Oregon Society of CPAs
GROUP HEALTH TRUST

OSCPA GROUP HEALTH PLAN
SUMMARY PLAN DESCRIPTION

January 1, 2023

To All Participants and Beneficiaries:

The OSCPA Group Health Plan (the Plan) is a multiple employer welfare arrangement adopted by the Board of Trustees of the Oregon Society of Certified Public Accountants Group Health Trust (the Plan Sponsor and Plan Administrator). The Plan is a single welfare benefit plan consisting of benefit programs that provide medical (including prescription drug), dental, vision, and long-term disability insurance benefits. The Plan was last amended and restated effective January 1, 2023.

Each participating employer has elected particular benefit coverages from among these benefit programs, including electing not to provide certain benefits, and thus each employer has different Plan coverage for its employees. This summary supplements the insurance booklets and the summaries of benefits (Insurance Booklets) provided by the insurers listed in the Plan Information Section below. This summary, together with the Insurance Booklets, constitute the summary plan description for the Plan. Copies of that information have been distributed to you by the Plan Administrator. In the case of any conflict between this summary or the separate Insurance Booklets and the actual terms of the Plan, the terms of the Plan will control.

If your address changes, please notify your employer's human resources department.

This summary plan description describes the terms of the Plan as of January 1, 2023, and has the following sections:

1. PLAN INFORMATION

Important administrative information about the Plan is summarized below:

Plan Name: OSCPA Group Health Plan

Plan Sponsor and Plan Administrator: Trustees of the Oregon Society of Certified Public Accountants Group Health Trust
10206 SW Laurel Street
Beaverton, OR 97005-3209
(503) 641-7200

Employers Maintaining the Plan: The Plan is maintained by more than one employer. The Trustees are the representative of the employers maintaining the Plan. Participants and beneficiaries may receive from the Trustees, upon written request, information as to whether a particular employer sponsors the Plan and if so, the employer's address.

Classes of Employees Covered by this Summary: This, together with the applicable Insurance Booklets, is the summary plan description for your employer's coverage. There is a separate summary and thereby class of employees for each employer that has different Plan coverage for its employees. The insurance benefits, and the eligibility, participation, enrollment, and termination rules that govern them, are described in the respective Insurance Booklets. Benefit information is available from the Plan Administrator.

Agent for Service of Legal Process: Sherri L.D. McPherson, President/CEO
Oregon Society of Certified Public Accountants
10206 SW Laurel Street
Beaverton, OR 97005-3209

Service of legal process also may be made on the Trustees at the foregoing address and any individual Trustee at his or her address below.

Name and Address of the Insurance Carriers:

Medical, Prescription Drug, and Vision
Providence Health Plan
PO Box 4327
Portland, OR 97208
(800) 878-4445

Long-Term Disability
Hartford Life and Accident Insurance Company
One Hartford Plaza
Hartford, CT 06155
(800) 523-2233

Dental
Delta Dental Plan of Oregon
PO Box 40384
Portland, OR 97240
(888) 217-2365

Name and Address of the COBRA Administrator:

PacificSource Administrators
PO Box 70168
Springfield, OR 97475
(877) 355-2760

Trustees:

James A. Carnegie, Chair Carnegie Accounting LLP 7300 SW Hunziker Rd, Ste 102 Portland, OR 97223	Darlene E. Boles Oregon Society of Certified Public Accountants 10206 SW Laurel Street Beaverton, OR 97005
David A. Buettner DiLorenzo & Company LLC 10300 SW Greenburg Rd, Ste 360 Portland, OR 97223	Stanley C. Compton Compton English and Hunsaker PC 1845 Fairgrounds Rd NE Salem, OR 97301
Geoffrey T. Dougall Dougall Conradie LLC 9400 SW Barnes Rd, Ste 309 Portland, OR 97225	Brendan A. Hoem Top Kohlbush & Hoem LLP 1201 SW 12th Ave, Ste 610 Portland, OR 97205
Gary S. Leavitt Gary S. Leavitt CPA 1209 7th St Oregon City, OR 97045	Sherri L.D. McPherson Oregon Society of Certified Public Accountants 10206 SW Laurel St Beaverton, OR 97005
Patrick Priest CIS PO Box 1469 Lake Oswego, OR 97035	Donald W. Schmidt c/o Oregon Society of Certified Public Accountants 10206 SW Laurel St Beaverton, OR 97005
Michael N. Stone Stone Associates CPAs LLC 1 Centerpointe Dr, Ste 130 Lake Oswego, OR 97035	

Plan Sponsor's and Administrator's Internal Revenue Service Employer Identification Number: 32-0422987

Plan Number: 501

Plan Year: The 12-month period beginning January 1 and ending December 31.

Type of Plan: A welfare benefit plan providing medical (including prescription drug), dental, vision, and long-term disability insurance benefits. Your employer elects which specific benefit programs are available to you.

Type of Administration and Funding: The Plan benefits are fully insured. Benefits are provided under group insurance contracts between the Trustees of the Oregon Society of Certified Public Accounts Group Health Trust and the insurance carriers listed above (Insurers). The Trustees are the policyholder of the group insurance contracts. The insurance contracts contain specific information regarding eligibility and benefits. Under the insurance contracts, the Insurers, not the policyholder, are responsible for paying claims. However, the policyholder and the Insurers share responsibility for administering the Plan's eligibility and enrollment requirements. The Insurers have discretionary authority to make eligibility and benefit determinations, to make factual determinations, and to interpret the terms of the Plan. The Insurers administer the benefits under the applicable insurance policy and are responsible for determining to what extent claims are payable, paying claims, and handling any appeals.

Insurance premiums are paid by the participating employers, the covered employees, and qualified beneficiaries who have continuation coverage rights under the federal COBRA law or Oregon state insurance law.

2. CONTINUATION COVERAGE

Participants and their dependents are permitted to separately elect to continue coverage under the medical, dental, and vision benefit programs if such coverage would otherwise terminate because of an employee's termination of employment (other than by reason of the employee's gross misconduct, although the employee may be entitled to continuation coverage under applicable state law) or reduction in hours of employment. A participant's dependents may also elect to continue medical, dental, and vision coverage if they lose coverage because of the participant's death, divorce, legal separation, or entitlement to Medicare. In addition, a participant's dependent child may elect to continue health coverage if coverage terminates because of the participant's child ceasing to be a dependent under that program. These circumstances are referred to as "qualifying events," and individuals eligible for continuation coverage are referred to as "qualified beneficiaries." The medical and vision benefits are combined for purposes of continuation coverage, so if a qualified beneficiary is losing medical

and vision coverage, an election of continuation coverage will apply to both medical and vision benefits. This continuation coverage is often referred to as "COBRA coverage."

For purposes of continuation coverage, dependents are a participant's spouse and children (including domestic partner children). "Dependent" as it is used in this section does not include a participant's domestic partner, except to the extent the programs treat domestic partners as COBRA qualified beneficiaries. For information about whether a domestic partner is a COBRA qualified beneficiary, whether the termination of a domestic partnership is a qualifying event, and the rights of domestic partners under a particular program, please see the Insurance Booklets or contact the COBRA Administrator.

If you are a retired employee covered by the medical, dental, or vision programs, you, your spouse, and your dependent children have a right to elect continuation coverage if you or your dependents lose coverage because your prior employer is subject to a bankruptcy proceeding in a case under Title 11, United States Code. A loss of coverage by reason of this event includes a substantial elimination of coverage within one year before or after the date of commencement of the proceeding. Bankruptcy proceeding continuation is limited to covered employees who retired on or before the date of the substantial elimination of coverage and any other individual who, on the day before such elimination, is a program beneficiary as the spouse, surviving spouse, or dependent child of the retired employee.

A participant's rights to continuation coverage are the same as required by federal or applicable state insurance law. Except as provided in the Insurance Booklets for a particular program, the Plan and the summary plan description do not grant anyone more rights than the law requires. Any state law continuation rights are described in the applicable Insurer's Insurance Booklet.

Contact the COBRA Administrator for additional information about continuation coverage.

(a) **Election Period:** To receive continuation coverage, qualified beneficiaries must elect continuation coverage within 60 days after the later of the date coverage terminates because of the occurrence of a qualifying event or notification by the Plan of a loss of coverage. Failure to elect continuation coverage within that period eliminates the right to continuation coverage by reason of that event.

(b) **<u>Adding Dependents</u>:** If a Plan participant or a participant's dependents elect continuation coverage, the participant or the participant's dependents will be entitled to add dependents at the Plan's open enrollment period or within 30 days from a birth, adoption, or marriage. If a child is born to or placed for adoption with a participant during the period of continuation coverage, the child is considered a qualified beneficiary as long as, if the participant is a qualified beneficiary, the participant elects continuation coverage for the participant. If the child is added as a dependent, the child will have independent election rights and second qualifying event rights.

(c) **<u>Length of Continuation Coverage</u>:** A participant or a participant's dependents can extend coverage for up to 18 months if the participant and the participant's dependents lose coverage because the participant terminates employment or has a reduction in hours. A participant's dependents can extend coverage for up to 36 months if they lose coverage because of the participant's death, legal separation or divorce, the participant's child's loss of dependent status, or the participant becoming entitled to Medicare. If one of these 36-month qualifying events occurs during the 18-month period after the loss of coverage as a result of the participant's termination of employment or reduction in hours (or during the 29-month period if continuation coverage is extended due to disability, as described below), the total continuation period may be extended to a total of 36 months after the initial loss of coverage if the event would have caused a loss of coverage had the termination of employment or reduction in hours not occurred.

If a participant has a termination of employment or reduction in hours within 18 months after the date the participant becomes entitled to Medicare, the period of continuation coverage available to the participant's dependents will be 36 months after the date on which the participant became entitled to Medicare, or 18 months (29 months or 36 months if coverage is extended due to disability or a 36-month qualifying event) after the date of loss of coverage, whichever period is longer.

If the participant or a dependent is entitled to continuation coverage because of a termination of employment or reduction in hours and the Social Security Administration determines that any qualified beneficiary was disabled at any time during the first 60 days of continuation coverage, coverage may be extended for up to 11 months after the end of the first 18-month period. All family members who are entitled to continuation coverage because of a termination of employment or reduction in hours are eligible for this extension. This extended coverage will end for all family members who are entitled to the disability extension if, during the 11-month period, the Social Security Administration determines that the disabled person is no longer disabled.

If retiree coverage is lost or substantially eliminated because of a bankruptcy proceeding in a case under Title 11, United States Code, the required continuation coverage period is for the life of the retiree and on his or her death for three more years for the spouse or dependent children. If the retiree is deceased at the date of the bankruptcy proceeding and the retiree's surviving spouse is covered under the medical, dental, or vision programs, the required continuation coverage period is for the life of the surviving spouse.

If one of the following events occurs, continuation coverage under this Plan will end before the end of the continuation period, on the earliest of the following:

(i) The date that the cost of continuation coverage is not paid in a timely manner, as explained below.

(ii) The date on which, after electing continuation coverage, the covered person first becomes covered under another group health plan (as an employee or otherwise), which does not contain any exclusion or limitation with respect to any preexisting condition of the covered person (other than an exclusion or limitation that does not apply to, or is satisfied by, the covered person by reason of the portability provisions of federal law).

(iii) The date on which, after electing continuation coverage, the covered person first becomes entitled to Medicare benefits (but if Medicare Part A or B is effective on or before the date of the election, continuation coverage may not be discontinued on account of Medicare entitlement, even if the covered person enrolls in the other part of Medicare after the date of the election of continuation coverage). Medicare entitlement does not terminate the coverage of a retiree or his or her dependent on continuation coverage by reason of a bankruptcy.

(iv) The date on which the employer no longer provides group health coverage to any of its employees.

(v) The first day of the month that begins at least 30 days after a disabled qualified beneficiary is determined to no longer be disabled by the Social Security Administration during a period of extended continuation coverage due to the qualified beneficiary's disability.

(vi) Upon the occurrence of any event that would result in the termination of coverage for anyone under the program who is not receiving continuation coverage.

(d) **Cost of Continuation Coverage:** The qualified beneficiary must pay the entire premium for continuation coverage. The premium will be no more than 102 percent of the cost of providing coverage, except that, for any month after the 18th month of continuation coverage (including the 30th through 36th month of continuation if a 36-month qualifying event occurs after the end of the original 18-month period of continuation coverage), the premium for extended coverage due to disability for any coverage group that includes the disabled person will be no more than 150 percent of the cost of providing coverage.

The right to any continuation coverage is permanently lost if the premium is not timely paid. If continuation coverage is elected within the 60-day period, but after coverage has ceased, the cost of coverage before the election must

be paid within 45 days after the election or there will not be any continuation coverage. The cost of continuation coverage after the election must be paid within 30 days after it is due, or continuation coverage will cease as of the due date. Notwithstanding the foregoing, no premium payment will be required until 45 days after the date on which continuation coverage is elected.

(e) **Notice to COBRA Administrator:** You or a dependent must notify the COBRA Administrator in writing of a divorce, a legal separation, or a child's loss of dependent status that causes a loss of coverage under the medical, dental, or vision program, within 60 days after the later of the date of the event or the date of loss of coverage. The written notice must be sent to the COBRA Administrator and must include the names, addresses, and social security numbers of the employee and dependents who are losing coverage, the nature of the qualifying event, the date of the qualifying event, and proof of the qualifying event, which could include a court filing. Failure to provide this notice eliminates the right to continuation coverage by reason of that event.

If a dependent who is receiving 18-month continuation coverage (or 29-month continuation coverage in the case of a disability extension) because the covered employee terminated employment or had a reduction in hours experiences one of the 36-month qualifying events during that 18-month (or 29-month) period, one of the qualified beneficiaries must notify the COBRA Administrator in writing of the occurrence of the 36-month event, as that dependent will be able to continue coverage for up to 36 months after the initial loss of coverage. The notice must be sent to the COBRA Administrator within 60 days after the later of the date of the 36-month event or the date coverage would have been lost due to the event if the termination of employment or reduction in hours had not occurred. The notice must include the names, addresses, and social security numbers of the employee and affected dependents, the nature of the 36-month qualifying event, the date of the event, and proof of the event. Failure to provide this notice eliminates the right to extend continuation coverage

beyond the first 18-month (or 29-month) period by reason of the 36-month event.

If any qualified beneficiary is disabled at any time during the first 60 days of continuation coverage, one of the qualified beneficiaries must notify the COBRA Administrator in writing of the Social Security Administration's disability determination within 60 days after the latest of (i) the date of that determination, (ii) the date of the qualifying event, or (iii) the date of the loss of coverage, but no later than the end of the original 18-month period of continuation coverage. One of the qualified beneficiaries who is receiving extended coverage must also notify the COBRA Administrator in writing within 30 days after any Social Security Administration determination that the disabled qualified beneficiary is no longer disabled. The notice must be sent to the COBRA Administrator and must include the names, addresses, and social security numbers of the employee and the affected dependents, the date of the termination of employment or reduction in hours, and an award letter of disability (or notice of cessation of disability) from the Social Security Administration. Failure to provide these notices eliminates the right to extend continuation coverage beyond the first 18-month period by reason of the qualified beneficiary's disability.

(f) **Notice by COBRA Administrator:** Once the COBRA Administrator has received notice of a qualifying event, you or your dependents will be notified by the COBRA Administrator of a termination of coverage that entitles you or your dependents to elect continuation coverage. Notice to your spouse constitutes notification to any dependent child residing with your spouse. If your spouse has a different address, you and any dependent living with you will be separately notified. In order to protect your dependents' rights, you should keep the COBRA Administrator informed of any changes in the address of dependents.

(g) **Other Coverage Options Besides COBRA:** Instead of enrolling in COBRA continuation coverage under the medical, dental, and vision programs, there may be other coverage options through the Health Insurance Marketplace, Medicare, Medicaid, CHIP, or another group health plan (such as a spouse's

plan) under a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

(h) **Employees Eligible for Medicare:** In general, if you do not enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period to sign up for Medicare Part A or B. This special enrollment period begins on the earlier of (i) the month after your employment ends, or (ii) the month after group health plan coverage based on current employment ends. If you do not enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Medicare Part B late enrollment penalty and you may have a gap in coverage if you decide you want Medicare Part B coverage later. There is other information throughout this Section 2 that will be important to Medicare-eligible employees and qualified beneficiaries so you should review this section carefully.

3. MILITARY SERVICE

If a Plan participant is absent from employment because of military service, the participant may elect to continue coverage in the medical, dental, and vision programs under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). The participant and the participant's dependents' coverage will terminate at the date specified in the Insurance Booklets if the participant does not elect to continue coverage as described in (a) below.

(a) **Election Period:** Except as described in the following paragraph, the participant must elect to continue coverage within the time period described in Section 2(a) above. If coverage has been terminated, it will be reinstated retroactively on the timely election to continue the coverage and payment of all premiums due.

If the participant leaves without giving advance notice of military service and that notice was not excused as described in the following sentence, the participant loses his or her right to elect continuation coverage under

USERRA. If advance notice of military service is prevented by military necessity or is otherwise impossible or unreasonable, the election to continue coverage must be made by the later of (i) 60 days from the date it becomes possible and reasonable to make the election, or (ii) the end of the election period described in Section 2(a) above.

(b) **Length of Continuation Coverage:** The participant may elect to continue coverage for up to 24 months or, if earlier, until the day after the participant fails to meet the reporting deadline described in (e)(iii) below.

Continuation coverage will terminate if premiums are not paid by the due date or if the participant receives a dishonorable discharge or another type of discharge or separation from service that terminates USERRA rights.

(c) **Cost of Continuation Coverage:** If a participant's military service is for less than 31 days, the participant will not be required to pay more than the normal employee share for the coverage. If the participant's military service exceeds 30 days, the participant must pay the entire premium for the coverage, which will be no more than 102 percent of the cost of providing coverage. Premiums are due on the dates described in Section 2(d) above. If military necessity makes it impossible or unreasonable for the participant to pay a premium by the due date, the participant must pay the premium within 30 days after the date it becomes possible and reasonable.

(d) **Reinstatement of Coverage:** If the participant's coverage terminates because of military service, a waiting period will not be imposed on the participant or the participant's dependents in connection with the reinstatement of coverage upon qualifying reemployment if the waiting period would not have been imposed had coverage not been terminated due to military service. The preceding sentence does not apply to the coverage of any illness or injury incurred in, or aggravated during, military service.

(e) **Qualifying Reemployment:** Under USERRA, if a participant is absent from employment because of military service, the participant is generally entitled to reemployment rights and benefits if:

(i) The participant (or a military officer) provides advance notice of the military service to the employer, unless advance notice is prevented by military necessity or is otherwise impossible or unreasonable.

(ii) A participant's military absence from the employer is for a cumulative period of less than five years, unless a longer period of time is necessary to complete an initial period of obligated service or the participant is ordered to or retained on active duty.

(iii) The participant reports to or applies for reemployment with the employer within a certain number of days after the completion of military service as follows:

Period of Military Service	**Reporting/Application Deadline**
Less than 31 days*	One day*
31-180 days	14 days
More than 180 days	90 days

* If the period of military service is less than 31 days, or if the absence from employment is for the purposes of an examination to determine the participant's fitness for military service, the participant must report to the employer not later than the first workday following completion of the military service and the expiration of eight hours after a period allowing for safe transportation to the participant's residence.

If a participant is hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, military service, the participant must report to the employer or submit an application for reemployment at the end of the recovery period. The recovery period may not exceed two calendar years.

These deadlines may be extended if reporting by the deadline is impossible or unreasonable.

(iv) The participant did not receive a dishonorable discharge or another type of discharge or separation from service that terminates your USERRA rights.

(v) The participant provides documentation that requirements (ii) through (iv) are satisfied, if requested by the employer and the participant's military service is greater than 30 days. That documentation is not required if it does not exist or is not readily available.

4. ADDITIONAL LEGAL REQUIREMENTS

(a) **Qualified Medical Child Support Order:** A child of a participant who might not otherwise be eligible for coverage under the Plan's medical, dental, or vision programs may be eligible for coverage by reason of a qualified medical child support order, as defined in Section 609(a) of the Employee Retirement Income Security Act of 1974, as amended (ERISA). The participant or the participant's dependents may obtain, without charge, a copy of the procedures governing medical child support order determinations from the Plan Administrator.

(b) **Medicaid Recipients:** The following rules will apply with respect to any participant or dependent who is eligible for Medicaid benefits:

(i) Benefit payments under the Plan will be made in accordance with any assignment of rights made by or on behalf of the participant or dependent, to the extent that the assignment is required by a state Medicaid program.

(ii) In enrolling any individual as a participant or dependent, or in determining or making any benefit payments to or on behalf of any individual, the Plan will not take into account the fact that the individual is eligible for or provided medical assistance under a state Medicaid program.

(iii) To the extent that a state Medicaid program has made payments that the Plan is legally responsible for, the Plan's benefit payments will be made in accordance with any state law, provided that the state has acquired the participant's rights with respect to those benefit payments.

(c) **Maternity Benefits:** Group health plans and health insurance issuers offering group insurance coverage 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 normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of the above periods. 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 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plans or the insurance issuers for prescribing a length of stay not in excess of 48 hours (or 96 hours).

In some states (not Oregon), group health plans are exempt from the federal law requirements because state law requirements apply. If the state law requirements differ from the federal law requirements, they will be described in the Insurance Booklet describing your medical benefits.

(d) **Mastectomy Benefits:** If the participant or a dependent has had or is going to have a mastectomy, the participant or his or her dependent may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998. If the participant or his or her dependent is receiving benefits under the medical program in connection with a mastectomy and elects breast reconstruction, coverage will be 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, and treatment of physical complications of the mastectomy, including lymphedema. These benefits are subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under the Plan. The separate Insurance Booklets describing your medical insurance benefits contain information regarding any applicable deductibles and coinsurance provisions.

(e) **COVID-19:** The Plan, through the applicable Insurers and COBRA Administrator, will comply with federal requirements that apply to it with respect to the COVID-19 crisis.

(i) **COVID Tests.** The medical program covers diagnostic COVID-19 testing (including certain items and services related to the testing), without cost sharing or prior authorization, during the declared COVID-19 public health emergency. Coverage for diagnostic COVID-19 testing includes over-the-counter (OTC) COVID tests, which can be purchased without the involvement of a health care provider. Coverage is only provided if the OTC tests are purchased to diagnose or treat COVID-19. You may be limited to a certain number of OTC tests per 30-day period (or per calendar month) and to purchasing such OTC tests from an established retailer that would typically be expected to sell OTC COVID tests. You may also be required to provide documentation regarding the purchase and attest to certain information in order to be reimbursed (e.g., that the test is for your use, you will not resell the test, you will not be reimbursed from another source, and the test will be used for diagnosis or treatment purposes only and not for employment or other purposes). See the medical program Insurance Booklet for more information about COVID tests.

(ii) **COVID Vaccines.** The medical program also covers any qualifying COVID-19 preventive services (including vaccines), without cost sharing, beginning 15 business days after the recommendation of the applicable federal agency. Any FDA-approved COVID-19 vaccines are now immediately covered upon becoming authorized or approved.

(iii) **Extension of Due Dates.** Certain due dates under the programs have been extended because of the COVID-19 pandemic. For purposes of the following periods and dates, the programs will disregard the period from March 1, 2020, until the earlier of (A) 60 days after the announced end of the COVID-19 national emergency, or (B) one year from the date you are first eligible for this relief:

(1) The 30- or 60-day special enrollment period described in the respective Insurance Booklets.

(2) The 60-day COBRA election period described in Section 2(a). (This extension period was cut short with respect to assistance eligible

individuals who elected COBRA coverage with the COBRA subsidy under the extended election period. The extension period ended 60 days after the individual received notice of the extended election period.)

(3) The date for making COBRA premium payments described in Section 2(d). (The disregarded period is not a premium holiday. Rather, the due date for the COBRA premiums has simply been postponed. If a qualified beneficiary does not make timely payments, as modified by the delayed due date, then COBRA coverage will not be provided for that portion of the disregarded period for which premiums have not been timely paid.) The disregarded period for you to elect COBRA continuation coverage and the disregarded period for your initial and subsequent COBRA premium payments generally run concurrently.

(4) The date for individuals to notify the COBRA Administrator of a COBRA qualifying event or a determination of disability, as described in Section 2(e).

(5) The date by which the COBRA Administrator must notify individuals of the right to elect COBRA coverage, as described in Section 2(f)).

(6) The date by which an individual may file a benefit claim under the program's claims procedure.

(7) The date by which a claimant may request review of a denied claim described in Section 5(c)(i).

(8) The date by which a claimant may request an external review of a denied claim under the medical and vision program, as described in Section 5(d), and the date by which a claimant may file information to complete a request for external review of a denied claim under the medical and vision program.

5. CLAIMS PROCEDURE

(a) **Filing of Claim.** The Insurance Booklets describe the claims procedures for the respective benefit programs. The claimant or his or her authorized representative should follow those procedures in order to claim a benefit or to request an interpretation, ruling, or information under a benefit program. To the extent there is a conflict between the claims procedure described in this summary and the claims procedure described in the separate Insurance Booklets, the claims procedure described in the Insurance Booklets will control if it complies with applicable law.

In general, claims for medical, vision, dental, and long-term disability benefits may be filed in writing with the Insurer or company that administers those benefits (Claim Reviewer), and any other claim should be submitted to the Plan Administrator. If a claimant needs any assistance, he or she should contact the Plan Administrator. The claimant must follow and exhaust the Plan's claims procedure before he or she can file suit for benefits.

Special rules apply to "urgent care claims" made under the medical, vision, or dental programs. Urgent care claims may be made by telephone, facsimile, or other similar method. In addition, a health care professional with knowledge of the person's medical condition may act as their authorized representative with respect to urgent care claims.

An "urgent care claim" is a claim for medical, vision, or dental care where the application of the time periods for deciding non-urgent care claims could seriously jeopardize your life, health, or ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the claimed care.

The following additional rules apply with respect to an initial claim for benefits under the medical and vision program:

(i) For purposes of this Section 5, if a person's medical and vision coverage is terminated retroactively for any reason other than the failure to pay required contributions, the person may file a claim, regardless of whether the rescission has an adverse effect on any particular benefit at that time.

(ii) The claimant may review the claim file and present evidence and testimony as part of the claim.

(iii) Upon request, the Claim Reviewer must provide the claimant with the diagnosis and treatment codes and their corresponding meanings associated with any claim denial. A request for that information itself will not be treated as a request for review under (c)(i) below.

A claim for disability benefits includes a rescission of disability coverage as described in (i) above.

(b) Initial Review.

(i) Time Period for Notice of Decision.

(A) Group Health Plans. If a claim is for the Plan's medical, vision, or dental benefits, the claimant will be given written or electronic notice of the decision on the claim within the time periods described below, depending on the type of claim.

(1) Post-Service Claims. If a claim is a "post-service claim," as defined below, the claimant will be notified of a claim denial within 30 days after receipt of the claim, unless an extension is necessary due to matters beyond the control of the program. If there is an extension, the claimant will be notified of the extension, the reason for the extension, and the date by which a decision is expected, before the end of the initial 30-day period. If an extension is required because the claimant failed to submit necessary information, the extension notice will describe the required information and the claimant will have at least 45 days from receipt of that notice to provide the information. The extension will not exceed 15 days from the end of the initial response period (except that, if the claimant is asked to provide additional

information, this 15-day extension period will not include the period of time before the claimant responds to the request).

A "post-service claim" is any claim other than a "pre-service claim" discussed in (2) below. A "pre-service claim" is any claim for a benefit for which the program requires a person to obtain authorization before receiving the medical care.

(2) **Pre-Service Claims.** Except as otherwise provided in (3) and (4) below for urgent care claims and concurrent care decisions, if a claim is a "pre-service claim," as defined in (1) above, the claimant will be notified of the decision within 15 days after receipt of the claim unless an extension is necessary due to matters beyond the control of the program. If there is an extension, the claimant will be notified of the extension, the reason for the extension, and the date by which a decision is expected, before the end of the initial 15-day period. If an extension is required because the claimant failed to submit necessary information, the extension notice will describe the required information and the claimant will have at least 45 days from receipt of that notice to provide the information. The extension will not exceed 15 days from the end of the initial response period (except that, if the claimant is asked to provide additional information, this 15-day extension period will not include the period of time before the claimant responds to the request).

If the claimant fails to follow the program's procedures for filing a pre-service claim, the claimant will be notified of the failure and the proper procedures

within five days after the failure (or 24 hours after the failure, in the case of an urgent care claim). This notification may be oral unless the claimant requests written notification. This notification shall be required only if the person or organizational unit customarily responsible for handling benefit matters receives a communication by the claimant or his or her representative that names a specific claimant, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

(3) **Claims Involving Urgent Care.** Except as otherwise provided in (4) below for concurrent care decisions, a claimant will be notified of the decision on an urgent care claim as soon as possible, taking into account the medical exigencies. The decision will be given as soon as possible and not later than 72 hours after receipt of the claim unless the claimant fails to provide necessary information. If additional information is needed, the claimant will be notified within 24 hours after receipt of the claim of the specific information necessary to complete the claim. The claimant will be given at least 48 hours to provide the requested information. If the requested information cannot reasonably be provided within 48 hours, the claimant will be given a reasonable period of time, taking into account the circumstances, to provide the information. If additional information is required, the claimant will be notified of the decision within 48 hours after the earlier of the program's receipt of the requested information or the deadline for providing the information.

Notice of a denied urgent care claim may be given orally within the time periods described above. If the claimant receives an oral notice, the claimant will also be given a written or electronic notice within three days after the claimant receives the oral notice.

(4) **Concurrent Care Decisions.** If the program has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination of the course of treatment (other than by program amendment or termination) before the end of the specified period or number of treatments will be treated as a claim denial. The claimant will be notified of such a denial in time to allow the claimant to appeal and obtain a determination on review before the course of treatment is reduced or terminated.

If the claimant requests that an ongoing course of treatment be extended beyond the previously approved time period or number of treatments, and the claimant's request constitutes an urgent care claim, the claim will be decided as soon as possible, taking into account the medical exigencies. If the claimant's request was made at least 24 hours before the end of the prescribed period of time or number of treatments, the claimant will be notified of the decision within 24 hours after the program received the request.

(B) **Disability Claims.** If a claim is for disability benefits, the claimant will be notified of a claim denial within 45 days after receipt of the claim, unless a 30-day extension is necessary due to matters beyond the control of the program. The claimant will be notified of any extension, the reason for the extension, and the date by

which a decision is expected before the end of the initial 45-day period. The claimant will also be notified of the standards on which entitlement to a benefit is based, any unresolved issues, and the information needed to resolve those issues. If a decision cannot be made within the 30-day extension period due to matters beyond the control of the program, the claimant will be notified before the end of the extension period that an additional 30-day extension period is necessary. The extension notice will include the information described above. If an extension is required because the claimant failed to submit necessary information, the extension notice will describe the required information and the claimant will have at least 45 days from receipt of that notice to provide the information. If the claimant is asked to provide additional information, the extension periods will not include the period of time before the claimant responds to the request.

(ii) **Contents of Notice.** The notice will indicate the specific reason or reasons for denial, the Plan or contract provision(s) involved, an explanation of the claims review procedure described below, a description of any additional material or information necessary to complete the claim, and a statement of the claimant's right to bring a civil action under ERISA.

If the claim is denied under the medical, vision, or dental programs, the claim denial notice will include the following additional information:

(A) If an internal rule, guideline, protocol, or other similar criterion was relied on in deciding the claim, the notice will either provide a copy of the criterion that was relied on, or it will state that the claimant may obtain a copy of the criterion free of charge on request.

(B) If the denial was based on a medical necessity, experimental treatment, or similar exclusion, the notice will either explain the scientific or clinical judgment for the decision, or it will state that

the claimant may obtain such an explanation free of charge on request.

(C) If the claim was an urgent care claim, the notice will describe the expedited review process available for such claims.

If your claim is denied under the medical and vision program, the denial notice will contain the following additional information:

(1) Information sufficient to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable).

(2) A statement describing the claimant's ability to request the diagnosis and treatment codes and their corresponding meanings.

(3) The applicable denial code and its corresponding meaning.

(4) A description of the standard, if any, that was used in denying the claim.

(5) A description of available internal and external review processes, including information regarding how to initiate a request for review.

(6) The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established to assist individuals with the review process.

If your denied claim is for disability benefits, the denial notice will contain the following additional information:

(I) Either the internal rules used to make the decision or a statement that such rules do not exist.

(II) The information described in (b)(ii)(B) above.

(III) A discussion of the decision, including the basis for not following the views of medical or vocational professionals or a determination of disability by the Social Security Administration.

(IV) A statement that you may receive reasonable access to and copies of all documents relevant to your claim on request and free of charge.

(c) Review of Denied Claim.

(i) Time Period to Request Review. If the claim is denied in whole or in part, the claimant has the right to request a review of their claim by the Claim Reviewer or the Plan Administrator, whichever decided the initial claim. Such request, prepared by either the claimant or his or her representative, must be in writing and must be made by personal delivery or mailing to the Claim Reviewer or the Plan Administrator, as applicable. A claimant's request for review must be made within 180 days after the claimant is advised of the denial. If the written request is not made within this time period, the claimant waives any right to review and also loses the right to sue in state or federal court, as described in Section 7.

(ii) Review Procedure. The Claim Reviewer or the Plan Administrator will conduct a review as a part of which the claimant may present his or her position in writing. In doing so, the claimant or his or her representative may review all pertinent documents, if any, supporting the claim and may submit issues and comments in writing.

The information the claimant submits will be taken into account in the review process even if it was not considered in deciding the initial claim. The claimant will also be provided, on request and free of charge, reasonable access to, and copies of, all information relevant to the claim. Additionally:

(A) The review will not give any deference to the initial claim decision. It will be conducted by a program fiduciary who did not decide the initial claim and who is not a subordinate of the person who decided the initial claim.

(B) If the initial claim denial was based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment is experimental, investigational, or not medically necessary or appropriate), the program fiduciary shall consult a health care professional with appropriate training and experience. The health care professional must be someone who was not consulted in connection with the initial claim decision, and who is not a subordinate of any health care professional who was consulted on the initial claim.

(C) You will be notified of any medical or vocational experts who were consulted in connection with the initial claim decision.

(D) If the claim is an urgent care claim under the medical, vision, or dental programs, the claimant may request an expedited appeal either orally or in writing. Under the expedited review process, all necessary information, including the decision on review, may be given by telephone, facsimile, or other similar method.

If your claim is denied under the Plan's medical and vision program, the following additional rules will apply:

(1) The claimant may review the claim file and present evidence and testimony as part of the claim's review.

(2) The Claim Reviewer will provide the claimant with any new or additional evidence considered, relied upon, or generated by, or at the direction of, the program or Insurer in connection with the claim. Before the Claim Reviewer can issue the decision on review based on a new or additional rationale, the claimant must be provided with the rationale. Such new evidence or rationale will be provided free of charge and as soon as possible (at least sufficiently in advance of the date on which the notice of the decision on review is required to be provided to give the claimant a reasonable opportunity to respond before that date). If the evidence is received late in the process, such that it would not be

possible to provide it to the claimant in time for the claimant to respond, the period for providing the decision on review under (c)(iii) below is tolled until the claimant has a reasonable opportunity to respond. After the claimant responds, or has a reasonable opportunity to respond but fails to do so, the Claim Reviewer will notify the claimant of the decision as soon as reasonably possible.

If the claimant's claim for disability benefits is denied, before the Claim Reviewer issues its decision on review, the claimant will be provided any new evidence considered or new rationale used to potentially deny the claim and will be given sufficient time to respond.

(iii) Time Period for Decision on Review.

(A) Group Health Plans. If the claim was filed under the medical, vision, or dental programs, the notice of the decision will be provided within the time periods described below. There will be no extensions of time.

(1) Post-Service Claims. The claimant will be notified of the decision on review of a post-service claim within 60 days after receipt of the request for review. If the Insurer's or contract administrator's procedure provides for two appeals of a denied claim, the claimant will be notified within 30 days after receipt of the request for review of either appeal.

(2) Pre-Service Claims. Except as otherwise provided below for urgent care claims, the claimant will be notified of the decision on review of a pre-service claim within 30 days after receipt of the request for review. If the Insurer's or contract administrator's procedure provides for two appeals of a denied claim, the claimant will be notified within 15 days after receipt of the request for review of either appeal.

(3) **Claims Involving Urgent Care.** The claimant will be notified of the decision on review of an urgent care claim as soon as possible but no later than 72 hours after receipt of the request for review.

(B) **Disability Claims.** The Claim Reviewer will issue a written or electronic decision regarding a claim for disability benefits within 45 days after receipt of the request for review. If special circumstances require an extension of time for processing, a decision will be made and furnished to the claimant not later than 90 days after receipt of the request for review. If an extension is required, the claimant will be notified within 45 days after review is requested. The notice will indicate the special circumstances and the date by which a decision is expected.

(iv) **Contents of Review Decision.** The decision will be provided to you in writing or by electronic notice. It will include the specific reasons for the decision and the Plan or insurance contract provision(s) on which it is based. The decision will also inform the claimant of his or her right to request information relevant to the claim and to bring a civil action under ERISA.

If the claim was filed under the medical, vision, or dental programs, the decision will include the information described in (b)(ii)(A) and (B) above.

If your claim is denied under the medical and vision program, the decision will also include the information described in (b)(ii)(1)-(6) above. In addition, with respect to the final decision on review, there must be a discussion of the decision.

If your claim for disability benefits is denied, the decision will also include the information described in (b)(ii)(I)-(III) above and will describe any applicable Plan-imposed limitation period, including the calendar date on which the limitations period ends for the claim.

(v) **Effect of Review.** Subject to the external review described in (d) below, the decision is final and binding upon the claimant, the Claim Reviewer or the Plan Administrator, as applicable, and all other persons involved.

(d) **External Review of Denied Claim.** If the claimant's claim for medical or vision program benefits is denied on review, the claimant may be eligible for external review by an independent third party if it involves medical judgment (including, but not limited to, a denial based on the program's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, or its determination that a treatment is experimental or investigational), rescission of coverage (regardless of whether the rescission has any adverse effect on any particular benefit at the time), or a determination of whether the medical and vision program is complying with the surprise billing and cost-sharing rules applicable to out-of-network emergency services, nonemergency services performed by nonparticipating providers at participating facilities, and air ambulance services provided by nonparticipating providers. A claim denial that relates to the claimant's (or a dependent's) failure to meet the Plan's eligibility requirements is not eligible for an external review. The claimant will not be charged a fee for using the external review process. Information about the external review process, including how to initiate a request for review, will be in the final claim denial notice and is in the Insurance Booklet provided by the Insurer or contract administrator for the applicable benefit program.

(e) **Subsequent Review.** If your claim is denied on review and you would like to sue for benefits, you must file suit within one year from the date the final decision on review was sent to you. A suit for benefits brought in a U.S. district court must be filed in the district in which the Plan is administered. Except as provided for in Section 5(d) above, any further review, judicial or otherwise, will be based on the record considered by the Claim Reviewer or the Plan Administrator and is limited to whether the Claim Reviewer or Plan Administrator acted arbitrarily or capriciously in the exercise of its discretion.

6. RIGHT TO AMEND OR TERMINATE

The Plan Sponsor reserves the right to terminate the Plan or any benefit program at any time and for any reason. The employers reserve the right to withdraw from the Plan and to not

continue with a benefit program at any time for any reason. The Plan Sponsor also reserves the right to amend the Plan or any benefit program from time to time and, therefore, a person is not entitled to rely and should not rely on any particular provision remaining in the Plan. Participants will be notified of an amendment as required by federal law. If such notice is not required, or until the due date for any such notice, a person is not entitled to rely on the terms of the Plan as described in this summary or any Insurance Booklet. Before making an important decision based on the Plan terms, a person should confirm with the Plan Administrator and Insurer that the applicable Plan or contract provisions have not changed.

7. STATEMENT OF ERISA RIGHTS:

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants are entitled to:

RECEIVE INFORMATION ABOUT
YOUR PLAN AND BENEFITS

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

(b) Obtain copies of all Plan documents and other Plan information, including insurance contracts, copies of the latest annual report (Form 5500 Series), and an updated summary plan description, upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

(c) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish you with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

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

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for Plan participants, ERISA imposes duties upon the persons who are responsible for the operation of the Plan. These persons (called fiduciaries) have a duty to operate the Plan prudently and must act solely in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit from the Plan or exercising your rights under ERISA.

ENFORCE YOUR RIGHTS

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

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

If your claim for a welfare benefit is denied or is ignored, in whole or in part, you may file suit in a state or federal court. (A suit brought in a U.S. district court must be filed in the district in which the Plan is administered.) If your claim for benefits is denied, however, you must appeal the decision and follow the claims procedure described in Section 5 before you may file suit. You must file suit within one year from the date the final decision on review was sent to you. If

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

ASSISTANCE WITH YOUR QUESTIONS

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