization) is denied in whole or in part, you will receive verbal and written notification of the decision, and the reason for the determination, and if applicable a description of any additional information needed. If additional information is needed, you may be requested to provide information prior to payment of your claim.

First & Second Level: You may request a review **within 180 days** by filing a written appeal with the Plan Supervisor. The appeal must clearly state that it is an appeal, and clearly state the reason for appeal. It is also recommended that you supply any additional information to support your appeal reason. The Plan supervisor will make a decision **within 72 hours** to include both the First and Second level appeals. This decision will be delivered to you verbally and in writing setting forth specific references to the pertinent Plan provision rule, protocol or guidelines upon which the decision is based. You will also be given a description of any additional information needed to overturn the decision.

Subsequent Action: Upon exhaustion of the full member appeals process, you may have a right to pursue voluntary appeals procedures, and for most group coverage, may bring action under section 502(a) of ERISA.

AUDIT AND CASE MANAGEMENT FEES

Reasonable charges made by an audit and/or case management firm when the services are requested by the Plan Supervisor and approved by the Plan Administrator shall be payable.

MEDICARE

Medicare - As used in this section shall mean Title XVIII (Health Insurance for the Aged) of the United States Social Security Act, as added to by the Social Security Amendments of 1965, the Tax Equity and Fiscal Responsibility Act of 1982, or as later amended.

Person - As used in this section means a person who is eligible for benefits as an employee in an eligible class of this Plan and who is or could be covered by Medicare Parts A and B, whether or not actually enrolled.

Eligible Expenses - As used in this section with respect to services, supplies and treatment shall mean the same benefits, limits and exclusions as defined in this Plan Document. However, if the provider accepts Medicare assignment as payment in full, then Eligible Expenses shall mean the lesser of the total amount of charges allowable by Medicare, whether enrolled or not, and the total eligible expenses allowable under this Plan exclusive of coinsurance and deductible.

Order of Benefits Determination - As used in this section shall mean the order in which Medicare benefits are paid, in relation to the benefits of this Plan.

Total benefits of this Plan shall be determined as follows:

Active Employees - For active employees and/or non-working spouses of active employees age 65 or over: This Plan will be primary and Medicare will be secondary.

Disabled Employees with Medicare (Except those with End-Stage Renal Disease) - For persons eligible for Medicare by reason of Disability the order of determination will be as shown below:

> ***If employed by a company with 100 or more employees:*** This Plan will be primary and Medicare will be secondary. The Employer will remain the primary payor of medical benefits until the earliest of the following events occurs: (1) the group coverage ends for all employees; (2) the group coverage as an active individual ends.
>
> ***If employed by a company with less than 100 employees:*** This Plan will be secondary and Medicare will be primary.

The Omnibus Budget Reconciliation Act of 1986 defines a large group health plan as one that covers employees of at least one employer that normally employed at least 100 employees on a typical business day during the previous calendar year. A typical business day is defined as 50 percent or more of the employer's regular business days during the previous calendar year.

Disabled Employees with End-Stage Renal Disease (ESRD)

This Plan shall be primary for ESRD Medicare beneficiaries during the initial 30 months of Medicare coverage, in addition to the usual three month waiting period, or a maximum of 33 months. ESRD Medicare Entitlement usually begins on the fourth month of renal dialysis, but can start as early as the first month of dialysis for individuals who take a course in self-dialysis training during the three month waiting period.

DENTAL BENEFITS

QUESTIONS REGARDING YOUR PROGRAM

If you have questions regarding your dental benefits program, you may call:

Washington Dental Service Customer Service
(206) 522-2300
(800) 554-1907

Written inquiries may be sent to:

Washington Dental Service
Customer Service Department
P.O. Box 75983
Seattle, WA 98175-0983

You can also reach us through Internet e-mail at ***info@DeltaDentalWA.com*****.**

For the most current listing of Washington Dental Service participating dentists, visit our online directory at **www.DeltaDentalWA.com**

COMMUNICATION ACCESS FOR INDIVIDUALS WHO ARE DEAF, HARD OF HEARING, DEAF-BLIND AND SPEECH-DISABLED

Communications with WDS for people who are deaf, hard of hearing, deaf-blind and/or speech disabled is available through Washington Relay Service. This is a free telecommunications relay service provided by the Washington State Office of the Deaf and Hard of Hearing.

The relay service allows individuals who use a Teletypewriter (TTY) to communicate with WDS through specially trained communications assistants.

Anyone wishing to use Washington Relay Service can simply dial 711 (the statewide telephone relay number) *or* 1-800-833-6384 to connect with a communications assistant. Ask the communications assistant to dial WDS Customer Service at 1-800-554-1907. The communications assistant will then relay the conversation between you and the WDS customer service representative.

This service is free of charge in local calling areas. Calls can be made anywhere in the world, 24 hours a day, 365 days a year, with no restrictions on the number, length or type of calls. All calls are confidential, and no records of any conversation are maintained.

MYSMILE® PERSONAL BENEFITS CENTER

Washington Dental Service is proud to present MySmile® personal benefits center: a unique online tool that provides personalized strategies to improve the oral health of employees and their families. Here are examples of what it can do for you:

- MySmile gives personalized tips for improving oral health and lowering out-of-pocket costs
- Aids in tax preparation and financial planning
- Provides clear guidance for effectively using flexible spending accounts (FSAs)

Learn more about MySmile by visiting our website at www.DeltaDentalWA.com/MySmile

SCHEDULE OF DENTAL BENEFITS

Reimbursement Levels for Allowable Benefits for Delta Dental PPO Dentists

*Class I ..... Constant 100%
**Class II..... Constant 90%
**Class III..... Constant 50%

Reimbursement Levels for Allowable Benefits for Non-Participating PPO Dentists

*Class I ..... Constant 100%
**Class II..... Constant 80%
**Class III..... Constant 50%

Plan Deductibles and Maximum

*Annual Deductible per Person $50
*Annual Deductible - Family Maximum $150
Annual Program Maximum per Person $1,500
*/**Annual Orthodontic Benefits per Person..... 40% to $500
**Annual TMJ Maximum ..... 50% to $300

All covered employees and covered dependents are eligible for Class I, Class II, Class III Covered Dental Benefits, Orthodontic Benefits and Temporomandibular Joint (TMJ) Benefits.

*Annual deductible is waived for Class I Covered Dental Benefits and Orthodontic Benefits.

**There is a 12 month waiting period on Class II, Class III, Ortho and TMJ covered benefits for employees and dependents that do not enroll within 31 days of becoming eligible.

Welcome to the Delta Dental PPO Plan, Washington Dental Service's preferred provider organization (PPO) plan. Washington Dental Service, the state's largest and most experienced dental benefits carrier, is a member of the nationwide Delta Dental Plans Association. With a Delta Dental plan from Washington Dental Service, you join approximately 2 million people who have discovered the value of our coverage.

HOW TO USE YOUR PROGRAM

The best way to take full advantage of your dental plan is to understand its features. You can do this most easily by reading this benefits booklet *before* you go to the dentist. The booklet is designed to give you a clear understanding of how your dental coverage works and how to make it work for you. It also answers some common questions and defines a few technical terms. If this booklet doesn't answer all of your questions, or if you don't understand something, call a Washington Dental Service customer service representative at (206) 522-2300 or (800) 554-1907. **Please be sure to consult your provider regarding any charges that may be your responsibility before treatment begins.**

CHOOSING A DENTIST

With Washington Dental Service, you may select any licensed dentist. Tell your dentist that you are covered by a Washington Dental Service dental plan and give him or her, your Social Security number, the program name and the group number — which is ***00427***.

DELTA DENTAL PARTICIPATING DENTISTS

If you select a dentist who is a Washington Dental Service participating dentist, that dentist has agreed to provide treatment for eligible persons covered by Washington Dental Service programs according to the provisions of his or her participating dentist contract. You won't have to hassle with sending in claim forms. Delta Dental participating dentists complete claim forms and submit them directly to Washington Dental Service. They receive payment directly from Washington Dental Service. You will not be charged for more than the approved fee or the fee that the Delta Dental participating dentist has filed with us. You may, however, be responsible for copayments (see Copayment), deductibles, any amount over the plan maximum and for any elective care you choose to receive outside the covered benefits.

Delta Dental PPO Dentists must be Delta Dental participating dentists in order to participate in the Delta Dental PPO network. Delta Dental PPO dentists receive payment based on their Delta Dental PPO filed fees at the percentage levels listed on your plan for Delta Dental PPO dentists. Patients are responsible for percentage copayments up to the Delta Dental PPO filed fees. Delta Dental PPO is a point-of-service plan, meaning that you can choose any dentist — in or out of the Delta Dental PPO network — at the time you need treatment. However, if you select a dentist who is a Delta Dental PPO dentist, your benefits will be paid at a higher level and your out-of-pocket expenses may be lower.

Delta Dental Participating Dentists (Non-PPO) are members of Delta Dental Premier, Washington Dental Service's traditional fee-for-service plan, but they are not part of the Delta Dental PPO network. Payments to Delta Dental participating (non-PPO) dentists are based on their Delta Dental filed fees at the percentage levels listed under the group's benefits for non-PPO dentists.

NONPARTICIPATING DENTISTS IN WASHINGTON STATE

If you select a dentist who is not a Washington Dental Service participating dentist, you are responsible for having your dentist complete and sign a claim form. We accept any American Dental Association-approved claim form that your dentist may provide. You can also download claim forms from our Web site at www.DeltaDentalWA.com. It is up to you to ensure that the claim is sent to Washington Dental Service. *Since Washington Dental Service does not have fees on file for nonparticipating dentists, the payment for services performed by a nonparticipating dentist is based upon actual charges or Washington Dental Service's allowable fees for nonparticipating dentists, whichever is less.* You are responsible for payment of any amounts over the allowable fees for nonparticipating dentist services.

OUT-OF-STATE DENTISTS

If you receive treatment from a dentist outside Washington state, you are responsible for having the dentist complete and sign a claim form. It is up to you to pay the dentist's bill and submit the claim to Washington Dental Service. Payment will be based upon actual charges or Washington Dental Service's maximum allowable fees for participating dentists, whichever is less.

CLAIM FORMS

American Dental Association-approved claim forms may be obtained from your dentist, or you may also download claim forms from our website at www.DeltaDentalWA.com. Washington Dental Service is not obligated to pay for treatment performed in the event that a claim form is submitted for payment more than 12 months after the date the treatment is provided.

PREDETERMINATION OF BENEFITS

If your dental care will be extensive, you may ask your dentist to complete and submit a request for an estimate, called a "predetermination of benefits." This will allow you to know in advance what procedures are covered, the amount Washington Dental Service will pay toward the treatment and your financial responsibility.

BENEFIT PERIOD

Most dental benefits are calculated within a "benefit period," which is typically for one year. For this program, the benefit period is the period from January 1 through December 31.

REIMBURSEMENT LEVELS

Your dental plan offers three classes of covered treatment. Each class also specifies limitations and exclusions (see the explanation of these terms elsewhere in this section). For a summary of reimbursement levels for your plan, see the Summary of Benefits section in the front of this booklet.

LIMITATIONS AND EXCLUSIONS

Dental plans typically include limitations and exclusions, meaning that the plans don't cover every aspect of dental care. This can affect the type of procedures performed or the number of visits. These limitations are detailed in this booklet under the sections called "Benefits Covered by Your Program" and "General Exclusions." They warrant careful reading.

COPAYMENTS

A copayment policy is typical of most benefit plans. This means the carrier (Washington Dental Service) will pay a predetermined percentage of the cost of your treatment, and you are responsible for paying the balance. What you pay is called the copayment. It is paid even after a deductible is reached.

PROGRAM MAXIMUM

The program maximum is the maximum dollar amount a dental plan will pay toward the cost of dental care within a specific benefit period. You are personally responsible for paying costs above the annual maximum.

For your program, the maximum amount payable by Washington Dental Service for Class I, II and III covered dental benefits per eligible person is $1,500 each benefit period. Charges for dental procedures requiring multiple treatment dates are considered incurred on the date the services are completed. Amounts paid for such procedures will be applied to the program maximum based on the incurred date.

The annual maximum amount payable by WDS for Orthodontic Benefits is $500 per eligible person.

The annual maximum amount payable by Washington Dental Service for TMJ benefits is $300 per eligible person.

PROGRAM DEDUCTIBLE

Most dental plans have a specific dollar deductible. It works like your car insurance deductible. During a benefit period, you may have to personally pay a portion of your dental bill before your carrier — Washington Dental Service — will contribute to your bill.

Your program has a $50 deductible per eligible person each benefit period. This means that from the first payment or payments made for covered dental benefits, a deduction of $50 is made. Once each eligible person has satisfied the deductible during the period, no further deduction will apply to that eligible person until the next period. The maximum deductible per family each benefit period is $150. This means that the maximum amount that will be deducted for a family, regardless of the number of eligible persons, will be $150. Once a family has satisfied the maximum deductible amount during the period, no further deduction will apply to that family until the next succeeding period. The deductible does not apply to Class I covered dental benefits or Orthodontic Benefits.

DENTAL BENEFITS COVERED BY YOUR PROGRAM

The following are Class I, Class II and Class III covered dental benefits under this program that are subject to the limitations and exclusions contained in this booklet. Such benefits ***(as defined)*** are available only when rendered by a licensed dentist or other WDS-approved licensed professional when appropriate and necessary as determined by the standards of generally accepted dental practice and Washington Dental Service.

The amounts payable by Washington Dental Service for Class I, II and III covered dental benefits are described under Reimbursement Levels in this booklet.

CLASS I

DIAGNOSTIC

Covered Dental Benefits

- Routine examination (periodic oral evaluation).
- Comprehensive oral evaluation.
- X-Rays.
- Emergency examination.
- Specialist examination performed by a specialist in an American Dental Association recognized specialty.
- WDS-approved caries and periodontal susceptibility/risk tests.

Limitations

- Routine examination is covered twice in a benefit period.
- Comprehensive oral evaluation is covered once in a 3-year period as one of the two covered examinations in a benefit period per eligible person per dental office. Additional comprehensive oral evaluations will be allowed as routine examinations. You will not be responsible for any difference in cost when services are provided by a participating dentist.
- Complete series (any number or combination of intraoral and/or extraoral x-rays, billed for same date of service, that equals or exceeds the allowed fee for a complete series is considered a complete series for payment purposes) or panorex x-rays are covered once in a 5-year period.
- Supplementary bitewing x-rays are covered once in a benefit period.
- Diagnostic services and x-rays related to temporomandibular joints (jaw joints) are not a covered benefit. (See TMJ section)

Exclusions

- Consultations or elective second opinions.
- Study models.

PREVENTIVE

Covered Dental Benefits

- Prophylaxis (cleaning).
- Periodontal maintenance.
- Fissure sealants.
- Topical application of fluoride or preventive therapies (e.g. fluoridated varnishes).

- Prescription strength fluoride toothpaste.

- Antimicrobial mouth rinse dispensed in a dental office.

Limitations

- Prophylaxis and/or periodontal maintenance procedures will be limited to 2 procedures in a benefit period.

- Under certain conditions of oral health, prophylaxis or periodontal maintenance (*but not both*) *may be* covered up to a total of 4 times in a benefit period. *Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.*

- Topical application of fluoride or preventive therapies (*but not both*) is covered twice in a benefit period.

- Payment for application of sealants will be for permanent maxillary (upper) or mandibular (lower) molars with incipient or no caries (decay) on an intact occlusal surface. The application of fissure sealants is a covered benefit only once in a 2-year period per tooth.

- Replacement of a space maintainer previously paid for by WDS is not a covered benefit.

Exclusions

- Plaque control program (oral hygiene instruction, dietary instruction and home fluoride kits).

- Cleaning of a prosthetic appliance.

PERIODONTICS

Covered Dental Benefits

- Prescription strength fluoride toothpaste.

- Antimicrobial mounth rinse dispensed in a dental office.

Limitations

- Prescription strength fluoride toothpaste and antimicrobial mouth rinse is a covered benefit following periodontal surgery or other covered periodontal procedures when dispensed in a dental office.

- Proof of a periodontal procedure must accompany the claim or the patient's WDS history must show a periodontal procedure within the 180 days.

- Antimicrobial mouth rinse is covered once per periodontal treatment.

- Antimicrobial mouth rinse is available for women during pregnancy without any periodontal procedure.

REFER ALSO TO GENERAL DENTAL EXCLUSIONS

CLASS II

There is a 12-month waiting period for employees and dependents that do not enroll within 31 days of becoming eligible.

The subscriber should consult the provider regarding any charges that may be the patient's responsibility before treatment begins.

GENERAL ANESTHESIA

Covered Dental Benefits

- General anesthesia when administered by a licensed Dentist or other WDS-approved Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are rendered.

Limitations

- General anesthesia is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS, or when medically necessary, for children through age 6, or a physically or developmentally disabled person, when in conjunction with Class I, II, III, Orthodontic and TMJ covered dental procedures. Either general anesthesia or intravenous sedation (*but not both*) is covered when performed on the same day.

- General anesthesia for routine post-operative procedures is not a covered benefit.

INTRAVENOUS SEDATION

Covered Dental Benefits

- Intravenous sedation when administered by a licensed Dentist or other WDS-approved Licensed Professional who meets the educational, credentialing and privileging guidelines established by the Dental Quality Assurance Commission of the state of Washington or as determined by the state in which the services are rendered.

Limitations

- Intravenous sedation is covered in conjunction with certain covered endodontic, periodontic and oral surgery procedures, as determined by WDS. Either general anesthesia or intravenous sedation (*but not both*) is covered when performed on the same day.

- Intravenous sedation for routine post-operative procedures is not a covered benefit.

RESTORATIVE

Covered Dental Benefits

- Amalgam restorations and, in anterior teeth, resin-based composite or glass ionomer restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp).

- Resin-based composite or glass ionomer restorations placed in the buccal (facial) surface of bicuspids.

- Stainless steel crowns.

Limitations

- Restorations on the same surface(s) of the same tooth are covered once in a 2-year period.

- If a resin-based composite or glass ionomer restoration is placed in a posterior tooth (except on bicuspids as noted above), it will be considered as a cosmetic procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.

- Restorations necessary to correct vertical dimension or to alter the morphology (shape) or occlusion are not a covered benefit.

- Stainless steel crowns are covered once in a 2-year period.

- **Refer to Class III Limitations if teeth are restored with crowns, veneers, inlays or onlays.**

Exclusions

- Overhang removal, copings, re-contouring or polishing of restoration.

ORAL SURGERY

Covered Dental Benefits

- Removal of teeth.

- Preparation of the mouth for insertion of dentures.

- Treatment of pathological conditions and traumatic injuries of the mouth.

- **Refer to Class II General Anesthesia or Intravenous Sedation for additional information.**

Exclusions

- Bone grafts, of any kind, to the upper or lower jaws not associated with periodontal treatment of natural teeth.

- Tooth transplants.

- Materials placed in tooth extraction sockets for the purpose of generating osseous filling.

PERIODONTICS

Covered Dental Benefits

- Surgical and nonsurgical procedures for treatment of the tissues supporting the teeth. Services covered include periodontal scaling/root planing and periodontal surgery.

- Limited adjustments to occlusion (8 teeth or less).

- WDS-approved localized delivery of antimicrobial agents.

- **Refer to Class I Covered Dental Benefits and Limitations for periodontal maintenance benefits.**

- **Refer to Class III Periodontics for benefits and limitations on complete occlusal equilibration and occlusal guard (nightguard)**.

Limitations

- Periodontal scaling/root planing is covered once in a 3-year period.

- Periodontal surgery (per site) is covered once in a 3-year period.

- Soft tissue grafts (per site) are covered once in a 3-year period.

- Limited occlusal adjustments are covered once in a 12-month period.

- Localized delivery of antimicrobial agents approved by WDS are a covered benefit under certain conditions of oral health. Localized delivery of antimicrobial agents is limited to 2 teeth per quadrant and up to 2 times (per tooth) in a benefit period. *Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.*

- Periodontal surgery and localized delivery of antimicrobial agents must be preceded by scaling and root planing a minimum of 6 weeks and a maximum of 6 months, or the patient must have been in active supportive periodontal therapy, prior to such treatment.

- Localized delivery of antimicrobial agents is not a covered benefit when used for the purpose of maintaining non-covered dental procedures or implants.

- Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are not a covered benefit.

Exclusions

- Periodontal splinting.

- Gingival curettage.

ENDODONTICS

Covered Dental Benefits

- Procedures for pulpal and root canal treatment.
- Services covered include pulp exposure treatment, pulpotomy and apicoectomy.

Limitations

- Root canal treatment on the same tooth is covered only once in a 2-year period.
- Re-treatment of the same tooth is allowed when performed by a different dental office.
- **Refer to Class III Limitations if the root canals are placed in conjunction with a prosthetic appliance.**

Exclusions

- Bleaching of teeth.

PROSTHODONTICS

Covered Dental Benefits

- Bridge and denture repair and modifications to existing partial dentures to accommodate the addition of teeth.

REFER ALSO TO GENERAL DENTAL EXCLUSIONS

CLASS III

There is a 12-month waiting period for employees and dependents that do not enroll within 31 days of becoming eligible.

The subscriber should consult the provider regarding any charges that may be the patient's responsibility before treatment begins.

PERIODONTICS

Covered Dental Benefits

- Under certain conditions of oral health, services covered are occlusal guard (nightguard), repair and relines of occlusal guard (nightguard) and complete occlusal equilibration. *Please note: These benefits are available only under certain conditions of oral health. It is strongly recommended that you have your dentist submit a predetermination of benefits to determine if the treatment will be covered.*

Limitations

- Occlusal guard (nightguard) is covered once in a 3-year period.

- Repair and relines done more than 6 months after the initial placement are covered.

- Complete occlusal equilibration is covered once in a lifetime.

RESTORATIVE

Covered Dental Benefits

- Crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays (whether they are gold, porcelain, WDS-approved gold substitute castings [except laboratory processed resin] or combinations thereof) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay) or fracture resulting in significant loss of tooth structure (missing cusp), when teeth cannot reasonably be restored with filling materials such as amalgam or resin-based composites.

- Crown buildups, subject to limitations.

- Cast post and core, subject to limitation.

Limitations

- Crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays on the same teeth are covered once in a 7-year period.

- Inlays (as a single tooth restoration) will be considered as a cosmetic procedure and an amalgam allowance will be made, with any difference in cost being the responsibility of the patient.

- If a tooth can be restored with a filling material such as amalgam or resin-based composites, an allowance will be made for such a procedure toward the cost of any other type of restoration that may be provided.

- WDS will allow the appropriate amount for an amalgam restoration (posterior tooth) or resin-based composite restoration (anterior tooth) toward the cost of a laboratory processed resin inlay (as a single tooth restoration – with limitations), onlay, veneer or crown.

- Payment for crowns, veneers, inlays (as a single tooth restoration – with limitations) or onlays shall be paid upon the seat date.

- Crown buildups are a covered benefit when more than 50% of the natural coronal tooth structure is missing or there is less than 2mm of vertical height remaining for 180 degrees or more of the tooth circumference and there is evidence of decay or other significant pathology.

- Crown buildups are covered once in a 7-year period.

- Crown buildups are not a covered benefit within 2 years of a restoration on the same tooth.

- Crown buildups for the purpose of improving tooth form, filling in undercuts or reducing bulk in castings are considered basing materials and are not a covered benefit.

- A crown used for purposes of re-contouring or repositioning a tooth to provide additional retention for a removable partial denture is not a covered benefit unless the tooth is decayed to the extent that a crown would be required to restore the tooth whether or not a removable partial denture is part of the treatment.

- Crowns or onlays are not a covered benefit when used to repair micro-fractures of tooth structure when the tooth is asymptomatic (displays no symptoms) or there are existing restorations with defective margins when there is no decay or other significant pathology present.

- Crowns and/or onlays placed because of weakened cusps or existing large restorations without overt pathology are not a covered benefit.

- Crown and bridgework in conjunction with periodontal splinting or other periodontal therapy and periodontal appliances are not a covered benefit.

- Cast post and core are covered once in a 7-year period on the same tooth in keeping with the policy for all cast restorations.

Exclusions

- Copings.

PROSTHODONTICS

Covered Dental Benefits

- Dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge), removable partial dentures and the adjustment or repair of an existing prosthetic device.

- Surgical placement or removal of implants or attachments to implants.

Limitations

- Replacement of an existing prosthetic device is covered only once every 5 years and only then if it is unserviceable and cannot be made serviceable.

- Inlays are a covered benefit on the same teeth once in a 5-year period only when used as an abutment for a fixed bridge.

- Payment for dentures, fixed partial dentures (fixed bridges), inlays (only when used as an abutment for a fixed bridge) and removable partial dentures shall be paid upon the delivery date.

- Replacement of implants and superstructures is covered only after 5 years have elapsed from any prior provision of the implant.

- Implants are covered only to the extent that the cost does not exceed the amount for comparable fixed bridgework to fill the gap.

- Crowns in conjunction with overdentures are not a covered benefit.

- Full, immediate and overdentures - WDS will allow the appropriate amount for a full, immediate or overdenture toward the cost of any other procedure that may be provided, such as personalized restorations or specialized treatment.

- Temporary/interim dentures - WDS will allow the amount of a reline toward the cost of an interim partial or full denture. After placement of the permanent prosthesis, an initial reline will be a benefit after 6 months.

- Root canal treatment performed in conjunction with overdentures is limited to 2 teeth per arch and is paid at the Class III payment level.

- Partial dentures - If a more elaborate or precision device is used to restore the case, WDS will allow the cost of a cast chrome and acrylic partial denture toward the cost of any other procedure that may be provided.

- Denture adjustments and relines - Denture adjustments and relines done more than 6 months after the initial placement are covered. Subsequent relines or rebases (*but not both*) will be covered once in a 12-month period.

Exclusions

- Duplicate dentures.

- Personalized dentures.

- Cleaning of prosthetic appliances.

- Copings.

REFER ALSO TO GENERAL DENTAL EXCLUSIONS

ORTHODONTIC BENEFITS FOR ADULTS AND ELIGIBLE CHILDREN

There is a 12-month waiting period for employees and dependents that do not enroll within 31 days of becoming eligible.

It is strongly suggested that an orthodontic treatment plan be submitted to, and a predetermination be made by, WDS prior to commencement of treatment. A predetermination is not a guarantee of payment. Additionally, payment for orthodontic benefits is based upon your eligibility. If you become ineligible prior to the secondary payment of benefits, the secondary payment is not covered.

Orthodontic treatment is defined as the necessary procedures of treatment, performed by a licensed dentist, involving surgical or appliance therapy for movement of teeth and post-treatment retention.

The annual maximum amount payable by WDS for Orthodontic Benefits rendered to an eligible person shall be $500. The entire annual maximum is available to pay for either the initial placement of appliances (lump sum) or the adjustment phase (monthly payments), or a combination of the two, as necessary. When payments cease because the annual maximum has been reached, the patient will be responsible to coordinate with their provider to resume payments when the next benefit period begins.

WDS will pay a constant 40% of the lesser of the Maximum Allowable Fees or the fees actually charged for Orthodontic Benefits.

Covered Dental Benefits

- Treatment of malalignment of teeth and/or jaws.

- Orthodontic records: Exams (initial, periodic, comprehensive, detailed and extensive), X-rays (intraoral, extraoral, diagnostic radiographs, panoramic), diagnostic photographs, diagnostic casts (study models) or cephalometric films.

Limitations - Payment is limited to:

- Completion, or through limiting age (refer to **Dependent Eligibility And Termination.**), whichever occurs first.

- Termination of the treatment plan prior to completion of the case.

- Termination of this program.

Exclusions

- Charges for replacement or repair of an appliance.

- No benefits shall be provided for services considered inappropriate and unnecessary, as determined by WDS.

TEMPOROMANDIBULAR JOINT BENEFITS

There is a 12 month waiting period for employees and dependents that do not enroll within 31 days of becoming eligible.

For the purpose of this program, Temporomandibular Joint (TMJ) treatment is defined as dental services provided by a licensed dentist for the treatment of disorders associated with the temporomandibular joint. TMJ disorders shall include those disorders which have one or more of the following characteristics: Pain in the musculature associated with the temporomandibular joint, internal derangements of the temporomandibular joint, arthritic problems with the temporomandibular joint, or an abnormal range of motion or limitation of motion of the temporomandibular joint.

"Dental Services" are those which are:

1) Appropriate, as determined by WDS, for the treatment of a disorder of the temporomandibular joint under all the factual circumstances of the case;

2) Effective for the control or elimination of one or more of the following, caused by a disorder of the temporomandibular joint: Pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food;

3) Recognized as effective, according to the professional standards of good dental practice; and

4) Not experimental or primarily for cosmetic purposes.

Services covered will be non-surgical procedures only and shall include but are not limited to:

> TMJ examination, X-rays (including TMJ film and arthrogram), temporary repositioning splint, occlusal orthotic device, removable metal overlay stabilizing appliance, fixed stabilizing appliance, occlusal equilibration, arthrocentesis, and manipulation under anesthesia.

The annual maximum amount payable by WDS for dental services related to the treatment of TMJ disorders shall be $300 per covered individual, after the application of deductibles and copayments. The amounts payable for TMJ benefits during the year shall not be applied to the eligible person's annual maximum for Class I, Class II, and Class III Covered Dental Benefits or Orthodontic Benefits.

Notwithstanding the payment levels set forth in this booklet, the amount payable by WDS for TMJ benefits shall be 50% of the lesser of the Maximum Allowable Fees or the fees actually charged.

It is strongly suggested that a TMJ treatment plan be submitted to, and a predetermination be made by, WDS prior to commencement of treatment. A predetermination is not a guarantee of payment.

In addition to the limitations and exclusions set forth in this booklet, the following also apply to TMJ benefits:

> Any procedures which are defined as TMJ services as stated above, but which may otherwise be services covered under the provisions of this program, shall be considered defined under the program and subject to all the terms and provisions thereof, and are not covered under this TMJ portion of the program.

GENERAL DENTAL LIMITATIONS

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1. Dentistry for cosmetic reasons is not a covered benefit.

2. Restorations or appliances necessary to correct vertical dimension or to restore the occlusion. Such procedures include restoration of tooth structure lost from attrition, abrasion or erosion and restorations for malalignment of teeth are not a covered benefit.

3. General anesthesia/intravenous (deep) sedation is not a covered benefit, except as specified by WDS for certain oral, periodontal, or endodontic surgical procedures. General anesthesia is not a covered benefit except when medically necessary, for children through age 6, or a physically or developmentally disabled person, when in conjunction with covered dental procedures.

GENERAL EXCLUSIONS TO THE DENTAL PLAN

1. Services for injuries or conditions that are compensable under Worker's Compensation or Employers' Liability laws, and services that are provided to the eligible person by any federal or state or provincial government agency or provided without cost to the eligible person by any municipality, county, or other political subdivision, other than medical assistance in this state, under medical assistance RCW 74.09.500, or any other state, under 42 U.S.C., Section 1396a, section 1902 of the Social Security Act.

2. Application of desensitizing agents.

3. Experimental services or supplies. Experimental services or supplies are those whose use and acceptance as a course of dental treatment for a specific condition is still under investigation/observation. In determining whether services are experimental, Washington Dental Service, in conjunction with the American Dental Association, will consider if: (1) the services are in general use in the dental community in the state of Washington; (2) the services are under continued scientific testing and research; (3) the services show a demonstrable benefit for a particular dental condition; and (4) they are proven to be safe and effective. Any individual whose claim is denied due to this experimental exclusion clause will be notified of the denial within 20 working days of receipt of a fully documented request.

   Any denial of benefits by Washington Dental Service on the grounds that a given procedure is deemed experimental, may be appealed to Washington Dental Service. By law, Washington Dental Service must respond to such appeal within 20 working days after receipt of all documentation reasonably required to make a decision. The 20-day period may be extended only with written consent of the covered individual.

4. Analgesics such as nitrous oxide, conscious sedation, euphoric drugs, injections or prescription drugs.

5. In the event an eligible person fails to obtain a required examination from a WDS-appointed consultant dentist for certain treatments, no benefits shall be provided for such treatment.

6. Hospitalization charges and any additional fees charged by the dentist for hospital treatment.

7. Broken appointments.

8. Patient management problems.

9. Completing claim forms.

10. Habit breaking appliances.

11. This program does not provide benefits for services or supplies to the extent that benefits are payable for them under any motor vehicle medical, motor vehicle no-fault, uninsured motorist, underinsured motorist, personal injury protection (PIP), commercial liability, homeowner's policy, or other similar type of coverage.

12. All other services not specifically included in this program as covered dental benefits.

Important Information – Please Read

FREQUENTLY ASKED QUESTIONS ABOUT YOUR DENTAL BENEFITS

What is a Washington Dental Service "participating dentist"?

A Washington Dental Service participating dentist is a dentist who has signed an agreement with Washington Dental Service stipulating that he or she will provide dental treatment to subscribers covered by Washington Dental Service's group dental care programs. WDS participating dentists submit claims directly to Washington Dental Service for their patients.

Can I choose my own dentist?

See "Choosing A Dentist" under the "How To Use Your Program" section in the front of this booklet.

How can I obtain a list of Washington Dental Service participating dentists?

You can obtain a Washington Dental Service Directory of Dentists from your employer or by going to our Internet Web site at **www.DeltaDentalWA.com** and selecting the "Find a Dentist" option.

How can I get claim forms?

You can obtain American Dental Association-approved claim forms from your dentist. You can also download claim forms from our web site at www.DeltaDentalWA.com.

What is the mailing address for Washington Dental Service claim forms?

If you see a Washington Dental Service participating dentist, the dental office will submit your claims for you. If your dentist is a nonparticipating dentist, you may send your claims to Washington Dental Service at P.O. Box 75983, Seattle, WA 98175-0983.

Whom do I call if I have questions about my dental plan benefits?

If you have questions about your dental benefits, call Washington Dental Service's customer service department at (206) 522-2300 or call toll-free at (800) 554-1907.

Why does Washington Dental Service pay less for tooth-colored fillings on my back teeth?

Tooth-colored fillings, or fillings made of resin-based composite are considered to be cosmetic. Dental amalgams, or what we normally think of as silver fillings, are less expensive and clinically equivalent to resin-based composite. Because of this, your plan reimburses your dentist for the least costly clinically equivalent fillings in back (posterior) teeth. If you have questions about this, feel free to discuss them with your dentist.

Do I have to get an "estimate" before having dental treatment done?

If your dental care will be extensive, you may ask your dentist to complete and submit a request for an estimate, called a "predetermination of benefits." This service is very helpful because it will allow you to know in advance what procedures are covered, the amount Washington Dental Service will pay toward the treatment and your financial responsibility.

I am divorced. If my former spouse and I both have dental coverage, whose plan covers the children first?

It usually depends on who has financial responsibility for the children. If the parents have joint custody, then the parent with the birthday earliest in the calendar year has primary coverage. If the custodial parent does not have financial responsibility, the parent who does has primary coverage. For more information, see the *Coordination of Benefits* section in this book.

My former spouse and I are divorced. What kind of documentation do I need to provide to Washington Dental Service to maintain the children's dental coverage?

A parenting plan or statement of financial responsibility is required to verify which parent has primary coverage and which has secondary coverage for children in a divorce situation.

What is Delta Dental?

Delta Dental Plans Association is a national organization made up of local, nonprofit Delta Dental plans that provide employer groups with dental benefits coverage. Washington Dental Service is a member of the Delta Dental Plans Association.

GENERAL DENTAL DEFINITIONS

Alveolar — Pertaining to the ridge, crest or process of bone that projects from the upper and lower jaw and supports the roots of the teeth.

Amalgam — A mostly silver filling often used to restore decayed teeth.

Appeal — An oral or written communication by a subscriber requesting the reconsideration of the resolution of a previously submitted complaint or, in the case of claim determination, the determination to deny, modify, reduce, or terminate payment, coverage, authorization, or provision of health care services or benefits.

Bitewing X-ray — An x-ray picture that shows, simultaneously, the portions of the upper and lower back teeth that extend above the gumline, as well as a portion of the roots and supporting structures of these teeth.

Bridge — A replacement for a missing tooth or teeth. The bridge consists of the artificial tooth (pontic) and attachments to the adjoining abutment teeth (retainers). Bridges are cemented (fixed) in place and therefore are not removable.

Caries — Decay. A disease process initiated by bacterially produced acids on the tooth surface.

Caries Susceptibility Test — A test done to determine how likely someone is to develop tooth decay. The test is usually done by measuring the concentration of certain bacteria in the mouth.

Complaint — An oral or written report by a subscriber or authorized representative regarding dissatisfaction with customer service or the availability of a health service.

Comprehensive Oral Evaluation – Typically used by a general dentist and/or a specialist when evaluating a patient comprehensively. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues.

Coping - A thin thimble of a crown with no anatomic features. It is placed on teeth prior to the placement of either an overdenture or a large span bridge. The purpose of a coping is to allow the removal and modification of the bridge without requiring a major remake of the bridge work if the tooth is lost.

Covered Dental Benefit - Those dental services which are covered under this program, subject to the limitations set forth in Dental Benefits Covered By Your Program.

Crown — A restoration that replaces the entire surface of the visible portion of tooth.

Delivery Date — the date a prosthetic appliance is permanently cemented into place.

Denture — A removable prosthesis that replaces missing teeth. A complete (or "full") denture replaces all of the upper or lower teeth. A partial denture replaces one to several missing upper or lower teeth.

Endodontics — The diagnosis and treatment of dental diseases, including root canal treatment, affecting dental nerves and blood vessels.

Exclusions — Dental services which are not a contract benefit set forth in Dental Benefits Covered By Your Program and all other services not specifically included as a Covered Dental Benefit set forth in Dental Benefits Covered By Your Program.

Filed Fees — Approved fees that Washington Dental Service participating dentists have agreed to accept as the total fees for the specific services performed.

Fluoride — A chemical agent used to strengthen teeth to prevent cavities.

Fluoride Varnish — A fluoride treatment contained in a varnish base that is applied to the teeth to reduce acid damage from the bacteria that causes tooth decay. It remains on the teeth longer than regular fluoride and is typically more effective than other fluoride delivery systems.

General Anesthesia — A drug or gas that produces unconsciousness and insensibility to pain.

Implant — A device specifically designed to be placed surgically within the jawbone as a means of providing an anchor for an artificial tooth or denture.

Inlay — A dental filling shaped to the form of a cavity and then inserted and secured with cement.

Intravenous (I.V.) Sedation — A form of sedation where the patient experiences a lowered level of consciousness but is still awake and can respond.

Licensed Professional – means an individual legally authorized to perform services as defined in their license. Licensed Professional includes, but is not limited to, denturist, hygienist and radiology technician.

Limitations — Restricting conditions, such as age, period of time covered and waiting periods, under which a group or individual is insured. Dental services which are subject to restricting conditions set forth in Dental Benefits Covered By Your Program.

Localized delivery of antimicrobial agents — Treating isolated areas of advanced gum disease by placing antibiotics or other germ-killing drugs into the gum pocket. This therapy is viewed as an alternative to gum surgery when conditions are favorable.

Maximum Allowable Fees — The maximum dollar amount that will be allowed toward the reimbursement for any service provided for a covered dental benefit.

Nightguard — See Occlusal Guard.

Not A Covered Benefit — Refers to any dental service covered in "Dental Benefits Covered By Your Program" that has been subjected to a limitation(s).

Occlusal Adjustment — Modification of the occluding surfaces of opposing teeth to develop harmonious relationships between the teeth themselves and neuromuscular mechanism, the temporomandibular joints and the structure supporting the teeth.

Occlusal Guard — A removable dental appliance — sometimes called a nightguard — that is designed to minimize the effects of gnashing or grinding of the teeth (bruxism). An occlusal guard (nightguard) is typically used at night.

Onlay — A restoration of the contact surface of the tooth that covers the entire surface.

Orthodontics — Diagnosis, prevention and treatment of irregularities in tooth and jaw alignment and function, frequently involving braces.

Overdenture — A removable denture constructed over existing natural teeth or implanted studs.

Panorex X-ray — An x-ray, taken from outside the mouth, that shows the upper and lower teeth and the associated structures in a single picture.

Periodic Oral Evaluation (routine examination) - An evaluation performed on a patient of record to determine any changes in the patient's dental and medical health status following a previous comprehensive or periodic evaluation.

Periodontics — The diagnosis, prevention and treatment of diseases of gums and the bone that supports teeth.

Prophylaxis — Cleaning and polishing of teeth.

Prosthodontics — The replacement of missing teeth by artificial means such as bridges and dentures.

Qualified Medical Child Support Order (QMCSO) - means an order issued by a court under which an employee must provide medical coverage for a dependent child. QMCSOs are often issued, for example, following a divorce or legal separation.

Resin-based composite — A tooth colored filling, made of a combination of materials, used to restore teeth.

Restorative — Replacing portions of lost or diseased tooth structure with a filling or crown to restore proper dental function.

Root Planing — A procedure done to smooth roughened root surfaces.

Sealants — A material applied to teeth to seal surface irregularities and prevent tooth decay.

Seat Date — The date a crown, veneer, inlay or onlay is permanently cemented into place on the tooth.

Temporomandibular Joints — The joint just ahead of the ear, upon which the lower jaw swings open and shut, and can also slide forward.

Veneer — A layer of tooth-colored material, usually porcelain or acrylic resin, attached to the surface by direct fusion, cementation, or mechanical retention.

CLAIM REVIEW AND APPEAL

Predetermination of Benefits

A predetermination is a request made by your dentist to WDS to determine your benefits for a particular service. This predetermination will provide you and your dentist with general coverage information regarding your benefits and your potential out-of-pocket cost for services. Please be aware that the predetermination is not a guarantee of payment but strictly an estimate for services. Payment for services is determined when the claim is submitted. (Please refer to the Initial Benefits Determination section regarding claims requirements.)

A standard predetermination is processed within **15 days** from the date of receipt if all appropriate information is completed. If it is incomplete, WDS may request additional information, request an extension of **15 days** and pend the predetermination until all of the information is received. Once all of the information is received a determination will be made within **15 days** of receipt. If no information is received at the end of **45 days**, the predetermination will be denied.

Urgent Predetermination Requests

Should a predetermination request be of an urgent nature, where a delay in the standard process may seriously jeopardize life, health, the ability to regain maximum function, or could cause severe pain in the opinion of a physician or dentist who has knowledge of the medical condition, WDS will review the request within **72 hours** from receipt of the request and all supporting documentation. When practical, WDS may provide notice of determination orally with written or electronic confirmation to follow within **72 hours**. Immediate treatment is allowed without a requirement to obtain a predetermination in an emergency situation subject to the contract provisions.

Initial Benefit Determinations

An initial benefit determination is conducted at the time of claim submission to WDS for payment, modification, or denial of services. In accordance with regulatory requirements, WDS processes all clean claims within **30 days** from the date of receipt. Clean claims are claims that have no defect or impropriety, including a lack of any required substantiating documentation, or particular circumstances requiring special treatment that prevents timely payments from being made on the claim. Claims no meeting this definition are paid or denied within **60 days** of receipt.

If a claim is denied, in whole or in part, or is modified, you will be furnished with written explanation of benefits (EOB) that will include the following information:

- The specific reason for the denial or modification.
- Reference to the specific plan provision on which the determination was based.
- Your appeal rights should you wish to dispute the original determination.

Appeals of Denied Claims

Informal Review

If your claim for dental benefits has been denied, either in whole or in part, you have the right to request an informal review of the decision. Either you, or your Authorized Representative, must submit your request for a review within **180 days** from the date your claim was denied (please see your Explanation of Benefits form). A request for a review may be made orally or in writing, and must include the following information:

- Your name and ID number
- The group name and number
- The claim number (from your Explanation of Benefits form)
- The name of the dentist

Please submit your request for a review to:

Washington Dental Service
Attn: Appeals Coordinator
P.O. Box 75983
Seattle, WA 98175-0983

For oral appeals, please refer to the phone numbers listed on the inside front cover of your benefit booklet.

You may include any written comments, documents or other information that you believe supports your claim.

WDS will review your claim and make a determination within **30 days** of receiving your request and send you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision.

Informal reviews of wholly or partially denied claims are conducted by persons not involved in the initial claim determination. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, WDS will consult with a dental professional advisor.

Appeals Committee

If you are dissatisfied with the outcome of the informal review, you may request that your claim be reviewed formally by the WDS Appeals Committee. This committee includes only persons who were not involved in either the original claim decision or the informal review.

Your request for a review by the Appeals Committee must be made within **90 days** of the post-marked date of the letter notifying you of the informal review decision. Your request should include the information noted above plus a copy of the informal review decision letter. You may also submit any other documentation or information you believe supports your case.

The Appeals Committee will review your claim and make a determination within **30 days** of receiving your request or within **20 days** for Experimental/Investigational procedure appeals and send you a written notification of the review decision. Upon request, you will be granted access to and copies of all relevant information used in making the review decision. In the event the review decision is based in whole or in part on a dental clinical judgment as to whether a particular treatment, drug or other service is experimental or investigational in nature, WDS will consult with a dental professional advisor.

The decision of the Appeals Committee is final. If you disagree with the outcome of your appeal and you have exhausted the appeals process provided by your group plan, there may be other avenues available for further action. If so, these will be provided to you in the final decision letter.

Authorized Representative

You may authorize another person to represent you and to whom WDS can communicate regarding specific appeals. The authorization must be in writing and signed by you. If an appeal is submitted by another party without this authorization a request will be made to obtain a completed Authorized Representative form. The appeal process will not commence until this form is received. Should the form not be returned or any document confirming the right of the individual to act on your behalf (i.e., power of attorney), the appeal will be closed.

DISCLOSURE INFORMATION

In accordance with section 4 of ESSB 6392, Chapter 312, Laws of 1996, the Managed Care Entities Disclosure Act, WDS is pleased to provide important information about our various dental care plans. The goal of this law is to provide individuals who are making health care decisions for themselves and their families with as much information as possible to make the best decisions. Washington Dental Service fully supports this principle and supplies most of the required information in enrollee benefit booklets, which are supplied to each enrollee at the start of their coverage.

The items of information which you may request Washington Dental Service to provide you are:

1a) The availability of a point of service plan and how the plan operates within the coverage.

1b) Documents, instruments or other information referred to in the enrollment agreement.

1c) Procedures to be followed for consulting a provider other than the primary care provider (applies primarily to capitation plans).

1d) Existence of plan list or formulary for prescription drugs, for plans with that specific benefit.

1e) Procedures that must be followed for obtaining prior authorization for health care services.

1f) Reimbursement or payment arrangements, between a carrier and a provider.

1g) Circumstances under which a plan may retrospectively deny coverage for care that had prior authorization.

1h) Copy of all grievance procedures for claim or service denial and for dissatisfaction with care.

1i) Description and justification for provider compensation programs, including any incentive or penalties that are intended to encourage providers to withhold services or minimize or avoid referrals to specialists.

2) Enrollees of Washington Dental Service dental care plans may, at any time, freely contract to obtain other forms of dental care or health care services outside Washington Dental Service plan coverage for any reason they choose, however, the enrollee must pay for all such services.

In order to obtain this information, you must call 1-800-554-1907. A Washington Dental Service employee will take your name and send you the information you requested. If you are an enrollee of a dental care plan with Washington Dental Service, we may also refer you to your benefit booklet for additional information about your plan that may be useful. You can also write Washington Dental Service and request the above information at P.O. Box 75983, Seattle, WA 98175-0983.

Washington Dental Service, a member of the nationwide Delta Dental Plans Association, has been working to improve the oral health of our subscribers and our community since 1954. Today, as part of the nation's largest dental benefits provider, we serve approximately 2 million people through our Delta Dental plans.

We specialize exclusively in dental benefits, which allows us to offer the most knowledgeable customer service and to partner with our large participating dentist networks to offer you the widest choice of dentists. We are an innovative company that is a national leader in supporting dental research so that we can include the latest effective dental treatments in our plans. Healthy teeth for a wonderful smile – that is what we are all about!

To learn more about Washington Dental Service and your benefits, visit our Internet Web site at **www.DeltaDentalWA.com**.

MEDICAL & DENTAL GENERAL PROVISIONS

ADMINISTRATION OF THE GROUP PLAN

The Plan is administered through the Plan Administrator. The Plan Administrator has retained the services of independent Plan Supervisors experienced in claims processing. The Plan Administrator has the right to determine eligibility for benefits and to construe the terms of the plan. Benefits under this Plan will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them. The Plan Administrator has made the Plan Supervisors its representatives to carry out its decisions.

Legal notices may be filed with, and legal process served upon the Plan Administrator.

AMENDMENT OF PLAN DOCUMENT

The Plan Administrator may terminate, modify or amend the Plan in its sole discretion without prior notice. The Plan Administrator must notify the Plan Supervisor in writing requesting an amendment to the Plan. The Plan Supervisor will prepare an amendment to be signed by the Plan Administrator. Once the Plan Administrator has signed the amendment, such termination, amendment or modification, which affects covered employees and their dependents, will be communicated to the employees in the manner of a new Plan document or employer communication. The amended Plan Benefits shall be the basis for determining all Plan payments for all expenses incurred on or after the effective date of such amendment. Plan payments made under the Plan prior to amendment shall continue to be included as Plan payments in determining the total benefits remaining toward satisfaction of any benefit maximums calculated on either a Plan year, calendar year, or lifetime basis.

APPLICABLE LAW

It is the intent of the parties to this Plan that the provisions herein shall be subject to and interpreted by the Employee Retirement Income Security Act as amended (ERISA) and not the insurance laws of the individual states. This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations.

APPLICATION AND IDENTIFICATION CARD

Upon completion of the probationary period, to obtain coverage an eligible employee must complete and deliver to the Plan Administrator, an application on the enrollment form supplied by the Plan Supervisors. Acceptance of this application will be evidenced by the delivery of Medical and Dental identification cards.

ASSIGNMENT OF PAYMENT

The Plan will pay any benefits accruing under this Plan to the employee unless the employee shall assign benefits to the provider(s) of service. No assignment, however, shall be binding on the Plan unless the Plan Supervisor is notified in writing of such assignment prior to payment.

CANCELLATION

An employee may cancel their coverage by giving written notice to the Plan Administrator who will notify the Plan Supervisor. Check with the Plan Administrator as to limitations on when coverage may be cancelled.
No person shall acquire a vested right to receive benefits after the date this plan is terminated.

In the event of the cancellation of this Plan, all employees' and dependents' coverage shall cease automatically without notice. Employees and dependents shall not be entitled to further coverage or benefits, whether or not any medical condition was covered by the Plan prior to termination or cancellation.

The Plan may be cancelled or terminated at any time without advance notice by YVMH.

Upon cancellation or termination of this Plan, all claims incurred prior to termination, but not submitted to the Plan Supervisor within 75 days of the effective date of termination of this Plan, will be excluded from any benefit consideration.

CONDITIONS PRECEDENT TO THE PAYMENT OF BENEFITS

The employee or dependent shall present the appropriate Plan identification card to the provider of service upon admission to a medical facility or upon receiving service from a provider.

Written proof of the nature and extent of service performed by a physician or other provider of service shall be furnished to the Plan Supervisor within one year after the service was rendered. Claim forms are available through the Plan Supervisor and Plan Administrator, and are required along with an itemized billing with a diagnosis, the employee's name and Social Security or Identification number and the name of the Plan Administrator.

The employee and all dependents agree that in order to receive benefits, any physician, nurse, medical facility or other provider of service, having rendered service or being in possession of information or records relating thereof, is authorized and directed to furnish the Plan Supervisor, at any time, upon request, any and all such information and records, or copies thereof.

The Plan Supervisor shall have the right to review these records with the Plan's Insurance Company and with any medical consultant or with the UR Coordinator as needed to determine the medical necessity of the treatment being rendered.

COORDINATION OF BENEFITS

Definitions

The term "allowable expense" shall mean the usual, customary and reasonable (UCR) expense, at least a portion of which is paid under at least one of any multiple plans covering the participant for whom the claim is made. In no event will more than 100% of total allowable expenses be paid between all plans, nor will total payment by this Plan exceed the amount which this Plan would have paid as primary Plan.

Coordination of Benefits does not apply to outpatient prescription drug card programs.

The term "order of benefits determination" shall mean the method for ascertaining the order in which the Plan renders payment. The principle applies when another plan has a Coordination of Benefits provision.

Application

Under the order of benefits determination method, the plan that is obligated to pay its benefits first is known as the primary Plan. The plan that is obligated to pay additional benefits for allowable expenses not paid by the primary Plan is known as the secondary Plan. When a participant is enrolled under two or more plans (policies), an order of benefits determination will be made regarding which plan will pay first. The order of benefit determination is as follows:

1. The plan which does not include a Coordination of Benefits provision will be primary.

2. The plan covering the person as the employee (or insured, member, subscriber, or retiree) of the policy will be primary.

3. This Plan will pay secondary to any individual policy.

4. If this Plan is covering the participant as a COBRA participant or a participant of continuation coverage pursuant to state law, this plan is secondary to the participant's other plan.

5. When a dependent child is covered under more than one plan, the following rules apply. Unless there is a court decree stating otherwise, plans covering a dependent child shall determine the order of benefits as follows:

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

      (i) The plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or

      (ii) If both parents have the same birthday, the plan that has covered the parent longest is the primary plan.

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

      (i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This item shall not apply with respect to any claim determination period or plan year during which benefits are paid or provided before the entity has actual knowledge of the court decree provision;

      (ii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits;

(iii) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of Subparagraph (a) of this paragraph shall determine the order of benefits; or

(iv) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the order of benefits for the child are as follows:

I. The plan covering the custodial parent;

II. The plan covering the custodial parent's spouse;

III. The plan covering the non-custodial parent; and then

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

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as applicable, under Subparagraph (a) or (b) of this paragraph as if those individuals were parents of the child.

6. Where the order of payment cannot be determined in accordance with (1), (2), (3), (4), or (5) above, the primary Plan shall be deemed to be the plan which has covered the patient for the longer period of time.

7. Where the order of payment cannot be determined in accordance with (1), (2), (3), (4), (5), or (6) above, the primary Plan shall be deemed to be the plan which has covered the employee for the longest time.

Coordination of benefits with Medicare is governed by the Medicare Secondary Payer rules.

CREDIT FOR PRIOR GROUP COVERAGE

This Plan amends and replaces the prior Plan. Employees and dependents that were covered under the prior Plan sponsored by YVMH immediately prior to the time this Plan became effective shall not lose their eligibility or benefits due to the change in Plans. If a participant is disabled on the date a Plan change is to take effect that increases the benefit, the disabled participant will remain at the old benefit level until they are no longer disabled. All charges incurred on or after the effective date of this Plan will be subject to the benefits available under this Plan and not the prior Plan. Credit will be given for time enrolled under the prior Plan in meeting the pre-existing waiting periods and for payments toward coinsurance and deductibles.

EFFECT OF TERMINATION OF THE PLAN

Upon complete or partial termination of the Plan, the Plan Administrator may, after the payment or provision for payment of all benefits to each employee who has incurred covered expenses and charges properly payable, including all expenses incurred and to be incurred in the liquidation and distribution of the Trust Fund or separate account, direct the disposition of all assets held in the Trust Fund or separate account to YVMH, subject to any applicable requirement of an accompanying Trust Document or applicable law or regulation.

FACILITY OF PAYMENT

If, in the opinion of the Plan Supervisors, a valid release cannot be rendered for the payment of any benefit payable under this Plan, the Plan Supervisors may, at its option, make such payment to the individuals as have, in the Plan Supervisors' opinion, assumed the care and principal support of the covered person and are therefore equitably entitled thereto. In the event of the death of the covered person prior to such time as all benefit payments due him/her have been made, the Plan Supervisors may, at its sole discretion and option, honor benefit assignments, if any, prior to the death of such covered person.

Any payment made by the Plan Supervisors in accordance with the above provisions shall fully discharge the Plan and the Plan Supervisors to the extent of such payment.

FIDUCIARY OPERATION

Each fiduciary shall discharge their duties with respect to the Plan solely in the interest of the employees and beneficiaries and: (1) for the exclusive purposes of providing benefits to employees and their beneficiaries and defraying reasonable expenses of administering the Plan, (2) with care, skill, prudence and diligence under the circumstances then prevailing that a prudent person, acting in a like capacity and familiar with such matters, would use in the conduct of an enterprise of a like character and with like aims, and (3) in accordance with the documents and instruments governing the Plan to the extent that they are consistent with the provisions of the Employee Retirement Income Security Act of 1974 (ERISA).

FREE CHOICE OF PHYSICIAN OR DENTAL PROVIDER

The employee and dependents shall have free choice of any licensed physician, surgeon or dental provider, and the provider-patient relationship shall be maintained. Please refer to the Schedule of Benefits for the appropriate coinsurance reimbursement level.

Nothing contained herein shall confer upon an employee or dependent any claim, right, or cause of action, either at law or in equity, against the Plan for the acts of any medical facility in which he/she receives care, for the acts of any physician from whom he/she receives service under this Plan, or for the acts of the Utilization Review Coordinator in performing their duties under this Plan.

FUNDING

If contributions are required of employees or dependents covered under this Plan, the Plan Administrator will maintain a Trust, or otherwise account for the receipt of money and property to fund the Plan, for the management and investment of such funds and for the payment of claims and expenses from such funds. The terms of the Trust (when applicable) are hereby incorporated by reference, as of the effective date of the Trust, as a part of this Plan.

YVMH shall hold in Trust such amounts of money and property as shall be necessary to provide the Trust with sufficient funds to pay all claims and reasonable expenses of administering the Plan as the same shall be due and payable. The Plan Administrator may provide for all or any part of such funding by insurance issued by a company duly qualified to issue insurance for such purpose in the state of

All funds received by the Trust and all earnings of the Trust shall be applied toward the payment of claims and reasonable expenses of administration of the Plan except to the extent otherwise provided by the Plan Documents. The Plan Administrator may appoint an investment manager(s) to manage (including the power to acquire and dispose of) any assets of the Plan.

Any fiduciary, employee, agent, representative or other individual performing services to or for the Plan or Trust shall be entitled to reasonable compensation for services rendered, unless such individual is the Plan Administrator, and for reimbursement of expenses properly and actually incurred.

HIPAA PRIVACY

Employer (Plan Sponsor) Obligations Regarding Electronic Protecting Health Information

Effective April 21, 2006, the Employer (Plan Sponsor) will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.

- Ensure that the adequate separation between the Plan and Plan Sponsor with respect to electronic PHI is supported by reasonable and appropriate security measures.

- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI.

- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Use and Disclosure of Protected Health Information

Under the HIPAA privacy rules effective **April 14, 2003/2004,** the Plan Sponsor must establish the permitted and required uses of Protected Health Information (PHI).

Plan Sponsor's Certification of Compliance

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Enrollees' Protected Health Information to the Employer (Plan Sponsor) unless the Employer (Plan Sponsor) certifies its compliance with 45 Code of Federal Regulations §164.504(f)(2) (collectively referred to as The Privacy Rule) as set forth in this Article, and agrees to abide by such amendments.

Restrictions on Disclosure of Protected Health Information to Employer (Plan Sponsor)

The Plan and any health insurance issuer or business associate servicing the Plan will disclose Plan Enrollees' Protected Health Information to the Employer (Plan Sponsor) only to permit the Employer (Plan Sponsor) to carry out plan administration functions for the Plan consistent with the requirements of the Privacy Rule. Any disclosure to and use by the Employer (Plan Sponsor) of Plan Enrollees' Protected Health Information will be subject to and consistent with the provisions of paragraphs 3 and 4 of this Article.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Enrollees' Protected Health Information to the Employer (Plan Sponsor) unless the disclosures are explained in the Notice of Privacy Practices distributed to the Plan Enrollees.

Neither the Plan nor any health insurance issuer or business associate servicing the Plan will disclose Plan Enrollees' Protected Health Information to the Employer (Plan Sponsor) for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (Plan Sponsor).

Employer (Plan Sponsor) Obligations Regarding Protecting Health Information

The Employer (Plan Sponsor) will:

- Neither use nor further disclose Plan Enrollees' Protected Health Information, except as permitted by the Plan Documents as amended, or permitted or required by law.

- Ensure that any agent, including any subcontractor, to whom it provides Plan Enrollees' Protected Health Information, agrees to the restrictions and conditions of the Plan Documents, including this Article, with respect to Plan Enrollees' Protected Health Information.

- Not use or disclose Plan Enrollees' Protected Health Information for employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer (Plan Sponsor.)

- Report to the Plan any use or disclosure of the Plan Enrollees' Protected Health Information that is inconsistent with the uses and disclosures allowed under this Article promptly upon learning of such inconsistent use or disclosure.

- Make Protected Health Information available to the Plan Enrollee who is the subject of the information in accordance with 45 Code of Federal Regulations § 164.524.

- Make Plan Enrollees' Protected Health Information available for amendment, and will on notice amend Plan Enrollees' Protected Health Information, in accordance with 45 Code of Federal Regulations § 164.526.

- Track disclosures it may make of Plan Enrollees' Protected Health Information so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with 45 Code of Federal Regulations § 164.528.

- Make available its internal practices, books, and records, relating to its use and disclosure of Plan Enrollees' Protected Health Information, to the Plan and to the U.S. Department of Health and Human Services to determine compliance with 45 Code of Federal Regulations Parts 160-64.

- If feasible, return or destroy all Plan Enrollee Protected Health Information, in whatever form or medium (including in any electronic medium under the Employer's (Plan Sponsor's) custody or control), received from the Plan, including all copies of and any data or compilations derived from and allowing identification of any Enrollee who is the subject of the Protected Health Information, when the Plan Enrollee's Protected Health Information is no longer needed for the plan administration functions for which the disclosure was made. If it is not feasible to return or destroy all Plan Enrollee Protected Health Information, the Employer (plan Sponsor) will limit the use or disclosure of any Plan Enrollee Protected Health Information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

Employer (Plan Sponsor) Obligations Regarding Electronic Protecting Health Information

Effective April 21, 2005, the Employer (Plan Sponsor) will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.

- Ensure that the adequate separation between the Plan and Plan Sponsor with respect to electronic PHI is supported by reasonable and appropriate security measures.

- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI.

- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Adequate Separation Between the Employer (Plan Sponsor) and the Plan

The following classes of employees or other workforce members under the control of the Employer (Plan Sponsor) may be given access to Plan Enrollees' Protected Health Information received from the Plan or a health insurance issuer or business associate servicing the Plan:

- **Human Resources Director**

- **Human Resources Representative**

The list includes every class of employees or other workforce members under the control of the Employer (Plan Sponsor) who may receive Plan Enrollees' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business. The identified classes of employees or other workforce members will have access to Plan Enrollees' Protected Health Information only to perform the plan administration functions that the Employer (Plan Sponsor) provides for the Plan.

The identified classes of employees or other workforce members will be subject to disciplinary action and sanctions, including termination of employment or affiliation with the Employer (Plan Sponsor), for any use or disclosure of Plan Enrollees' Protected Health Information in breach or violation of or noncompliance with the provisions of this Article to the Plan Documents. Employer (Plan Sponsor) will promptly report such breach, violation or noncompliance to the Plan, and will cooperate with the Plan to correct the breach, violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee or other workforce member causing the breach, violation or noncompliance, and to mitigate any deleterious effect of the breach, violation or noncompliance on any Enrollee, the privacy of whose Protected Health Information may have been compromised by the breach, violation or noncompliance.

INADVERTENT ERROR

Inadvertent error by the Plan Administrator in the keeping of records or in the transmission of employees' applications shall not deprive any employee or dependent of benefits otherwise due, provided that such inadvertent error be corrected by the Plan Administrator within ninety (90) days after it was made. The Plan Supervisor shall only be liable to YVMH and to the employees of YVMH for its actions or failure to act with regard to processing and payment of claims as provided in the Plan Agreement at the level expected of a professional claim administrator; or for its gross negligence or willful misconduct. YVMH shall hold the Plan Supervisor harmless from and indemnify it against any claims and all costs and expense or fees incurred in connection therewith, which might be asserted by the Plan, YVMH's employees or other persons which are beyond the Plan Supervisor's control or beyond the scope of this Agreement.

INTERNATIONAL COVERAGE

This Plan will cover charges for medically or dentally necessary expenses incurred outside the United States, subject to all plan provisions and limitations. Claims must be submitted in English and U.S. Dollars. It is the participant's responsibility to have claims translated if necessary. Expenses for translation are not covered by the Plan.

MISREPRESENTATION

Any material misrepresentation on the part of the Plan Administrator or the employee in making application for coverage, or any application for reclassification thereof, or for service thereunder shall render the coverage null and void.

NOTICE

Any notice given under this Plan shall be sufficient, if given to the Plan Administrator when addressed to it at its office; if given to the Plan Supervisor, when addressed to it at its office; or if given to an employee, when addressed to the employee at his/her address as it appears on the records of the Plan Supervisor on the employee's enrollment form and any corrections made to it.

PHOTOCOPIES

Reasonable charges made by a provider for photocopies of medical or dental records when the copies are requested by the Plan Supervisor shall be payable.

PLAN ADMINISTRATION

The Plan Administrator shall be responsible for compliance by the Plan with all requirements of Part 1, Subtitle B of Title 1 of the Employee Retirement Income Security Act of 1974 (ERISA).

PLAN IS NOT A CONTRACT OF EMPLOYMENT

The Plan shall not be deemed to constitute a contract of employment between the Plan Administrator and any employee or to be a consideration for, or an inducement to or condition of the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Plan Administrator or to interfere with the right of the Plan Administrator to discharge any employee at any time; provided however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the Plan Administrator with the bargaining representative of any employees.

PLAN SUPERVISORS ARE NOT FIDUCIARIES

The Plan Supervisors are not fiduciaries with respect to this engagement and shall not exercise any discretionary authority or control over the management or administration of the Plan, or the management or disposition of the Plan's Assets. The Plan Supervisors shall limit their activities to carrying out ministerial acts of notifying Plan Participants and making benefit payments as required by the Plan. Any matters for which discretion is required shall be referred by Plan Supervisors to the Plan Administrator, and Plan Supervisors shall take direction from Plan Administrator in all such matters. The Plan Supervisors shall not be responsible for advising the Company or Plan Administrator with respect to their fiduciary responsibilities under the Plan nor for making any recommendations with respect to the investment of Plan Assets. The Plan Supervisors may rely on all information provided to it by the Company, Plan Administrator, and the Trustees, as well as the Plan's other vendors. The Plan Supervisors shall not be responsible for determining the existence of Plan Assets.

PRIVILEGES AS TO DEPENDENTS

The employee shall have the privilege of adding or withdrawing the name or names of any dependent(s) to or from this coverage, as permitted by the Plan, by submitting to the Plan Administrator an application for reclassification on the enrollment form furnished by the Plan Supervisor. Each dependent added to the coverage shall be subject to all conditions and limitations contained in this Plan.

RIGHT OF RECOVERY

Whenever payments have been made (or benefits have been quoted) by the Plan Supervisor in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Plan, the Plan Supervisor shall have the right to recover such payment (or avoid making such payment), to the extent of such excess, from among one or more of the following as the Plan Supervisor shall determine: any individuals to or for, or with respect to whom such payments were made, and/or any insurance companies and other organizations.

SPOUSE

For the purposes of determining coverage under this Group Health Plan, spouse refers only to a person of the opposite gender who is the employee's husband or wife, not including a common-law marriage.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT – THE PLAN'S RIGHT TO RESTITUTION

The Plan does not provide benefits for any accident, Injury or sickness for which you or your eligible Dependents have, or may have, any claim for damages or entitlement to recover from another party or parties arising from the acts or omissions of such third party (for example, an auto accident). In the event that another party fails or refuses to make prompt payment for the medical expenses incurred by you or your eligible Dependents which expenses arise from an accident, Injury or sickness, subject to the terms of the Plan, the Plan may conditionally advance the payment of the eligible medical benefits.

Benefits Conditional Upon Cooperation

The Plan's payment of eligible benefits is conditional upon:

- The cooperation of you and eligible Dependents, or your respective agent(s) (including your attorneys) or guardian (of a minor or incapacitated individual) working on your behalf to recover damages from another party. You may be asked to complete, sign, and return a questionnaire and possibly a restitution agreement.

If you or your eligible Dependents, or your agent(s) or guardian (of a minor or incapacitated individual) refuse to sign and return a restitution agreement, or to cooperate with the Plan and/or its assignee, such refusal and non-cooperation may be grounds to deny payment of any medical benefits.

By participating in the Plan, you and your eligible Dependents acknowledge and agree to the terms of the Plan's equitable or other rights to full restitution. You will take no action to prejudice the Plan's rights to restitution. You and your eligible Dependents agree that you are required to cooperate in providing and obtaining all applicable documents requested by the Plan Administrator or the Company, including the signing of any documents or agreements necessary for the Plan to obtain full restitution.

You and your eligible Dependents are also required to:

- Notify the Plan Supervisor at 800/700-7153 as soon as possible, that the Plan may have a right to obtain restitution of any and all benefits paid by the Plan. You will later be contacted by HMA, and you must provide the information requested. If you retain legal counsel, your counsel must also contact HMA;

- Inform HMA in advance of any settlement proposals advanced or agreed to by another party or another party's insurer;

- Provide the Plan Administrator all information requested by the Plan Administrator regarding an action against another party, including an insurance carrier; this includes responding to letters from the Plan Supervisor (and other parties designated by Plan Administrator acting on behalf of the Plan) on a timely basis;

- Not settle, without the prior written consent of the Plan Administrator, or its designee, any claim that you or your eligible Dependents may have against another party, including an insurance carrier; and

- Take all other action as may be necessary to protect the interests of the Plan.

In the event you or your eligible Dependents do not comply with the requirements of this section, the Plan may deny benefits to you or your eligible Dependents or take such other action as the Plan Administrator deems appropriate.

Right of Full Restitution

If you or your eligible Dependents are eligible to receive benefits from the Plan for injuries caused by another party or as a result of any accident or personal Injury, or if you or your eligible Dependents receive an overpayment of benefits from the Plan, the Plan has the right to obtain full restitution of the benefits paid by the Plan from:

- Any full or partial payment which an insurance carrier makes (or is obligated or liable to make) to you or your eligible Dependents; and

- You or your eligible Dependents, if any full or partial payments are made to you or your eligible Dependents by any party, including an insurance carrier, in connection with, but not limited to, your or another party's:

  - Uninsured motorist coverage;

  - Under-insured motorist coverage;

  - Other medical coverage;

  - No fault coverage;

  - Workers' compensation coverage;

  - Personal injury coverage;

  - Homeowner's coverage; or

  - Any other insurance coverage available.

This means that, with respect to benefits which the Plan pays in connection with an Injury or accident, the Plan has the right to full restitution from any payment, settlement or recovery received by you or your eligible Dependents from any other party, regardless of whether the payment, recovery or settlement terms state that there is a separate allocation of an amount for the restitution of medical expenses or the types of expenses covered by the Plan or the benefits provided under the Plan.

Payment Recovery to be Held in Trust

You, your eligible Dependents, your agents (including your attorneys) and/or the legal guardian of a minor or incapacitated person agree by request for and acceptance of the Plan's payment of eligible medical benefits, to maintain 100% of the Plan's payment of benefits or the full extent of any payment from any one or combination of any of the sources listed above in trust and without dissipation except for reimbursement to the Plan or its assignee.

Any payment or settlement from another party received by you or your eligible Dependents must be used first to provide restitution to the Plan to the full extent of the benefits paid by or payable under the Plan. The balance of any payment by another party must, first, be applied to reduce the amount of benefits which are paid by the Plan for benefits after the payment and, second, be retained by you or your eligible Dependents. You and your eligible Dependents are responsible for all expenses incurred to obtain payment from any other parties, including attorneys' fees and costs or other lien holders, which amounts will not reduce the amount due to the Plan as restitution.

The Plan is entitled to obtain restitution of any amounts owed to it either from funds received by you or your eligible Dependents from other parties, regardless of whether you or your eligible Dependents have been fully indemnified for losses sustained at the hands of the other party. A Plan representative may commence or intervene in any proceeding or take any other necessary action to protect or exercise the Plan's equitable (or other) right to obtain full restitution.

SUMMARY PLAN DESCRIPTION

This document is the Summary Plan Description.

SPECIAL DISCLOSURE INFORMATION (ERISA)

STATEMENT OF ERISA RIGHTS

As a participant in the Yakima Valley Memorial Hospital Employee Health Care Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, 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 [*note: previously called the Pension and Welfare Benefits Administration*].

Obtain, on written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts, 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 may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for up to 12 months, (and up to 18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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 reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the plan, 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 if frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration [*note: previously called the Pension and Welfare Benefits 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 N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN SPECIFICATIONS

PLAN ADMINISTRATOR	Yakima Valley Memorial Hospital 2811 Tieton Drive Yakima, WA 98902 509/575-8085
EMPLOYER ID NUMBER	91-0567263
NAME OF PLAN	Yakima Valley Memorial Hospital Employee Health Care Plan
EMPLOYEES	Eligible Employees of Yakima Valley Memorial Hospital
EFFECTIVE DATE	1/1/1985
AMENDED EFFECTIVE DATE	1/1/2007
GROUP NUMBER	Medical: GM048 Dental: 00427
TYPE/PLAN NUMBER	Health Care Plan/501 (Medical and Dental)
CONTRIBUTION REQUIRED	Part Time Employee Coverage - Yes Full Time Employee Coverage - No Dependent Coverage - Yes
CONTRIBUTION AMOUNTS	See attached schedule.
PLAN SUPERVISOR	Medical: Healthcare Management Administrators, Inc. PO Box 85008 Bellevue, WA 98015-5008 425/462-1000 Seattle Area 800/700-7153 All Other Areas Dental: Washington Dental Service PO Box 75983 Seattle, WA 98175-0983 (206) 522-1300 Seattle Area (800) 564-8832 All Other Areas
CUSTOMER SERVICE	Medical: Healthcare Management Administrators, Inc. Larson Building 6 S. 2nd Street, Suite 210 Yakima, WA 98901 509/574-8462 Toll Free 877/581-9109 Dental: Washington Dental Service PO Box 75983 Seattle, WA 98175-0983 (206) 522-2300 Seattle Area (800) 554-1907 All Other Areas

PLAN ACCEPTANCE

Yakima Valley Memorial Hospital, of Yakima, Washington hereby establishes this Plan for the payment of certain expenses for the benefit of its eligible employees to be known as Yakima Valley Memorial Hospital Employee Health Care Plan.

Yakima Valley Memorial Hospital assures its covered employees that during the continuance of the Plan, all benefits herein described shall be paid to or on behalf of the employees in the event they become eligible for benefits.

The Plan is subject to all the terms, provisions and conditions stated on the preceding pages hereof (and any amendments hereafter).

This Plan is not in lieu of and does not affect any requirement for coverage by Worker's Compensation Insurance.

Yakima Valley Memorial Hospital has caused this Plan to take effect as of 12:01 A.M. on January 1, 2007 at Yakima, Washington.

Yakima Valley Memorial Hospital

_____
Authorized Signature

_____
Printed Name and Title

_____
Date

Amended Plan effective January 1, 2007

Local Medical Customer Service By:

HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
Larson Building
6 S. 2nd Street, Suite 210
Yakima, WA 98901

509/574-8462
Toll Free 877/581-9109

Medical Claim Administration By:

HEALTHCARE MANAGEMENT ADMINISTRATORS, INC.
PO Box 85008
Bellevue, WA 98015-5008

425/462-1000 Seattle Area
800/700-7153 All Other Areas

Dental Claim Administration & Customer Service By:

WASHINGTON DENTAL SERVICE
PO Box 75983
Seattle, WA 98175-0983

(206) 522-2300 Seattle Area
(800) 554-1907 All Other Areas

Plan Arranged By:

WELLS FARGO INSURANCE SERVICES NORTHWEST, INC.
1430 N. 16th Ave.
Lake Aspen Office Park
PO Box 2547
Yakima, WA 98907

509/248-7460
800/572-9170

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