Important notice
This guide includes all changes made to the Employee Benefits Guide since Jan. 1, 2012.
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This comprehensive guide will help you understand your benefits and how to use them. We strongly encourage you to read the entire document — it’s your best resource for any benefit question. Call the HR Answer Center at 503-415-5100 for other information you need.

This booklet is the Summary Plan Description (SPD) for the Medical Plan, Prescription Drug Plan, Dental Plan, Vision Plan and Flexible Spending Accounts. Refer to the relevant insurance contract, plan or policy for more details on the other benefits, as this booklet only summarizes those benefits. Although we have made every effort to ensure this guide is accurate, provisions of the official plan documents, contracts or policies will govern in case of any discrepancy.

Reminder
Review this guide and all Legacy employee benefits Summary of Material Modifications (SMMs) issued after the date of this guide for changes before scheduling appointments or making decisions.
Contact summary

**ActiveHealth Management**
Chronic conditions program: 866-939-4717
Lifestyle coaching and tobacco cessation: 866-939-4717

**Cascade Centers, Inc. (EAP)**
Nationwide: 800-433-2320, ext. 130
Portland: 503-639-3009
Salem: 503-588-0777
7180 S.W. Fir Loop, Suite 1-A
Portland, OR 97223-8077
www.cascadecenters.com

**The Hartford (life and accidental death and dismemberment)**
Group Life/Accidental Death & Dismemberment Claims Unit
P.O. Box 2999
Hartford, CT 06104-2999
HR Answer Center
503-415-5100
Fax: 503-415-5150
Hours of operation 7 a.m.–6 p.m., M–F

**Legacy’s Absence Management Program**
1919 N.W. Lovejoy St.
Portland, OR 97209-1503
Portland: 503-415-5100
Fax: 503-415-5909

**Legacy + Network (administered by UMR)**
866-868-7761
www.legacyhealthandwellness.org

**MedImpact Healthcare Systems, Inc. (prescription claims)**
Claims Department
10680 Treena St., Fifth Floor
San Diego, CA 92131-2433
800-788-2949
www.medimpact.com
customerservice@medimpact.com

**Moda Health (dental)**
601 S.W. Second Ave.
Portland, OR 97204-3113
Portland: 503-243-3886
Outside Portland: 888-281-0405
www.modahealth.com

**UMR (medical and vision)**
P.O. Box 30541
Salt Lake City, UT 84130-0541
Medical and vision claims: 866-868-7761
Case management and pre-certification for medical necessity: 866-494-4502
www.umr.com

**UMR (flexible spending accounts)**
P.O. Box 8022
Wausau, WI 54402-8022
866-868-7761
Fax: 877-390-4782
umr-fsa@umr.com
www.umr.com

**UMR (COBRA)**
P.O. Box 1206
Wausau, WI 54402-1206
800-207-1824
Fax: 877-291-3241
www.umr.com
This section explains benefit eligibility (for you and your dependents), benefit options and how to choose them, when you can make changes, how to continue coverage if you become ineligible, how to file or appeal a claim and other details of how the plans work.

Legacy partners with you to provide comprehensive, affordable benefits. Under these plans, you and your enrolled dependents have the right to:

• Receive a clear explanation regarding benefits and exclusions
• Be informed of your rights to appeal a denial of coverage and the process involved.

You and your enrolled dependents have the responsibility to:

• Read the most current Legacy Employee Benefits Guide to know if a service or supply is covered
• Review all Legacy employee benefit SMMs published after the date of this guide for changes
• Ensure your provider obtains pre-certification approval from UMR for care that requires it (otherwise those services or supplies are not covered)
• See the Legacy + Network provider list before scheduling health appointments
• Notify the Legacy Benefits Department and take the necessary actions to change your benefits due to qualified life events within 31 days
• Be honest in your plan participation; if you or your enrolled dependents engage in fraudulent conduct or intentionally misrepresent any material facts, coverage may be terminated (including back to the date the fraud occurred)
• Be considerate when interacting with plan representatives.

You and your enrolled dependents understand:

• Your Legacy plan may use or disclose your health information, in compliance with all applicable laws and regulations, with business and service associates to carry out plan operations. See the HIPAA privacy notice on page 100 for complete information.
Eligibility

For you
You are eligible to participate in Legacy benefits if you are a regular full- or part-time employee budgeted to work at least 24 hours each week (0.6 FTE or greater). Participation for union employees is determined by the bargaining contract and may be subject to change as a result of future negotiations.

You remain eligible to participate in Legacy benefits as long as you are a regular employee in an eligible status, including while on paid or unpaid leave of absence qualified under the federal Family and Medical Leave Act, or other leave for which Legacy policies explicitly provide for continued participation.

You are not eligible to participate in Legacy benefits if you are a:

• Part-time employee budgeted to work less than 24 hours each week (eligible to accrue Annual Paid Leave only)
• Temporary, on-call, supplemental, per diem employee
• Contracted employee
• Member in a union that does not provide coverage under these plans.

For you during a stability period
You are also eligible to participate in the Medical Plan only if you are in an active benefit-ineligible status and have qualified for continued coverage during the remainder of an active stability period. You must have averaged at least 30 eligible hours of service during your measurement period.

You will be sent continuation instructions and additional information about this coverage if you are eligible for this continued coverage. Your coverage will terminate if timely premium payments are not made to UMR. Stability period eligibility is determined using the look-back measurement method. The stability period for terminated employees expires 91 days after the date of termination.

This coverage runs concurrently with your COBRA coverage, if you qualify. See page 95 for additional COBRA eligibility information.

For your dependents
You may enroll eligible dependents in medical, dental, vision, life and accidental death and dismemberment coverage. Eligibility documentation (such as a marriage certificate or birth certificate) is required when you enroll in the medical, dental or vision plans. You must send copies of required dependent documentation to the Benefits Department within 31 days of becoming eligible.

Social Security numbers are required for all employees and dependents covered under medical benefits. If your dependent is not eligible for a Social Security number, you’ll need other documentation.

Eligible dependents include:

• Your legal spouse (same or opposite sex)
• Your domestic partner (see domestic partner eligibility, coverage and taxation details on page 80)
• Your biological children under age 26
• The children of your spouse or domestic partner under age 26
• Your child or stepchild who is at least age 26 and incapable of sustaining employment because of a developmental disability, mental illness or physical disability; the disability must have existed before his or her 26th birthday.

— Disability, under the medical plan, means inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that seriously limits his or her activities and can be expected to last for a continuous period of no less than 12 months.

— The attending physician must submit documentation of the disability — physician’s notes or Social Security Administration’s Notice of Award for Disability Insurance — to the Benefits Department for approval.

— You may be required to provide proof each year that the child remains disabled, unmarried and still incapable of self-support.
For purposes of the Legacy benefits program, “children” are defined as:

- Your biological child
- A legally adopted child or a child placed for adoption with you
- A stepchild or child of your domestic partner
- A child related to you by blood or marriage for whom you have been named by a court of competent jurisdiction as the legal guardian or custodian, provided all four of the following criteria are met:
  - The child lives in your household on a permanent basis.
  - The order must be for an indefinite period of time or until the child’s age of majority.
  - The child must qualify as your tax dependent.
  - The order must require you to provide health coverage.

Ineligible dependents include:

- The spouse, domestic partner or children of your dependents and other persons not listed above as being an eligible dependent

Duplicate coverage

If two or more immediate family members are benefit-eligible Legacy employees, the following rules apply:

- One of you may waive health coverage and be covered under your immediate family member’s Legacy medical, dental or vision benefits only.
- Child dependents may be insured by only one Legacy employee for dependent life and accidental death and dismemberment insurance.

Your coverage options

You may select from the following six levels of health (medical, dental and vision) coverage:

- Employee only
- Employee plus child(ren)
- Employee plus spouse/domestic partner
- Employee plus spouse/domestic partner with other coverage
- Employee plus family
- Employee plus family with other coverage.

You may choose the benefit options that best fit your needs; however, all benefit-eligible employees have at least the following basic coverage:

- Employee-only medical coverage — tobacco or non-tobacco user (unless waived with proof of other medical coverage)
- Employee basic life insurance (Legacy-paid life coverage)
- Short-term income supplement (Legacy-paid disability coverage)
- Long-term income supplement 50 percent (Legacy-paid disability coverage)

Additional premium for spouse/domestic partner eligible for other coverage

For a spouse/domestic partner with other employer coverage available (whether enrolled or not) who enrolls in Legacy medical, dental or vision benefits, you’ll pay an additional premium each pay period. If your covered spouse/domestic partner experiences a change in benefit eligibility during the year, you have 31 days from the event date to make changes. Contact the Benefits Department for details and to add/remove the additional premium.

The additional premium does not apply if your spouse/domestic partner is covered under TRICARE, Medicare or COBRA.

Tobacco use surcharge

If you or your spouse/domestic partner is covered under Legacy medical benefits and used a tobacco product in the past six months, you’ll pay a surcharge in addition to the medical premium.

If at any time throughout the year tobacco use status changes, it’s your responsibility to complete and submit an updated Tobacco Use Affidavit to the Benefits Department. The surcharge starts or stops as of the first paycheck of the month after the Benefits Department receives the affidavit.
You must re-certify tobacco use every year during Annual Enrollment. Otherwise, your status or your spouse/domestic partner’s status becomes tobacco user for the next plan year.

If you or your spouse/domestic partner used a tobacco product in the last six months, you can avoid the surcharge by either:

- Obtaining a written certification from your primary care provider that it is medically inadvisable to quit using tobacco.
  — Legacy has a right to seek a second opinion at Legacy’s cost.
  — If the second opinion conflicts with your provider’s opinion, Legacy may seek an opinion from a mutually agreed third provider as a tie-breaker at Legacy’s cost.
  — The written certification is good for one year (you must re-certify at least once each year).

Or:

- Obtaining a written certification from your primary care provider that indicates that you have a medical condition that makes it unreasonably difficult for you to quit using tobacco.
  — Legacy Health has a right to seek a second opinion at Legacy’s cost.
  — If the second opinion conflicts with your provider’s opinion, Legacy may pursue an opinion from a mutually-agreed-upon third provider as a tie-breaker at Legacy’s cost.
  — The written certification is good for one year and you must re-certify at least once each year.

- Providing documentation of active participation in a tobacco cessation program.
  — You can enroll in Legacy’s tobacco cessation program through ActiveHealth at no cost or any other tobacco cessation program at your cost.
  — Being in Legacy’s program longer than a year does not avoid the surcharge.
  — By enrolling in Legacy’s program, you’re allowing our Benefits Department to request program participation updates from ActiveHealth.
  — You must provide documentation on any other program, its length and your active participation.

**Enrolling and changing your coverage**

**New employees**

Legacy health (medical, dental, vision), life, accidental death and dismemberment and flexible spending account coverage is effective the first of the month following date of hire; if you’re hired on the first of the month, benefits are effective that day. Short-term income supplement and long-term income supplement disability coverage is effective the first of the month following six months in a benefit-eligible position.

New hires receive benefit enrollment instructions during New Employee Orientation and must use Legacy’s Employee Self-Service portal (myess.lhs.org) to enroll.

Within 31 days of your hire date, you must:

- Log on to myess.lhs.org and complete your enrollment
- Mail, fax or drop off all required documentation to the Benefits Department.

You’ll find instructions in your new hire packet and in the benefit section of Legacy’s intranet, MyLegacy.

Premiums for your benefit elections begin accruing on the first payday of your initial benefit coverage month. If you complete enrollment (elect benefits and submit required documentation) after your benefit effective date, there may be missed deductions; you’ll be responsible for making them up from future paychecks, with a maximum of three deductions (two past due plus the current) taken each pay period until you’re caught up.

If you are disabled before coverage begins, short-term income supplement and long-term income supplement coverage are delayed until you are no longer disabled and return to a regular work schedule. If you are absent due to injury, sickness, temporary layoff or leave of absence, your life insurance and accidental death and dismemberment coverage begins on the date you return to active employment.
**Default coverage for new benefit enrollments**

Only dependents you enroll in benefits, including submitting required eligibility documentation to the Benefits Department, can be approved for coverage.

If you don’t enroll by the deadline, you’ll have default coverage:

- Employee-only medical coverage (with tobacco use surcharge)
- No dental coverage
- No vision coverage
- Employee basic life insurance
- No supplemental employee, spouse or dependent life insurance
- No accidental death and dismemberment insurance
- No flexible spending accounts
- Short-term income supplement coverage (after a six-month waiting period)
- Long-term income supplement coverage 50 percent (after a six-month waiting period).

Changes to default coverage can be made only during the next Annual Enrollment or if you have a qualified life event during the year (as described in the next section).

**Current employees**

Qualified life events include marriage, forming a domestic partnership, divorce, terminating a domestic partnership, death, birth, adoption, losing or gaining other coverage, becoming eligible or ineligible for Medicare or Medicaid and change in employment.

If you experience a qualified life event outside Annual Enrollment, you may be able to change your benefit elections mid-year using Legacy’s Employee Self-Service portal (myess.lhs.org). Within 31 days of the event, you must:

- Log on to myess.lhs.org and complete your enrollment change request
- Mail, fax or drop off all required documentation to the Benefits Department.

See the MyLegacy benefit section for instructions. Mid-year benefit changes are effective the first of the month after you complete all the above steps. Benefit changes for birth, adoption or placement for adoption are effective retroactively to the event date, once you complete all the above steps. Benefit election changes must be consistent with the event, as shown in **Table 1, Allowable benefit changes as a result of a qualified life event**, on the following pages.
# TABLE 1 Allowable benefit changes as a result of a qualified life event

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<td>Add newborn</td>
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<td>Add adopted child(ren)</td>
<td>Add adopted child(ren)</td>
<td>Add adopted child(ren)</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
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<td>Waive coverage or add spouse/domestic partner and eligible child(ren)</td>
<td>Waive coverage or add spouse/domestic partner and eligible child(ren)</td>
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<td>Add coverage; remove ex-spouse/domestic partner; add or remove eligible child(ren)</td>
<td>Add coverage; remove ex-spouse/domestic partner; add or remove eligible child(ren)</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Stop coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
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<td>Death of spouse/domestic partner and/or children</td>
<td>Remove spouse/domestic partner and/or child(ren) or add coverage</td>
<td>Remove spouse/domestic partner and/or child(ren) or add coverage</td>
<td>Remove spouse/domestic partner and/or child(ren) or add coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Stop coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
</tr>
<tr>
<td>Losing Medicaid or Children’s Health Insurance Program (CHIP) coverage</td>
<td>Add eligible individuals losing coverage</td>
<td>Add eligible individuals losing coverage</td>
<td>Add eligible individuals losing coverage</td>
<td>No changes allowed</td>
<td>No changes allowed</td>
<td>No changes allowed</td>
<td>No changes allowed</td>
</tr>
<tr>
<td>Becoming eligible to participate in a Medicaid or CHIP premium assistance program</td>
<td>Remove individuals gaining coverage</td>
<td>Remove individuals gaining coverage</td>
<td>Remove individuals gaining coverage</td>
<td>No changes allowed</td>
<td>No changes allowed</td>
<td>No changes allowed</td>
<td>No changes allowed</td>
</tr>
</tbody>
</table>
### TABLE 1  Allowable benefit changes as a result of a qualified life event  

<table>
<thead>
<tr>
<th>Qualifying event</th>
<th>Medical Plan</th>
<th>Dental Plan</th>
<th>Vision Plan</th>
<th>Employee Life¹</th>
<th>Spouse Life¹</th>
<th>Dependent Life</th>
<th>Accidental Death &amp; Dismemberment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child dependent gaining coverage</td>
<td>Remove child dependent</td>
<td>Remove child dependent</td>
<td>Remove child dependent</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
</tr>
<tr>
<td>Child dependent losing coverage</td>
<td>Add child dependent</td>
<td>Add child dependent</td>
<td>Add child dependent</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
</tr>
<tr>
<td>Becoming eligible for Medicare or Medicaid</td>
<td>Remove individuals gaining coverage</td>
<td>Remove individuals gaining coverage</td>
<td>Remove individuals gaining coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
</tr>
<tr>
<td>Becoming ineligible for Medicare or Medicaid</td>
<td>Add individuals losing coverage</td>
<td>Add individuals losing coverage</td>
<td>Add individuals losing coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
</tr>
<tr>
<td>Spouse/domestic partner gaining employment or benefit coverage²</td>
<td>Remove self, spouse/domestic partner and eligible child(ren)</td>
<td>Remove self, spouse/domestic partner and eligible child(ren)</td>
<td>Remove self, spouse/domestic partner and eligible child(ren)</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
</tr>
<tr>
<td>Spouse/domestic partner losing employment or benefit coverage²</td>
<td>Add spouse/domestic partner and eligible child(ren)</td>
<td>Add spouse/domestic partner and eligible child(ren)</td>
<td>Add spouse/domestic partner and eligible child(ren)</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
<td>Add, stop, increase or decrease coverage</td>
</tr>
</tbody>
</table>

¹A personal health application (PHA) may be required to add or increase coverage, subject to underwriting approval by the life insurance carrier.

²Health premiums may change based on spouse/domestic partner’s eligibility for other coverage.

³Individuals gaining or losing Medicaid or CHIP coverage have 60 days from the date of eligibility or loss of coverage to request special enrollment in Legacy medical, dental or vision benefits. Contact the HR Answer Center if it has been more than 31 days from the date of loss or eligibility.

See the flexible spending account section on page 53 for information on eligible account changes as the result of a qualified life event.

**Changes in employment status: Benefit-eligible to benefit-eligible**

The premium you pay for some benefits and your amount of life insurance is affected when changing between full-time and part-time status, effective the first of the month following your status change date.

If you change from a full-time benefit-eligible to part-time benefit-eligible position, or vice versa, you can make a change only to your Dependent Care Flexible Spending Account, within 31 days from your status change date, at myess.lhs.org.

**Changes in employment status: Non-benefit-eligible to benefit-eligible**

As a newly benefit-eligible employee, your health, life, accidental death and dismemberment insurance and flexible spending account benefits are...
effective the first of the month following your status change date; if your status change date is the first of the month, benefits are effective that day. Short-term income supplement and long-term income supplement coverage is effective the first of the month following six months in a benefit-eligible position.

You have 31 days from your status change date to log on to myess.lhs.org, make your benefit elections and submit all required dependent eligibility documentation to the Benefits Department. If you do not complete enrollment by the deadline, you’ll have default coverage (see page 7).

**Changes in employment status:**

**Benefit-eligible to non-benefit-eligible**

Your health and flexible spending account benefits end on the last of the month of your status change date. You’ll receive a COBRA packet (see “Continuation coverage” on page 95 for information) in the mail within a few weeks of your benefits ending.

Short-term income supplement, long-term income supplement, life, and accidental death and dismemberment benefits terminate at midnight the last day of your benefit-eligible status. Refer to “When Legacy coverage ends” (page 94) and “Continuation coverage” for more information.

**Employees returning to benefit-eligible status**

As a previously benefit-eligible employee, your health, life, accidental death and dismemberment and flexible spending account coverage is effective the first of the month following your rehire or status change date; if your rehire date or status change date is the first of the month, benefits are effective that day. Short-term income supplement and long-term income supplement coverage is effective the first of the month following six months in a benefit-eligible position.

If you’re rehired within 12 months of your termination date, or return to a benefit-eligible status within 12 months, you won’t have to satisfy a new waiting period for dental or short- and long-term income supplement benefits. You are credited with the number of months already served.

**In the same calendar year:** **Rehired within 12 months of termination date or returned to benefit-eligible status within 12 months**

You are re-enrolled into your previous benefit elections and options except for flexible spending accounts (contact the HR Answer Center to re-enroll in flexible spending accounts). Changes are allowed only if you experienced any other intervening qualified life event during benefit-ineligibility.

A new flexible spending account election must be made every year — those elections do not carry over.

**Across two calendar years:** **Rehired within 12 months of termination date or returned to benefit-eligible status after more than 12 months**

You have 31 days from your rehire date or status change date to log on to myess.lhs.org, make your benefit elections and submit all required dependent eligibility documentation to the Benefits Department.

If you do not complete enrollment by the deadline, you’ll be re-enrolled into your previous benefit elections and options except for flexible spending accounts. If you were enrolled in medical benefits, you and your covered spouse/domestic partner’s status becomes tobacco user.

**Rehired more than 12 months after termination date or returned to benefit-eligible status after more than 12 months**

You have 31 days from your rehire date or status change date to make your benefit elections through myess.lhs.org and submit all required dependent eligibility documentation to the Benefits Department.

Your prior benefit elections are not reinstated and you must re-enroll in all benefits. If you do not complete enrollment by the deadline, you’ll have default coverage (see page 7).

**Changes during Annual Enrollment**

Annual Enrollment is your opportunity each year to re-certify tobacco use status, make benefit changes, add or drop coverage for you or your dependents and re-enroll in the flexible spending accounts.
During Annual Enrollment, you’ll log on to myess.lhs.org to make your benefit elections and re-certify tobacco use status. You must then submit all required documentation for any new dependents. The Benefits Department approves changes only if you submit completed documentation by the deadline.

If you don’t complete enrollment, you and your spouse/domestic partner’s status becomes tobacco user and flexible spending accounts are waived. All other benefit elections remain the same.

You’ll receive a Benefit Confirmation Statement showing your approved Annual Enrollment elections once all necessary processing actions are complete.

**Newborn or adopted children**

Your newborn children are covered under your medical benefits from birth for 31 days. Adopted children and those placed with you for adoption are covered under your medical benefits for 31 days after the date of adoption or the date the child is placed.

Placement means you’ve assumed and retained a legal obligation for full or partial support in anticipation of adoption and started legal adoption proceedings in your state of residence. You must submit a placement order (or a similar order issued by a domestic court) and proof of starting proceedings to the Benefits Department to prove placement. The Benefits Department may contact you later to obtain the final adoption paperwork.

To continue coverage beyond the 31 days you must log on to myess.lhs.org, complete a life event enrollment and submit the proof of birth record/birth certificate or court adoption/placement order within 31 days of the birth or placement to the Benefits Department.

If this process is not completed, the child’s coverage stops at the end of the 31st day after birth, adoption or placement. If the child’s placement is disrupted before legal adoption, the child’s coverage ends on the date the child is removed from placement.

This requirement applies even if you are already enrolled in the “Employee plus child(ren)” or “Employee plus family” coverage options. If this process is not completed, the child’s coverage stops at the end of the 31st day after birth, adoption or placement.

The newborn of an enrolled child dependent is covered only if the employee has been named by a court of competent jurisdiction as legal guardian, and the child lives in the employee’s household on a permanent basis, with the guardianship for an indefinite period or until the child’s age of majority.
Life events

Life is continually changing, and some changes to your employment status, family situation and other milestones affect your Legacy benefits. This table summarizes events and adjustments you may need to your benefits, W-4, beneficiary and other items. Visit myess.lhs.org to review and make changes.

<table>
<thead>
<tr>
<th>TABLE 2 Life events</th>
</tr>
</thead>
<tbody>
<tr>
<td>Event</td>
</tr>
<tr>
<td><strong>Employment-related events</strong></td>
</tr>
<tr>
<td><strong>New hire</strong></td>
</tr>
<tr>
<td>Regular, full- or part-time employee budgeted to work at least 24 hours a week (0.6 FTE or greater)</td>
</tr>
<tr>
<td>Regular part-time employee budgeted to work less than 24 hours a week (0.1 FTE to .59 FTE)</td>
</tr>
<tr>
<td>All employees</td>
</tr>
<tr>
<td><strong>Status change</strong></td>
</tr>
<tr>
<td>To a benefit-eligible position</td>
</tr>
<tr>
<td>To a non-benefit-eligible position</td>
</tr>
<tr>
<td>Event</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td><strong>Leave of absence</strong></td>
</tr>
<tr>
<td>Approved family (FMLA/OFLA) or medical leave of absence</td>
</tr>
</tbody>
</table>
| Approved personal or educational leave of absence | Your medical, dental, vision and flexible spending account benefits end the last day of the month your leave begins. Disability, life and accident benefits end at midnight on your last day worked.  
If you are in a current stability period, your medical coverage continues through the end of that period.  
You may continue medical, dental, vision and Health Care Flexible Spending Account benefits on a self-paid basis through COBRA. You may continue life insurance on a self-paid basis through portability or converting coverage. | Legacy policy 500.401                                                                                                                                                                                                   |
| Approved military leave of absence | You may either discontinue your benefits or continue them by paying your portion of the cost through payroll deductions. You are responsible for making up any missed deductions. | HR Answer Center at 503-415-5100                                                                                                                                                                                          |
| Termination/layoff (for any reason) | Your medical, dental, vision and flexible spending account benefits end the last day of the month you terminate employment. If your last day worked is the last day of the month, your benefits end that day. Your life, short-term income supplement, long-term income supplement, and accidental death and dismemberment benefits end at midnight on the last day you work.  
A COBRA packet is mailed to your home within two weeks of your termination date. You may be eligible to continue medical, dental, vision and Health Care Flexible Spending Account benefits under COBRA for up to 18 months. You may continue life insurance on a self-paid basis through portability or converting coverage.  
If you participated in the 403(b) and/or the 401(a) plan, you are eligible for a distribution. Request paperwork from Lincoln Financial Group to be mailed to your home.  
If you have a vested benefit in the Pension Plan, you’ll receive benefit information by the sixth month following your termination date. | *“Continuation coverage” in this guide*                                                                                                                                  Lincoln Financial Group at 503-625-3394 or 800-234-3500                                                                                                                                 |

**TABLE 2  Life events continued**
### TABLE 2  Life events continued

<table>
<thead>
<tr>
<th>Event</th>
<th>What happens now</th>
<th>For more information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual events</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Enrollment</td>
<td>Re-certify your tobacco status and you may change your medical, dental, vision, flexible spending account, life, long-term income supplement and accidental death and dismemberment benefits for the next calendar year, effective Jan. 1.</td>
<td>myess.lhs.org</td>
</tr>
<tr>
<td><strong>Age-related events</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Child age 26</td>
<td>Your child no longer qualifies as a dependent under any Legacy benefit plan at the end of the month of their 26th birthday (unless dependent on you because of a physical or mental disability that existed before the child's 26th birthday). The child automatically is removed from your coverage and receive COBRA information, and may be eligible to continue the same group coverage on a self-paid basis for up to 36 months.</td>
<td>Benefits Department</td>
</tr>
<tr>
<td>Age 70 and 75</td>
<td>Your life insurance coverage amount is decreased.</td>
<td></td>
</tr>
<tr>
<td><strong>Personal life events</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>You get married</td>
<td>You may enroll your spouse and/or newly eligible dependents in medical, dental, vision, life and accident coverage. Go to the Employee Self-Service portal to add your spouse and submit supporting documentation within 31 days of the marriage date.</td>
<td>Benefits Department myess.lhs.org</td>
</tr>
<tr>
<td>You become a qualified domestic partner</td>
<td>You may enroll your domestic partner in medical, dental, vision, life and accidental death and dismemberment coverage. Go to the Employee Self-Service portal to add your domestic partner, submit an Affidavit of Domestic Partnership and provide supporting documentation within 31 days of the qualification date.</td>
<td>“Legacy domestic partner benefits” in this guide Benefits Department myess.lhs.org</td>
</tr>
<tr>
<td>You become legally separated or divorced or terminate a domestic partnership</td>
<td>Your spouse/domestic partner is no longer eligible for benefits. Go to the Employee Self-Service portal to remove your ex-spouse/domestic partner from benefits and submit supporting documentation with 31 days. You automatically receive COBRA information that you must forward to your ex-spouse, who may be eligible to continue the same group coverage on a self-paid basis for up to 36 months.</td>
<td>Benefits Department myess.lhs.org</td>
</tr>
<tr>
<td>You have or adopt a baby</td>
<td>Newborns, adopted children or children placed for adoption are covered under your medical benefits automatically for the first 31 days from birth, adoption or placement. During the initial 31 days, go to the Employee Self-Service portal and submit supporting documentation to add the child to your medical, dental, vision, life and accident coverage.</td>
<td>HR Answer Center at 503-415-5100 Benefits Department myess.lhs.org</td>
</tr>
<tr>
<td>You become disabled from an illness or injury</td>
<td>Call the HR Answer Center to start your medical leave of absence.</td>
<td>HR Answer Center at 503-415-5100</td>
</tr>
</tbody>
</table>
### TABLE 2  Life events continued

<table>
<thead>
<tr>
<th>Event</th>
<th>What happens now</th>
<th>For more information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Your spouse/domestic partner or child enrolled in any Legacy benefit dies</td>
<td>Contact the HR Answer Center for a bereavement leave. If the dependent was covered under Legacy life insurance, contact the HR Answer Center to start the claim process. You’ll need to provide the death certificate. Update your beneficiaries on the Employee Self-Service portal.</td>
<td>HR Answer Center at 503-415-5100 myess.lhs.org</td>
</tr>
<tr>
<td>You are unable to work due to an illness or injury</td>
<td>Confirm whether you’re eligible for a leave of absence, short-term income supplement or long-term income supplement benefits.</td>
<td>HR Answer Center at 503-415-5100</td>
</tr>
<tr>
<td>You die</td>
<td>Your family should contact the HR Answer Center, which works with the Benefits Department to assist with life and accident claims, your last paycheck and any retirement benefits payable to a beneficiary. Your dependents enrolled in medical, dental or vision benefits automatically receive COBRA information. They may be eligible to continue their coverage on a self-paid basis for up to 36 months.</td>
<td>HR Answer Center at 503-415-5100</td>
</tr>
<tr>
<td>Your dependent becomes ineligible for coverage (turns 26, etc.)</td>
<td>Your child’s coverage under your benefits ends on the last day of the month he/she is eligible. Go to the Employee Self-Service portal within 31 days. A child enrolled in your medical, dental or vision benefits automatically receives COBRA information and may be eligible to continue coverage for up to 36 months.</td>
<td>myess.lhs.org</td>
</tr>
<tr>
<td>Your spouse/domestic partner becomes eligible for other employer coverage</td>
<td>You have 31 days from the effective date of coverage to remove him/her from your coverage. Go to the Employee Self-Service portal and submit supporting documentation. If your spouse/domestic partner has other coverage available (whether they enroll or not) and they remain on your Legacy medical, dental or vision benefits, you pay an additional premium.</td>
<td>“Legacy domestic partner benefits” in this guide Benefits Department myess.lhs.org</td>
</tr>
<tr>
<td>Your spouse/domestic partner stops working or becomes ineligible for health benefits</td>
<td>You have 31 days from the date your spouse/domestic partner loses coverage to add him/her to your coverage and submit supporting documentation. Go to the Employee Self-Service portal and submit supporting documentation.</td>
<td>“Legacy domestic partner benefits” in this guide Benefits Department myess.lhs.org</td>
</tr>
</tbody>
</table>

#### Changes you can make at any time

<table>
<thead>
<tr>
<th>Change your W-4 tax withholdings</th>
<th>Update W-4 withholding elections using the Employee Self-Service portal.</th>
<th>myess.lhs.org</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change your beneficiaries</td>
<td>For employee life and accidental death and dismemberment insurance.</td>
<td>myess.lhs.org</td>
</tr>
<tr>
<td>Report a name or address change</td>
<td>Update your name or address change using the Employee Self-Service portal.</td>
<td>myess.lhs.org</td>
</tr>
</tbody>
</table>
How the Medical Plan works

The Medical Plan does not require you to select a primary care provider to manage your care. You decide whether to see a primary care provider or a specialist. We do recommend establishing a relationship with a primary care provider because he or she can:

- Manage all of your health care needs
- Help you decide if specialist treatment is required
- Coordinate the care you receive from multiple providers
- Facilitate hospitalization when necessary
- Work closely with UMR, our Medical Plan administrator, in managing your care.

Providers eligible for reimbursement under this plan perform medically necessary services that are within the scope of their license. In all cases, the services must be covered under the plan to be eligible for benefits. See the professional providers definition on page 36 for a list of eligible providers.

Treatment and services covered under the Medical Plan must be medically necessary as determined by UMR or as defined on page 35.

Waiving medical coverage

If you have health benefits from another source, you may want to choose the waive coverage option. Proof of other medical coverage is required.

Co-pay

Co-pays are what you pay each time you use a covered service or supply requiring a co-pay. You may also need to pay co-insurance.
Co-insurance

Co-insurance is the percent you and the plan each pay for eligible expenses. Co-insurance amounts count toward your individual and family out-of-pocket maximum limits except for:

- Services incurred while your co-insurance responsibility was increased due to not participating in the case management or chronic conditions program
- Out-of-network services not pre-approved by UMR
- Services not covered under this plan
- Services not pre-certified by UMR if required.

Coordination of Benefits (COB)

COB is how the Plan works in conjunction with other coverage you may have through a non-Legacy plan. See page 93 for additional information.

Legacy + Network service area

The Medical Plan service area extends to within 30 miles of any Legacy + Network hospital or medical center.

Coverage within the Legacy + Network

The Medical Plan covers eligible services and supplies received from Legacy + Network facilities and providers. Coverage outside the Legacy + Network is limited to:

- Emergency and urgent care services for non-routine care (see “Important medical plan terms” on page 34 for details)
- Covered services not available within the Legacy + Network when pre-approved by UMR
- Covered services received from any licensed chiropractor or acupuncturist.

Review the Legacy + Network provider list before scheduling health appointments. See “Summary of medical benefits” on page 20 for more information.

Coverage outside the country

For all enrolled employees and dependents, coverage outside the country is limited to non-routine emergency and urgent care services only.

No-cost preventive care services

In accordance with the Patient Protection and Affordable Care Act (PPACA) and related laws and regulations, you pay no co-pay or co-insurance for certain eligible in-network preventive care services if:

- You meet all applicable age, medical history, frequency or other requirements
- The service is billed separately or is the primary purpose of the office visit
- The service is properly coded (CPT and ICD-9 or ICD-10 codes, as appropriate) by the provider.
- The service is provided by an in-network provider.

Contact UMR at 866-868-7761 to verify whether a specific service is an eligible no-cost preventive care service. Eligible preventive care services are subject to change and are updated at least annually; a list is posted on the Benefits section of MyLegacy.

This no-cost provision takes precedence over all stated benefit reimbursement coverage levels for eligible services provided by Legacy + Network providers and facilities; it does not apply to out-of-network services and expenses.

Non-emergency hospitalization

If your provider determines that you need non-emergency hospitalization, remind him or her to admit you to a Legacy + Network facility and to pre-certify your treatment otherwise you will not receive coverage. UMR reviews elective or non-emergency hospitalization and works with your provider to ensure your treatment schedule is medically necessary and avoids unnecessary time in the hospital.

Membership ID card

Upon enrolling, you’ll receive ID cards. Please keep them in a safe place; you and/or your dependents need to present the card when obtaining care.

Note: Dependent names also are on your ID cards; they do not receive separate cards.
Personal responsibility co-pay

A $2,000 co-pay applies to each individual if medical expenses are incurred as a result of an accident because the injured person:

- Was not wearing a seat belt
- Was not wearing a helmet while riding a motorcycle, similar motorized vehicle or bicycle
- Was using illegal drugs or was illegally intoxicated
- Was driving without liability auto insurance (if required by the state where the employee lives).

Services are reimbursed based on eligibility at the time expenses are incurred.

Medical management program

Legacy has contracted with ActiveHealth and UMR to oversee medical management for you and your covered dependents. ActiveHealth is responsible for the chronic conditions program. UMR is responsible for pre-certifying for medical necessity, case management, patient transfer to participating facilities following medical emergency, authorizing alternative services and out-of-network exception reviews due to in-network unavailability. UMR reserves the option to request a second opinion by a provider of their choosing if they believe it is warranted.

Out-of-network exception review

UMR reviews requests for out-of-network exceptions. If you or your provider believes a covered service is not available within the Legacy + Network, contact UMR at 866-494-4502. Medical services that are not medically necessary, as defined on page 35, are not covered.

If UMR determined a requested covered service is medically necessary and not available from a Legacy + Network provider or facility, the service is paid at a minimum of 80 percent and subject to the out-of-pocket maximum.

If UMR does not approve an out-of-network exception, the service is not covered and your costs are not included in the out-of-pocket maximum.

Pre-certification for medical necessity

Always remind your health care provider that your Medical Plan requires pre-certification in advance for the services and supplies listed below; otherwise the plan will pay zero percent and your costs will not be included in the annual out-of-pocket maximum. See page 35 for the Medical Plan’s definition of medically necessary services. You are financially responsible to ensure your provider obtains pre-certification approval from UMR.

If you need a service or supply that requires pre-certification or are unsure if it’s required, call UMR at 866-494-4502.

Your provider can also request an urgent pre-certification review if services or care are urgently needed. See page 76 for more information on urgent care pre-service claim procedures.

Only written approval from UMR about a proposed service constitutes an approved pre-certification.

The following services and supplies require pre-certification approval from UMR to be covered:

- Bariatric surgery
- Durable medical equipment over $1,000
- Emergency inpatient admissions at any hospital, within 48 hours
- Experimental and investigational clinical trials
- Genetic testing including BRCA 1 and 2; exceptions: first trimester screenings (FTS), amniocentesis during second trimester if FTS and chorionic villus sampling (CVS) have not been completed, cystic fibrosis testing and fluorescence in situ hybridization (FISH)
- Home health, home infusion and hospice services
- Injectable medications, including but not limited to growth hormone/Increlex, darbepoetin alpha, epoetin alfa, Epogen, Procrit and Micera blood clotting factor, IVIG, Synagis, Pegasys, Peg-Intron, Rebetron, Remicade, Roferon-A, Intron A, Infergen, Xoliar (call UMR for the current list)
- Inpatient mental health and chemical dependency treatments, including partial hospitalizations and residential treatment programs
- Inpatient rehabilitative care
- Non-emergency inpatient admissions at any hospital
• Outpatient hospital-based surgery
• Outpatient procedures — back and neck procedures, cranial banding, external counterpulsation (EECP), hyperbaric therapy, uvulopalatopharyngoplasty (UPPP), unlisted laparoscopic procedures of the abdomen, facet joint injection, temporomandibular joint disorder (TMJ) procedures, dental implants and hysterectomy
• Outpatient rehabilitative physical, occupational or speech therapy visits beyond 60 per calendar year
• Physical, occupational or speech therapy for developmental delay beyond 18 visits each per calendar year
• Prosthetic devices over $1,000
• Radiology procedures: MRA, CT scan sinus, CT scan brain, CT angi, MRI hip/knee/ankle, MRI cervical, thoracic and lumbar spine, or brain and lung SPECT scans
• Skilled nursing facility or long-term acute care center admissions
• Sleep studies or treatment
• Surgery performed at free-standing outpatient surgery facilities
• Transplants.

The chronic conditions program also provides Care Considerations — a safety net — where ActiveHealth works with the plan to review your health information using a computer system called The CareEngine to compare your claim information to current medical knowledge. It determines whether a certain medication or treatment may benefit you or if there are any changes you and your provider should consider. If it finds anything, ActiveHealth sends you and/or your provider a health alert. If you receive a Care Consideration, be sure to discuss it with your health provider.

All ActiveHealth services are private, confidential and in accordance with applicable federal and state laws.

Call 866-939-4717 to reach an ActiveHealth nurse coach.

**Case management services**

UMR assists plan members with complex or challenging health care needs. The case management program provides integrated medical management of such cases to meet patient needs efficiently and cost-effectively. This program involves the patient, family, physicians and other medical providers in a cooperative effort to assure improved delivery of health care services. Nurse case managers at UMR contact eligible employees and dependents with information and to develop an individualized plan in consultation with UMR physician advisers.

Employees and covered dependents are required to participate if they meet the program’s requirements, as determined by UMR, or medically necessary expenses are paid at 30 percent; the 70 percent balance will not apply to the annual out-of-pocket maximum.

The nurse case manager follows the patient’s care and verifies:

• Recommendations to physicians and other providers are followed
• Medical appointments are kept
• The patient receives timely treatment that is medically necessary and appropriate from participating providers.

Call 866-494-4502 to reach a UMR case manager.

---

**Chronic conditions program**

This program provides support for more than 40 chronic conditions such as asthma, diabetes, high blood pressure, heart failure and obesity/weight management, including special services for children. If you have or are at risk for a chronic condition, ActiveHealth may reach out to you by phone and mail.

You can work one-on-one over the phone with an ActiveHealth R.N., who:

• Acts as your personal health coach
• Answers your questions
• Helps you take steps to be as healthy as possible and avoid future complications.

Employees and covered dependents are required to participate if they meet the program’s requirements, as determined by ActiveHealth, or covered medical expenses are paid at 30 percent; the 70 percent balance does not apply to the annual out-of-pocket maximum.
**Patient transfer to participating facilities following medical emergency**

UMR nurse case managers assist with medical transfer of a patient hospitalized at an out-of-network hospital or other facility as a result of medical emergency (see "Important medical plan terms" on page 34) once the patient’s medical condition is stabilized. If the patient refuses transfer, subsequent services from out-of-network providers and facilities are not covered.

Call 866-494-4502 to reach a UMR case manager.

**Summary of medical benefits**

The following summary describes coverage levels and maximums of your medical benefits. For more information about your medical benefits and requirements, also read the “Medical coverage details” section after this summary.

Services identified with an asterisk (*) have pre-certification for medical necessity requirement. See page 18 for the complete list of services that require pre-certification.

---

**TABLE 3 Summary of medical benefits**

<table>
<thead>
<tr>
<th>Medical Plan limits</th>
<th>Legacy + Network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual out-of-pocket maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual</td>
<td>$2,000</td>
<td>None</td>
</tr>
<tr>
<td>Family</td>
<td>$6,000</td>
<td>None</td>
</tr>
<tr>
<td>Deductible</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Lifetime benefit maximum</td>
<td>None</td>
<td>None</td>
</tr>
</tbody>
</table>

**Tier 1: No-cost preventive care services**

Eligible preventive care services (applicable age, medical history, frequency or other requirements are met and the service is billed separately or is the primary purpose of the office visit)

- 100% with no co-pay
- 0%

**Tier 2: Chronic conditions** (see page 19 for participation and eligibility details)

- Diabetes education (outpatient type 1, type 2 or metabolic syndrome)
  - Self-management training program every 5 years
  - 100%
  - 0%
  - Diabetes education, 3 hours per calendar year
  - 100%
  - 0%
  - Insulin pump training program if starting pump therapy
  - 100%
  - 0%
- Lab tests
  - 90%
  - 0%
- Office visits
  - 90%
  - 0%

**Tier 3: Accident, sickness and routine care**

- Bariatric surgery*
  - Hospital services
  - 80%
  - 0%
  - Non-hospital, physician and professional services
  - 80%
  - 0%
- Chemical dependency treatment
  - Inpatient facility care*
  - 80%
  - 0%
  - Office visit
  - 80%
  - 0%
- Chemotherapy*
  - Chemotherapy treatment
  - 80%
  - 0%

*These services require pre-certification for medical necessity. See page 18 for the complete list of services that require pre-certification.
<table>
<thead>
<tr>
<th>TABLE 3</th>
<th>Summary of medical benefits continued</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Legacy + Network</td>
</tr>
<tr>
<td>Clinical trials*</td>
<td></td>
</tr>
<tr>
<td>Routine patient care provided by a hospital as part of approved clinical trial</td>
<td>80%</td>
</tr>
<tr>
<td>Routine patient care provided by non-hospital physician and professional providers as part of an approved clinical trial</td>
<td>80%</td>
</tr>
<tr>
<td>Diagnostic and imaging procedures</td>
<td></td>
</tr>
<tr>
<td>Breast-specific gamma imaging (BSGI)</td>
<td>Legacy facilities: 80% Non-Legacy facilities: 0%</td>
</tr>
<tr>
<td>Colonoscopy or sigmoidoscopy</td>
<td>100%</td>
</tr>
<tr>
<td>Invasive diagnostic procedures (diagnostic procedures that require entry into the body cavity such as angiograms and endoscopy)</td>
<td>80%</td>
</tr>
<tr>
<td>Lab, X-ray and non-invasive ultrasound</td>
<td>80%</td>
</tr>
<tr>
<td>Mammogram</td>
<td>100%</td>
</tr>
<tr>
<td>Specialty imaging* — CT (computed tomography), DEXA (dual-energy X-ray absorptiometry), MRA (magnetic resonance angiography), MRI (magnetic resonance imaging) and PET (positron emission tomography) scans</td>
<td>Legacy facilities: 80% after a $100 co-pay Non-Legacy facilities: 0% (except in qualified emergency)</td>
</tr>
<tr>
<td>Durable medical equipment (DME)*</td>
<td>80%</td>
</tr>
<tr>
<td>Emergency services</td>
<td></td>
</tr>
<tr>
<td>Ambulance* — ground and air</td>
<td>80% when medically necessary</td>
</tr>
<tr>
<td>Emergency room services (non-emergency care not covered outside Legacy + Network)</td>
<td>80% after a $100 co-pay (unless admitted within 24 hours)</td>
</tr>
<tr>
<td>Family planning</td>
<td></td>
</tr>
<tr>
<td>Breast pump (1 per birth)</td>
<td>100%</td>
</tr>
<tr>
<td>Certain genetic tests for a viable pregnancy (see page 26)</td>
<td>80%</td>
</tr>
<tr>
<td>Diagnostic procedures relating to infertility; elective abortion</td>
<td>80%</td>
</tr>
<tr>
<td>Facility charges for maternity care* (pregnancy, childbirth and related conditions)</td>
<td>80%</td>
</tr>
<tr>
<td>Home births (performed by a certified midwife)</td>
<td>80%</td>
</tr>
<tr>
<td>Lactation consultation</td>
<td>100%</td>
</tr>
<tr>
<td>Routine pre-natal office visits</td>
<td>100%</td>
</tr>
<tr>
<td>Vasectomy, tubal ligation, fitting of diaphragm, contraceptive injections or implants, prescription contraceptive devices or IUD insertion and removal</td>
<td>100%</td>
</tr>
<tr>
<td>Genetic testing*</td>
<td></td>
</tr>
<tr>
<td>BRCA1 and BRCA2 pre- and post-counseling</td>
<td>100%</td>
</tr>
<tr>
<td>BRCA1 and BRCA2 testing</td>
<td>100%</td>
</tr>
<tr>
<td>Home health services*</td>
<td></td>
</tr>
<tr>
<td>Home health visits and home infusion therapy</td>
<td>80%</td>
</tr>
</tbody>
</table>

*These services require pre-certification for medical necessity. See page 18 for the complete list of services that require pre-certification.
<table>
<thead>
<tr>
<th>Service</th>
<th>Legacy + Network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice care*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Palliative care at a hospice facility</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Inpatient care*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute care and inpatient facility services</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Hospital co-pay (per admission)</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Inpatient physician services</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Maternity care</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Mental illness treatment</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient facility services*</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Office visit</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Nutrition counseling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>One visit lifetime maximum (except for exceptions below)</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>For bariatric surgery candidates, 3 visits during the 6-month supervised weight loss program and 3 visits per calendar year post-surgery for 2 years</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>For members with cardiovascular disease, diabetes, hypertension, kidney disease, eating disorders, gastrointestinal disorders, seizures, ketogenic diet or other chronic conditions (determined by ActiveHealth), 2 visits per year</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Outpatient care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy shots and serum</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Alternative care (does not include lab or X-ray services)</td>
<td>80% up to $500 per calendar year maximum</td>
<td>80% up to $500 per calendar year maximum</td>
</tr>
<tr>
<td>Immunizations — under Tier 1</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Immunizations — all others</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Hearing exams (once every 24 months through age 18)</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Office visit</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Urgent/immediate care (routine care not covered outside Legacy + Network)</td>
<td>80%</td>
<td>80% (non-routine care only)</td>
</tr>
<tr>
<td>Outpatient surgery* — facility services</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Outpatient surgery* — physician services</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Pap smear (1 per calendar year; no additional reimbursement if done at the same time as a physical exam)</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Pelvic and breast exam for females (one per calendar year; no additional reimbursement if done at the same time as a physical exam)</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Prostate rectal exam and PSA test (one each calendar year age 40 and older)</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Prostate rectal exam and PSA test (one each calendar year under age 40)</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Well-adult exam</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Well-baby exam</td>
<td>100%</td>
<td>0%</td>
</tr>
<tr>
<td>Well-child exam</td>
<td>100%</td>
<td>0%</td>
</tr>
</tbody>
</table>

*These services require pre-certification for medical necessity. See page 18 for the complete list of services that require pre-certification.
Medical coverage details

See Table 3, “Summary of medical benefits,” for coverage levels.

See “Summary of medical benefits” for coverage levels between Legacy + Network and out-of-network providers/facilities and maximums of the benefits described in this section.

**Accident, sickness and routine care services (Tier 3)**

Accident, sickness and routine services are covered medical services that are not covered under no-cost preventive care services, chronic conditions and pre-authorization tiers.

**Bariatric surgery**

The Medical Plan will cover one bariatric surgery (gastric bypass, lap gastric bands, lap gastric sleeves, vertical banded gastroplasty, or biliopancreatic bypass with or without duodenal switch) per person per lifetime with the following two exceptions:

- Revisions or repeats of the original bariatric procedure are covered when approved by UMR as medically necessary.
- Surgery for subsequent bariatric procedures (conversion) are covered when approved by UMR as medically necessary due to either device failure or medical complications resulting from the original bariatric surgery.

Bariatric surgery is covered if you’ve been in the Medical Plan for 24 consecutive months immediately before surgery and meet all pre-surgery criteria below (bariatric surgery is not covered if you’ve ever had this surgery covered under the Medical Plan):

- Participate in case management with UMR beginning before your physician-supervised weight loss program and continuing through surgery and 12 months after surgery. While performing case management duties, UMR initiates the pre-certification process described on page 18. You must contact UMR at 866-868-7761 before starting your weight management program at the Legacy Weight Management Institute.

### TABLE 3 Summary of medical benefits continued

<table>
<thead>
<tr>
<th></th>
<th>Legacy + Network</th>
<th>Out-of-network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Rehabilitative therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient rehabilitative services — up to 60 days per episode as determined by the plan</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Outpatient rehabilitative services — visits beyond 60 per year require pre-certification*</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Outpatient rehabilitative services for developmental delay — visits beyond 18 each per year require pre-certification*</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Skilled nursing facility services* — up to 60 days per calendar year</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Surgery*</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Therapeutic radiology</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radium, radioisotope and X-ray</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Transplants*</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Tier 4: Pre-authorization services</strong> (see pages 28 and 29)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Elective spine surgery*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient facility services</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Inpatient physician services</td>
<td>80%</td>
<td>0%</td>
</tr>
<tr>
<td>Physical therapy, psychological evaluations and follow-up visits required by the Legacy spine program</td>
<td>100%</td>
<td>0%</td>
</tr>
</tbody>
</table>

*These services require pre-certification for medical necessity. See page 18 for the complete list of services that require pre-certification.
• Meet the age and BMI requirements of either:
  — At least age 24 and a BMI of 40 or greater
  Or:
  — At least age 24 and a BMI of 35–39.99 with a documented history of one or more serious obesity-related problems that can be improved with weight loss, such as sleep apnea, diabetes, moderate to severe hypertension, heart disease, debilitating joint pain

• Documentation of participation in Legacy Weight and Diabetes Institute-supervised weight loss program for at least six months immediately before surgery.
  — The program combines diet, physical activity and behavior therapy for all patients with a BMI of 35 or greater. It includes monthly visits at the Institute to monitor progress, record weight loss or health status changes and modify medications or other treatments as health improves.
  — The Legacy Weight and Diabetes Institute takes a supervisory role, initially assessing health status and making referrals to other providers, such as physical therapist, nutritionist, behavioral health professional, as appropriate.
  — You must seek nutrition counseling before surgery and at least once after.

Chemical dependency treatment
Chemical dependency is an addictive relationship with any drug or alcoholic substance. It may be either physical or psychological, or both, to the extent that it interferes with the person’s social, psychological or physical adjustment. Chemical dependency does not include dependence on tobacco, tobacco products or food. UMR must pre-certify inpatient services to determine the appropriate setting for inpatient chemical dependency treatment.

Emergency chemical dependency admission
This occurs when condition requires admission to a health care facility, residential/partial hospitalization/day care facility (inpatient chemical dependency facility, as defined in “Important Medical Plan terms”) due to threat of immediate harm to the patient’s health.

Expenses for facility care are covered only if its records reflect that the patient’s medical circumstances require 24-hour skilled nursing supervision and physician assessment not readily available in a less costly setting.

If, in UMR’s judgment, the facility care is for an inappropriate length of time, based on the criteria above, benefits are limited to the amount that would have been paid if those services had been received in the least costly treatment setting appropriate to provide that care.

See Table 3, “Summary of medical benefits,” for coverage levels.

Outpatient chemical dependency care
This includes treatment under a program through a physician, psychologist, physician assistant, nurse practitioner, licensed state-registered clinical social worker or health care facility, or residential/partial hospitalization/day care facility.

Chronic condition services
Members who participate in the chronic conditions program through ActiveHealth for asthma, diabetes, hypertension, coronary artery disease/congestive heart failure and chronic obstructive pulmonary disease receive enhanced in-network coverage for related office visits and lab services.

Clinical trials
All clinical trials must be pre-certified by UMR. Participation in case management with UMR during the clinical trial is required. Contact UMR for the approved clinical trial list. Eligible services include office visits, X-rays, IV therapy, inpatient care and other services as required by applicable laws and regulations. An experimental drug or device being investigated is not eligible.

All co-pays and co-insurances apply.

Durable medical equipment
This refers to equipment and related supplies UMR determines to be primarily used to serve a medical purpose, generally not useful to a person in the absence of illness, injury or disease, appropriate for use in the patient’s home and designed to withstand repeated use. Examples and descriptions follow.
Cochlear implant

Cochlear implants must be pre-certified by UMR. Recipients must participate in a post-cochlear implant rehabilitation program. Replacement parts, such as batteries, headset or microphones, are covered; however, upgrades of a covered functional external system to achieve aesthetic improvement, such as smaller profile components or a switch from a body-worn, external sound processor to a behind-the-ear model, are considered not medically necessary for all indications.

Other durable medical equipment, supplies, appliances, orthotics and prosthetics

The plan covers the items described below at the in-network level when prescribed or ordered by a physician and purchased from a participating Legacy + Network provider. Covered products or services not available from a Legacy + Network provider or facility are covered if pre-approved by UMR. They must be medically necessary for the diagnosis and/or treatment of an illness or disease.

Pre-certification is required for the purchase of all medical equipment — heart monitors, CPAP machines, wheelchairs, etc. — and for repairs costing over $1,000. In addition, all prosthetic devices costing over $1,000 must be pre-certified for medical necessity by UMR.

• Appliances (items to perform or facilitate a body function) and orthopedic braces are covered. Dental appliances and braces, supporting devices such as corsets or elastic stockings, hearing aids, eyeglasses and contact lenses are not covered.

• Colostomy, diabetic (test strips, needles, syringes, monitors) and mastectomy supplies are covered, limited to a 90-day supply at any one time. Colostomy and diabetic supplies are reimbursed at the in-network level; you pay the full cost at the time of purchase and submit the receipt to UMR for reimbursement.

• First extremity prosthesis after loss of a body part is covered, including:
  — Artificial eye
  — Mastectomy prosthesis, in a manner determined in consultation with the attending physician and patient, subject to co-insurance provisions

  — One intraocular lens or one contact lens or eyeglasses for each eye operated on following cataract surgery
  — Testicular prosthesis following surgical procedure for testicular cancer.

• Medical foods, such as PKU formula, are covered to treat genetic conditions that involve amino acid carbohydrate and fat metabolism and for which there exists medically standard methods of diagnosis, treatment and monitoring. Coverage is limited to a 90-day supply at any one time. Medical foods include those:
  — Prescribed by a physician
  — Formulated to be consumed or administered internally under a physician’s supervision
  — Specifically processed or formulated to be deficient in one or more of the nutrients present in typical nutrition counterparts
  — For the medical and nutrition management of patients with limited capacity to metabolize ordinary foodstuffs or certain nutrients, or other specific nutrient requirements as established by medical evaluation
  — Essential to optimize growth, health and metabolic homeostasis.

In addition, non-prescription elemental enteral formula for home use when prescribed by your physician is covered if it’s medically necessary to treat severe intestinal malabsorption and comprises the sole or an essential source of nutrition.

• Medical supplies used, and casts applied, in the office of a participating professional provider (see definition in “Important Medical Plan terms”) are covered along with surgical implants, including such items as pacemakers and artificial joints.

• Orthopedic shoes are covered if an integral part of a leg brace or if individually designed to correct or support a deformity or disease-related condition, according to a professional provider’s order. If the correction or support is accomplished by modifying a mass-produced shoe, then only the cost of the modification, not the original cost of the shoe, is covered.

• Orthotic foot devices prescribed by a doctor to restore or improve function are covered.
Orthopedic shoes or other non-prescription supportive devices for the feet are not covered.

You may be required to authorize a medical supplier furnishing durable medical equipment to make available information about orders or other records needed to approve a claim. The Medical Plan cannot be held liable for any claim or damages connected with illness or injuries caused by the use of any durable medical equipment.

“Limitations and exclusions” on page 30 lists additional coverage restrictions for durable medical equipment.

Emergency room services

Although emergency room services do not require pre-certification, UMR must be notified within 48 hours of any emergency room inpatient admission. There is no out-of-network coverage for routine care received in an out-of-network emergency room.

Emergency medical conditions or medical emergencies are recent and severe condition, sickness or injury (including but not limited to severe pain), that a prudent layperson (including parent or guardian of a minor child or guardian of a disabled individual), possessing an average knowledge of medicine and health, would reasonably expect could result in any of the following if care was not received immediately:

• Placing health in serious jeopardy
• Seriously impairing a body function
• Causing serious dysfunction to a body part(s) or organ(s)
• In the case of a pregnant woman, creating serious jeopardy to the unborn child’s health.

Genetic testing

BRCA genetic testing

BRCA testing and counseling must be pre-certified by UMR. Testing criteria to be eligible for BRCA testing follow:

• Family member with a known BRCA1/BRCA2 mutation
• Personal history of breast cancer plus one or more of these factors:
  — Diagnosed age less or equal to 40 years
  — Diagnosed age less or equal to 50 years, two primary relatives with breast cancer, more than one close blood relative with breast cancer under age 50 and/or more than one close blood relative with epithelial ovarian cancer
  — Diagnosed at any age, with two or more blood relatives with breast and/or epithelial ovarian cancer at any age
  — Close male blood relative with breast cancer
  — Personal history of epithelial ovarian cancer
• For an individual of ethnicity associated with higher mutation frequency — for example, founder populations of Ashkenazi Jewish, Icelandic, Swedish, Hungarian or other — no additional family history may be required
  • Personal history of epithelial ovarian cancer
  • Personal history of male breast cancer, particularly if one or both of these factors is also present:
    — One or more close male blood relatives with breast cancer
    — One or more close female blood relatives with breast or epithelial ovarian cancer
• Family history only — a close family member meets any of the above criteria.

During pregnancy

Only the following genetic testing is covered in the event of a viable pregnancy when medically necessary:

• Amniocentesis during the second trimester if FTS and CVS have not been completed
• Chorionic villus sampling (CVS) when determined medically necessary after abnormal FTS results or increased risk due to family history
• Cystic fibrosis testing
• First trimester screening
• Fluorescence in situ hybridization (FISH)

See Table 3, “Summary of medical benefits,” for coverage levels.
**Home health services**

Home health visits are covered if pre-certified by UMR, including services of a registered or licensed practical nurse, a physical therapist, speech therapist, occupational therapist or licensed social worker. There is an eight-hour maximum per day for a registered or licensed practical nurse; the maximum for other home health care providers is one visit per day.

Members receiving home health care exceeding eight hours per day before Sept. 1, 2013 maintain the existing level of care as it remains medically necessary.

Custodial care in the home — whether or not performed or supervised by someone with a certificate or license in a medical profession — is not covered.

Home infusion therapy services and supplies are covered if pre-certified by UMR and required for administering a home infusion therapy regimen, when ordered by a physician and provided by an accredited home infusion therapy agency.

**Hospice care**

Hospice care is a 24-hour coordinated program of home and inpatient care that uses an interdisciplinary team of personnel to provide palliative and supporting services to a patient/family experiencing a life-threatening disease with a limited prognosis. Services include acute, palliative, respite and home care to meet the physical, psychosocial and special needs of a patient/family during the final stages of disease and life.

To qualify for palliative hospice care, the patient’s physician must certify that the patient is terminally ill with a life expectancy of six months or less if the illness runs its course. A patient who elects this care is not eligible for any other benefits to actively treat the terminal illness. Hospice care must be pre-certified by UMR.

**Immunizations**

Immunizations that do not qualify as an eligible no-cost preventive service:

- Must not be for the sole purposes of travel
- Must follow CDC guidelines and recommendations

The Legacy Employee Health Department provides eligible employees and dependents (age 18 and older) certain immunizations at no charge. See “Employee wellness” for details.

**Inpatient care**

When your physician obtains pre-certification approval and admits you to a hospital for acute care, the plan covers:

- Hospital services and supplies necessary for treatment and furnished by the hospital, such as operating and recovery rooms, blood and blood components, traction equipment and special diets
- Isolation, coronary or other special acute care unit services, when medically necessary
- Room and board
- Three-day supply of take-home prescription drugs (additional prescription drugs are covered under your prescription benefits; see page 37)

**Maternity care**

Inpatient facility charges for pregnancy, childbirth, homebirth and related conditions are covered when pre-certified by UMR. You are entitled to remain hospitalized for maternity care for a minimum of 48 hours after actual delivery for a normal vaginal delivery and 96 hours after actual delivery for a C-section (this applies to newborns as well).

UMR reimburses the cost of one breast pump per birth.

Pre-natal services from Legacy + Network providers covered at no cost to you include:

- All lab services explicitly identified in the PPACA
- Counseling for breast-feeding and rental equipment (breast pumps) plus supplies
- Gestational diabetes screening
- Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP)
- Routine pre-natal obstetric office visits
- Tobacco cessation counseling specific to pregnant women.

Contact UMR at 866-868-7761 to confirm which pre-natal services qualify.
Mental illness treatment

Mental illness refers to any mental health disorders listed in the most current *Diagnostic and Statistical Manual of Mental Disorders* that are not excluded under Medical Plan “Limitations and exclusions” in this guide. UMR must pre-certify to determine the appropriate setting for inpatient mental illness treatment. Benefits are subject to periodic utilization review.

*Emergency mental health admission*

This occurs when a condition requires admission to a health care facility, residential facility or partial hospitalization/day care facility (inpatient mental health facility, as defined in “Important Medical Plan terms”) due to threat of immediate harm to the patient’s health.

Expenses for facility care are covered only if the facility records reflect that the patient’s medical circumstances require 24-hour skilled nursing supervision and physician assessment not readily available in a less costly setting.

If, in UMR’s judgment, the facility care is for an inappropriate length of time, based on the criteria above, benefits are limited to the amount that would have been paid if those services would have been received in the least costly treatment setting appropriate to provide that care.

See Table 3, “Summary of medical benefits,” for coverage levels.

Outpatient mental health care

This includes treatment under a program through a physician, psychologist, physician assistant, nurse practitioner, licensed state-registered clinical social worker or health care facility, or residential/partial hospitalization/day care facility.

No-cost preventive care services (Tier 1)

See PPACA criteria and other details on page 17. Contact UMR at 866-868-7761 to verify whether a specific service is an eligible no-cost preventive service; an updated list is posted on the Benefits section of MyLegacy.

Outpatient care

*Alternative care*

The plan covers services of licensed chiropractors and acupuncturists (alternative care providers) up to a calendar year maximum if within the scope of their license and not excluded.

Naturopaths are considered primary care providers (as defined in “Important Medical Plan terms”), not alternative care providers.

Lab tests, diagnostic X-rays or physical therapy ordered by a chiropractor are subject to the out-of-pocket maximum but not the calendar year maximum.

*Colonoscopy and sigmoidoscopy*

These procedures are covered if they qualify as an eligible no-cost preventive service; otherwise one routine sigmoidoscopy or colonoscopy is covered every calendar year or as recommended by your physician.

*Pre-authorization services (Tier 4)*

Pre-authorization services, for elective spine surgery only, are covered with pre-certification by UMR, including an evaluation by Legacy’s spine program. A physical therapy and psychological evaluation in addition to other evidenced-based treatment (nutrition counseling or other services) may also be required for pre-certification; co-insurance is waived.

Rehabilitative therapy

*Inpatient rehabilitative services*

Inpatient rehabilitative services are covered when a full rehabilitation team approach is necessary and the services can be provided only as an inpatient. Such services must be part of your physician’s program to improve or restore lost function caused by illness or injury. The admission and rehabilitative services must be pre-certified by UMR, with notification of emergency admissions within 48 hours.

*Outpatient rehabilitative services*

Outpatient rehabilitative services are covered, including physical, occupational and speech therapy necessary to restore or improve lost function caused by illness or injury. Additional visits beyond 60 total visits per year must be pre-certified by UMR.
Outpatient rehabilitative services for developmental delay are covered for children under age 18 for medically based and directed physical therapy, occupational therapy or speech therapy. Additional visits beyond 18 visits each per year must be pre-certified by UMR.

The prescribed therapy must be expected to result in a significant improvement in the patient's condition.

**Skilled nursing facility services**
A skilled nursing facility is an institution (or distinct part of an institution), not primarily for the care and treatment of mental disease, which primarily provides residents with any of the following services:

- Health care and services required above the level of room and board because of physical or mental condition and available only through institutional facilities
- Rehabilitation services for injured, disabled or sick persons
- Skilled nursing care and related services.

Skilled nursing facility benefits are limited to the daily service rate that would be paid if the patient were in a semi-private hospital room. To be covered, this care must be medically necessary and pre-certified by UMR.

**Surgery**
Surgery at a hospital — on an inpatient or outpatient basis — must be pre-certified for medical necessity by UMR. The benefit level for provider services is based on the lead surgeon's network status; the benefit level for facility services is based on the facility's network status. All out-of-network exceptions must be approved by UMR to determine whether the covered service is available within the Legacy + Network.

See the “Pre-authorization services (Tier 4)” section on page 28 for information about elective spine surgery requirements

**Non-emergent spine surgery program**
Pre-authorization tier services are for non-emergent spine surgery only. Coverage is 80 percent with pre-certification by UMR. The pre-certification process includes an evaluation by Legacy's spine program. A physical therapy and psychological evaluation in addition to other evidenced-based treatment may also be required before non-emergent spinal surgery is considered for pre-certification. Evidenced-based treatment includes nutritional counseling or other services.

Co-payments are waived for any evaluations or evidenced-based treatment required for pre-certification consideration.

Without pre-certification, non-emergent spine surgery coverage is zero percent and member costs are not included in the annual individual or family out-of-pocket maximum limits.

**Outpatient surgery**
This refers to surgery that does not require an inpatient admission or overnight stay. Operating and recovery rooms, surgical supplies and other services ordinarily provided by hospitals for day surgeries. Outpatient facility-based surgery requires pre-certification by UMR.

**Temporomandibular joint (TMJ) surgery**
TMJ surgery is covered only for medical conditions. All TMJ-related surgical procedures must be pre-certified by UMR and are covered only if UMR determines they are medically necessary.

**Transplants**
This refers to a procedure (or series of procedures) to remove tissue (except blood and blood derivatives) from the body of one person (donor) and implant it in the body of another person (recipient).

All transplants must be pre-certified by UMR to be covered — as soon as possible after a member is identified as a possible candidate. If the donor is a member in this plan but the recipient is not, the transplant is not covered.

Benefits are payable for the following transplants:

- Bone marrow or stem cell transplant (allogeneic and autologous) for certain conditions
- Heart
- Heart/lung
- Kidney
- Kidney/pancreas
- Liver
- Lung
- Pancreas (if utilization review criteria are met)
- Small bowel
The cost of organ and tissue acquisition/procurement from a living human or cadaver is covered if the donor’s own plan does not cover it. This includes donor testing, blood typing and evaluation to determine if the donor is a suitable match. Donor-related complications are covered only if the recipient and donor both are covered by this plan.

**Transplant exclusions**

In addition to the items listed under “Limitations and exclusions,” the Medical Plan does not pay for the following:

- Organ and tissue acquisition/procurement and storage of cord blood, stem cells or bone marrow unless the member has been diagnosed with a condition requiring an approved transplant
- Purchase of any organ
- Solid organ transplant in patients with carcinoma unless it is in complete remission for five years or considered cured; exceptions require additional review for medical necessity and include diagnoses of squamous cell and basal cell carcinoma of the skin and hepatocellular carcinoma
- Solid organ transplant, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell) for conditions not considered medically necessary or not appropriate, based on the National Comprehensive Cancer Network (NCCN) compendium
- Transplants considered experimental, investigational or unproven unless covered under a qualifying clinical trial or approved by UMR.

See Table 3, “Summary of medical benefits,” for coverage levels.

**Urgent care**

In an urgent situation, seek medical attention from the closest appropriate facility, such as a clinic, physician’s office or urgent care center. Urgent care from out-of-network providers or facilities is covered at the in-network benefit level and does not require pre-certification. There is no coverage for routine care received in an out-of-network urgent care facility.

Routine care such as adult physical exams, women’s routine health exams, well-baby and well-child care, preventive immunizations (as recommended by the CDC), routine eye exams for chronic conditions, diagnostic work-ups for chronic conditions and elective surgery/hospitalization is covered only from Legacy + Network providers and facilities.

**Limitations and exclusions**

In addition to limitations and exclusions described elsewhere, the following treatments, procedures and conditions (including services or supplies related to the condition) are not covered even if otherwise medically necessary or if recommended, referred or provided by a participating facility or provider. Services or supplies not specifically described as covered or those requiring but not receiving pre-certification by UMR are not covered.

- Alopecia
- Amounts over the maximum plan allowance
- Behavior modification, counseling or treatment for psychological enrichment or self-help programs for mentally healthy individuals, including assertiveness training, consciousness raising, image therapy, sensory movement groups, marathon group therapy and sensitivity training
- Biofeedback for any condition (except tension/migraine headaches, tension and chronic pain)
- Blood donor expenses
- Chemotherapy with autologous, allogeneic or syngeneic hematopoietic stem cells transplant to treat any type of cancer not specifically named as covered
- Chronic or long-term psychotherapy (services provided in excess of crisis intervention/short-term therapy)
- Completion of reports, claim forms, obtaining medical records necessary to determine benefits, or duplicate services and charges
- Counseling or treatment in the absence of illness, including individual or family counseling or treatment for marital, behavioral, family, occupational or religious problems, or “normal” transitional response to stress
- Court-ordered treatment or services
• Custodial care, including routine nursing care and hospitalization for environmental change
• Dental or orthodontic services or supplies (except to treat fractured jaw and other accidental injury) or hospitalization for a dental procedure if not pre-certified by UMR
• Devices and equipment used for environmental control or to enhance the environmental setting such as air conditioners, humidifiers or air filters
• Diet or rest cure hospitalization, custodial care, personal hygiene or other forms of supervised self-care
• Diversion services or related educational programs required as a result of intoxicated driving or a DUI or other similar offense
• Disorders (as defined by the most current edition of the Diagnostic and Statistical Manual of Mental Disorders):
  — Autism spectrum disorders
  — Behavioral disorders
  — Gender dysphoria
  — Habilitative care for learning disorders
  — Intellectual disabilities
  — Obsessive-compulsive and related disorders
  — Personality disorders
  — Sexual deviations and dysfunction
• Exercise equipment
• Experimental or investigational procedures, services or supplies that support or are performed in connection with the procedure, or expenses incidental to or incurred as a direct consequence of the procedure, which in our judgment:
  — Are not rendered by an accredited institution, physician or provider within the United States, or by one that has not demonstrated medical proficiency by the rendering of the service or supplies
  — Are not recognized by the medical community in the service area in which they are received
  — Involve a treatment for which the approval of one or more government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered
  — Involve a treatment for which scientific or medical assessment has not been completed, or effectiveness has not been generally established
• Faith healing or similar services
• Family education or support groups
• Financial counseling services
• Fitness or exercise programs or health club memberships
• Food services such as Meals on Wheels
• Guest meals in a hospital or skilled nursing facility
• Hearing aids (internal and external), including fitting, providing or replacing (except for cochlear implants, described under durable medical equipment)
• Heat lamps or tanning lights
• Homeopathic services, vitamins, herbs, food supplements or other related services recommended or prescribed by a homeopathic practitioner
• Homemaker or housekeeping services
• Immunizations for the primary purpose of travel or to prevent illness, which may be caused by a work environment
• Infertility treatment including:
  — Artificial insemination procedures
  — In-vitro fertilization (IVF)
  — Gamete intrafallopian transfer (GIFT)
  — Tubal embryo transplant (TET)
  — Zygote intrafallopian transplant (ZIFT)
• Injury or illness caused by an act of war
• Injury or illness incurred while committing a crime
• Items lost, stolen or broken
• Laser eye surgery
• Legal counseling
• Marriage and family services
• Marriage counseling
• Massage or massage therapy (whether or not recommended by provider)
• Mental exams or psychological testing and evaluations not provided as an adjunct to treatment or
Medical Plan

diagnosis of a mental disorder, including those for adjudication of legal rights, administrative awards or benefits, corrections or social service placement or any use except as a diagnostic tool for providing mental illness or chemical dependency treatments as described

- Missed appointments or related fees
- Motor vehicle coverage services or supplies to treat illness or injury to the extent the member recovers or is entitled to recover from motor vehicle insurance, including but not limited to primary medical payments coverage, uninsured motorists or underinsured motorist coverage
- Necessities of normal living, including but not limited to food, clothing and household supplies
- Non-prescription contraceptive devices
- Orthognathic surgeries that require hardware or bone graft to repair head and facial structures for the following indications:
  - Necessary to correct a physical disorder or injury that prevents the ability to ingest nutrition or causes a secondary or resultant disorder that prevents performing activities of daily living
  - Facial skeletal discrepancies associated with documented sleep apnea, airway defects and soft tissue discrepancies
  - Facial skeletal discrepancies associated with documented TMJ pathology
  - Gross jaw discrepancies (anteroposterior, vertical and/or transverse discrepancies)
- Orthognathic surgery including maxillary or mandibular osteotomies and dental care except prosthetics to repair head and facial structures damaged by trauma, disease, surgery or congenital deformity that cannot be managed with living tissue
- Orthopedic shoes or other supportive devices for the feet except as described
- Orthoptics, vitamin therapy, low-vision therapy or eye exercises, or fundus photography and routine contact lens checks
- Pastoral or spiritual counseling
- Personal comfort items such as television, telephone and guest meals while in a hospital if charged separately from the cost of the room
- Physical exercise programs even though they may be prescribed for a specific condition otherwise covered by the plan
- Portable whirlpool pumps
- Private duty nursing
- Procedures or treatments to reverse sterilization
- Registered or licensed practical nurse services that exceed two visits per day or services by other classification of home health care provider that exceed one visit per day
- Routine foot care
- Routine physical exams primarily for coverage, licensing, employment and non-preventive purposes or other medical exams or tests not connected with care and treatment of an actual illness or injury (unless covered under preventive care benefits); school physicals occurring more often than the scheduled preventive care benefits are also excluded
- Self-help, training or instructional programs, including but not limited to how to use durable medical equipment or how to care for a family member; special education, job training, music therapy or recreational therapy
- Services or materials in an institution for the mentally retarded except while a bed patient in an acute care hospital for conditions other than mental retardation
- Services or supplies to diagnose, rule out or treat paraphilia
- Services or supplies a member receives while in the custody of any city, county, state or federal law enforcement authorities or while in jail or prison
- Services or supplies, except for office visits and lab services, provided solely to treat obesity, including:
  - Biofeedback
  - Guided imagery or other forms of relaxation training, as well as subliminal suggestions used to modify eating behavior
  - Hypnosis
  - Neurolinguistic programming
  - Weight loss programs (except as provided under employee wellness benefits
• Services or supplies (including drugs) for cosmetic or reconstructive purposes, including complications resulting from cosmetic or reconstructive surgery except as follows:
  — If the surgery is performed to correct a physical disorder that prevents performing activities of daily living
  — If the surgery is performed to correct congenital anomalies in children under age 18
  — For reconstructive surgery immediately following a mastectomy to reconstruct the breast, produce a symmetrical appearance in the other breast and to correct physical complications for all stages of mastectomy, including lymphedemas
• Services or supplies for any transplant not specifically named as covered, including the transplant of animal organs or artificial organs
• Services otherwise available — a category that includes:
  — Services or supplies for which payment could be obtained in whole or in part if the individual had applied for payment under any city, county, state or federal law (except for Medicaid coverage)
  — Services or supplies the individual could have or did receive in a hospital or program operated by a government agency or authority (for veterans of the armed forces, covered expenses for services and supplies furnished by the Veterans’ Administration of the United States and not service related are eligible for payment according to this plan)
  — Care for military service-connected disabilities for which a member is legally entitled to services and for which facilities are reasonably available
  — Services or supplies for which no charge is made, or for which no charge is normally made in the absence of coverage
  — Services provided by an immediate family member
  — Services provided by volunteer workers
• Sex change procedures or resulting complications

• Support education, including:
  — Family education or support groups
  — Level I educational programs related to a DUII or similar offenses
  — Voluntary mutual support groups, such as Alcoholics Anonymous
• Supportive environmental materials, including but not limited to hand rails, ramps, bath benches, humidifiers, air filters, air conditioners, heat lamps, tanning lights, whirlpools, hot tubs and telephones, regardless of whether they relate to a condition otherwise covered by the plan
• Surgical procedures that alter the refractive character of the eye (including but not limited to radial keratotomy, myopic keratomileusis and other surgical procedures of the refractive keratoplasty type), with the purpose to cure or reduce myopia, presbyopia or astigmatism; reversals or revisions of surgical procedures that alter the refractive character of the eye also are excluded
• Surrogate mother expenses
• Taxes
• Telephone visits/consultations or telephone psychotherapy
• Therapeutic devices, except for transcutaneous nerve stimulators
• Third-party liability services or supplies to treat an illness or injury for which a third party is responsible to the extent of any recovery received from or on behalf of the third party
• Transportation (separate charges) except medically necessary ambulance
• Treatment of the following:
  — Addiction to tobacco, tobacco products or nicotine substitutes, including hypnosis, biofeedback and forms of relaxation training or counseling used to modify tobacco use, except as described for wellness benefits or as required by law
  — Illness or injury arising out of or in the course of employment or self-employment for wages or profit, whether or not the expense for the service or supply is paid under workers’
compensation, except when the insured patient is exempt from state and federal workers’ compensation law

- Reproductive or sexual disorders and defects, whether or not the consequence of illness, disease or injury, including but not limited to impotency, frigidity, infertility, sterility and invitro fertilization

- Treatment or services not medically necessary as determined by UMR or as defined by the plan

- Treatment received before coverage under this plan begins or received after coverage under this plan ends

- Vitamins, minerals, herbs or food supplements, whether oral, injectable or transdermal

- Vocational or industrial rehabilitation services or counseling

- Wigs, toupees or hair transplants

- Work-related or management referrals

- Youth behavioral/substance abuse diversion wilderness experience camps or outdoor programs.

Important Medical Plan terms

Activities of daily living — Basic tasks of everyday life, such as eating, bathing, dressing, toileting and transferring (as in moving from a bed to a chair).

Administrative period — A period used to determine stability period eligibility, send eligible employees offers of medical coverage and take other necessary actions. This period is no longer than 90 days, starts at the end of a measurement period and ends immediately before the start of an associated stability period.

Approved transplant services — Services and supplies for certified transplants when ordered by a physician, including but not limited to hospital charges, physician’s charges, organ and tissue procurement, tissue typing and ancillary services.

Covered service — Medical service or supply specifically described as a benefit of this plan or an alternative service approved by UMR.

Custodial care — Care that helps a person conduct activities of daily living and can be provided by people without a medical or paramedical certificate, license or supervision. This includes care primarily to separate a patient from others or prevent a patient from harming himself or herself.

Dental care — Services and supplies to prevent, diagnose or treat diseases of the teeth and supporting tissues or structures, including those to repair defects that developed because of tooth loss and to restore the ability to chew.

Dependent — Spouse, domestic partner or child dependent who is eligible for benefits under the Medical Plan.

Designated transplant facility — A facility that has agreed to perform approved transplant services under an agreement with a transplant provider network or rental network with which the plan has a contract.

Emergency medical condition or medical emergency — Recent and severe condition, sickness or injury (including but not limited to severe pain), that a prudent layperson (including parent or guardian of a minor child or guardian of a disabled individual), possessing an average knowledge of medicine and health, would reasonably expect could result in any of the following if care was not received immediately:

- Placing health in serious jeopardy
- Seriously impairing a body function
- Causing serious dysfunction to a body part(s) or organ(s)
- In the case of a pregnant woman, creating serious jeopardy to the unborn child’s health.

Emergency room services — Services and items furnished in a hospital emergency department, ancillary services routinely available to an emergency department and other hospital services required to stabilize a patient who seeks medical services for an emergency medical condition.

Member (enrollee) — Employee or eligible dependent of an employee who is enrolled for coverage under the Medical Plan.

Illness — Physical or mental infirmity.

Injury — Personal bodily injury caused solely by external, violent and accidental means which results directly and independently of all other causes in a covered expense.
Inpatient mental health or chemical dependency facility — Hospital or other facility licensed for such care under state law or accredited by The Joint Commission on Accreditation of Healthcare Organizations or Commission on the Accreditation of Rehabilitative Facilities. The facility provides full-day or part-day acute treatment for mental illness or chemical dependency and is licensed to admit patients who require 24-hour skilled nursing care.

Legacy + Network — The Exclusive Provider Organization (EPO) selected by Legacy and maintained by UMR. Legacy + Network participating physicians and providers are physicians, hospitals, health care professionals and facilities that contract to provide health care services to members.

Legacy Administrative Committee — Plan Administrator — the body of appointed Legacy employees who establish administrative processes and safeguards to ensure and verify that claim decisions are made in accordance with the Welfare Benefits Plan and that its provisions are applied consistently to similarly situated members. The Plan Administrator makes a determination regarding all requests for reconsideration of denied claims.

Maximum Plan Allowance — Maximum amount that UMR will reimburse physicians and providers. For participating physicians/providers, this is the amount they agreed to accept for a particular service. For non-participating physicians/providers, no coverage is provided.

Measurement period, initial — A fixed look back period of 23 pay periods used to determine whether a new regular employee is eligible for an initial stability period. The initial measurement period starts with the first full pay period after a new employee’s adjusted date of hire.

Measurement period, standard — A fixed look back period of 26 pay periods used to determine whether a current regular employee is eligible for a standard stability period. The standard measurement period is from the 25th pay period through the 24th pay period (23rd in 27 pay period years).

Medically necessary — Services and supplies required to diagnose or treat illness or injury which, in the plan’s judgment, are:

• Appropriate to the treatment setting and level of care in amount, duration and frequency of care and consistent with the symptoms or diagnosis and treatment of the member’s condition
• Appropriate with regard to widely accepted standards of medical practice
• Not primarily for the convenience of the member or a provider of services or supplies
• The least costly of the treatment settings, alternative supplies or levels of service that can be safely provided to the patient; this means, for example, that care in a hospital inpatient setting or by a nurse in the patient’s home is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility, without harm to the patient.

The fact that an eligible provider may prescribe, order, recommend or approve a service or supply does not, of itself, make a service or supply medically necessary and covered by the plan. The claim administrator determines whether services are necessary in consultation with professional consultants, peer review committees or other appropriate sources for recommendations.

Organ and tissue acquisition/procurement — Harvesting, preparing, transporting and storing human organ and tissue that is transplanted to a member, including related medical expenses of a living donor.

Out-of-network providers — Physicians, other health care professionals, hospitals and facilities not contracted to participate in the Legacy + Network.

Out-of-pocket maximum — Maximum annual amount of the co-insurance and co-pays a member is responsible to pay. Once a member reaches this maximum amount allowed under the Medical Plan during a calendar year, the plan pays 100 percent of that individual’s (or family’s) incurred eligible medical expenses for the rest of the calendar year. The following expenses do not count toward the individual and family out-of-pocket maximum:

• Out-of-network services not approved by UMR
• Prescription drug charges and co-pays
• Services incurred while the member’s co-insurance responsibility increased due to not participating in the case management or chronic conditions program
• Services that are not covered under this plan
• Services that were not pre-certified when pre-certification was required.

**Participating provider** — One of the hospitals, skilled nursing facilities, physicians, psychologists or other health care professionals contracted to participate in the Legacy + Network.

**Participating women’s health care provider** — One of the following providers contracted to participate in the Legacy + Network:

- Advanced registered nurse practitioner specializing in women’s health
- Certified nurse midwife
- Obstetrician or gynecologist
- Physician assistant specializing in women’s health.

**Physical illness** — Disease or bodily disorder.

**Physician** — Doctor of medicine (MD) or osteopathy (DO).

**Primary care provider** — Physician, naturopath, physician assistant, nurse practitioner or women’s health care provider a member chooses to be primarily responsible for continuing medical care.

**Professional providers** — Providers who perform medically necessary services within the scope of their license. In all cases, the services must be covered under this plan to be eligible for benefits. Professional providers include only: acupuncturist; audiologist; chiropractor; clinical social worker; dentist (DMD or DDS, but only to treat accidental injury to natural teeth or to perform surgery that does not involve repair, removal or replacement of teeth, gums or supporting tissue); doctor of medicine; doctor of osteopathy; midwife; naturopath; nurse practitioner; optometrist or ophthalmologist; physical, occupational, speech or audiological therapist (but only for rehabilitative services provided upon the written referral of a physician); physician assistant; podiatrist; registered nurse or licensed practical nurse (but only for services provided upon the written referral of a doctor of medicine or osteopathy, and only for those services for which nurses customarily bill patients); and registered psychologist.

No benefits will be paid for services by any class of provider not listed above.

**Regular employee** — Active employee who is classified in a full-time, part-time, per diem, on call, supplemental, temporary or leave status. Contract and terminated employees are not regular employees.

**Routine care** — Care received from a health care provider or facility that is not due to an emergency medical condition or urgent care.

**Skilled nursing care** — Nursing care that must be provided by a registered nurse or licensed practical nurse, or by a person supervised by a registered nurse or licensed practical nurse. Skilled nursing care does not support the activities of daily living and cannot be performed by an untrained adult with minimum instruction and/or supervision. Examples include intravenous or intramuscular injections, Levin or tube feedings or tracheotomy aspiration and insertion.

**Stability period, initial** — A 12-month period where a regular employee is eligible for Medical Plan benefits. This period usually starts the first of the month following the one-year anniversary of a new employee’s adjusted hire date. Regular employees who are not in a benefit-eligible status are eligible only for Medical Plan benefits. The stability period for terminated employees expires 91 days after their termination date.

**Stability period, standard** — A 12-month period starting Jan. 1 where a regular employee is eligible for Medical Plan benefits. Regular employees who are not in a benefit-eligible status are eligible only for Medical Plan benefits. The stability period for terminated employees expires 91 days after their termination date.

**Stem cell transplant** — Autologous, allogeneic and syngeneic transplants of bone marrow, peripheral and cord blood stem cells.

**Urgent care** — Immediate, short-term medical care for minor but urgent medical conditions that do not pose a significant threat to life or health when services are rendered, but that a prudent layperson would reasonably expect should not wait to be treated.
How the Prescription Drug Plan works

Legacy provides prescription benefits for you and your dependents enrolled in the Medical Plan. This plan is administered by MedImpact Healthcare Systems, Inc.

When you enroll in the Medical Plan, your prescription drug information is included on your ID card. Be sure to keep this card with you at all times — you must present it at Legacy or MedImpact network pharmacies. Prescription drug coverage is available only for prescriptions filled at a Legacy or MedImpact network pharmacy. The plan reimburses covered prescription expenses filled at all other pharmacies at the MedImpact network contract rate.

This prescription plan is designed to encourage the use of generic drugs in place of brand-name drugs. Co-pays are lowest for generic drugs on the formulary.

MedImpact updates the formulary quarterly for any changes that occur throughout the year, such as brand-name preferred drugs becoming non-preferred due to the expiration of patents. These updates to the formulary are on the MedImpact website (mp.medimpact.com). Each network pharmacy has access to these quarterly changes. If you have a prescription for a brand-name preferred drug, ask the pharmacist if the drug is on the formulary and if there is a generic alternative.

If a prescription is written for a non-preferred or non-stocked medication, ask the pharmacist to consult with your physician to determine the possibility of using a therapeutically similar generic drug or a brand-name preferred drug as an alternative.

Prescriptions are dispensed at a maximum quantity of a 34-day supply or 100 unit doses, whichever is greater, or a lesser amount if prescribed by your physician. One co-pay is required for each 34-day supply (except for mail order, as described below). Prescriptions are refilled only if prescribed by your physician and if 75 percent of the current prescription has been used.

Legacy apothecary/pharmacy locations

Legacy Emanuel — 503-413-4225; refills/mail order, 503-413-0927
Legacy Good Samaritan — 503-413-8122; refills/mail order, 503-413-7473
Legacy Meridian Park — 503-692-7470; refills, 503-692-2662
Legacy Mount Hood — 503-674-1227; refills, 503-674-1527
Legacy Salmon Creek — 360-487-3700; refills/mail order, 360-487-3709
Summary of prescription drug benefits

Mail order
You can fill prescriptions by mail order through the apothecaries at Legacy Emanuel, Good Samaritan and Salmon Creek medical centers. Maintenance prescriptions can be refilled by mail order as long as you have refills remaining. When you refill your prescription using mail order, you’re charged only two co-pays for three 34-day supplies of a maintenance drug.

The apothecaries recommend calling in a refill at least 10 business days before you’ll use the last of your medication to allow time for refill and delivery. If you would prefer your order sent by expedited shipping (such as overnight or second-day delivery), request this service when you call in your refill. You pay the cost of expedited shipping along with your prescription co-pays.

For maintenance medicines that need to be refrigerated (such as insulin), a gel or ice pack is included.

Out-of-pocket maximum
There is a separate $1,250 per member ($3,750 per family) per calendar year out-of-pocket maximum for prescription drugs. All co-pays apply toward this maximum. Once you meet the member or family limit, the plan pays 100 percent of generic, preferred and specialty drug costs (including mail order) for the rest of the calendar year. You continue to pay the co-pay only for any non-preferred drug.

Quantity Level Limits
Quantity Level Limits (QLL) are guidelines designed by the manufacturer and approved by the Food and Drug Administration and clinical studies for all medications. These limits represent the highest dose proven appropriate for the vast majority of people.

If your prescription quantity is more than the recommended dosage, the pharmacist notifies you and fills the prescription only up to the QLL. Contact your physician if you disagree with the QLL. A physician who disagrees with the QLL needs to call MedImpact at 800-788-2949 and provide medical justification to request a prior authorization for the additional quantity. If MedImpact approves the additional quantity, a prior authorization is entered into the system, valid for one year.

Note: Some medications cannot have authorized additional quantities because they don’t have sufficient clinical studies to support approval.

### TABLE 4 Summary of prescription drug benefits

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<th>Value</th>
<th>Generic</th>
<th>Preferred</th>
<th>Non-Preferred</th>
<th>Specialty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Legacy pharmacies and MedImpact network pharmacies</td>
<td>$5</td>
<td>$10</td>
<td>$25 or cost of drug, whichever is less</td>
<td>$50 + 20% of drug cost or cost of drug, whichever is less</td>
<td>$100 Limited to 30-day supply on first fill</td>
</tr>
<tr>
<td>Mail order</td>
<td>3 months’ supply for 2 co-pays (plus shipping) for maintenance medication at Legacy apothecaries only</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Step therapy</td>
<td>For certain drugs in specific therapeutic classes, our step therapy program requires providers to prescribe generic or other preferred brand-name drugs prior to prescribing certain brand-name drugs.</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Step therapy
For certain drugs in specific therapeutic classes, our step therapy program requires providers to prescribe generic or other preferred brand-name drugs before prescribing certain brand-name drugs.

Medicare Part D
Medicare Part D is the prescription drug benefit available to everyone eligible for Medicare. Legacy’s prescription benefits provide coverage as good as or better than the Standard Medicare Part D coverage. Legacy sends certificates of credible coverage to you and your enrolled dependents eligible for Medicare Part D every year regarding your choice of Medicare coverage and the impact on Legacy medical and prescription drug coverage. This certificate may be sent individually or listed as a notice in another mailed communication. For general information about Medicare Part D, call 800-MEDICARE (800-633-4227) or visit www.medicare.gov.

Coordination with other prescription drug plans
Legacy’s Prescription Drug Plan does not coordinate with other prescription drug plans.

Important Prescription Drug Plan terms

Brand-name preferred drugs — Drugs on the formulary that have been evaluated and recommended for use by MedImpact’s Therapeutics Committee of physicians, pharmacists and other health care professionals. Drugs are evaluated on the basis of need, effectiveness, safety and cost. The formulary is subject to change throughout the year; a current formulary is available on the MedImpact website.

Generic drugs — Drugs that meet the same FDA standards for safety, purity, strength and quality as brand-name prescriptions. Once patents expire for brand-name drugs, other manufacturers can offer the same drugs under generic names. The price of generic drugs is lower because the upfront research and development costs have already been paid by the original manufacturer.

Maintenance medication — Drugs prescribed for chronic, long-term conditions and taken on a regular, recurring basis, as classified by MedImpact.

MedImpact network pharmacy — Pharmacies contracted by MedImpact to provide prescription drug benefits to members. See “Summary of prescription drug benefits” for co-pay information.

Non-preferred drugs — Drugs not on MedImpact’s formulary (they may have a brand-name preferred or generic equivalent).

Specialty drugs — Certain drugs used to treat complex conditions that are on the specialty drug list available in the Benefits section of MyLegacy. Specialty drugs are limited to a 30-day supply on the first fill.

Value drugs — Certain drugs used to treat one of the conditions identified for enhanced coverage under the Medical Plan’s chronic conditions (Tier 1) benefits and that are on the Value Tier medication list. Value Tier drugs also include certain medications used to treat nicotine dependence when a member is participating in the Legacy tobacco cessation program.

Limitations and exclusions
In addition to limitations and exclusions described elsewhere, the following prescription drugs are not covered under this plan, even if otherwise medically necessary or if recommended or referred by a participating physician or provider:

• Diabetic supplies (these are reimbursed under the Medical Plan’s durable medical equipment benefits)

• Drugs considered by the plan to be experimental or under investigation, including those that are not recognized as accepted medical practice, for which scientific assessment has not been completed or effectiveness established, or for which the required approval of a government agency has not been granted

• Drugs used to treat illness or injury arising out of or in the course of employment or self-employment for wages or profit, whether or not the prescription is paid under workers’ compensation; exception: the member is exempt from state or federal workers’ compensation law
• Growth hormones unless approved and pre-certified by UMR
• Immunization agents (except antiRho(D) immune globulin used to prevent Rh immune fetal reaction), biological sera, blood or blood plasma
• Minerals
• New prescriptions for specialty medications are limited to a 30-day supply; refills are not subject to the 30-day limit
• Non-prescription or over-the-counter drugs, syringes, devices or supplies (even when prescribed), except insulin
• Oral legend vitamins; exception: pregnancy, lactation or multivitamin supplements with fluoride (for children through age 17)
• Over-the-counter items, even when prescribed, including non-federal legend drugs, such as pseudoephedrine
• Prescriptions for cosmetic purposes or weight loss purposes
• Prescriptions for the sole purpose of travel or for illnesses contracted during travel
• Rogaine or other hair loss treatments
• Prescriptions for reproductive or sexual disorders and defects, whether or not the consequence of illness, disease or injury, including but not limited to impotency, frigidity, infertility, sterility and in-vitro fertilization
• Prescriptions received before or after coverage under this plan ends; members are responsible for paying the full amount of any prescription for a non-covered drug
• Prescriptions received from a provider with whom you do not have a valid patient-provider relationship.
At Legacy, we’re committed to improving your overall health and wellness. We encourage you to take advantage of the programs and workshops offered through Community Health Education to help you achieve and maintain good physical and mental health. Visit the Classes & Events section of www.legacyhealth.org for more information.

As Medical Plan members, you and your dependents have access to a wide variety of wellness programs, including:

• Adult immunizations
• Alternative care
• Flu shots available to all active Legacy employees; contact the Legacy Employee Health Department for more information
• Health education, including classes, screenings and support groups on topics such as cancer, diabetes, grief and wellness; for more information, visit the Classes & Events section of www.legacyhealth.org
• Lactation counseling and breast pump allowance
• Nutrition counseling
• Preventive health care benefits, including Pap smears, mammograms, PSAs, physical exams, well-child exams and childhood immunizations

ActiveHealth Management

ActiveHealth provides many wellness programs to help you and your family get and stay healthy. For more information on these programs or to get started, contact ActiveHealth at 866-939-4717.

Chronic Conditions Program

This program provides support for Medical Plan enrollees at risk for any of more than 40 chronic conditions such as asthma, diabetes, high blood pressure and heart disease. If you have a chronic condition, you can work one-on-one with a nurse from ActiveHealth over the phone.

Diabetes Wellness Program

For all Medical Plan enrollees, this program offers:

• 100 percent reimbursement of diabetes supplies including test strips, needles, syringes and monitors (you pay the full cost at the time of purchase and submit the receipt to UMR for reimbursement; the UMR Diabetes Supplies Reimbursement form is available on MyLegacy)
• Phone-based nursing interventions and coaching
• Additional diabetes education resources
• Reduced insulin co-pays under the Prescription Plan's Value Tier.

**Lifestyle coaching**
This free program empowers you to practice healthy exercise, nutrition, weight control and stress management habits. Health coaches establish an ongoing telephone relationship with you and use various methods to encourage consistency in these habits so you can feel your best.

**Tobacco cessation**
For you, your spouse/domestic partner and enrolled children over 18, the tobacco cessation program includes:
• Five telephone counseling sessions
• Self-help materials
• An eight-week supply of nicotine replacement therapy at no charge.

**Online tools**
• Health Risk Assessment — You can make the MyActiveHealth portal (www.myactivehealth.com/legacy) work for you by answering the questions in this assessment. It only takes 10 to 15 minutes and you’ll get a personal report on your health, along with new health actions for improvement.
• MyActiveHealth Web portal — Through the MyActiveHealth portal, you can access digital coaching, track health numbers, view information about being healthier and more. The site’s Health Center gives you the tools to be healthy and stay informed.

**Biometric screening**
The Know Your Numbers cardiac wellness screening offered through Cardiac and Pulmonary Rehabilitation Services (Legacy Good Samaritan) includes:
• Blood pressure assessment
• Body fat analysis
• Cholesterol screenings
• Diabetes screening

• Educational information
• Personal consultation with a cardiac nurse.

The Medical Plan pays the cost of this program for all employees. Call 503-335-3500 for details.

**Employee Assistance Program (EAP)**
Through Cascade Centers, Inc. (www.cascadecenters.com), our EAP offers assistance for you and your family with concerns such as:
• Alcohol or drug abuse
• Conflict at work
• Depression or anxiety
• Family relationships
• Financial/legal/consumer issues
• Grieving a loss
• Marital/interpersonal conflict
• Personal decision making
• Referrals to community resources
• Stress management.

EAP services include:
• Intake/assessment — Up to three sessions per incident, per year for identifying problems, establishing outcome goals and recommending actions.
• The Line — Cascade’s anonymous information line is available for information about general mental health and EAP services.
• E-Support — A live online session with an EAP consultant answers your questions, helps with resolution and offers customized advice.
• Crisis counseling — This support is available 24 hours a day, seven days a week.
• Work/family/life — Cascade also helps locate resources and information nationwide related to these services:
  — Elder care — Solutions to the needs of aging parents such as housing, alternative living, home health, community services, legal concerns and medical issues
  — Child care — Infant to college-age information and resources for education, parenting and adoption
— Concierge — Time-saving help to identify, research and verify resources, from dry cleaners to dog sitters.

- Identity theft services — You have unlimited phone consultations for identity theft recovery, support and prevention techniques.

- Legal/financial consultation — Licensed professionals are available to advise you and your family:
  
  — Legal: An initial 30-minute office or telephone consultation per legal matter (up to three per year) at no cost with a network attorney; if you decide to retain the attorney after the initial consultation, you’ll have a discounted rate (25 percent off the attorney’s normal hourly rate)
  
  — Financial: No-cost telephone consultations (30 to 60 minutes per issue) for credit counseling, debt and budgeting assistance, tax planning, retirement or college planning questions and referrals; rate discounts apply to additional counseling.

- Home ownership program — If you want to buy, sell, refinance or invest in a home, this program offers a network of pre-screened service providers that offer free, no-obligation consultations; pre-negotiated discounts are available.

EAP contact is completely confidential. (See “Contact summary” on page 2 for phone numbers.) No information is disclosed to anyone outside Cascade Centers without your written consent, and your identity is protected within the limits of the law.

**Immunizations**

The Legacy Employee Health Department provides you and your dependents (age 18 and older) with certain immunizations at no charge from these clinics:

Legacy Emanuel — Room 2049, 503-413-4282

Legacy Research Institute (Holladay Park) — Room 456, 503-413-5116

Legacy Good Samaritan — Suite 287, 503-413-7487 or 503-413-7871

Legacy Salmon Creek — Room 1A-119, 360-487-1070

Legacy Mount Hood — Cascade Building, Room A27, 503-674-1260

Legacy Meridian Park — Unit 1C, 503-692-2118

System Office — 1120 Building, Suite 105, 503-415-5300

**LA Fitness**

You and your family (including children to age 22, living at the same address) are eligible for discounted memberships at LA Fitness. The facilities offer state-of-the-art equipment and exercise programs close to most Legacy locations. To enroll, visit the Wellness section of MyLegacy and access the LA Fitness site at www.lafitness.com. (Legacy volunteers also are eligible.)

**Live It!**

Legacy Weight and Diabetes Institute created Live It! — a six-month, medically supervised nutrition program to help you learn long-term changes for weight management and better health. The goal is to educate, remove obstacles and provide support. The program does not use a special diet, but changes in current eating habits — through learning, examining overeating triggers and enjoying the right foods.

As a benefit-eligible employee, you, your spouse/domestic partner or dependent children age 18 or older can receive 100 percent reimbursement ($600 in 2014) after meeting an 80 percent participation requirement if you submit the request within 180 days of completing the program. See the Benefits section of MyLegacy for the form. The reimbursement is taxable unless a physician’s referral to participate in the program is provided with the reimbursement request.

Call the Legacy Weight and Diabetes Institute at 503-413-7557 for program details, or the HR Answer Center at 503-415-5100 with reimbursement questions.

**Pregnancy and newborn education**

This program offers 100 percent reimbursement of Legacy-sponsored pregnancy and newborn classes for all benefit-eligible employees. You must first use the discount code EMPLOYEE20 when signing up for classes. You then submit your proof of payment to the Benefits Department within 180 days of
completing the class(es) using a Pregnancy and Newborn Education claim form (see the Benefits section of MyLegacy).

**Weight Watchers**

Legacy offers reimbursement up to 100 percent if you, your spouse/domestic partner or dependent children age 18 or older complete a 10-week or 13-week session with Weight Watchers. To qualify, you must be benefit-eligible when you (or an eligible family member) enroll as well as for the duration of the program and follow these guidelines:

- Pay the cost of the meetings up front.
- Document attendance by having the session leader stamp the weight log booklet.
- For Weight Watchers @ Work: Attend nine out of 10 meetings or 11 out of 13 meetings each session. For monthly passes: Attend at least 11 meetings in three consecutive months.
- Submit a Weight Watchers reimbursement form (see the Benefits section of MyLegacy), proof of payment and copy of the log booklet to the Benefits Department within 180 days of completing the last meeting of a session.

The Benefits Department reviews your documents and, if approved, reimburses you on your paycheck. The reimbursement is taxable unless a physician’s referral to participate in the program is provided with your request.
How the Dental Plan works

You and your eligible dependents may enroll in the Dental Plan. You have the option of seeing the dentist of your choice or a preferred network dentist for a higher benefit.

You may choose any licensed dentist or licensed denturist; however, the plan pays a higher percentage for major services when you see a Moda Health preferred network provider (Delta Dental PPO). The Dental Plan provides four levels of coverage:

• Diagnostic/preventive
• Basic
• Major (waiting period applies)
• Orthodontia (waiting period applies)

If you select a more expensive treatment plan than is functionally adequate, the plan pays the applicable percentage of the maximum plan allowance (see “Important Dental Plan terms”) for the least costly treatment; you’re responsible for the remainder of the fee.

Moda Health is our dental administrator. You can contact them at 503-243-3886 (Portland), 888-281-0405 (outside Portland) or www.modahealth.com.

Dental coverage waiting period/limit

Dental coverage is restricted for the first 12 months to diagnostic/preventive and basic services. Once you’ve been covered for 12 months under the Dental Plan, you’re eligible for major and orthodontia benefits. If you are rehired (with a break in service longer than 12 months), this applies to you and your dependents for the first 12 months you are re-enrolled. If you waive dental coverage for more than 12 months, you and your dependents are limited to diagnostic/preventive and basic services for the first 12 months of coverage after re-enrollment.

Waiving dental coverage

If you waive dental coverage, you receive a credit on your paycheck. (Employees who waive Legacy dental coverage to be covered under another Legacy employee’s dental coverage are not eligible for waive credits.)
Summary of dental benefits

Pre-determination
For treatment and procedures costing more than $500, Moda Health recommends asking for an estimate of available coverage before beginning treatment. Your dentist submits a predetermination request, processed according to the plan’s current contract, to specify the amount of your coverage.

Diagnostic/preventive services
The annual deductible does not apply to diagnostic/preventive services. The plan pays contracted amounts (except when prescribed by your dentist as part of disease treatment) for:
• Complete mouth X-rays or panoramic film once in any five-year period
• Supplementary bitewings once per calendar year
• Fluoride treatment twice per calendar year for age 18 and under or for age 19 and over if there is a history of periodontal disease or high risk of decay due to a medical disease, chemotherapy or similar treatment
• Prophylaxis (cleaning) or periodontal maintenance for all ages, twice per calendar year.

Basic services
The plan pays for:
• Emergency treatment primarily for relief, not cure
• Services and supplies to diagnose or treat the temporomandibular joint (TMJ), up to a $1,000 lifetime maximum for oral splints, nightguards and other appliances or non-surgical procedures.

Major services
The plan pays for major services after a 12-month waiting period. A statement certifying oral health from a dentist or physician must be obtained before a denturist provides prosthetic services, except when the services are to repair a denture.

<table>
<thead>
<tr>
<th>Provision</th>
<th>Preferred provider</th>
<th>Any provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-determination</td>
<td>Suggested for any treatment over $500</td>
<td></td>
</tr>
<tr>
<td>Deductible (calendar year)</td>
<td>$25 per person for basic and major services</td>
<td>$50 per person for basic and major services</td>
</tr>
<tr>
<td></td>
<td>$75 per family for basic and major services</td>
<td>$150 per family for basic and major services</td>
</tr>
<tr>
<td>Maximum benefit</td>
<td>$1,500 per year per person for all services, except $3,000 per lifetime for orthodontia and pre-orthodontic services</td>
<td></td>
</tr>
<tr>
<td>Diagnostic/preventive services</td>
<td>100% of maximum plan allowance</td>
<td></td>
</tr>
<tr>
<td>Basic services (amalgam fillings, simple extractions, surgical extractions, endodontics including direct pulp capping and apicoectomies, root canal, treatment of periodontal disease per quadrant, inlays and surgical services)</td>
<td>80% of maximum plan allowance</td>
<td></td>
</tr>
<tr>
<td>Major services (crowns, prosthetic devices including bridges, partials and dentures, repair of dentures, implants, bridges and athletic mouthguards)</td>
<td>70% of maximum plan allowance</td>
<td>50% of maximum plan allowance</td>
</tr>
<tr>
<td>Orthodontia (pre-orthodontic services)</td>
<td>60% of maximum plan allowance up to a $3,000 lifetime maximum per person</td>
<td></td>
</tr>
<tr>
<td>Temporomandibular joint (TMJ)</td>
<td>80% of maximum plan allowance up to $1,000 lifetime maximum per person</td>
<td>60% of maximum plan allowance up to $1,000 lifetime maximum per person</td>
</tr>
</tbody>
</table>
Orthodontia

The plan pays for orthodontia services after a 12-month waiting period. When your orthodontist determines the treatment needed, he or she is required to submit a pre-treatment plan to Moda Health stating:

• Total orthodontia fee
• Initial banding fee
• Estimated monthly fee

Moda Health notifies you and your orthodontist of benefit payments you can expect. Benefit payments are made every three months, regardless of the orthodontist’s billing procedures.

If orthodontia treatment began before coverage under the Dental Plan, benefits are prorated based on the stage of treatment completed when coverage begins. Your orthodontist must submit the initial orthodontia treatment plan to Moda Health to determine the amount that would have been paid if you had been covered; that amount is subtracted from the benefit maximum otherwise available.

If orthodontic treatment stops before the estimated treatment period ends, orthodontic services incurred after treatment ends are not covered.

Reminder

Major and orthodontia services are subject to the 12-month waiting period.

Coordination of Benefits (COB)

COB is how the Plan works in conjunction with other coverage you may have through a non-Legacy plan. See page 93 for additional information.

Limitations and exclusions

In addition to limitations and exclusions described elsewhere, the following services, procedures and conditions (including services or supplies related to the condition) are not covered even if otherwise dentally necessary (see "Important Dental Plan terms" on page 48) or if recommended, referred or provided by a participating dentist or dental provider:

• Athletic mouthguard coverage exceeding one per calendar year for age 15 and under and one every two calendar years for age 16 and over
• Bridges or dentures that are lost, stolen or broken
• Charge exceeding a standard full or partial denture when replacing missing teeth with full or partial dentures
• Claims submitted more than 12 months after the date of service
• Cosmetic procedures, appliances, restorations or services, including complications arising from them
• Crown buildups are included in crown restoration cost; a buildup is covered only if necessary for tooth retention
• Dental services as a result of accidents (these dental services are covered under the Medical Plan)
• Experimental procedures or treatments or those under investigation, including any not recognized as accepted dental practice in the plan’s service area or for which the required approval of a government agency has not been granted
• Fee for writing a prescription or filling out a claim form
• Fixed bridges or removable cast partials for members under age 16
• General anesthesia, IV sedation and/or nitrous oxide, except when administered by a dentist in conjunction with covered oral surgery in the dentist’s office
• Gnathologic recordings or similar procedures
• Hospital charges
• Hypnosis, premedications, analgesics, local anesthetics or any other prescribed drugs
• Injury or illness caused by an act of war
• Injury or illness incurred while committing a crime
• Inlays are an optional service; the alternative benefit of an amalgam is covered
• Missed or canceled appointments
• Models of teeth and surrounding tissue for study and treatment planning
• Periodontal scaling and root planing exceeding once per quadrant in a 24-month period
• Porcelain restorations (crowns/facings) are considered cosmetic dentistry if placed on the upper
second or third molars or lower first, second or third molars; coverage is limited to gold without porcelain

• Prosthetic devices, crowns or other cast restorations (including onlays and replacement inlays) exceeding once every seven years per tooth since the most recent placement

• Recording of jaw movements or positions, except for diagnosing TMJ

• Repair or replacement of orthodontic appliances

• Replacement of an existing bridge, denture or partial less than seven years after the date of the most recent placement made necessary by loss, theft or breakage

• Sealants to the unrestored occlusal surfaces of permanent molars exceeding one per tooth during any five-year period

• Separate, additional charge for alveoloplasty done with removal of teeth or for denture adjustment and relines done within six months after initial placement (subsequent relines are covered once in a 12-month period)

• Separate charge for periodontal charting or for post-operative care done within six months following periodontal surgery

• Services or supplies:
  — Covered by Medicare for persons eligible for Medicare, except as required by law
  — For which a member could have obtained payment, in whole or in part, under any city, county, state or federal law
  — For which no charge is made or for which a charge increased because insurance is available
  — Received before coverage starts or after coverage ends; for artificial teeth, crowns and bridgework, the date they are placed is considered the date of service
  — Received from a dental or medical department maintained by or on behalf of any employer, mutual benefit association, labor union trustee or similar person or group
  — That could have been received in a hospital operated by a government agency

— To rebuild or maintain chewing surfaces due to teeth out of alignment or occlusion, or to stabilize teeth (services only to prevent wear or protect worn or cracked teeth also are excluded), including but not limited to increasing vertical dimension, equilibration, periodontal, splinting and night guards (occlusal guard)

— To treat illness or injury arising from or in the course of employment or self-employment for wages or profit, whether or not its expense is paid under workers’ compensation (except if the member is exempt from state or federal workers’ compensation law)

• Services or supplies not specifically described as covered in this plan description

• Services performed by immediate family members

• Services that are not necessary dental care

• Surgical placement or removal of implants or attachments exceeding the equivalent amount for a full or partial denture

• Taxes

• Teeth whitening services or supplies

• Temporary dentures

• Treatment received outside the country

• Veneer coverage exceeding the maximum plan allowance for crowns.

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**Important Dental Plan terms**

**Abutment** — Tooth used to support a prosthetic device (implant crowns, bridges, partial dentures or overdentures).

**Accepted fee** — Filed fee approved by Moda Health for a specific dental procedure performed by a participating dentist submitting that fee and performing that dental service. If the database does not contain a fee for a particular procedure in a particular area, the claim is referred to the plan’s dental consultant, who determines a comparable code to the one billed. Moda Health uses the Maximum Plan Allowance for the comparable code to price the claim.

**Amalgam** — Silver-colored material used in restoring teeth
An anterior — Teeth located at the front of the mouth
Alveoloplasty — The surgical alteration of the shape and condition of the alveolar process.
Bridge (also called fixed partial denture) — Replaces one or more missing teeth using a pontic (false tooth or teeth) permanently attached to the adjacent teeth. Abutment crowns (crowns placed on adjacent teeth) are considered part of the bridge.
Broken — When a piece or pieces of the tooth have been completely separated from the rest of the tooth. A tooth with cracks is not considered broken.
Cast restoration — Crowns, inlays, onlays and any other restoration to fit a specific patient’s tooth that is made at a lab and cemented into the tooth.
Composite — Tooth-colored material used in restoring teeth.
Dental care — Services or supplies to prevent, diagnose or treat diseases of the teeth and supporting tissues or structures, including to repair defects that have developed because of tooth loss and to restore the ability to chew.
Dental providers — Duly licensed dentists, certified denturists or registered hygienists, legally entitled to practice dentistry at the time and in the place services are performed; they operate within the scope of their license, certificate, or registration, as required under law within the state of practice.
Dentally necessary — Services that:
• Are established as necessary to treat or prevent a dental injury or disease otherwise covered under this plan
• Are appropriate with regard to standards of good dental practice in the service area
• Have a good prognosis
• Are the least costly of the alternative supplies or levels of service that can be safely provided; for example, coverage would not be allowed for a crown when a filling would be adequate to restore the tooth appropriately.

The fact a dentist may recommend or approve a service or supply does not, of itself, make it covered or dentally necessary.

Implant — Artificial, permanent tooth root replacement for a missing tooth, surgically placed into the upper or lower jaw bone to support a single crown, fixed bridge, or partial or full denture.
Implant abutment — Attachment used to connect an implant and an implant-supported prosthetic.
Implant-supported prosthetic — Crown, bridge, or removable partial or full denture supported by or attached to an implant.
Maximum payment limit — Amount payable by the plan for covered services received each calendar year or portion of the calendar year for each member.
Maximum plan allowance — For participating dentists or dental providers, the maximum plan allowance is based on a fee filed with Moda Health. For non-participating dentists or dental providers, the maximum plan allowance is based on a per-service average allowance of participating dentist or dental provider filed fees. A non-participating provider has the right to bill the patient for the difference between the Moda Health maximum plan allowance and the actual charge.
Non-participating dentists and dental providers — Dentists and dental providers who have not agreed to render services in accordance with Moda Health terms and conditions.
Palliative treatment — Treatment performed only to control pain, swelling or bleeding in or around the teeth and gums; does not refer to follow-up care or definitive restorations, including but not limited to crowns, extractions or root canals.
Participating dentists and dental providers — Licensed dentists and dental providers who have agreed to render services in accordance with Moda Health terms and conditions and have satisfied Moda Health that they comply with those terms and conditions.
Periodic exam — Routine exam (check-up), commonly performed twice each calendar year.
Periodontal maintenance — Procedure for patients who have previously been treated for periodontal disease. In addition to cleaning visible surfaces of the teeth (as in prophylaxis), surfaces below the gumline are also cleaned. This is a more comprehensive service than a regular prophylaxis.
Pontic — Artificial tooth that replaces a missing tooth and is part of a bridge.

Posterior — Teeth located toward the back of the mouth.

Prophylaxis — Cleaning and polishing of all teeth.

Restoration — Treatment to repair a broken or decayed tooth, including but not limited to fillings and crowns.

Veneer (chairside and lab) — Layer of tooth-colored material attached to the surface of an anterior tooth to repair chips or cracks, fix gaps and change the tooth’s shape and size. Chairside veneer is a restoration created in the dentist’s office; lab veneer is a restoration created (cast) at a lab. Each may be paid at different benefit levels.
How the Vision Plan works

You and your eligible dependents may enroll in the Vision Plan.

The Vision Plan covers routine exams and provides an allowance for corrective lenses, frames or contacts, which require a prescription by a licensed ophthalmologist or optometrist.

UMR is our vision administrator. You can contact them at 866-868-7761 or www.umr.com.

Summary of vision benefits

If performed by an ophthalmologist or optometrist, coverage includes one annual routine exam for you and your covered dependents. The plan pays 100 percent of covered charges up to the maximum plan allowance after you pay:

• $15 co-pay for an optometrist or Legacy + Network ophthalmologist
• $50 co-pay for a non-Legacy + Network ophthalmologist.

Refraction services performed during a medical eye exam may be denied if not coded using a routine eye exam diagnostic code by your provider’s office.

You also receive an annual vision hardware allowance of $200 toward the purchase of lenses, frames or contacts from any provider. You need to purchase the item in full, then submit a vision claim form (see the Benefits page of the MyLegacy intranet) and itemized receipt for reimbursement. Contact lens exam fees are not covered under the vision exam benefit, but are reimbursed from any remaining annual hardware benefit balance.

The Vision Plan does not provide coordination of benefits with other coverage you might have.

Contact lenses, intraocular lenses or eyeglasses needed after cataract surgery are covered under the Medical Plan’s durable medical equipment benefit.

Limitations and exclusions

In addition to limitations and exclusions described elsewhere, the following services, procedures and conditions (including services or supplies related to the condition) are not covered even if otherwise medically necessary or if recommended, referred or provided by a physician or provider:

• Additional charges for partially covered frames
• Colored contacts for cosmetic purposes only
• Injury or illness caused by an act of war
• Injury or illness incurred while committing a crime
• Laser eye surgery or follow-up visits
• Routine eye exams other than provided under the plan, including fitting, providing or replacing eyeglasses
• Services or supplies not specifically described as covered in this plan description.
• Treatment of eyes or special procedures such as orthoptics or vision training
• Treatment received outside the country

**Important Vision Plan terms**

**Maximum plan allowance** — Maximum amount that UMR will reimburse physicians and providers. For participating physicians/providers, this is the amount they agreed to accept for a particular service. For non-participating physicians/providers, you are responsible for any billed amount over the maximum plan allowance.

**Ophthalmologist** — Medical doctor who specializes in examining, diagnosing and treating eyes and eye diseases.

**Optometrist** — Eye care professional who is licensed to provide refractory exams and vision consultation.
Understanding flexible spending accounts

A flexible spending account is a tax-favored program that allows you to pay for eligible out-of-pocket health care or dependent care expenses with pre-tax dollars from payroll deductions. This means a savings equal to the tax you would otherwise have paid. Legacy offers you a Health Care Flexible Spending Account and Dependent Care Flexible Spending Account, as described below. You can elect to participate in either or both of these accounts.

UMR is our flexible spending account administrator. You can reach them at 866-868-7761, umr-fsa@umr.com or www.umr.com.

Federal regulations and other limits

Be sure to consult with your tax adviser for a complete understanding of how all federal regulations affect your situation. Some main regulations state:

• You must make a new benefit election for each calendar year you decide to participate in a flexible spending account.

• If you decide to participate, you must enroll for the full calendar year. If you enroll after January, your enrollment is for the rest of the calendar year.

• Your flexible spending account elections are irrevocable unless you experience a qualified life event or are eligible for a qualified reservist distribution (described later in this section). For a summary of eligible changes, see Table 6, “Effect of qualified life events on Health Care Flexible Spending Account elections” on page 55, and Table 7, “Effect of qualified life events on Dependent Care Flexible Spending Account elections” on page 57. Flexible spending account elections cannot be reduced to an amount less than your total contributions in the current year.

• Both flexible spending accounts are subject to federal non-discrimination rules. Highly compensated employees may have their current annual flexible spending account elections adjusted in the current plan year in order for the flexible spending account to pass the non-discrimination test.

• Dependent care expenses incurred while on a leave of absence are not eligible for reimbursement. When you return, your Dependent
Flexible Spending Accounts

Care Flexible Spending Account contribution is reduced based on the number of missed pay dates.

- You must use the entire amount set aside in the Dependent Care Flexible Spending Account during the calendar year. Any amounts remaining are forfeited (except for a qualified reservist distribution).
- You must use the entire amount set aside in the Health Care Flexible Spending Account during the calendar year and file claims by March 31 of the following year. Amounts over $500 remaining after year-end are forfeited (except for a qualified reservist distribution). Remaining amounts of $500 or less automatically roll over and are added to your Health Care Flexible Spending Account funds available in the next calendar year as long as you remain a benefit-eligible employee.
- Only expenses incurred while actively participating in a flexible spending account are eligible for reimbursement. Expenses are considered incurred on the date the service is actually provided, rather than when you are billed or make payment.
- Any reimbursed expense from a flexible spending account cannot be a deduction or credit on your income tax return.
- The Plan will only reissue stale reimbursement checks within one year from the date of the initial reimbursement check.
- You must continue flexible spending account contributions during approved FMLA leaves of absence. When you return to work, up to two past payments and your current payment are deducted from your paycheck until you’re current.
- The Dependent Care Flexible Spending Account and Health Care Flexible Spending Account accounts are separate — you may not be reimbursed for health care expenses from your Dependent Care Flexible Spending Account and vice versa.

Health Care Flexible Spending Account

You can contribute pre-tax up to $2,500 a year (minimum $52) to your Health Care Flexible Spending Account to pay IRS-qualified health care expenses for you and eligible dependents.

Up to $500 in unused Health Care Flexible Spending Account funds automatically rolls over to the next calendar year, regardless of whether you make a new election during Annual Enrollment as long as you remain a benefit-eligible employee.

For a list of eligible and excluded health care expenses, see the Benefits section of MyLegacy or call the HR Answer Center.

Important considerations

Your Health Care Flexible Spending Account contributions end at the end of the month you either lose plan eligibility or terminate employment. Under federal COBRA rules, you’ll have the opportunity to maintain eligibility for services incurred after you terminate employment by continuing to self-pay your contribution; however, these payments are on an after-tax basis. (See “Continuation coverage” on page 95.) You must have a positive balance in your account to qualify.

If you choose not to continue contributing to your account, any services incurred after the last day of the month you terminate employment are not eligible for reimbursement. You forfeit any balance remaining in your account on the first day you fail to make a contribution, except claim reimbursement for eligible expenses incurred during your enrollment. You have until March 31 of the next year to submit claims for services received while you contributed to the account. Additional information for incomplete claims also must be faxed or postmarked by March 31 to be eligible for consideration.

To submit claims, fill out the Health Care Flexible Spending Account Claim Form (available from the Benefits section of MyLegacy), attach proof of payment and mail or fax it to UMR for processing and reimbursement. You can be reimbursed for eligible health care expenses as long as the amount requested is at least $10 and doesn’t exceed your contribution limit for the year, including any prior withdrawals and availability restrictions. The $10 minimum claim requirement is waived at plan year-end to assure you receive the tax benefit of all covered expenses, up to your contribution limit.
Expenses can be submitted for reimbursement from your Health Care Flexible Spending Account only after all available insurance has paid its benefit and if the expense is not covered or reimbursable from any other source.

**Autopay and direct deposit programs**

UMR offers an autopay option that allows you to be automatically reimbursed from your Health Care Flexible Spending Account for eligible medical, dental and prescription expenses without having to submit claim forms or supporting documents. You can also sign up to have your flexible spending account reimbursements directly deposited into your bank account.

You’ll receive information and an Autopay and Direct Deposit election form in your flexible spending account packet when you enroll in the Health Care Flexible Spending Account. When UMR, Moda Health or MedImpact receives a claim from your provider, they process and pay the eligible expenses according to the plan (orthodontia expenses cannot be reimbursed through Autopay). After the claim is processed, UMR or Moda Health sends you an Explanation of Benefits (EOB). Moda Health also notifies UMR, and they reimburse you from your Health Care Flexible Spending Account for the Patient Responsibility portion noted on your EOB (up to your annual available contribution). Reimbursement timing depends on how quickly your provider submits the claim.

**Qualified reservist distribution**

In accordance with the Heroes Earning Assistance and Relief Tax Act of 2008 (the HEART Act), a qualified distribution is permitted of all or part of any unused Health Care Flexible Spending Account benefits if you are a reservist called to active duty and:

- You are called up for more than 179 days or for an indefinite period
- The distribution is made during the time between when the order or call is made and the last day that a reimbursement could be made from the account for the plan year.

You must request this qualified distribution from the Benefits Department as soon as you receive your orders or are called to active duty. If you’re determined eligible, the distribution is included in your paycheck and is subject to taxation.

The qualified reservist distribution provision is administered according to current IRS regulations.

| TABLE 6  Effect of qualified life events on Health Care Flexible Spending Account elections |
| --- | --- | --- | --- | --- | --- |
| Event | Start election | Stop election | Increase election | Decrease election |
| Birth, adoption or placement for adoption | Yes | No | Yes | No |
| Marriage or forming a domestic partnership | Yes | Yes | Yes | Yes |
| Divorce or terminating a domestic partnership | Yes | Yes | Yes | Yes |
| Death | Yes | Yes | Yes | Yes |
| Starting/stopping FMLA leave | No | No | No | No |
| Spouse/domestic partner/dependent child gains benefit coverage or employment | No | Yes | No | Yes |
| Spouse/domestic partner/dependent child loses benefit coverage or employment | Yes | No | Yes | No |
| Cost change for health coverage | No | No | No | No |
| Need/no longer need a health procedure | No | No | No | No |
| Cannot afford flexible spending account deductions | No | No | No | No |
| Employee changes from full-time to part-time (with benefits) employment status | No | No | No | No |
| Employee changes from part-time (with benefits) to full-time employment status | No | No | No | No |
Dependent Care Flexible Spending Account

You can contribute pre-tax up to $5,000 a year (per household) or $2,500 if you are married and file a separate return (minimum $52) to your Dependent Care Flexible Spending Account to pay IRS-qualified dependent care expenses for children under age 13, a disabled spouse or dependent parents. Eligible dependent care expenses include the cost of services from qualified dependent care centers or from individuals who provide care inside or outside your home but are not family members claimed on your taxes. Dependent care expenses do not include co-pays, co-insurance or other unreimbursed medical expenses.

To qualify for reimbursement, the dependent care must be necessary to enable you (and your spouse if you’re married) to work or actively look for work. Dependent care expenses incurred while you are not working are not eligible for reimbursement. Your spouse must be employed, actively looking for work, disabled or a full-time student.

For a list of eligible and excluded dependent care expenses, see the Benefits section of MyLegacy or call the HR Answer Center.

The cost of the care claimed cannot be more than your or your spouse’s earned income, whichever is less. For this purpose, your earned income is reduced by the amount you elect to contribute to the Dependent Care Flexible Spending Account. If your spouse is a full-time student or mentally or physically handicapped, the IRS considers your spouse to earn:

- $200 per month if you have one dependent
- $400 per month if you have more than one dependent.

Consult a licensed tax professional to see how dependent care regulations apply to you.

Important considerations

Your Dependent Care Flexible Spending Account contributions stop at the end of the month you either lose plan eligibility or terminate employment. You have until March 31 of the next year to submit claims for eligible expenses incurred while you contributed to the account. Additional information for incomplete claims also must be faxed or postmarked by March 31.

To submit claims, fill out the Dependent Care Flexible Spending Account Claim Form (available from the Benefits section of MyLegacy), attach proof of payment and mail or fax it to UMR for processing and reimbursement. You are reimbursed for eligible dependent care expenses as long as the amount requested is at least $10 and does not exceed your contribution limit for the year, including any prior withdrawals and availability restrictions. The $10 minimum claim requirement is waived at plan year-end to ensure you receive the tax benefit of all covered expenses, up to your contribution limit.

Expenses can be submitted for reimbursement from your Dependent Care Flexible Spending Account only after your insurance has paid its benefit and if the expense is not covered or reimbursable from any other source.
<table>
<thead>
<tr>
<th>Event</th>
<th>Start election</th>
<th>Stop election</th>
<th>Increase election</th>
<th>Decrease election</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth, adoption or placement for adoption</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Marriage or forming a domestic partnership</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Divorce or terminating a domestic partnership</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Death</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Starting/stopping FMLA leave</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Spouse/domestic partner/dependent child gains or loses benefit coverage or employment</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Cost change for day care*</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Enrolling in day care late*</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Cannot afford flexible spending account deductions</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Employee changes from full-time to part-time (with benefits) employment status</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Employee changes from part-time (with benefits) to full-time employment status</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

*Documentation required from day care provider.*
Understanding life insurance

Legacy offers several life insurance options to you and your dependents, as summarized below. For a complete description see the relevant insurance policy.

The Hartford is our life insurance administrator. Call the HR Answer Center at 503-415-5100 with questions.

Employee life insurance options

Legacy pays for one times your annual base salary for basic life coverage; you are enrolled automatically. You can elect to buy additional amounts, up to five times your annual salary, in supplemental life coverage. If you elect supplemental life coverage greater than your basic coverage amount, the premium you pay is withheld on a pre-tax basis.

If you elect employee life insurance of $50,000 or more, the value of employer-sponsored coverage greater than $50,000 is imputed income — taxable to you under current regulations. Imputed income is included in gross earnings on your paycheck and year-end W-2 form and is taxed accordingly.

The tables below list employee life insurance options available to you and monthly rates per $1,000, based on your age. The premium is based on your age as of Jan. 1 of the current year. If your annual base salary and/or budgeted hours change during the benefit year, your coverage amount and premium change the first of the next month to reflect current hours and earnings. Your annual base salary is multiplied by your coverage election, then rounded to the next higher $1,000.

<table>
<thead>
<tr>
<th>Coverage Type</th>
<th>Rate Calculation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Basic coverage — paid by Legacy</td>
<td>1x annual base salary</td>
</tr>
<tr>
<td>Supplemental coverage — paid by the employee</td>
<td>1x annual base salary&lt;br&gt;2x annual base salary&lt;br&gt;3x annual base salary&lt;br&gt;4x annual base salary&lt;br&gt;5x annual base salary</td>
</tr>
</tbody>
</table>

Guarantee issue = $500,000; Benefit maximum = $1,100,000
Spouse/domestic partner life insurance options

You may elect spouse/domestic partner life coverage in increments of $25,000, with a minimum of $25,000 and a maximum of $500,000. The first $100,000 of coverage is guarantee issue if you enroll within the 31-day initial enrollment or life event enrollment period.

If you request coverage over the guarantee issue amount, a Personal Health Application (described later in this section) is required. Spouse/domestic partner life insurance may not exceed your total employee life coverage amount by more than $24,999.

Cost of spouse/domestic partner life insurance

The cost of spouse/domestic partner life insurance is based on their age as of Jan. 1 of the current year and the cost per $1,000 of coverage. The premium you pay is withheld on an after-tax basis.

<table>
<thead>
<tr>
<th>Age</th>
<th>Monthly rate per $1,000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under age 30</td>
<td>$0.07</td>
</tr>
<tr>
<td>30–34</td>
<td>$0.09</td>
</tr>
<tr>
<td>35–39</td>
<td>$0.10</td>
</tr>
<tr>
<td>40–44</td>
<td>$0.11</td>
</tr>
<tr>
<td>45–49</td>
<td>$0.19</td>
</tr>
<tr>
<td>50–54</td>
<td>$0.31</td>
</tr>
<tr>
<td>55–59</td>
<td>$0.57</td>
</tr>
<tr>
<td>60–64</td>
<td>$0.75</td>
</tr>
<tr>
<td>65–69</td>
<td>$1.45</td>
</tr>
<tr>
<td>70+</td>
<td>$2.35</td>
</tr>
</tbody>
</table>

Duplicate coverage

You may not cover your spouse/domestic partner as a dependent if he/she is already enrolled for coverage as a Legacy employee. In addition, if you and your spouse/domestic partner are both employed by Legacy, only one of you may cover your children as dependents.

If your dependent is disabled

Life insurance for a totally disabled eligible spouse or dependent child, including any increased amounts, begins on the date he or she is no longer totally disabled. (This provision does not apply to a newborn child while dependent insurance is in effect.) Totally disabled means that, as a result of an injury, sickness or disorder, one or more of the following applies — your dependent:

- Is confined in a hospital or similar institution
- Is unable to perform two or more activities of daily living because of a physical or mental incapacity resulting from an injury or sickness
- Is cognitively impaired
- Has a life-threatening condition
- Is approved for Social Security Disability Insurance (SSDI).

Personal health application (PHA)

A PHA is an application process where you provide medical information regarding the condition of your and your spouse/domestic partner’s health. To meet the evidence of insurability (EOI) requirement, you both must complete and sign a PHA form. If you request employee or spouse/domestic partner coverage that requires a PHA, The Hartford will mail and email (to your Legacy email) instructions to complete an online PHA about two weeks after your benefit enrollment window closes. You have 60 days to complete the online PHA.

This form gives The Hartford authorization to obtain additional health information, if necessary. The Hartford may also request blood tests and a doctor’s exam (at its expense). When a PHA form is required, coverage becomes effective the first of the month following the approval date. Completion of the PHA form is not a guarantee of an increase in coverage.
Spouse/domestic partner life insurance changes during Annual Enrollment

You may increase your spouse/domestic partner’s life insurance during Annual Enrollment. If you increase coverage by only one level and the requested amount does not exceed $100,000, a PHA is not required.

If you increase coverage by more than one level or the requested amount exceeds $100,000, a PHA is required. If you previously waived spouse/domestic partner life coverage and elect it at a future enrollment, a PHA is required. The Hartford will mail and email (to your Legacy email) instructions to complete an online PHA about two weeks after you make your life insurance election. You have 60 days to complete the online PHA.

Dependent child life insurance options

You may elect life coverage for your dependent child(ren) in the amounts listed below. The premium you pay is withheld on an after-tax basis.

<table>
<thead>
<tr>
<th>Dependent option</th>
<th>Coverage amount per child</th>
<th>Total cost per pay period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>$2,000</td>
<td>$0.24</td>
</tr>
<tr>
<td>Option 2</td>
<td>$5,000</td>
<td>$0.61</td>
</tr>
<tr>
<td>Option 3</td>
<td>$10,000</td>
<td>$1.22</td>
</tr>
</tbody>
</table>

When coverage changes take effect

Once life coverage begins, any increased or additional coverage due to a change in your annual base salary or a plan change by Legacy takes effect on the first of the month following the date of the change. You must be actively employed or on a benefit-eligible leave of absence. If you are not in active employment due to injury or sickness, any increased or additional coverage due to a change in your annual base salary or a plan change takes effect on the date you return to active employment.

Any decrease in coverage due to a change in your annual base salary or a plan change by Legacy takes effect on the first of the month following the date of the change or on the date you return to active employment.

Coverage while not working

If you become permanently or totally disabled, your employee, spouse/domestic partner and dependent child life coverage continues at no cost to you until you reach normal retirement age, if you meet all of the following conditions:

- You are prevented by injury or sickness from doing any work for which you are, or could become, qualified by education, training or experience.
- You apply for waiver of premium before reaching age 60.
- You meet the definition of disability, as defined by the insurance contract, and provide proof that you have been disabled for nine consecutive months. (You also are considered disabled if diagnosed with a life expectancy of 12 months or less.)
- You provide proof of disability within one year from your last date of active work as an eligible employee under Legacy life coverage.

Waiver of premium continues until the earliest of the date:

- You die.
- You are no longer totally disabled.
- You reach normal retirement age, when you may elect to pay for your own portability coverage.
- The policy terminates. If it terminates after you qualify for waiver of premium, your coverage continues; however, your spouse/domestic partner and dependent child coverage ends. Your spouse/domestic partner and dependent child(ren) have the option to pay for their own portability coverage.
- Your dependents are no longer in an eligible class or no longer meet the definition of an eligible dependent.

Living needs benefit

If you or your covered dependent is diagnosed as terminally ill with a life expectancy of less than 12 months, this benefit allows you to receive a portion of your life insurance benefit to assist with medical treatment, family needs, etc. Once your application is approved by The Hartford, you receive up to 80 percent of your life insurance benefit, with a
maximum payout of $750,000. The amount of life insurance remaining after payment of the living needs benefit is paid to your or your covered dependent’s beneficiary after death.

**Assignment of benefit**

Your life insurance benefits are assign-able, meaning you can transfer the value of your insurance to a lender — the assignee — as collateral for a loan. The Hartford recognizes an assignee only if:

• The assignment is in writing, signed by you and on The Hartford’s form
• A signed or certified copy of the written assignment has been received and registered by The Hartford home office.

**Beneficiary designation**

You may change beneficiary(ies) at any time by logging on to Legacy’s Employee Self-Service portal (myess.lhs.org) and completing the beneficiary section. Only beneficiary elections made in Legacy’s Employee Self-Service portal are valid; designations made using paper forms or the bswift portal in prior years are not valid.

If you have not designated beneficiaries for your employee life insurance policies, the death benefit is paid in this order, at The Hartford’s discretion: your estate, spouse, children, grandchildren, parents and siblings. You are automatically the primary beneficiary on the spouse and/or dependent child life policies.

**Limitations and exclusions**

Any losses where death is caused by, contributed to by or results from suicide occurring within 24 months after:

• Your or your dependent’s initial effective date of insurance
• The date any increased or additional insurance becomes effective for you or your dependent.

This suicide exclusion applies to any insurance amount for which you pay all or part of the premium and to any amount subject to evidence of insurability requirements (if The Hartford approved the PHA and the amount you or your dependent applied for at that time).

**Coverage at age 70 and age 75**

If you are still an active benefit-eligible employee, your and your spouse/domestic partner’s life insurance amount is reduced by 35 percent on the Jan. 1 following the date you turn 70 and 50 percent when you turn 75, rounded up to the nearest $500. The age 75 reduction is based on the amount of coverage in force immediately before the first reduction. To retain full coverage, you have the option to convert your life insurance as described under “Conversion and portability policies” on page 97.

**Important life insurance terms**

**Active employment** — Working at least 24 budgeted hours per week for Legacy for earnings paid regularly and performing the regular occupation’s material and substantial duties at a work site that is:

• Employer’s usual place of business
• Alternative work site at the employer’s direction, including home
Or:
• Location to which the job requires the employee to travel.

Normal vacation is considered active employment.

**Annual base salary** — Hourly rate or salary paid each year for a job performed; does not include shift differential, on-call, standby, overtime, incentive premiums, per diem or any pay element other than base rate.

**Beneficiaries** — The person(s) selected to receive the covered member’s life insurance amount.

**Coverage amount** — Based on annual base salary and budgeted hours.

**Guarantee issue** — Coverage amount you can elect without medical underwriting approval.

**Medical underwriting** — Medical background check and Personal Health Application requirement to qualify for life insurance.

**Personal Health Application (PHA)** — Application process to provide medical information regarding the condition of your and your spouse/domestic partner’s health.
Understanding your short-term income supplement benefits

Legacy provides short-term income supplement benefits at no cost to you. It gives you income protection if sickness, injury or pregnancy prevents you from working, as summarized below. For a complete description, see the relevant plan document.

Legacy’s Absence Management Program administers the Short-Term Income Supplement Plan. Call the HR Answer Center at 503-415-5100 or go to MyLegacy for more information.

Eligibility

Short-term income supplement coverage is effective the first month following six months of employment in a benefit-eligible status. If you have a break in active benefit-eligible status, then are rehired or return to benefit-eligible status within 12 months, the eligibility waiting period resumes at the point it left off. If the break is 12 months or longer, you have a new six-month waiting period.

How the Short-Term Income Supplement Plan works

You must file a leave under Report It on the Human Resources page of MyLegacy or call the Legacy HR Answer Center at 503-415-5100 within 45 days if you experience:

- Any absence due to illness or injury lasting longer than three consecutive calendar days or to overnight hospitalization
- On-the-job injuries, including blood and body fluid exposures
- Temporary modified work (defined under “Important Short-Term Income Supplement Plan terms”).

If you are unable to perform all substantial and material duties of your regular occupation due to illness, injury or pregnancy, short-term income supplement provides 50 percent of your base salary, up to a $500 weekly maximum, reduced by any other income (described later in this section). Base salary does not include other pay such as bonuses, overtime, shift differential, etc. The short-term income supplement benefit begins after a 21-day waiting period from the date your disability starts and may continue for up to 69 consecutive days.

About your short-term income supplement benefit

- Benefits are not payable for pre-existing conditions (defined under “Important Short-Term Income Supplement Plan terms”) and circumstances listed under “Limitations and exclusions” later in this section.
• To receive short-term income supplement benefits, you must have an established physician-patient relationship with a qualifying physician you are seeing at least once every 30 days for regular medical treatment. Under normal treatment standards, that treatment would be necessary to improve your condition, and without it your recovery would be slower.

• You must use your available Annual Paid Leave (APL) or Extended Illness Bank (EIB) balance during the 21-day waiting period. You may elect to use APL/EIB once short-term income supplement benefits begin. Your APL and/or EIB pay, plus your short-term income supplement income, may not exceed 100 percent of your base salary.

• Temporary modified work may be available or required; contact the Absence Management Program for details.

• You’ll be paid every two weeks, coinciding with Legacy pay periods.

• Taxes are withheld according to W-4 information on file in Legacy’s payroll system.

**Pregnancy leave**

The short-term income supplement maximum coverage period is six weeks after delivery date (including the waiting period) for a vaginal childbirth and eight weeks after a Caesarean section (including the waiting period), unless complications prevent you from being released. For example, if you start your waiting period the day the baby is delivered, you have 21 calendar days (three weeks) until benefits begin, and then receive three weeks of disability payments.

Three weeks of waiting period + three weeks of benefits = six weeks of maximum coverage

Remember: You have only 31 days after delivery date to enroll the baby in your benefit plans. Refer to “Enrolling and changing your coverage” on page 11.

**When short-term income supplement ends**

This coverage stops:

• When you are no longer disabled

• The date you return to active employment (whether or not with Legacy), except in the case of temporary modified work

• After the 90th day of disability

• The date you stop following the prescribed treatment plan and are not under active treatment

• The date you retire

• When you fail to attend an appointment scheduled by Legacy’s Absence Management Program to be examined or interviewed in connection with your disability

• When you fail to accept or report for temporary modified work offered by Legacy

• The date you voluntarily terminate employment or are terminated for reasons unrelated to your disability

• The date you enroll in school at the full-time equivalent

• The date of your death

**Subrogation and reimbursement**

Short-term income supplement benefits are reduced by any compensation you receive, or the value of any compensation you are entitled to receive, from any third party. This plan is subrogated to any claim for compensation you may have against a third party on account of your disability. The plan has a right to reimbursement of any amount you receive from a third party because of your disability, up to the amount the plan has paid. You’ll be required to sign an agreement recognizing this right, which applies even if your recovery doesn’t make you whole or otherwise fully compensate you for expenses and damages. The plan also is entitled to subrogation and reimbursement from any source (other than your general assets), including but not limited to first-party auto insurance, underinsured or uninsured motorist coverage, liability insurance, victim’s compensation fund, assets of a bankruptcy estate and workers’ compensation. The plan does not pay, offset any recovery or in any way take responsibility for fees or costs associated with pursuing a claim unless the plan agrees to do so in writing.
Other income benefit reduction

Your short-term income supplement benefit is reduced by income you receive, or are eligible to receive, from:

- Severance paid by Legacy that, together with short-term income supplement benefits and temporary modified work, exceeds 100 percent of your base salary
- Employment or self-employment (temporary modified work reduces short-term income supplement by 50 percent)
- Disability under a workers’ compensation law or similar law, including amounts for vocational assistance or for partial or total disability, whether permanent or temporary
- State unemployment compensation or any disability income benefits under any other compulsory benefit act or law
- Another group disability plan
- Personal injury protection, such as auto insurance
- Social Security or other similar government disability or retirement benefits

The total amount of other income, APL, EIB, temporary modified work and short-term income supplement benefits cannot exceed 100 percent of your base salary.

Limitations and exclusions

Short-term income supplement benefits are not paid for:

- Disability caused by elective cosmetic surgical procedures
- Injury or illness:
  - Caused by an act of war or act of terrorism
  - For which payment is made or available through workers’ compensation or other similar laws
  - Incurred while committing a crime
  - That occurs in the course of self-employment or employment outside of Legacy
  - Resulting from an accident where your blood alcohol level exceeds the legal limit of the state where the accident occurred
- Intentional, self-inflicted injury, whether sane or insane
- Loss of professional license or certification necessary for employment
- Pre-existing conditions.

Important Short-Term Income Supplement Plan terms

Active treatment — Medical treatment, with physician visits at least every 30 days, necessary to improve the condition under normal treatment standards that, if not received, would slow recovery.

Base salary — Hourly rate or salary times budgeted hours (up to 40 hours per week) paid for a job performed, as of the date the disability began, not including shift differential, on-call, bonuses, standby, overtime, incentive premiums, per diem or any pay element other than the base rate.

Disability week — The disability week runs for seven days from Sunday through Saturday. If benefits are due for less than a full disability week, the full weekly benefit is divided by seven days and that amount is multiplied by the number of days of disability.

Disabled/disability — Unable to perform all of the substantial and material duties of regular employment; must be caused by a medically verifiable illness, accidental injury or pregnancy verified by a health care provider.

Health care provider — Medical doctor (M.D.), doctor of osteopathy (D.O.), doctor of podiatry (DPM), Ph.D. in clinical psychology, nurse practitioner or certified nurse midwife (for pregnancies) who either specializes in the treatment or has, by training or experience, specialized competency in the field sufficient to render the necessary diagnosis and treatment. Health care providers cannot be an immediate family member.

New or unrelated disability — While receiving short-term income supplement benefits, the member does not have to satisfy a new waiting periods if he or she incurs a new unrelated disability.

Pre-existing condition — Any condition for which the member was treated in the six months before the effective date of coverage, including medical treatment, consultation, diagnostic care or service
or prescription drugs/medications. Pre-existing conditions become covered after 12 months of plan participation as an eligible employee.

**Recurrent disability** — After return to active eligible employee status, becoming disabled for the same or related disability within 30 calendar days; member is required to satisfy only the number of waiting period days not met during the previous absence.

**Subrogation** — Assumption by a third party (as a second creditor or an insurance company) of another’s legal right to collect a debt or damages.

**Temporary modified work** — Modified Legacy job to support temporary restrictions in physical requirements and/or hours worked so an employee can resume work if the treating health care provider determines the employee is able. There is a 21-day waiting period for non-work-related injury/illness. The short-term income supplement benefit is reduced by 50 percent of the amount earned from temporary modified work.

**Waiting period** — First 21 consecutive calendar days from the date the disability began, when no short-term income supplement benefit is payable. The employee must be disabled throughout this period.
Understanding your long-term income supplement benefits

Legacy’s long-term income supplement benefits give you income protection if sickness, injury or pregnancy prevents you from working for an extended period, as summarized below. For a complete description, see the relevant plan document.

Legacy’s Absence Management Program administers the Long-Term Income Supplement Plan. Call the HR Answer Center at 503-415-5100 or go to MyLegacy for more information.

Eligibility

Long-term income supplement coverage is effective the first month following six months of employment in a benefit-eligible status. If you have a break in active benefit-eligible status, then are rehired or return to benefit-eligible status within 12 months, the eligibility waiting period resumes at the point it left off. If the break is 12 months or longer, you’ll have a new six-month waiting period, subsequent to receiving short-term income supplement benefits.

How the Long-Term Income Supplement Plan works

If you are unable to perform all substantial and material duties of your regular occupation for an extended period due to illness, injury or pregnancy, you have a choice between a 50 percent Legacy-paid long-term income supplement benefit, or if you pay an additional premium, a 66⅔ percent long-term income supplement benefit. (However, if you have a pre-existing condition for which you were treated six months before increasing coverage, any benefit payable for that condition is at the prior level of coverage.) The benefit amount is based on your base salary in effect on the date you become disabled. Base salary does not include other pay such as bonuses, overtime, shift differential, etc. Long-term income supplement is reduced by any other income (described later in this section). Long-term income supplement benefits begin after a 90-day waiting period.

<table>
<thead>
<tr>
<th>Plan</th>
<th>Paid by</th>
<th>Waiting period</th>
<th>Monthly benefit</th>
<th>Maximum monthly benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Long-term income supplement 50%</td>
<td>Legacy</td>
<td>90 days</td>
<td>50%</td>
<td>$3,000</td>
</tr>
<tr>
<td>Long-term income supplement 66⅔%</td>
<td>Employee</td>
<td>90 days</td>
<td>66⅔%</td>
<td>$5,000</td>
</tr>
</tbody>
</table>
About your long-term income supplement benefit

• Benefits are not payable for pre-existing conditions (defined under “Important Long-Term Income Supplement Plan terms”) and circumstances listed under “Limitations and exclusions” later in this section.

• If you are disabled on the date your coverage is to begin, your coverage is delayed until you complete one full day of active work after the disability ends. This also applies to increasing your long-term income supplement benefit to the $66\frac{2}{3}$ percent level.

• To receive long-term income supplement benefits, you must have an established physician-patient relationship with a qualifying physician you are seeing at least once every 30 days for regular medical treatment. Under normal treatment standards, that treatment would be necessary to improve your condition, and without it your recovery would be slower.

• Your APL and/or EIB pay plus your long-term income supplement income may not exceed 100 percent of your base salary.

• Temporary modified work may be available or required (see definition under “Important Long-Term Income Supplement Plan terms”).

• At Legacy’s discretion, a rehabilitation program may be recommended by a vocational or rehabilitative expert. If so, your participation is required to enable you to perform essential functions of a reasonably comparable job.

• You may be required to apply for Social Security disability benefits if it is determined that you have a Social Security qualifying disability.

• You’ll be paid every two weeks, coinciding with Legacy pay periods, unless you receive Social Security; in that case you’ll be paid at the last pay period of the month.

• Taxes are withheld according to W-4 information on file in Legacy’s payroll system.

When long-term income supplement ends

This coverage stops:

• When you are no longer disabled

• When you are able to return to a reasonably comparable position

• The date you return to active employment (whether or not with Legacy), except in the case of temporary modified work or a vocational or rehabilitation program

• The date you stop following the prescribed treatment plan or are not under active treatment

• The date you retire

• When you fail to attend an appointment scheduled by Legacy’s Absence Management Program to be examined or interviewed in connection with your disability

• When you fail to accept or report for temporary modified work offered by Legacy

• The date you enroll in school at the full-time equivalent

• The date you fail to report for any vocational rehabilitation services

• The date you are incarcerated

• The date of your death.

• When your maximum benefit period ends, in accordance with this table:

<table>
<thead>
<tr>
<th>Age at disability</th>
<th>Maximum benefit period</th>
</tr>
</thead>
<tbody>
<tr>
<td>61 and under</td>
<td>At age 65</td>
</tr>
<tr>
<td>62</td>
<td>After 42 months</td>
</tr>
<tr>
<td>63</td>
<td>After 36 months</td>
</tr>
<tr>
<td>64</td>
<td>After 30 months</td>
</tr>
<tr>
<td>65</td>
<td>After 24 months</td>
</tr>
<tr>
<td>66</td>
<td>After 21 months</td>
</tr>
<tr>
<td>67</td>
<td>After 18 months</td>
</tr>
<tr>
<td>68</td>
<td>After 15 months</td>
</tr>
<tr>
<td>69 and over</td>
<td>After 12 months</td>
</tr>
</tbody>
</table>
Maximum long-term income supplement benefit period for certain conditions

Benefits for alcoholism, drug addiction, mental disorder, chronic fatigue conditions (including fibromyalgia), or chemical and environmental sensitivities are limited to the shorter of 24 months or the maximum benefit period in the table above. Chemical and environmental sensitivities include but not limited to:

- Environmental allergies
- Sick building syndrome
- Multiple chemical sensitivity syndrome.

Subrogation and reimbursement

Long-term income supplement benefits are reduced by any compensation you receive, or the value of any compensation you are entitled to receive, from any third party. This plan is subrogated to any claim for compensation you may have against a third party on account of your disability. The plan has a right to reimbursement of any amount you receive from a third party because of your disability, up to the amount the plan has paid. You'll be required to sign an agreement recognizing this right, which applies even if your recovery doesn't make you whole or otherwise fully compensate you for expenses and damages. The plan also is entitled to subrogation and reimbursement from any source (other than your general assets), including but not limited to first-party auto insurance, under-insured or uninsured motorist coverage, liability insurance, victim's compensation fund, assets of a bankruptcy estate and workers' compensation. The plan does not pay, offset any recovery or in any way take responsibility for fees or costs associated with pursuing a claim unless the plan agrees to do so in writing.

Other income benefit reduction

Long-term income supplement benefits are reduced by income you receive, or are eligible to receive, from:

- Severance paid by Legacy that, together with long-term income supplement benefits and temporary modified work, exceeds 100 percent of your base salary
- Employment or self-employment (temporary modified work reduces long-term income supplement by 50 percent)
- Disability under a workers' compensation law or similar law, including amounts for vocational assistance or for partial or total disability, whether permanent or temporary
- State unemployment compensation or any disability income benefits under any other compulsory benefit act or law
- Another group disability plan
- Personal injury protection, such as auto insurance
- Social Security or other similar government disability or retirement benefits
- Legacy retirement benefits or disability benefits under any other employer plan.

The total amount of other income, APL, EIB, temporary modified work and long-term income supplement benefits cannot exceed 100 percent of your base salary.

Limitations and exclusions

Long-term income supplement benefits are not paid for:

- Disability caused by elective cosmetic surgical procedures
- Injury or illness:
  - Caused by an act of war or act of terrorism
  - For which payment is made or available through workers' compensation or other similar laws
  - Incurred while committing a crime
  - That occurs in the course of self-employment or employment outside of Legacy
  - Resulting from an accident where your blood alcohol level exceeds the legal limit of the state where the accident occurred
- Intentional, self-inflicted injury, whether sane or insane
- Loss of professional license or certification necessary for employment
- Pre-existing conditions.
Important Long-Term Income Supplement Plan terms

**Active treatment** — Medical treatment, with physician visits at least every 30 days, necessary to improve the condition under normal treatment standards that, if not received, would slow recovery.

**Base salary** — Hourly rate or salary times budgeted hours (up to 40 hours per week) paid for a job performed, as of the date the disability began, not including shift differential, on-call, bonuses, standby, overtime, incentive premiums, per diem or any pay element other than the base rate.

**Disability week** — The disability week runs for seven days from Sunday through Saturday. If benefits are due for less than a full disability week, the full weekly benefit is divided by seven days and that amount is multiplied by the number of days of disability.

**Disabled/disability** — Unable to perform all of the substantial and material duties of regular employment or any reasonably comparable position; must be caused by a medically verifiable illness, accidental injury or pregnancy verified by a health care provider.

**Health care provider** — Medical doctor (M.D.), doctor of osteopathy (D.O.), doctor of podiatry (DPM), Ph.D. in clinical psychology, nurse practitioner or certified nurse midwife (for pregnancies) who either specializes in the treatment or has, by training or experience, specialized competency in the field sufficient to render the necessary diagnosis and treatment. Health care providers cannot be an immediate family member.

**New or unrelated disability** — While receiving long-term income supplement benefits, the member does not have to satisfy a new waiting periods if he or she incurs a new unrelated disability.

**Pre-existing condition** — Any condition for which the member was treated in the six months before the effective date of coverage, including medical treatment, consultation, diagnostic care or service, or prescription drugs/medications. Pre-existing conditions become covered after 12 months of plan participation as an eligible employee.

**Reasonably comparable position** — A benefited position where:

- The employee works at the same worksite or one within 20 miles of the original position
- Base salary is at least 80 percent of the original position’s
- Qualifications are similar to the original position.

**Recurrent disability** — After return to active eligible employee status, becoming disabled for the same or related disability within 180 calendar days; member is required to satisfy only the number of waiting period days not met during the previous absence.

**Subrogation** — Assumption by a third party (as a second creditor or an insurance company) of another’s legal right to collect a debt or damages.

**Survivor benefit** — Benefit paid to a beneficiary if the employee dies after receiving a disability benefit. The amount equals three times the monthly benefit being received at the time of death, minus any overpayment of disability payments. The beneficiary is the spouse, otherwise child(ren), otherwise the estate.

**Temporary modified work** — Modified Legacy job to support temporary restrictions in physical requirements and/or hours worked so an employee can resume work if the treating health care provider determines the employee is able. There is a 21-day waiting period for non-work-related injury/illness. The long-term income supplement benefit is reduced by 50 percent of the amount earned from temporary modified work.

**Waiting period** — First 90 consecutive calendar days from the date the disability began. The employee must be disabled throughout this period.
Understanding your AD&D benefit

If you or a family member suffers a covered accidental injury or death, Legacy accidental death and dismemberment benefits provide compensation for the loss — in addition to any other life or accident coverage, as described below. For a complete description, see the relevant insurance policy.

The Hartford is our accidental death & dismemberment insurance administrator. Call the HR Answer Center at 503-415-5100 with questions.

How the Accidental Death & Dismemberment Plan works

This plan pays a percentage of your total coverage amount if you suffer, as the result of an accident, any of the covered losses within 365 days from the date of the accident. Only one benefit amount — the highest — is paid if you or your dependent suffers more than one loss in an accident.

The premium you pay for employee-only coverage is withheld on a pre-tax basis; any family member premium you pay is withheld on an after-tax basis.

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee-only coverage</td>
<td>$25,000</td>
</tr>
<tr>
<td></td>
<td>$50,000</td>
</tr>
<tr>
<td></td>
<td>$100,000</td>
</tr>
<tr>
<td></td>
<td>$200,000</td>
</tr>
<tr>
<td></td>
<td>$250,000</td>
</tr>
<tr>
<td>Spouse/domestic partner and child(ren)</td>
<td>40% of your coverage amount for your spouse/domestic partner; 10% of your coverage amount for each child</td>
</tr>
<tr>
<td>Spouse/domestic partner only</td>
<td>50% of your coverage amount</td>
</tr>
<tr>
<td>Child(ren) only</td>
<td>15% of your coverage amount, up to $37,500</td>
</tr>
</tbody>
</table>
### Additional accident benefits

- **Airbag benefit** — An additional amount, beyond the seat belt benefit (see below) of $5,000, may be paid if certain conditions are met at time of a vehicle accident.

- **Child care benefit** — In the event of your death, 5 percent of your accidental death and dismemberment coverage amount, up to a $3,000 benefit per year for four years (benefit maximum payable of $12,000), is provided for each eligible dependent child enrolled in a licensed day care or school facility.

- **Coma benefit (employee and dependent)** — A benefit of 1 percent of your or your dependent’s accidental death and dismemberment coverage amount is provided for each month you or your dependent remains in a coma. The benefit maximum equals your or your dependent’s accidental death & dismemberment coverage amount, less all other accident benefits payable for the same injury.

- **Education benefit** — In the event of your or your spouse/domestic partner’s death, 25 percent of your accidental death and dismemberment coverage amount, up to a $25,000 benefit maximum, is paid for any dependent child’s education beyond the 12th grade. Payments are made annually for a maximum of four years.

- **Exposure and disappearance benefit** — This covers loss resulting from unavoidable exposure to the elements, based on the actual loss (see Table 8, above).

- **HIV benefit** — Twenty percent of your accidental death and dismemberment coverage amount in effect on the date of the accident is paid in monthly installments, up to a $50,000 benefit maximum.

- **Paralysis benefit** — Depending on the extent of paralysis, you receive 25 percent to 100 percent of your accidental death and dismemberment coverage amount as a result of your accident.

- **Seat belt benefit** — An additional 10 percent of your accidental death and dismemberment coverage amount, up to a $25,000 benefit maximum, is paid if you or your dependent sustains an injury that causes either of you to die while driving or riding in a private passenger car, if seat belts were in use and properly fastened at the time of the covered accident.

- **Spouse/domestic partner training benefit** — In the event of your death, $3,000 is paid to your spouse/domestic partner to cover the expenses

---

#### Table 8: Accidental death and dismemberment covered losses

<table>
<thead>
<tr>
<th>For loss of</th>
<th>Percentage of coverage amount received</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life</td>
<td>100%</td>
</tr>
<tr>
<td>Both hands or both feet</td>
<td>100%</td>
</tr>
<tr>
<td>Sight in both eyes</td>
<td>100%</td>
</tr>
<tr>
<td>Speech and hearing of both ears</td>
<td>100%</td>
</tr>
<tr>
<td>One hand or foot and sight of one eye</td>
<td>100%</td>
</tr>
<tr>
<td>Quadriplegia</td>
<td>100%</td>
</tr>
<tr>
<td>One hand and one foot</td>
<td>100%</td>
</tr>
<tr>
<td>Trigeminalgia</td>
<td>75%</td>
</tr>
<tr>
<td>Paraplegia</td>
<td>75%</td>
</tr>
<tr>
<td>Hemiplegia</td>
<td>50%</td>
</tr>
<tr>
<td>One hand or one foot</td>
<td>50%</td>
</tr>
<tr>
<td>Sight in one eye</td>
<td>50%</td>
</tr>
<tr>
<td>Speech or hearing of both ears</td>
<td>50%</td>
</tr>
<tr>
<td>Thumb and index finger of same hand</td>
<td>25%</td>
</tr>
<tr>
<td>Uniplegia</td>
<td>25%</td>
</tr>
</tbody>
</table>
of learning a special skill or trade. This benefit is payable only within 30 months of the accident.

• Survivor benefit — In the event of your or your spouse/domestic partner’s death, your spouse/domestic partner or dependent child(ren) receives a monthly benefit of 1 percent of your accidental death and dismemberment coverage amount for six consecutive months.

**Beneficiary designation**

Your accidental death and dismemberment beneficiaries are the same as your employee life insurance beneficiaries, which must be designated on Legacy’s Employee Self-Service portal (myess.lhs.org). Paper beneficiary forms from prior years are not valid. If no beneficiaries are elected, any accidental death and dismemberment benefit is paid in this order, at The Hartford’s discretion: your estate, spouse, children, grandchildren, parents and siblings.

**Limitations and exclusions**

Losses resulting from the following are not covered under Legacy’s Accidental Death & Dismemberment Plan:

• Committing or attempting to commit a crime under state or federal law

• Disease of the body, bodily or mental infirmity, or any bacterial infection (other than bacterial infection due directly to an accidental cut or wound)

• Driving any vehicle while under the influence of alcohol

• Intentionally self-inflicted injury while sane, or self-inflicted injury while sane or insane

• Operating, learning to operate or serving as a member of an aircraft crew; while in any aircraft operated by or under a military authority; while in any aircraft being used for a test or experimental purpose; while in any aircraft owned or leased by or on behalf of the policyholder (or any division, subsidiary or affiliate of the policyholder (Legacy Health)) or by the member and family; or while boarding or alighting from that aircraft; this exclusion does not apply to:

— Legacy employees working in a medical capacity on all Life Flight missions who are not responsible for operating the aircraft

— Transport type aircraft operated by the Military Airlift Command of the United States

— Similar air transport service of any other country

• Service or full-time active duty in the armed forces of any country or international authority

• Suicide or any attempt at suicide

• Voluntary use of any controlled substance (drug or chemical whose manufacture, possession and use are regulated by a government); this exclusion does not apply if the controlled substance is prescribed by a doctor and taken in accordance with the doctor’s directions

• War or any act of war, declared or undeclared.

**Continuation benefit**

A dependent child’s accidental death and dismemberment coverage continues for the lesser of 12 months or to age 26.
Understanding business travel insurance

Employees traveling on a bona fide business trip for Legacy are covered under this plan. Legacy pays the cost of this coverage, which is insured and administered by The Hartford. Call 503-415-5100 with questions about this coverage.
Understanding claims and review procedures

Claims for Legacy benefits or any Component Plan are governed by the following procedures:

• The Administrative Committee has established processes and safeguards to ensure and verify that claim decisions are made according to the Legacy plan and that, where appropriate, plan provisions are applied consistently to similarly situated claimants.

• Any person claiming a benefit or requesting an interpretation, ruling or information should present the request in writing to the applicable claim administrator appointed by the Administrative Committee. The committee reserves the right to interpret the plan and decide any questions about the right of participants and their beneficiaries.

• If any claim administrator procedure, including a provision under any plan document or insurance contract, unduly inhibits or hampers the initiation or processing of a claim or appeal of a denied claim, the claimant may immediately submit the request in writing to the Administrative Committee.

• If Legacy overpays or incorrectly pays any benefit, the recipient must repay Legacy the amounts the recipient is not entitled to receive.

Filing a claim

Claims must be filed with the applicable claim administrator in writing, within one year of the date the service or supply was received or covered loss or disability occurred, unless otherwise noted below. In cases where plans reimburse for claims, the plans have the sole right to decide whether to pay benefits to the claimant, the provider or jointly to claimant and provider.

Claim administrators and claim filing methods for each Legacy plan follow.
<table>
<thead>
<tr>
<th>TABLE 9 Claim administrators and claim filing methods</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical management program administrator</strong></td>
</tr>
<tr>
<td>ActiveHealth Management</td>
</tr>
<tr>
<td>Chronic conditions program — 866-939-4717</td>
</tr>
<tr>
<td>UMR</td>
</tr>
<tr>
<td>Case management — 866-494-4502</td>
</tr>
<tr>
<td>Pre-certification — 866-494-4502</td>
</tr>
<tr>
<td>The Plan requires pre-certification of medical necessity by UMR for inpatient hospitalizations, outpatient facility-based surgery and certain other services. If these services are not pre-certified, no benefits under the Legacy plan are reimbursed. Member co-insurance does not apply to the out-of-pocket maximum.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Medical claim administrator and reviewing body</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>UMR</td>
</tr>
<tr>
<td>P.O. Box 30541</td>
</tr>
<tr>
<td>Salt Lake City, UT 84130-0541</td>
</tr>
<tr>
<td>866-868-7761</td>
</tr>
<tr>
<td><a href="http://www.umr.com">www.umr.com</a></td>
</tr>
<tr>
<td>There often is no need to submit claims to UMR. The participating Legacy + Network provider bills charges directly to UMR if the health care ID card is submitted. For a non-participating provider, including ambulance non-participating hospital, physician, professional or facility provider, UMR must receive the claim form and itemized bill, including employee ID number and group number, at this address. An Explanation of Benefits (EOB) from UMR shows the amount the member is responsible to pay.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Vision claim administrator and reviewing body</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>UMR</td>
</tr>
<tr>
<td>P.O. Box 30541</td>
</tr>
<tr>
<td>Salt Lake City, UT 84130-0541</td>
</tr>
<tr>
<td>866-868-7761</td>
</tr>
<tr>
<td><a href="http://www.umr.com">www.umr.com</a></td>
</tr>
<tr>
<td>There often is no need to submit claims to UMR. The participating Legacy + Network ophthalmologist or any licensed optometrist bills charges directly to UMR. Lenses, frames or contact lenses can be purchased anywhere, and for non-Legacy + Network provider, the member pays for the item in full, then sends a claim form and itemized receipt, including employee ID and group number, to this UMR address for reimbursement.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Dental claim administrator and reviewing body</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Oregon Dental Services — Moda Health</td>
</tr>
<tr>
<td>P.O. Box 40384</td>
</tr>
<tr>
<td>Portland, OR 97240-0384</td>
</tr>
<tr>
<td>Portland 503-243-3886</td>
</tr>
<tr>
<td>Outside Portland 888-281-0405</td>
</tr>
<tr>
<td><a href="http://www.modahealth.com">www.modahealth.com</a></td>
</tr>
<tr>
<td>The dental office generally files claims, or the member may send a claim form and itemized bill directly to Moda Health at this address.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Prescription drug claim administrator and reviewing body</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>MedImpact Healthcare Systems</td>
</tr>
<tr>
<td>Claims Department</td>
</tr>
<tr>
<td>10680 Treena St., Fifth Floor</td>
</tr>
<tr>
<td>San Diego, CA 92131-2433</td>
</tr>
<tr>
<td>800-788-2949</td>
</tr>
<tr>
<td><a href="http://www.medimpact.com">www.medimpact.com</a></td>
</tr>
<tr>
<td><a href="mailto:customerservice@medimpact.com">customerservice@medimpact.com</a></td>
</tr>
<tr>
<td>Member needs to file a claim for reimbursement for non-Legacy or non-MedImpact pharmacy.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Flexible spending account claim administrator</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>UMR</td>
</tr>
<tr>
<td>Flexible Spending Unit</td>
</tr>
<tr>
<td>P.O. Box 8022</td>
</tr>
<tr>
<td>Wausau, WI 54402-802</td>
</tr>
<tr>
<td>866-868-7761; fax 877-390-4782</td>
</tr>
<tr>
<td><a href="http://www.umr.com">www.umr.com</a></td>
</tr>
<tr>
<td><a href="mailto:umr-fsa@umr.com">umr-fsa@umr.com</a></td>
</tr>
<tr>
<td>Request must include a completed claim form and documentation.</td>
</tr>
</tbody>
</table>

continues on next page
CLAIM AND REVIEW PROCEDURES

TYPES OF HEALTH CLAIMS

Urgent Care Pre-Service Claim
Claim for benefits that are to be provided in connection with services needed urgently. Urgent means medical care that, if not performed, could result in any of the following:

• Seriously jeopardize the life or health of the claimant
• Impair the ability of the claimant to regain maximum function
• In the opinion of a physician familiar with the claimant’s medical condition, would subject him or her to severe pain that could not be adequately managed without the care.

Urgent Care Pre-Service Claim appeals do not need to be submitted in writing, but call the claim administrator as soon as possible.

Pre-Service Claim
Claim for a benefit requiring plan approval before obtaining care. For example, if the plan reduces benefits if a claimant fails to obtain pre-certification, the request for pre-certification would be treated as a Pre-Service Claim.

If services that require pre-approval have been received and the only issue is amount of payment, the claim is processed as a Post-Service Claim.

Post-Service Claim
Claimant has already received services when the claim is filed. For example, if a physician has performed a service, the claim is handled as a Post-Service Claim.

Urgent Care Pre-Service Claim procedures
On receipt of a Pre-Service Claim, the plan determines whether it involves urgent care, based on the opinion of a physician familiar with the claimant’s medical condition. An urgent care claim should include at least claimant identity, specific medical condition or symptom, and specific treatment, service or product for which approval or payment is requested.

These procedures do not apply to any request for benefits that is not made in accordance with these
Claim and review procedures

Claim and review procedures — except, in the case of an incorrectly filed Pre-Service Claim, the claimant is notified as soon as possible and in any event within five days after the plan receives the incorrectly filed claim. In the case of an incorrectly filed Urgent Care Pre-Service Claim, the claimant is notified as soon as possible and in any event within 24 hours after the plan receives the incorrectly filed claim. The notice explains that the request is not a claim and describes the proper procedures. The notice may be oral, unless the claimant requests written notice.

Similarly, if an Urgent Care Pre-Service Claim is incomplete, the plan notifies the claimant as soon as possible and in any event within 24 hours after receiving the incomplete claim. The notice may be oral, unless the claimant requests written notice. It describes the information necessary to complete the claim and specifies a reasonable time, not less than 48 hours, for the claim to be completed. The plan decides the claim as soon as possible and in any event within 48 hours after the earlier of receiving the specified information, or the end of the period provided to submit the specified information.

The plan decides an initial Urgent Care Pre-Service Claim as soon as possible, taking into account the medical circumstances, but no later than 72 hours after receiving it. If the plan denies the claim, in whole or in part, it notifies the claimant and explains the expedited appeal process.

Non-urgent Pre-Service and Post-Service Claim procedures

The claim administrator responds as follows:

• If a claim is for a non-urgent benefit requiring advance approval or pre-certification, the claim administrator notifies the claimant of its decision, adverse or not, within a reasonable time appropriate to the medical circumstances, but not later than 15 days after the claim administrator received the claim, unless it contains insufficient information to base a decision or an extension is required for other reasons beyond the plan’s control. In that case, the claim administrator may extend the time once for another period of up to 15 days.

• If an extension is required, the claim administrator notifies the claimant, before the end of the original 15-day period, of the circumstances requiring the extension and the date a decision is expected. If additional information is required, the claim administrator specifically describes it in the notice and gives the claimant a period of at least 45 days to provide it.

• If a claim is for a benefit not requiring advance approval, the claim administrator proceeds the same way, except the initial 15-day period is instead a 30-day period.

• The claim administrator provides the claimant with written or electronic notice of any adverse determination, including: specific reason or reasons for the determination; reference to specific plan provisions on which the determination is based; description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why it is necessary; description of the review procedure and applicable time limits; statement of the claimant’s right to bring a legal action under ERISA following any adverse determination on review.

• If an internal rule, guideline, protocol or other similar criterion was the basis of the decision, upon request a copy of the criterion, or a statement that the criterion was relied on and a copy of the criterion, are provided at no charge.

• If the decision was based on medical necessity, experimental treatment or similar exclusion or limit, upon request an explanation of the scientific or clinical judgment, applying the plan terms to the patient’s medical circumstances, or a statement to that effect, is provided at no charge.

Requests for review of denied claims under the medical, dental and vision plans must be presented in writing to the reviewing body as specified in the claim denial — except, for Urgent Care Pre-Service claims, the claimant may make an oral or written request for an expedited appeal of an adverse benefit determination. In that case, all necessary information, including the plan’s benefit determination on review, is transmitted between plan and claimant by phone, fax or other available similarly expedited method.


**Appeals**

If a claimant wants to request review of an adverse determination, the request must be filed within 180 days after receiving notice of the adverse determination; the following apply:

- The claimant may submit written comments, documents, records, and other information relating to the claim.

- Upon request and at no charge, the claimant may have copies of his or her claim file, any document, record or other information that:
  - Was submitted, considered or relied on in the course of making the determination, whether or not actually relied on
  - Demonstrates compliance with the reviewing body’s administrative processes and safeguards concerning claims
  - Is a statement of policy or guidance concerning the denied treatment option or benefit, whether or not relied on.

- The reviewing body takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, whether or not considered in the initial determination.

- The reviewing body affords no deference to the initial determination.

- No individual who either participated in considering the initial determination or who is the subordinate of such an individual participates in review on appeal.

- The reviewing body identifies any medical or vocational expert whose advice was obtained on behalf of the plan in connection with the claim, whether or not relied on.

**Urgent Care Pre-Service Claim appeals**

The claimant receives oral or written notice as soon as possible and in any event within 72 hours after the reviewing body receives the appeal. If it relates to this type of claim, the claimant may request an external review without first completing the internal appeals process. Not all Urgent Care Pre-Service Claims are eligible for external review. The claimant receives more information about the review process with notice of the adverse determination (including information about whether or not the claim is eligible for external review).

**Non-urgent Pre-Service and Post-Service Claim appeals**

These require two levels of internal review, plus one level of external review (if applicable) before bringing an administrative action (such as through the Department of Labor) or civil action (such as filing a lawsuit).

- The first level appeal of an adverse determination for a medical claim is submitted to UMR.

- If the denial is upheld, you may write a letter asking for a second level of appeal and submit it to the Legacy Health Administrative Committee along with all supporting documentation to:
  Administrative Committee
  1919 N.W. Lovejoy St.
  Portland, OR 97209

- If the determination is again upheld, you may request for UMR to contract with a third party for a review by an external review organization. Note: Certain types of appeals (including, but not limited to, those dealing with plan eligibility) are not eligible for external review. The decision by the external review organization is legal and binding.

You may request more information about the appeals process at any time. Otherwise, you will receive additional information after you submit the initial appeal. If the appeal is denied, the denial letter will provide you with a specific reason or reasons for the determination; reference to specific plan provisions on which the determination is based; information sufficient to identify the claim involved, including date of service, health care provider, claims amount (if applicable); diagnosis and treatment codes and their meanings.
Short-term income supplement and long-term income supplement claim procedures

The claim administrator responds to a claim by:

- Notifying the claimant of any adverse decision within a reasonable period, but not later than 45 days after receiving the application unless an extension is required for reasons beyond the plan's control. In that case the claim administrator may extend the time for up to two additional 30-day extension periods.

- If an extension is required, notifying the claimant before the end of the original 45-day period or the first 30-day extension of circumstances requiring the extension and the date a decision is expected. The notice explains the standards on which benefit entitlement is based, unresolved issues preventing a decision and additional information needed to resolve those issues. The claim administrator gives the claimant at least 45 days to provide any specified information. Periods for claim determinations run from the time the claim is filed, without regard to whether all needed information is filed. In case of an extension because more information is needed, the period for making the determination is suspended from the time the claimant is notified of the need until the claimant responds.

- Providing the claimant with written or electronic notice of any adverse determination on a claim, including: specific reason or reasons for the determination; reference to specific plan provisions on which the determination is based; description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why it is necessary; description of the review procedure and applicable time limits; statement of the claimant's right to bring a legal action under ERISA following any adverse determination on review.

- If an internal rule, guideline, protocol or other similar criterion was the basis of the decision, providing upon request a copy of the criterion, or a statement that the criterion was relied on and a copy of the criterion, at no charge.
Understanding domestic partner benefits

Domestic partners may be eligible for medical, dental, vision, life insurance and accidental death and dismemberment benefits if the partnership meets Legacy’s (or the relevant insurance carrier’s) definition of domestic partnership. This section describes our domestic partner benefits and how to enroll, costs, tax considerations and other details.

Definition of domestic partner

Legacy defines domestic partners as persons who have registered their partnership with the Oregon or Washington Domestic Partner Registries, or have satisfied all of these requirements:

• Have jointly shared a household from the present dating back at least 12 consecutive months
• Are not legally married to anyone else and not in a domestic partner relationship with anyone else
• Are each at least 18 years old and mentally competent to consent to contract
• Are financially responsible for each other’s well-being; this may include a contractual commitment for joint financial responsibilities or joint ownership of significant assets (car, home, bank accounts) or joint liability for debts (mortgage and major credit cards)
• Are not related by blood or kinship closer than would bar marriage in the state of residence
• Agree to immediately inform Legacy if the domestic partnership terminates.

Children of domestic partners are eligible for coverage if they meet all of the following requirements and the domestic partner is enrolled in coverage:

• Child(ren) under age 26
• Child(ren) at least age 26 who are principally dependent on you for support and incapable of self-support because of a physical or mental disability.

Benefit programs

Your domestic partner is eligible for coverage under our medical, dental, vision, life insurance and accidental death and dismemberment plans.
Flexible Spending Accounts

In limited circumstances, you may be able to use your flexible spending account to be reimbursed for health care or day care expenses for your domestic partner and his or her children:

- Health Care Flexible Spending Accounts may be used to reimburse an employee for domestic partner expenses if they meet the criteria for tax-favored health benefits under the Internal Revenue Code.

- Dependent Care Flexible Spending Accounts may be used to reimburse eligible expenses for qualified dependents, as defined by the Internal Revenue Code, including expenses incurred by an employee to provide care for:
  - A child who can be claimed as a dependent on the employee's federal tax return, lives with the employee for more than half the year, and is under age 13.
  - A domestic partner who lives with the employee for the entire calendar year, if the employee provides more than half of his or her support and he or she is physically or mentally incapable of self-care, regardless of age.

Dependent care expenses for a domestic partner's child do not qualify for reimbursement under current tax law.

How to enroll

Read the eligibility requirements in this guide carefully to make sure your domestic partner is eligible. Consult a tax professional if you have questions about whether your domestic partner qualifies as your tax dependent.

To enroll your domestic partner in the Legacy Benefits Plan, you must, within 31 days of a qualifying event or before the Annual Enrollment period deadline:

1. Enroll your domestic partner using Legacy’s Employee Self-Service portal (myess.lhs.org).
2. Submit to the Benefits Department either:
   a. State of Oregon or Washington Domestic Partner Registry certificate, or
   b. Legacy Affidavit of Domestic Partnership (available in Benefits section of MyLegacy) and one of the following: joint utility bill, bank statement, mortgage, lease or credit account bill from the most current period and one dated back at least 12 months, but no longer than 24 months.

Once you complete and return the required materials and eligibility is confirmed, your domestic partner’s coverage becomes effective in accordance with plan rules.

Domestic partner coverage costs

If you enroll your domestic partner, you pay the same amount for coverage as you would for a spouse. However, under current tax law, the value of Legacy’s contribution to cover your domestic partner and his or her children is considered taxable income, even though you don’t actually receive the additional income; it is shown on your paycheck and included on your W-2 form as “imputed income.”

Legacy pays the full cost of coverage, less any amount you pay. (See examples later in this section.) You’re subject to federal, FICA, local and other applicable income taxes for the value of adding domestic partner benefits, even if you already pay the family rate for coverage.

You pay the employee contribution attributable to domestic partner benefits with after-tax dollars.

Tax-favored benefits

Domestic partners

Current law indicates that a domestic partner who shares the employee’s residence as a household member generally satisfies the criteria for tax-free health benefits under the Internal Revenue Code if he or she lives with you for the entire calendar year, you provide more than half of his or her support and he or she is a U.S. citizen or resident.

In some instances, domestic partner benefits may be eligible for pre-tax treatment for state or federal taxes. Be sure to check with a licensed tax professional to see if any exceptions apply to you when filing your taxes.
**Children**

Children who meet the criteria for tax-free health benefits under the Internal Revenue Code include:

- Qualifying children under IRC Section 152(c)(1) — that is, the taxpayer’s children by birth, adoption, or stepchildren who are under age 26 on the last day of the tax year, are not married, do not provide more than half of their own support and have the same principal place of residence as the employee for more than six months of the year.

- Children (by birth, adoption or stepchildren) of any age who receive more than half of their support from the employee and are not the qualifying child of another taxpayer.

- Unrelated children of any age who share the employee’s residence as a member of his or her household, receive over half of their support from the employee and are not the qualifying child of another taxpayer.

Because children of your domestic partner generally are qualifying children, they won’t qualify for tax-free health benefits based on the requirements above. Coverage for your domestic partner’s children is therefore paid for on an after-tax basis, with the value of coverage imputed income to you.

**COBRA coverage**

Domestic partners and their children are not considered eligible dependents under COBRA and are not eligible for continuation coverage after Legacy coverage ends.

**Family medical leave**

Family medical leave under the federal FMLA is not available for a domestic partner. However, it may be available under the Oregon Family Leave Act (OFLA) for a same-sex domestic partner (ORS 659A.150 to ORS 659A.186). To be eligible, the employee must:

- Have worked for Legacy for at least 180 calendar days immediately preceding the date the leave is to begin

- Have averaged at least 25 work hours per week during the 180 days immediately preceding the date the leave is to begin.

Eligible employees may take family leave under OFLA for:

- Birth or adoption of a child by the same-sex domestic partner

- Serious health condition of the same-sex domestic partner or his or her child or parent.

FMLA and OFLA leaves of absences are administered in accordance with current laws and regulations, as applicable.

Contact the Legacy HR Answer Center at 503-415-5100 with any questions about this leave.
Tax consequences of mid-year changes

Under IRS rules, if a domestic partner doesn’t qualify for tax-free health benefits, mid-year election changes due to an event involving the domestic partner generally need to be made on an after-tax basis.

Some examples

Jean is a full-time employee whose annual salary is $31,200, or $1,200 a pay period. She has elected to cover her domestic partner under our Medical Plan. Below is a summary of 2015 Medical Plan rates and contributions per pay period.

<table>
<thead>
<tr>
<th>Coverage Plan</th>
<th>Total premium rate (per pay period)</th>
<th>Employee contribution (per pay period)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$270.03</td>
<td>$14.85</td>
</tr>
<tr>
<td>Employee and spouse/domestic partner</td>
<td>$565.39</td>
<td>$62.19</td>
</tr>
<tr>
<td>Employee and spouse/domestic partner with other coverage</td>
<td>$565.39</td>
<td>$236.38</td>
</tr>
<tr>
<td>Employee and child(ren)</td>
<td>$513.17</td>
<td>$56.45</td>
</tr>
<tr>
<td>Family coverage</td>
<td>$818.74</td>
<td>$98.25</td>
</tr>
<tr>
<td>Family coverage with other coverage</td>
<td>$818.74</td>
<td>$285.63</td>
</tr>
</tbody>
</table>

The premium rate is the total cost to cover Legacy Health employees and their families. The portion Legacy pays is the premium rate less the employee contribution.

<table>
<thead>
<tr>
<th>Spouse/domestic partner</th>
<th>minus</th>
<th>Premium rate</th>
<th>equals</th>
<th>Portion paid by Legacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td></td>
<td>$270.03</td>
<td>=</td>
<td>$295.36</td>
</tr>
</tbody>
</table>

Jean’s after-tax contribution is the difference between what she pays for her own coverage with pre-tax dollars and what she pays when she adds coverage for her domestic partner:

<table>
<thead>
<tr>
<th>Employee + spouse/domestic partner contribution</th>
<th>minus</th>
<th>What Jean pays for her own coverage (pre-tax)</th>
<th>equals</th>
<th>Jean’s after-tax contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>$62.19</td>
<td></td>
<td>$14.85</td>
<td>=</td>
<td>$47.34</td>
</tr>
</tbody>
</table>

Imputed income is added to Jean’s taxable income, increasing her tax liability. Imputed income is the portion paid by Legacy minus Jean’s after-tax contribution:

<table>
<thead>
<tr>
<th>Portion paid by Legacy</th>
<th>minus</th>
<th>Jean’s after-tax contribution</th>
<th>equals</th>
<th>Imputed income</th>
</tr>
</thead>
<tbody>
<tr>
<td>$295.36</td>
<td></td>
<td>$47.34</td>
<td>=</td>
<td>$248.02</td>
</tr>
</tbody>
</table>
Because Jean’s domestic partner doesn’t qualify for tax-free benefits under tax law, Legacy’s contribution toward her domestic partner’s coverage is taxable to Jean as imputed income. If Jean adds medical coverage for her domestic partner, the table below reflects how her pay would be affected each pay period.

<table>
<thead>
<tr>
<th>Category</th>
<th>Employee only</th>
<th>Employee and domestic partner</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Bi-weekly salary</td>
<td>$1,200.00</td>
<td>$1,200.00</td>
</tr>
<tr>
<td>B. Pre-tax contribution for employee coverage</td>
<td>$14.85</td>
<td>$0.00</td>
</tr>
<tr>
<td>C. Portion of domestic partner coverage paid by Legacy</td>
<td>n/a</td>
<td>$295.36</td>
</tr>
<tr>
<td>D. Imputed income (C–G)</td>
<td>$0.00</td>
<td>$248.02</td>
</tr>
<tr>
<td>E. Taxable pay (A–B+D)</td>
<td>$1,185.15</td>
<td>$1,448.02</td>
</tr>
<tr>
<td>F. Taxes (28% of E)*</td>
<td>$331.84</td>
<td>$405.45</td>
</tr>
<tr>
<td>G. Jean’s after-tax contribution</td>
<td>$0.00</td>
<td>$47.34</td>
</tr>
<tr>
<td>H. Net pay (A–B–F–G)</td>
<td>$853.31</td>
<td>$747.21</td>
</tr>
</tbody>
</table>

Impact on bi-weekly pay to add domestic partner ($853.31 – $747.21 = $106.10)

*Assumes a 28 percent tax rate for federal, state, local and FICA (Social Security) taxes up to the current year’s wage base. The taxable amount is subject to withholding for federal income taxes, applicable state incomes taxes and FICA.
Annual and gifted paid leave

Where to go for paid leave information

Annual Paid Leave (APL) is an account of available hours you accrue to use for paid time off, such as vacations, holidays, sick and personal days. Gifted Paid Leave (GPL) is a program that allows you to donate your APL hours to co-workers. Refer to Legacy’s APL policy (500.304) for complete program details and information on Portland sick leave eligibility.
Understanding leaves of absence

Many types of leaves — with varying eligibility and length — are available at Legacy for absences, which are governed by federal or state laws and regulations, such as FMLA and OFLA, or under Legacy policy 500.401. The various types of leave are described throughout this section.

You must file a leave request through Report It on MyLegacy or by calling the HR Answer Center at 503-415-5100 in these situations:

• Your own or a covered family member’s illness or injury if it lasts more than three consecutive calendar days or requires overnight hospitalization and results in your absence from work

• Temporary modified work.

For an on-the-job injury/illness, including blood and body fluid exposure, you must file through ICARE on MyLegacy or by contacting Risk Administration at 503-415-5717.

If you’re unable to report your absence, your manager may do this for you.

Legacy’s absence management program

Legacy’s Absence Management Program staff process leave requests. They help you determine which type of leave is needed as well as any state or federal regulations that apply and explain eligibility requirements, how much leave you may take and effect on your benefits. You receive a packet in the mail with any necessary applications based on the type of leave you need. The name of the person handling your leave is included in the packet. The Absence Management Program includes temporary modified work, medical, family, personal, military, bereavement or jury duty leave.

Call the HR Answer Center to notify Legacy regarding any leave and to get answers about leaves as well as their interaction with other programs/benefits.

Benefits during certain leaves

Personal and educational leaves

• APL must be used until exhausted. The APL period is part of the leave period and does not extend your leave.

• Medical, dental, vision and flexible spending account benefits end on the last day of the month that you are in a benefit-eligible status.
Leaves of absence

FMLA, OFLA and non-FMLA/OFLA medical leaves

To determine leave eligibility, Legacy uses a rolling 12-month period measured backward from the date an employee begins a family or medical leave. Each time the employee takes FMLA/OFLA leave, the time taken in the 12 months before the leave reduces the available FMLA/OFLA balance. Call the HR Answer Center for details.

Military leave including training

- APL may be used, cashed out or left intact until you return from leave.
- You may continue your health benefits for up to 24 months.
- Life insurance continues for up to 12 weeks.
- Short-term income supplement, long-term income supplement and accident benefits end on the last day worked.
- To stop benefits during military leave, go online to our Employee Self-Service portal (myess.lhs.org). (Directions are in your leave packet.)
- If you choose to discontinue health benefits, UMR sends you a COBRA enrollment packet within 30 days. Medical, dental, vision and flexible spending account benefits end on the last day of the month your leave began.
- Your 24-month COBRA timeline begins the first of the month following your first day of military leave.
- If you elect to continue health benefits, premium deductions continue until regular pay and APL are exhausted.
- Once APL is exhausted, your health benefits continue and missed premiums accrue. Upon your return, up to two catch-up premiums and your current premium are deducted from your paycheck until you’re current.
- If your military leave exceeds 24 months, your health benefits end on the last day of the month your leave exceeds the 24 months.
- Life, short-term income supplement, long-term income supplement and accident benefits end on your last day in a benefit-eligible status.
- You may elect to continue health benefits on a self-pay basis for up to 18 months through COBRA. You receive COBRA information within 30 days of your coverage terminating.
- When you return from personal or educational leave of absence, benefits are reinstated the first of the month following your return to a benefit-eligible status.

• APL must be used until exhausted, unless you are receiving workers’ compensation for an on-the-job injury or short-term income supplement or long-term income supplement payments.
• Benefit deductions continue as long as you receive paychecks, except when receiving workers’ compensation.
• Dependent care expenses incurred while on a leave of absence are not eligible for reimbursement from a Dependent Care Flexible Spending Account. When you return from your leave, your Dependent Care Flexible Spending Account contribution is reduced based on the number of missed pay dates.
• When you no longer receive paychecks, premium deductions cease and accrue until you return to work. When you return, up to two catch-up premiums and your current premium are deducted from your paycheck until you’re current.
• For FMLA/OFLA leaves, your COBRA timeline begins the first of the month following the end of the leave. For non-FMLA/OFLA leaves, your COBRA timeline begins the first of the month following your last day worked.
• If your absence exceeds 12 months, you may continue medical, dental, vision and Health Care Flexible Spending Account benefits on a self-pay basis through any remaining COBRA period.
• UMR sends you a COBRA enrollment packet within 30 days after either your termination date or the end of the 12th month of your leave, whichever comes first. To continue coverage, complete the COBRA enrollment paperwork and return it to UMR.
• Life, short-term income supplement, long-term income supplement and accident benefits end on your last day in a benefit-eligible status.
• You may elect to continue health benefits on a self-pay basis for up to 18 months through COBRA. You receive COBRA information within 30 days of your coverage terminating.
• When you return from personal or educational leave of absence, benefits are reinstated the first of the month following your return to a benefit-eligible status.
• APL must be used until exhausted, unless you are receiving workers’ compensation for an on-the-job injury or short-term income supplement or long-term income supplement payments.
• Benefit deductions continue as long as you receive paychecks, except when receiving workers’ compensation.
• Dependent care expenses incurred while on a leave of absence are not eligible for reimbursement from a Dependent Care Flexible Spending Account. When you return from your leave, your Dependent Care Flexible Spending Account contribution is reduced based on the number of missed pay dates.
• When you no longer receive paychecks, premium deductions cease and accrue until you return to work. When you return, up to two catch-up premiums and your current premium are deducted from your paycheck until you’re current.
• For FMLA/OFLA leaves, your COBRA timeline begins the first of the month following the end of the leave. For non-FMLA/OFLA leaves, your COBRA timeline begins the first of the month following your last day worked.
• If your absence exceeds 12 months, you may continue medical, dental, vision and Health Care Flexible Spending Account benefits on a self-pay basis through any remaining COBRA period.
• UMR sends you a COBRA enrollment packet within 30 days after either your termination date or the end of the 12th month of your leave, whichever comes first. To continue coverage, complete the COBRA enrollment paperwork and return it to UMR.
<table>
<thead>
<tr>
<th>Purpose</th>
<th>Eligibility</th>
<th>Duration</th>
<th>APL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bereavement</td>
<td>Grieving the death of a family member — parent, spouse/domestic partner, child, sibling, grandparent and grandchild (these include in-law and step relationships); paid time off.</td>
<td>Regular full-time and part-time employees (unless on leave and not working).</td>
<td>1 to 3 consecutive workdays, taken within 90 days of the death. Bereavement is paid up to 12 hours a day. Additional unpaid bereavement leave may be available under OFLA.</td>
</tr>
<tr>
<td>Call to active duty</td>
<td>“Qualifying exigency” (defined by Department of Labor) if family members listed below for each state are on active duty or have been notified of an order to active U.S. military duty. Oregon: Leave for a spouse with an “impending call or order to active duty or leave from deployment.” Washington: Leave for spouses or domestic partners of military personnel to take time off work while their spouse/domestic partner is on leave from deployment, or before and up to deployment, during times of military conflict declared by President or Congress.</td>
<td>Must have 12 months of service and 1,250 work hours during the 12 months before the leave. Oregon and Washington: Must work an average of 20 or more hours per week.</td>
<td>Up to 12 weeks of job protection during a 12-month period. Oregon: 14 days of leave per call to duty. Washington: Up to 21 days unpaid leave.</td>
</tr>
<tr>
<td>Care for injured service member (FMLA)</td>
<td>Family member (parent, spouse, child, or next of kin) caring for a U.S. armed forces service member (includes National Guard or reserves and veterans) injured in the line of duty while undergoing medical treatment, outpatient recuperation or therapy, or otherwise on the temporary disability retired list for serious injury or illness.</td>
<td>Must have 12 months service and 1,250 work hours during the 12 months before the leave.</td>
<td>Up to 26 weeks of job protection during a single 12-month period.</td>
</tr>
<tr>
<td>Crime victims (OFLA)</td>
<td>Attending criminal, juvenile and other court proceedings.</td>
<td>Must be an Oregon employee, employed for 180 days and averaging 25 work hours per week in the 180 days before the leave. Immediate family member (parent, spouse/domestic partner, child, sibling, stepchild and grandparent) or employee must be the victim of a felony.</td>
<td>Determined by business necessity.</td>
</tr>
</tbody>
</table>
### TABLE 10  Leaves of absence summary continued

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Eligibility</th>
<th>Duration</th>
<th>APL</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Domestic violence, sexual assault or stalking</strong></td>
<td>Oregon: Seeking legal or law enforcement assistance or remedies; seeking medical treatment or recovering from injuries; obtaining counseling or services from a victim services provider; relocating or taking steps to secure a safe home for the employee or minor child. Washington: Taking care of legal or law enforcement needs or receiving medical treatment, social services assistance or mental health counseling. Unpaid leave.</td>
<td>Reasonable period to take care of what Oregon and Washington law states as purpose of leave.</td>
<td>Balance must be used.</td>
</tr>
<tr>
<td><strong>Family or medical (FMLA/OFLA protected) — Oregon employees</strong></td>
<td>Oregon employees: FMLA (12 months service and 1,250 work hours during the 12 months before the leave; OFLA (employed 180 days and average 25 work hours per week in the 180 days before leave, except for parental leave).</td>
<td>Up to 12 weeks in a rolling 12-month period, except for pregnancy; leave reason determines maximum time. Legacy designates the leave, including temporary modified work, as FMLA/OFLA protected. FMLA/OFLA use reduces available leave balance if missing time from work.</td>
<td>APL and EIB balances must be used; APL may be used while receiving short-term income supplement or long-term income supplement payments and on the first three days of a job-related injury.</td>
</tr>
<tr>
<td><strong>FMLA and WLAD for Washington employees</strong></td>
<td>Washington employees: FMLA — 12 months service and 1,250 work hours during the 12 months before the leave; WLAD — Date of hire.</td>
<td>APL — 12 weeks in a rolling 12-month period; WLAD — As long as employee is disabled.</td>
<td>APL and EIB balances must be used; APL may be used while receiving short-term income supplement or long-term income supplement payments and on the first three days of an on-the-job injury.</td>
</tr>
</tbody>
</table>

For job-related illness or injury, report within 24 hours. For non-job-related illness or injury, report 30 days before a non-emergency (such as scheduled surgery) and as soon as possible for emergency leave (such as sudden heart attack).

For job-related illness or injury, report within 24 hours. For non-job-related illness or injury, report 30 days before a non-emergency (such as scheduled surgery) and as soon as possible for emergency leave (such as sudden heart attack).
TABLE 10  Leaves of absence summary  continued

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Eligibility</th>
<th>Duration</th>
<th>APL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jury duty</td>
<td>Performing juror duties. If pay received, reimbursement goes to Payroll, excluding mileage.</td>
<td>Regular full-time and part-time employees.</td>
<td>Length of active service as a juror; jury duty is paid up to 12 hours a day.</td>
</tr>
<tr>
<td>Medical</td>
<td>Being incapacitated longer than 3 consecutive calendar days or an overnight hospitalization due to job-related or non-job-related illness or injury, childbirth, pregnancy or temporary modified work. Report timing is same as for FMLA/OFLA-protected Oregon employees above.</td>
<td>All employees.</td>
<td>Up to 12 months combined with other leaves in a rolling 12-month period; temporary modified work counts toward maximum leave entitlement.</td>
</tr>
<tr>
<td>Personal/educational</td>
<td>Accommodating personal needs (excluding other employment and vacation) or furthering job-related knowledge/skills and career enhancement at Legacy. Requires obtaining verbal approval from manager 30 days in advance.</td>
<td>Regular full-time and part-time employees who have worked at least 12 consecutive months before the leave.</td>
<td>Up to 12 consecutive months combined with other leaves, whether paid or unpaid, including FMLA/OFLA/WLAD.</td>
</tr>
<tr>
<td>Temporary modified work</td>
<td>Returning to work after job-related or non-job-related illness or injury; time on this medical leave reduces available medical leave balance. Report as soon as physician provides work restrictions.</td>
<td>Job-related: All employees Non-job-related: Benefit-eligible employees after 21-day waiting period</td>
<td>Up to 90 calendar days for job-related and 30 days for non-job-related during a rolling 12-month period in a temporary modified position</td>
</tr>
<tr>
<td>Washington Law Against Discrimination (WLAD): pregnancy disability leave</td>
<td>Being incapacitated longer than three consecutive calendar days due to pregnancy and childbirth. Report as soon as physician provides work restrictions.</td>
<td>All Washington employees</td>
<td>Up to 12 months combined with other leaves in a rolling 12-month period</td>
</tr>
</tbody>
</table>

In addition to the leaves described above, Legacy also provides community service leave. It gives employees time off to perform service for a community organization — within the Legacy service area or outside the United States — that requires the employee’s skills and knowledge. Applications are on MyLegacy under Human Resources. For eligibility, duration and other details, see Legacy policy 500.405 and contact the HR Answer Center if you have questions.
Where to go for education assistance information

Legacy encourages you to enhance your education by partially reimbursing employee tuition for approved courses at accredited colleges and universities. Refer to Legacy's Education Assistance Policy (500.901) for complete information.
Benefit plan administrative information

This guide summarizes your benefit choices; it is intended to simply and clearly explain how they work. Since legal requirements must be met in providing this information, some of the explanations are necessarily complicated.

Legal plan documents and insurance contracts control administration for many plans described in this guide. Those documents and contracts determine your actual benefit. To read the document and contracts or obtain copies, contact the Benefits Department as explained under “Your ERISA rights” in this section.

The overall Legacy Benefit Program and this guide in no way constitute an employment contract or any part of a contract. They do not give you the right to continue Legacy employment, and do not limit Legacy’s right to discharge you with or without cause.

Future of plans

Legacy expects to continue the Legacy Benefit Program and all its benefit plans indefinitely. However, Legacy does reserve the right to change or end any of its benefit plans at any time.

Health plan discrimination testing

For the purpose of non-discrimination testing only, full-time and part-time employees are considered to be covered under separate health plans.

Legal process

Legacy always attempts to calculate benefits accurately. However, we reserve the right to correct any inaccurate calculations, whether caused by a mistake of fact in assumptions used to calculate the benefit or by error in the actual calculation. If you are underpaid a benefit, Legacy makes up the difference between paid and entitled amounts. If you are overpaid a benefit, you must arrange to repay the plan — in cash or reductions in future pay or future benefits.

The Plan Administrator serves as agent for service of legal process. In addition, service of legal process may be made on any plan trustee.
Plan details

Employer
Legacy Health
1919 N.W. Lovejoy St.
Portland, OR 97209
503-415-5600

Plan administrator
Administrative Committee
Legacy Health
1919 N.W. Lovejoy St.
Portland, OR 97209
503-415-5600

Program sponsor
Legacy Health
1919 N.W. Lovejoy St.
Portland, OR 97209
503-415-5600
Employer identification number 23-7426300

Plan year
The plan year for all plans is Jan. 1 to Dec. 31.

Welfare Benefits Plan
The Welfare Benefits Plan includes the plans below and is a single plan for Title I of ERISA annual reporting requirements.

Plan No. 504
• Medical Plan — self-insured by Legacy and paid out of general assets
• Dental Plan — self-insured by Legacy and paid out of general assets
• Vision Plan — self-insured by Legacy and paid out of general assets
• Section 125 Cafeteria Plan — includes Premium Payment Plan, Health Care Flexible Spending Account and Dependent Care Flexible Spending Account
• Short-Term Income Supplement Plan — self-insured by Legacy and paid out of general assets
• Long-Term Income Supplement Plan — self-insured by Legacy and paid out of general assets.

Plan No. 505
• Life Insurance Plan — subject to group insurance policy issued by The Hartford
• Accidental Death & Dismemberment Plan — subject to group insurance policy issued by The Hartford
• Business Travel Accident Insurance Plan — subject to insurance policy issued by The Hartford

Qualified Medical Child Support Order (QMCSO)
A QMCSO is a court judgment, decree, order or state administrative order with the force and effect of law. A QMCSO is typically issued as part of a divorce or state child support order that requires health plan coverage for an alternative recipient. The plan has detailed procedures for determining whether an order qualifies as a QMCSO. You may obtain a free copy of these procedures by sending a written request to the Benefits Department.

Legacy covers children deemed to be alternative recipients under a QMCSO. The effective date of coverage for a child added to the plan under a QMCSO is the first day of the first month following the determination that the order is qualified.

An alternative recipient is a child of an eligible employee who is recognized under a medical child support order as having a right to enrollment in the employee’s group health plan.

Coordination of Benefits (COB)
You and your dependents may be covered by more than one medical or dental plan. Legacy’s benefit plans contain a non-duplication of coverage COB provision. The purpose is to eliminate overpayments and determine which plan is primary (pays first — its normal benefit) and which plan is secondary (pays based on the eligible original expense incurred, up to the secondary plan’s maximum).

When you are covered by more than one group plan, any plan that does not contain a COB provision is primary and pays first.

If both plans have a COB provision, these rules apply:
• The plan that covers the claimant as an employee determines its benefits before a plan that covers the person as a dependent.

• Coverage for the dependent child of parents who are not separated or divorced is determined as follows:
  — Benefits of the plan of the parent whose birthday falls earlier in the calendar year, regardless of birth year, determines its benefits before the plan of the parent whose birthday falls later in that year.
  — If both parents’ birthdays are on the same day, the benefits of the plan that covered the parent the longest are determined before those of the plan that covered the other parent for a shorter time.
  — If another plan does not include this COB rule based on parent birthdays, but instead has a rule based on parent gender, that plan’s COB rule determines the order of benefits.

• Coverage for the dependent child of parents who are separated or divorced is determined as follows:
  — If a court decree awards joint custody without specifying that one parent has the responsibility to provide health coverage, the plan of the parent whose birthday is earlier in the year is primary.
  — If a QMCSO requires one parent to provide medical or dental coverage, that parent’s coverage pays first.
  — If there is no QMCSO, the plan of the parent with custody pays first, followed by the plan of the parent without custody.
  — If none of the rules applies, the plan that has covered the parent for the longest pays first.

How Legacy plans coordinate benefits

Medical
The Legacy plan, in coordination with another medical plan, pays up to the highest level of coverage allowed under the Legacy plan for covered expenses.
Example — If your spouse/domestic partner’s plan pays up to 70 percent toward an inpatient stay at a Legacy facility, the Legacy plan would coordinate and pay up to the plan maximum. In this case, that would be an additional 10 percent (Legacy pays up to 80 percent for services at a Legacy facility.)

Dental
The Legacy plan, in coordination with another dental plan, pays up to the highest level of coverage allowed under the Legacy plan for covered expenses
Example — If your spouse/domestic partner’s plan pays up to 90 percent toward basic services, the Legacy plan would coordinate and pay up to the plan maximum. In this case, Legacy would not pay anything toward basic services because the primary insurance paid more than Legacy would have paid if they were primary. (Legacy pays up to 80 percent for basic services at a participating provider.)

Legacy’s prescription and vision benefits do not coordinate with other plans.

When Legacy coverage ends

Short-term income supplement, long-term income supplement, life and accidental death and dismemberment coverage ends at midnight on the last day worked.
Medical, dental, vision and flexible spending account coverage ends on the last day of the month the earliest of the following occurs:
• You are no longer eligible.
• Your dependent is no longer eligible (except for flexible spending accounts).
• You drop coverage for yourself or your dependents because of a qualified life event.
• You or a plan member engages in fraudulent conduct or intentionally misrepresents any material facts; in that case the end of coverage may be retroactive to the date of the fraud or misrepresentation.
• Your employment terminates.
• You do not make a required COBRA premium payment.
• You are not actively at work because of a strike or a lockout.
• The plan terminates.

When an insured person is a hospital inpatient on the day coverage ends, the plan continues to pay claims for that hospitalization’s covered services until the insured person is discharged.

**Continuation coverage**

Through COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985), you and/or your eligible dependents may choose to continue medical, dental, vision and flexible spending account benefits on a self-pay basis following certain qualifying events. COBRA coverage limits and rules are determined by current law.

Dropping spouse/domestic partner/child coverage during Annual Enrollment is not considered a COBRA-qualifying event. Your dependent would not be eligible for COBRA.

You and your spouse (domestic partners and the children of domestic partners are not eligible for COBRA) may not continue coverage through COBRA if you become entitled to Medicare or other group benefits after the election date for your qualifying event unless:

• You are disabled at the time of the qualifying event or within 60 days of COBRA coverage

• The other plan you are qualified for limits or excludes coverage for a pre-existing condition of a qualified beneficiary according to federal law.

You, your eligible spouse and other dependents may continue coverage for up to 18 months if one of the following events occurs:

• Your employment terminates for reasons other than gross misconduct

• Your working hours are reduced and you are no longer eligible for coverage.

Continuation coverage may be extended to 29 months (rather than 18) for individuals meeting both of these requirements:

• The eligible employee or covered dependent is determined to have been disabled, under Title II or XVI of the Social Security Act, at the time of the qualifying event or during the first 60 days of COBRA coverage

• The COBRA Administrator, UMR, is notified of the determination within 60 days after the determination date, but in any event before the end of the 18-month continuation period.

Your eligible spouse and other dependents may choose to continue coverage for up to 36 months if one of the following events occurs:

• Your death

• Your divorce or legal separation

• You become enrolled in Medicare Part A or Part B or both

• Your dependent child no longer qualifies as a dependent

• The beginning of bankruptcy proceedings by Legacy (retirees only)

If you become entitled to Medicare benefits at the time of or before the qualifying event, your eligible spouse or other dependents not enrolled in Medicare may continue coverage for up to 36 months from the date of your entitlement to Medicare. If they have a second qualifying event, the entire period of continuation coverage cannot exceed 36 months.

**Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)**

USERRA provides certain rights to employees who are absent from work in the uniformed services. Because Legacy employees have rights under both COBRA and USERRA, any election under COBRA is also an election under USERRA; COBRA and USERRA both apply to the continuation coverage elected. COBRA and USERRA rights are similar, but not identical; the law that provides the better benefit applies. Some differences are listed below:

• 18-month maximum for COBRA; 24-month maximum for USERRA

• Individual election rights for COBRA; employee must enroll in order for dependents to enroll with USERRA

• If uniformed service period is less than 31 days, the premium costs 102 percent under COBRA, but stays the same as an active employee under USERRA.
Changes in status you must give the Benefits Department

You or your eligible spouse and other dependents are responsible for informing the Benefits Department of these events:

- **Birth, adoption or marriage**, within 31 days
- **Divorce, legal separation or a child’s loss of eligibility**, within 60 days of the event or of the date coverage would be lost on account of the event
- **Determination that you, your spouse or other dependent was disabled under Title II or XVI of the Social Security Act** at the time of the qualifying event, within 60 days of the determination date and before the end of the 18-month continuation period
- **Determination under Title II or XVI of the Social Security Act** that you, your spouse or other dependent is no longer disabled, within 30 days of the determination date.

If you do not inform the Benefits Department within the above time limits, your eligible spouse or other dependent who loses coverage cannot elect COBRA continuation coverage.

How to continue coverage

Following notice of a qualifying event, you and/or your eligible dependents receive a letter from our COBRA administrator advising of the right to continue coverage and the premiums you or your dependents must pay.

To continue coverage, you or your dependents must make the election on the forms provided and return them to the COBRA administrator within 60 days.

The 60-day period begins on the date coverage would be lost as a result of the qualifying event or the date of notification from the COBRA administrator, whichever is later. If completed COBRA election forms aren’t returned within the deadline, you and your dependents cannot continue coverage. Continuation coverage is the same as provided to active Legacy employees (you may select a lower coverage level), and all plan provisions that apply to them also apply to you. For example:

- **You participate in Annual Enrollment.**
- **You may make coverage changes following certain family status changes.**
- **Any benefit or premium changes made while you continue coverage also affect your coverage or costs.**

Cost of continuation

You are responsible for the entire cost of continued coverage plus any administrative charge assessed by the COBRA administrator. Your initial premium payment, due 45 days after the date of your election, must include the required monthly contribution retroactive to the start of COBRA coverage. After the initial premium is paid, you must pay each monthly premium to the COBRA administrator within 30 days of the due date, which is the first of the month. Covered services or supplies are not paid until premium payment has been received by the COBRA Administrator.

When continuation coverage ends

This coverage ends when Legacy no longer offers group coverage to any employees, or if you or your dependents:

- **Do not pay the full premium on time**
- **Become covered after your continuation date under any other group medical, dental or vision plan that does not contain any pre-existing condition exclusion or limitation that affects you or your dependents**

If the other group plan does limit coverage for your or your dependents’ pre-existing condition, Legacy’s plan is primary only for pre-existing condition expenses, and secondary for other expenses.

- **Give written notice to discontinue coverage**
- **Are entitled to Medicare**
- **Reach the end of the applicable continuation period**
- **Are no longer determined to be disabled, if you continued coverage beyond the 18th month because of disability**
Conversion and portability policies

Life insurance conversion
You may be eligible to convert all or part of your or your dependent’s life insurance to individual policies without evidence of insurability. The amount of coverage you buy cannot exceed the amount you have under your Legacy plan. You must apply and pay for an individual policy within 31 days after life coverage ends or is reduced. If you or your dependent dies within this 31-day period, a death benefit is paid to the designated beneficiary(ies).

If you convert your coverage to an individual policy, are later rehired by Legacy, become eligible for Legacy group life coverage and do not cancel your conversion policy, you must provide evidence of insurability before the group coverage becomes effective. You won’t have to provide evidence of insurability if you cancel your individual conversion policy immediately upon eligibility for Legacy group life coverage.

If the Legacy plan is canceled entirely, you may convert your life coverage to an individual policy of up to $10,000 if your insurance has been in force for five or more years.

Life insurance portability
All or part of your or your dependents’ life insurance may be portable without evidence of insurability if you or your dependents are under age 65. This portability option allows eligible employees who leave Legacy employment or become ineligible for benefits to continue life insurance at the same level, but not necessarily the same rate. The coverage amount you buy cannot exceed what you had under the Legacy plan (maximum $750,000).

You must apply for portable coverage for yourself and your dependents and pay the first premium within 31 days after life insurance ends or is reduced. If you or your dependents die within this period, a death benefit is paid to the designated beneficiary(ies). You pay your premium payment directly to The Hartford, Legacy's life insurance administrator.

• You and your spouse/domestic partner’s portable coverage ends if the required premium isn’t paid.
• Your dependent child’s portable coverage ends if the required premium isn’t paid, if the child no longer qualifies as a dependent or on the date the surviving spouse or domestic partner dies.

Benefits from other sources
In certain situations, your health care expenses may be the responsibility of other than your Legacy plan. In that case, claim payment is determined as described below.

Third-party liability
You and your covered dependents may have a legal right to recover health care costs from a third party that may be responsible. Third parties include:

• A person or entity alleged to have caused you to suffer a sickness, injury or damages, or who is legally responsible for the illness, injury or damages
• Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the illness, injury or damages
• The plan sponsor
• Any person or entity who is or may be obligated to provide benefits or payments to you — including those for underinsured or uninsured motorist coverage, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers’ compensation coverage, other insurance carriers or third-party administrators
• Any person or entity liable for payment to you on any equitable or legal liability theory.

In situations where a third party might be responsible, the following rules apply:

• The amount of Legacy benefit you are entitled to is reduced by the amount you recovered or expect to recover.
• If the Legacy plan has provided any benefits, it is entitled to recover the amount paid from the proceeds of any settlement or recovery you or a covered dependent receives from any third party, including any insurance policy maintained by you or a covered dependent. If you continue to receive medical treatment for illness or injury after obtaining the settlement or recovery, the Legacy plan does not provide benefits for that continuing treatment unless you can prove its total...
cost (including the cost of obtaining settlement or recovery) is more than you or your covered dependent recovered or expects to recover.

- You or your covered dependent must hold the rights of recovery in trust for the Legacy plan, up to the amount of benefits you have already been provided.

- The Legacy plan may require you to sign and deliver all legal papers necessary to secure its rights and yours. If requested, you must sign an agreement to hold the proceeds of any recovery in trust for the plan before any payment for benefits is provided. You may be required to sign an agreement to repay the plan any amount you recover after the plan has already paid benefits, up to the amount the plan paid.

Regardless of the provisions above, the Legacy plan’s right to reimbursement applies even if your recovery does not make you whole or otherwise fully compensate you for your expenses and damages associated with the applicable illness or injury (that is, the “make whole” doctrine will not apply).

In addition, the Legacy plan is entitled to subrogation and reimbursement from any source (other than your general assets), including but not limited to first-party auto insurance, underinsured or uninsured motorist coverage, liability insurance, victim’s compensation fund, assets of a bankruptcy estate and workers’ compensation. Furthermore, the Legacy plan’s subrogation and reimbursement rights apply to full and partial settlements, judgments or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include but are not limited to economic, non-economic and punitive damages.

The Legacy plan is not required to help you pursue your claim for damages or personal injuries. No amount of associated costs, including attorneys’ fees, are deducted from the plan’s recovery without the plan’s express written consent. (No “fund doctrine,” “common fund doctrine” or “attorney’s fund doctrine” defeats this right.)

**Motor vehicle coverage**

Most motor vehicle policies are required by law to provide liability insurance; many motor vehicle policies also provide other coverage. The Legacy plan does not pay benefits for health care or disability costs to the extent you are able or are entitled to recover from motor vehicle insurance.

If the Legacy plan pays benefits before motor vehicle insurance payments are made, you must reimburse the plan from any subsequent motor vehicle insurance payments made to you. In addition, when applicable, the plan may recover benefits already paid directly from the motor vehicle insurer or from any settlement or judgment you obtain by exercising your right against a third party.

Before the Legacy plan pays benefits:

- You must provide information about any motor vehicle insurance payments that may be available to you or to your covered dependents.
- If asked, you must sign an agreement to hold the proceeds of any recovery in trust for the plan.

**Medicare**

In certain situations, the Legacy Medical Plan is primary to Medicare. This means when you or your covered dependents are enrolled in Medicare and this plan at the same time, the Legacy plan may pay the benefit for covered expenses first and Medicare pays second. By law, Medicare is secondary to the Legacy plan:

- When you or your covered dependent is age 65 or over
- For up to 30 months, when you or your covered dependent incurs covered expenses for permanent kidney failure
- When you or your covered dependent is entitled to benefits under Section 226(b) of the Social Security Act (Medicare disability).

In all other instances, the plan does not pay benefits toward any part of a covered expense to the extent it is actually paid or would have been paid under Medicare Part A or B had you or your covered dependent properly applied for benefits.

**Other adopting employers**

In addition to Legacy, the following employers have adopted the overall Legacy Benefit Program:

- Legacy Medical Group
- Legacy Emanuel Medical Center
- Legacy Good Samaritan Medical Center
• Legacy Lab Services, LLC
• Legacy Meridian Park Medical Center
• Legacy Mount Hood Medical Center
• Legacy Salmon Creek Medical Center

You may obtain an updated list of adopting employers by writing to the Plan Administrator, or see the list at the Plan Administrator’s office.

Your ERISA rights

As a participant in the Legacy Benefit Program, you are entitled to certain rights and protection under the Employee Retirement Income Security Act (ERISA) of 1974, which provides that all participants be entitled to:

• Examine, without charge, at the appropriate Plan Administrator’s office and at other specified locations, such as work sites, all Plan documents, including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions

• In addition to creating rights for Legacy Benefit Program participants, ERISA imposes duties upon the people who are responsible for the operation of your employee benefit Plans. 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 Legacy Plan participants and beneficiaries.

• Obtain copies of all Legacy Plan documents and/or insurance contracts or other information upon written request to the appropriate Plan Administrator. The administrator may make a reasonable charge for the copies.

• Receive a summary of each plan’s annual financial reports. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

• You are entitled to continue health care coverage for yourself, spouse or dependents if there is a loss of coverage as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this SPD and the documents governing the Plan for the rules governing your COBRA continuation coverage rights (if applicable to your plan).

• 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 pension or welfare benefit or exercising your rights under ERISA.

• If your claim for a pension or welfare benefit is denied in whole or in part, you must receive a written explanation of the reason(s) for the denial. You have the right to have the Plan review and consider your claim.

Under ERISA there are steps you can take to enforce the above rights. If you request materials from the Plan and do not receive them within 30 days, you may file suit in federal court. In such a case, the court may require the appropriate Plan Administrator to provide materials and pay up to $110 per 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 that is denied or ignored, in whole or in part, you may file suit in state or federal court. If it should happen that Plan fiduciaries misuse Legacy Benefit Program 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 federal court.

The court decides 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 if, for example, it finds your claim is frivolous. If you have any questions about your plan, you should contact the appropriate Plan Administrator.

If you have any questions about this statement or your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, contact the Employee Benefits Security Administration, U.S. Department of Labor, 1111 Third Ave., Room 860, Seattle, WA, 98101, 206-553-4244, or the Office of Participant Assistance, Employee Benefits Security Administration, U.S. Department of Labor Room N-5623, 200 Constitution Ave. N.W., Washington DC 20210. You may also obtain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
Right to receive and release necessary information

You and your covered dependents must give Legacy or its claim administrators any facts they need to pay a claim. Legacy and its claim administrators have the right to decide which facts they need. Under some circumstances, they may obtain required facts from or give them to any other organization or person without telling you or getting your consent.

You and your covered dependents may be asked to authorize any health care provider to give Legacy, or its claim administrators, information about a condition for which you or your covered dependents claim benefits.

Facility of payment

If another organization makes a payment that should have been paid under a Legacy plan, the plan may reimburse the organization that made the payment. That amount then is treated as though it were a benefit paid under the plan. The term “payment” includes the reasonable cash value of benefits provided in the form of services.

Right of recovery

If the Legacy plan pays more than it should have under the COB provision, the plan may recover the excess from one or more of the following:

- Individuals it has paid or for whom it has paid
- Insurance companies
- Other organizations

A secondary plan that provides benefits in the form of services may recover the reasonable cash value of providing the services from the primary plan, if the services are covered by the primary plan and have not already been paid or provided. There is no provision in the Legacy Benefit Plan for providing cash instead of services.

Benefits are not transferable

Only you and your enrolled dependents are entitled to Legacy benefits. Except for life insurance, these benefits are not assignable or transferable to anyone else. Any attempt to assign or transfer is not binding.

HIPAA privacy notice

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Legacy is required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can release or “disclose” that information to others. You also have rights regarding your health information that are described in this notice. We are required by law to abide by this notice.

The terms “information” or “health information” in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health condition, providing health care to you, or payment for such health care. We comply with the requirements of applicable privacy laws related to notifying you in the event of a breach of your health information.

We have the right to change our privacy practices and the terms of this notice. If we make a material change to our privacy practices, we provide you either a revised notice, or information about the material change and how to obtain a revised notice, by direct mail or electronically, in accordance with applicable law. In all cases, we post the revised notice on www.legacyhealthandwellness.org. We reserve the right to make any revised or changed notice effective for information we already have and for information that we receive in the future.

The Legacy health plans collect and maintain oral, written and electronic information to administer the plans and to provide products, services and
information of importance to members. We maintain physical, electronic and procedural security safeguards in handling and maintaining this information, in accordance with applicable state and federal laws, to protect against risks such as loss, destruction, misappropriation or misuse.

**How we use or disclose information**

We must use and disclose your health information to provide that information:

- To you or someone who has the legal right to act for you (your personal representative) in order to administer your rights as described in this notice
- To the Department of Health and Human Services Secretary in connection with an investigation of our compliance with the privacy and security rules.

We have the right to use and disclose health information for your treatment, to pay for your health care and to operate the plans. For example, we may use or disclose your health information:

- For payment to determine your coverage and to process claims for health care services you receive, including for subrogation or coordination of other benefits you may have. For example, we may tell a doctor whether you are eligible for coverage and what percentage of the bill may be covered.
- To aid in your treatment or the coordination of your care. For example, we may disclose information to your physicians or hospitals to help them provide medical care to you.
- For health plan operations. For example, we might talk to your physician to suggest a disease management or wellness program that could help improve your health, or we may analyze health information data to determine how we can improve our services.
- To provide you with information on health-related programs or products, such as alternative medical treatments and programs or about health-related products and services, subject to limits imposed by law.
- For underwriting purposes; however, we do not use or disclose your genetic information for such purposes.
- To send you reminders about your benefits or care, such as appointment reminders with your medical providers.

We may use or disclose your health information for the following purposes under limited circumstances:

- When required to do so by law, such as national security laws or public health disclosure laws.
- To a person involved in your care or who helps pay for your care, such as a family member, when you are incapacitated or in an emergency, or when you agree or fail to object when given the opportunity. If you are unavailable or unable to object, we use our best judgment to decide if the disclosure is in your best interests. Special rules apply regarding when we may disclose health information to family members and others involved in a deceased individual’s care. We may disclose health information to any persons involved, before the death, in the care or payment for care of a deceased individual, unless we are aware that doing so would be inconsistent with a preference previously expressed by the deceased.
- For public health activities, such as giving the following types of notices:
  - To a public health authority to prevent disease outbreaks
  - Births and deaths
  - Child abuse or neglect
  - Reactions to medications or issues with health products
  - Recalls of health products
  - Involving exposure to disease or risk of spreading disease.
- For reporting victims of abuse, neglect or domestic violence to government authorities authorized by law to receive such information, including a social service or protective service agency.
- For health oversight activities authorized by law to a health oversight agency, such as licensure, government audits and fraud or abuse investigations.
- For judicial or administrative proceedings, such as in response to a court order, search warrant or subpoena.
• To a law enforcement official for purposes such as providing information to locate a missing person or report a crime.

• To avoid a serious threat to health or safety to you, another person, or the public, by, for example, disclosing information to public health agencies or law enforcement authorities, or in the event of an emergency or natural disaster.

• For specialized government functions, such as military and veteran activities, national security and intelligence activities, and protective services for the president and others.

• For workers’ compensation as authorized by, or to the extent necessary to comply with, state workers’ compensation laws that govern job-related injuries or illness.

• For research purposes, such as research to evaluate certain treatments or prevent disease or disability, if the research study meets federal privacy law requirements.

• To provide information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.

• To entities that handle procurement, banking or transplant of organs, eyes or tissue to facilitate donation and transplant.

• To correctional institutions or law enforcement officials if you are an inmate or under law enforcement official custody, but only if necessary for the institution to: provide you with health care; protect your health and safety or the health and safety of others; or for the institution’s safety and security.

• To business associates who perform functions on our behalf or provide us with services, in order for them to perform those services. Our business associates are required, under contract with us and under federal law, to protect the privacy and security of your information and are not allowed to use or disclose it other than as specified in our contract and as permitted by federal law.

• In addition, federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you; this may include confidential information under federal laws governing alcohol and drug abuse information and genetic information, as well as state laws that often protect information about:
  — Alcohol and drug abuse
  — Child or adult abuse or neglect, including sexual assault
  — Genetic tests
  — HIV/AIDS
  — Mental health
  — Sexually transmitted diseases and reproductive health information

If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.

Except for uses and disclosures described and limited as set forth in this notice, or otherwise required or permitted by law, we use and disclose your health information only with written authorization from you. This includes, except for limited circumstances allowed by federal privacy law, not using or disclosing psychotherapy notes about you, selling your health information to others, or using or disclosing your health information for certain promotional communications that are prohibited under federal law, without your written authorization. Once you give us authorization to release your health information, we cannot guarantee that the recipient to whom the information is provided will not disclose the information. You may take back or revoke your written authorization at any time in writing, except if we have already acted based on your authorization. To find out where to mail your written authorization and how to revoke an authorization, call the phone number on the back of your membership ID card.

Your rights regarding your health information

You have the right to:

• Ask to restrict uses or disclosures of your information for treatment, payment or health care
operations. You also have the right to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that authorize your dependents to request certain restrictions. While we try to honor your request and permit requests consistent with our policies, we are not required to agree to any restriction. Mail your request to the address below.

- Ask to receive confidential communications of information in a different manner or at a different place (for example, by sending information to a P.O. box instead of your home address). We use best efforts to accommodate reasonable requests. In certain circumstances, we accept your verbal request to receive confidential communications, however, we may also require you confirm your request in writing. In addition, any requests to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address below.

- See and obtain a copy of certain health information we maintain about you such as claims and case or medical management records. If we maintain your health information electronically, you have the right to request that we send you a copy in an electronic format. You can also request that we provide a copy to a third party that you identify. In some cases you may receive a summary of this health information. You must make a written request to the address below to inspect and copy your health information or have your information sent to a third party. In certain limited circumstances, we may deny your request to inspect and copy your health information. If we deny your request, you may have the right to have the denial reviewed. We may charge a reasonable fee for copying, mailing or other supplies related to your request.

- Ask to amend certain health information we maintain about you, such as claims and case or medical management records, if you believe the health information about you is wrong or incomplete. Your request must be in writing to the address below and provide the reasons for the requested amendment. If we deny your request, you may have a statement of your disagreement added to your health information.

- Receive an accounting of certain disclosures of your information we made during a period of up to six years before your request. This accounting does not include disclosures of information made: for treatment, payment and health care operations purposes; to you or pursuant to your authorization; to correctional institutions or law enforcement officials; or other disclosures for which federal law does not require us to provide an accounting. The first accounting you request within a 12-month period is provided free of charge. For additional accountings, we may charge you for the costs of providing the accounting. Once we notify you of the cost, you may choose to withdraw or modify your request before the cost is incurred. Mail your request to the address below.

- Be notified if we (or a business associate) discover a breach of unsecured protected health information.

- Ask for a copy of this notice at any time, even if you have agreed to receive it electronically. You may also obtain a copy at www.legacyhealthandwellness.org.

**Exercising your rights**

**Contacting your health plan**

If you have any questions about this notice or want information about exercising your rights, contact the Benefits Manager at the address below.

- Submitting a written request — Mail your written requests to exercise any of your rights, including modifying or canceling a confidential communication, requesting copies of your records or requesting amendments to your record, to the addresses below.

**Filing a complaint**

If you believe your privacy rights have been violated, you may file a written complaint.

**Health Plan and privacy officer**

Benefits Manager
Legacy Health
1919 N.W. Lovejoy St.
Portland, OR 97209
Required notices/other information

Medical and Vision Plan
UMR
P.O. Box 8006
Wausau, WI 54402-8006
866-868-7761

Dental Plan
Moda Health
601 S.W. Second Ave.
Portland, OR 97204
503-243-3886 (Portland)
888-281-0405 (outside Portland)

Prescription Plan
MedImpact Healthcare Systems, Inc.
Claims Department
10680 Treena St., Fifth Floor
San Diego, CA 92131
800-788-2949

Health Care Flexible Spending Account
UMR (Flexible Spending Unit)
P.O. Box 8022
Wausau, WI 54402-8022
866-868-7761
fax 877-390-4782

Employee Assistance Program
Cascade Centers, Inc.
7180 S.W. Fir Loop, Suite 1-A
Portland, OR 97223–8023
800-433-2320 (nationwide)
503-639-3009 (Portland)
503-588-0777 (Salem)

You may also notify the Office for Civil Rights of the U.S. Department of Health and Human Services of your complaint. We will not take any action against you for filing a complaint.

HIPAA special enrollment rights notice
If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents’ other coverage). You must request enrollment within 31 days after the marriage, birth, adoption or placement of your dependent.

In addition, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your dependents. You must request enrollment within 31 days after the marriage, birth, adoption or placement.

Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) notice

Group health plans must permit employees and their eligible dependents to enroll in the plan if they:

• Lose Medicaid or CHIP coverage

Or:

• Become eligible to participate in a Medicaid or CHIP premium assistance program.

Individuals gaining or losing Medicaid or CHIP coverage have 60 days from the date of loss of coverage or the date of eligibility to request special enrollment in the group health plan by contacting the HR Answer Center at 503-415-5100 or logging on to Legacy’s Employee Self-Service portal (myess.lhs.org).

Genetic Information Nondiscrimination Act of 2008 (GINA) notice

This federal law protects Americans from discrimination by health insurers and employers on the basis of DNA information. The law does not cover life insurance, disability insurance or long-term care insurance. Legacy is in compliance with GINA.

Premium assistance under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and for employer health coverage, your state may have a premium assistance program that can help pay for coverage. These states use Medicaid or CHIP funds to help people who are eligible. If you or your children are not eligible for Medicaid or CHIP, you are not eligible for these premium assistance programs.
If you or your dependents are already enrolled in Medicaid or CHIP, you can contact your state Medicaid or CHIP office to find out if premium assistance is available. If you or your dependents are not currently enrolled in Medicaid or CHIP, and you think you or any dependent might be eligible for either program, contact your state Medicaid or CHIP office, or dial 1-877-KIDS NOW or visit www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must permit you to enroll in your employer plan if you are not already enrolled. This is called a “special enrollment” opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askelsa.dol.gov or 866-444-EBSA (3272).

To see if any more states have added a premium assistance program since July 31, 2013, or for more information on special enrollment rights, contact:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
877-267-2323, menu option 4, ext. 61565

**Women’s Health and Cancer Rights Act of 1998 (WHCRA)**

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under this Act. For individuals receiving mastectomy-related benefits, coverage is provided in a manner determined in consultation with the attending physician and the patient for:

- All stages of reconstruction of the breast on which the mastectomy was performed
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses
- Treatment of physical complications of the mastectomy, including lymphedemas.

These benefits are subject to the same deductibles and co-insurance applicable to other medical and surgical benefits under the plan.

**Newborns’ and Mothers’ Health Protection Act notice**

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a Caesarean section. However, federal law generally does not prohibit the mother’s or newborn’s attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 or 96 hours. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 or 96 hours.

**Initial COBRA notice to employees, spouses and dependents**

If your Legacy coverage ends, you may be able to continue that coverage under certain circumstances and conditions. This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985.

COBRA continuation coverage can become available to you and to family members who are covered under the plan when coverage would otherwise end. This notice generally explains COBRA continuation coverage, when it may become available and what you need to do to receive it. For more information contact the Plan Administrator at 1919 N.W. Lovejoy St., Portland, OR 97209.

If you participate in the Legacy Health Care Flexible Spending Account, you may be able to elect COBRA for the flexible spending account if you have
a positive balance in your account at the time of your qualifying event. You’ll receive additional information about this if you have a qualifying event.

**Qualified beneficiaries and qualifying events**

COBRA continues plan coverage when it would otherwise end because of a “qualifying event.” COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” Qualified beneficiaries are employees, spouses and dependent children who were covered under the plan the day before a qualifying event. A retiree may also be a qualified beneficiary as indicated below. If you are an employee, you become a qualified beneficiary if you lose your plan coverage because one of the following qualifying events occurs:

- Your hours of employment are reduced
- Your employment ends for any reason other than gross misconduct.

If you are the spouse of an employee, you become a qualified beneficiary if you would lose your plan coverage because any of the following qualifying events occurs:

- Your spouse dies
- Your spouse’s hours of employment are reduced
- Your spouse’s employment ends for any reason other than gross misconduct
- Your spouse becomes enrolled in Medicare Part A or Part B, or both
- You become divorced or legally separated from your spouse.

Your dependent children become qualified beneficiaries if they would lose plan coverage because any of the following qualifying events occurs:

- The parent-employee dies
- The parent-employee’s hours of employment are reduced
- The parent-employee’s employment ends for any reason other than gross misconduct
- The parent-employee becomes enrolled in Medicare Part A or Part B, or both
- The parents become divorced or legally separated
- The child is no longer eligible for plan coverage as a “dependent child”

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Legacy, and that bankruptcy results in the loss of coverage of any retired employee under the plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children are also qualified beneficiaries if bankruptcy results in the loss of their plan coverage.

**When COBRA coverage is available**

COBRA coverage is available to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction in hours, employee death, bankruptcy proceeding regarding the employer or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days following the date coverage ends.

**Notices you must give**

For other qualifying events, under COBRA statutes, you, your spouse or dependent child has the responsibility to inform the Plan Administrator if you and your spouse divorce or become legally separated or your dependent child loses plan eligibility. The notice must be provided no later than 60 days after the date plan coverage terminates due to the divorce, legal separation or loss of eligibility. The notice must include: former employer’s name; policyholder’s name and Social Security number; affected beneficiary(ies); event (for example, a divorce); date the event occurred. You must send the notice to our Benefits Department, 1919 N.W. Lovejoy St., Portland, OR 97209 in writing. If you, your spouse or dependent child fails to provide the notice during the 60-day period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage.

**How COBRA coverage is provided**

If notified within the 60-day period of a divorce, legal separation or a child’s losing dependent status, the Plan Administrator notifies the affected family member(s) of COBRA continuation election.
Under the law, qualified beneficiaries have 60 days from the later of the date they would lose coverage because of one of the events described above, or the date the notice of their continuation rights was sent, to inform the Plan Administrator that they want to continue coverage.

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled at any time during or before the first 60 days of COBRA coverage, and you notify the plan administrator within 60 days of the determination and before the end of your COBRA election period, you and your entire family can receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. Send the notice of approval for disability benefits by the Social Security Administration to Legacy’s COBRA administrator, UMR, P.O. Box 1206, Wausau, WI 54402-1206, 800-207-1824, fax 877-291-3241.

An employee may elect continuation coverage for all qualified beneficiaries, or each qualified beneficiary may decide independently whether to elect. Covered employees may elect COBRA on behalf of their spouses, and parents may elect COBRA on behalf of their children. If timely election is not made, your group health plan coverage ends as of the loss of coverage date and may not be reinstated, subject to any rights you may have under any state/federal law to convert group coverage to an individual or portability policy.

If you terminate your spouse’s or dependent child’s coverage in anticipation of a qualifying event (such as a divorce), the spouse and/or dependent child may be eligible for continuation coverage when the qualifying event occurs. It is your responsibility to inform the Plan Administrator if coverage is terminated in anticipation of a qualifying event.

**Keep your plan informed of address changes**

If you, your spouse or your dependent child has an address change, you must notify UMR so that notice of COBRA election rights can be sent. You should also keep a copy, for your records, of any notices you send to UMR.

**Length of continuation coverage**

If loss of health coverage occurs due to end of employment or reduction in hours, qualified beneficiaries are entitled to 18 months of continued coverage. End of employment and reduction in hours are the only qualifying events for which an employee can be eligible for continuation coverage. For a spouse and/or dependent child, COBRA continuation coverage lasts for up to 36 months when the qualifying event is the employee’s death, employee and spouse divorce or legal separation, employee becoming entitled to Medicare, or a dependent child losing plan eligibility. These events are known as “second qualifying events.”

If a second qualifying event that gives rise to a 36-month maximum coverage period for the spouse or dependent child occurs within an 18-month or 29-month coverage period, then the maximum coverage period (for a spouse or dependent child) becomes 36 months from the date of the initial end of employment or reduction in hours. You must make sure the Plan Administrator is notified of the second qualifying event within 60 days by sending notice to UMR, P.O. Box 1206, Wausau, WI 54402-1206, 800-207-1824, fax 877-291-3241.

If the qualifying event occurs within 18 months after the employee becomes enrolled in Medicare, then the maximum coverage period (for the spouse and dependent child) ends 36 months from the date the employee became enrolled in Medicare. If the employee enrolls in Medicare after the initial qualifying event of termination or reduction in hours, the spouse or dependent child is eligible for a total of 36 months of coverage from the original effective date of COBRA coverage.

**Special notice for Oregon insured**

As required by Oregon Law, a covered spouse, age 55 or older, and covered dependents who lose Oregon insurance coverage due to divorce, legal separation or death of the employee may be eligible to extend the maximum continuation period until the spouse becomes eligible for Medicare.

**COBRA continuation coverage**

If you choose COBRA continuation coverage within the specified timeframe, Legacy is required to give you coverage that is identical to the coverage provided under the plan to similarly situated employees or family members at the time of your election. Under the law, qualified beneficiaries may have to
pay all or part of the premium for their continuation coverage, which in general is 102 percent of the full cost of providing coverage to active individuals under the plan. The premium may increase to 150 percent of the cost of coverage under the plan if extended beyond 18 months due to Social Security disability.

The first premium payment for continuation coverage is due within 45 days after the date of your election. This payment must include the amount necessary to cover all months that have ended between the date regular coverage ended and the payment date. Subsequent payments are due on the first of each month; however, as allowed by law, qualified beneficiaries have a grace period of 30 days to pay the premium. The law does not require that you be billed for premium due. If you do not pay the applicable premium, in good funds, when due, your continuation coverage ends and may not be reinstated.

**Termination of COBRA coverage**

A qualified beneficiary’s continuation coverage ends, before the end of the maximum continuation period, on the earliest of the following dates:

- The date Legacy no longer provides group health coverage to any employee
- The first day of the month for which the premium for continuation coverage is not paid when due, in good funds
- The date the qualified beneficiary first becomes, after electing continuation coverage, covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition the qualified beneficiary may have
- The date the qualified beneficiary first becomes enrolled in Medicare benefits, after electing continuation coverage, unless entitlement to Medicare is due to disability
- For continuation coverage extended by disability, the first of the month beginning at least 31 days after final determination that a relevant qualified beneficiary is no longer disabled under the Social Security Act. Qualified beneficiaries are required to notify UMR within 30 days that the relevant qualified beneficiary is no longer disabled.

- Coverage is terminated for cause, for example, a member submits a fraudulent claim.

**Important information**

During and/or at the end of a qualified beneficiary’s continuation period, if timely application is made, he or she may have additional rights to other coverage, including conversion and/or portability plans, which may be available under state and/or federal law. Qualified beneficiaries should contact the insurance company providing their coverage or the Insurance Commissioner in their state.

When coverage under the Legacy group health plan ends, qualified beneficiaries receive a Certificate of Creditable Coverage. Qualified beneficiaries may need to furnish the certificate if they become eligible under a group health plan that excludes coverage for certain pre-existing medical conditions. Qualified beneficiaries may also need this certificate to buy a personal insurance policy that does not contain an exclusion for pre-existing medical conditions. Qualified beneficiaries who do not receive a certificate, or who wish to request a certificate at any time with 24 months after group health plan coverage ends, may contact their plan administrator to request a certificate.

**Special notice if eligible for Medicare**

We strongly suggest that qualified beneficiaries who are eligible for Medicare consult the Social Security Administration about the need to enroll in both Parts A and B of Medicare. The date Medicare coverage becomes effective may affect COBRA coverage eligibility.

**If you have questions**

If you have questions about COBRA continuation coverage, call UMR at 800-207-1824 or contact the nearest regional or district office of the U.S. Department of Labor’s Employee Benefits Security Administration. Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at www.dol.gov/ebsa.

Potential qualified beneficiaries should save this notice with important papers for reference in case of a qualifying event.
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