Group Insurance Plan for
Salem Health Hospitals and Clinics

Plan Document
and
Summary Plan Description

Amended and Restated Effective January 1, 2024

How to Use Your Plan Document/Summary Plan Description

This document, together with policies, insurance contracts, summary plan descriptions, and other benefit summaries prepared by the carriers and administrators listed in Appendix A, constitutes the written plan document required by the Employee Retirement Income Security Act of 1974 ("ERISA") Section 402 and the Summary Plan Description required by ERISA Section 102 for the Group Insurance Plan for Salem Health Hospitals and Clinics ("Plan"). You may receive documents related to the benefits listed in Appendix A directly from the applicable carriers and administrators or from the Employer. All policies, insurance contracts, summary plan descriptions, and other benefit summaries prepared by the carriers and administrators listed in Appendix A for benefits under this Plan are incorporated herein through this reference. Please read them carefully and refer to them when you need information about how your Plan works. This document is also a wonderful source to learn about the benefits available to you through this Plan. This document is effective as of January 1, 2024. Certain benefits listed herein may not be subject to the requirements of ERISA and inclusion herein is not intended to subject such benefits to the requirements of ERISA. Benefits included not subject to ERISA are provided for information only.

DEFINITIONS

Capitalized terms used in the Plan have the following meanings. For a definition of any other term not specifically defined herein, you should first refer to any supplemental documents, which you may receive from the Employer or a particular insurance company directly.

AD&D "AD&D" means accidental death and dismemberment insurance.

COBRA "COBRA" means the Consolidated Omnibus Budget Reconciliation Act and its underlying regulations.

Code "Code" means the Internal Revenue Code of 1986, as amended and its underlying regulations.

Dependent "Dependent" means your child or Spouse, as defined in the terms of the incorporated documents, published by the carriers and administrators in Appendix A.

Domestic Partner "Domestic Partner" means "Domestic Partner" as that term is defined in the Governing Documents.

Employee "Employee" means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll. Any Employee who is reclassified as a common-law employee shall be an Employee prospectively only.

Employer "Employer" means Salem Health Hospitals & Clinics (dba Teufel Landscape), Teufel Holly Farms, and any successor thereto and shall not include any other related employer or affiliated service group unless specifically agreed by Salem Health Hospitals & Clinics and such employer has duly adopted this Plan.

ERISA "ERISA" means the Employee Retirement Income Security Act of 1974, as amended.

FSA "FSA" means flexible spending account and is an account through which participants and the Employer can contribute money on a pre-tax basis to be used to pay for approved medical expenses.

HIPAA "HIPAA" means the Health Insurance Accountability and Portability Act of 1996, as amended, and its underlying regulations.

HITECH "HITECH" means the Health Information Technology for Economic and Clinical Health Act.

MHPA "MHPA" means the Mental Health Parity Act.

MHPAEA	"MHPAEA" means the Mental Health Parity and Addiction Equity Act.
NMHPA	"NMHPA" means the Newborns' and Mothers' Health Protection Act of 1996, as amended and its underlying regulations.
Plan	"Plan" means this Group Insurance Plan for Salem Health Hospitals and Clinics.
Plan Administrator	"Plan Administrator" means Salem Health Hospitals & Clinics
Plan Sponsor	"Plan Sponsor" means Salem Health Hospitals & Clinics
ACA	"ACA" means The Patient Protection and Affordable Care Act.
Spouse	"Spouse" means an individual who is legally married to an Employee as determined under applicable state and/or federal law.
WHCRA	"WHCRA" means the Women's Health and Cancer Rights Act of 1998, as amended and its underlying regulations.

INTRODUCTION

The Employer maintains the Plan for the exclusive benefit of its eligible Employees and their Spouses, Domestic Partners (when covered by the underlying component programs), and other Dependents. The Plan provides benefits through the following component benefit programs:

- Medical (Moda)
  - Prime Plan
  - Classic Plan
  - Choice Plan
- Dental (Moda/Delta Dental of Oregon)
- Vision (VSP)
- Short-Term Disability (Standard Insurance Company)
- Long-Term Disability (Standard Insurance Company)
- Life Insurance (Standard Insurance Company)
- AD&D (Standard Insurance Company)
- FSA (Optum Financial)
- HSA(Optum Financial)
- DCAP (Optum Financial)
- EAP (Modern Health)

Certain of these component benefit programs require you to make an annual election to enroll for coverage. Please refer to the specific component benefit materials for details regarding annual enrollment requirements. Each of these component benefit programs is summarized in a certificate of insurance booklet issued by an insurance company, a summary plan description, and/or another governing document prepared by the Employer (the "Governing Documents"). A copy of each booklet, summary or other governing document is incorporated by reference to the coverage and carrier/administrator in Appendix A.

GENERAL PLAN INFORMATION

Plan Name:	Group Insurance Plan for Salem Health Hospitals and Clinics
Type of Plan:	ERISA Employee Welfare Benefit Plan
Regular Plan Year:	January 1 – December 31
Plan Number:	501
Effective Date:	This Plan was originally effective October 1, 1969. The Plan is restated effective January 1, 2024.
Plan Sponsor:	Salem Health Hospitals & Clinics
Plan Sponsor's Employer Identification Number:	93-0823471
Insurance Companies/Vendors or Administrators:	• Moda • Moda/Delta Dental of Oregon • VSP • Standard Insurance Company • Optum Financial • Modern Health Please see Appendix A for addresses and customer service telephone numbers.
Plan Administrator:	Salem Health Hospitals & Clinics 890 Oak Street SE Salem, OR 97301
Agent for Service of Legal Resident Process:	Salem Health Hospitals & Clinics 890 Oak Street SE Salem, OR 97301
Funding Medium and Type of Plan Administration:	All coverage is fully insured, except the medical, prescription, dental, and FSA plans.

Salem Health Hospitals & Clinics has entered into contracts with various insurance companies and plan administrators to provide Plan benefits. The various insurance companies are responsible for paying the Plan benefits. Claims for benefits are sent to the various insurance companies, and the claims are processed in accordance with the terms listed in the incorporated booklets prepared by the various insurance companies. Salem Health Hospitals & Clinics and various insurance companies are responsible for administering the Plan as outlined below.

Salem Health Hospitals & Clinics and Employees both may contribute towards the cost of the coverage under the Plan. In some instances, a component benefit plan may require only you or Salem Health Hospitals & Clinics to contribute. Salem Health Hospitals & Clinics's portion of the contributions is paid out of Salem Health Hospitals & Clinics's general assets. The Employees' share of the contributions is made through Employees' pre-tax or after-tax payroll deductions. The Plan Administrator provides a schedule of the applicable premiums when an Employee is initially eligible, during the initial and subsequent open enrollment periods, and upon request for each of the component benefit programs, as applicable. The Plan Administrator reserves the right, at any time, to modify the amount Employees have to contribute to participate in the Plan.

Benefits hereunder are provided pursuant to an insurance contract or pursuant to a governing plan document adopted by the Employer. If the terms of this document conflict with the terms of such insurance contract or governing plan document, then the terms of the insurance contract or governing plan document will control, rather than this document, unless otherwise required by law.

WHO IS ELIGIBLE TO PARTICIPATE IN THE PLAN?

Eligibility and Participation

An eligible Employee with respect to the Plan will be any common-law employee of the Employer who is eligible to participate in and receive benefits under one or more of the component benefit programs. To be eligible to participate in the Plan, you must meet the requirements detailed in this document.

An eligible Employee must affirmatively enroll in each of the component plans and may elect to waive coverage.

Active Employee Benefits

Part-time employees who are scheduled to work between 20 and 35 hours per week and full-time employees who are scheduled for more than 35 hours per week are eligible for benefits coverage effective the first of the month following an employee's first day of employment. However, all employees are eligible for the employee assistance plan. In addition, STD, LTD, Life, and AD&D coverage may vary based on employee classification (Executive, Physician, or not Executive or Physician) and in accordance with the Governing Documents related to that coverage. STD and LTD takes effect the first of the month following 90-days of employment.

The following categories of Employees are not eligible for coverage:

- Employees covered by a collective bargaining agreement to which the Plan Sponsor is a party and which does not provide for participation in the Plan;
- "Leased employees" within the meaning of Internal Revenue Code Section 414(n);
- Temporary employees;
- Individuals from whom the Plan Sponsor does not withhold federal income and employment taxes from such person's compensation; and
- Individuals not on the Employer's US payroll.

Coverage

If you are eligible for our benefits, then your dependents are too. In general, eligible dependents include your spouse, Domestic Partner, and children up to age 26. If your child is mentally or physically disabled, coverage may continue beyond age 26 once proof of the ongoing disability is provided. Children may include natural, adopted, step-children, and children obtained through court-appointed legal guardianship.

Special Rule for Adopted Children

With respect to component benefit plans that are group health plans, the Plan will extend benefits to dependent children placed with you for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of other participants.

Special Enrollment Rights

In certain special circumstances, you and/or your Dependents may enroll in the Plan at times other than open enrollment.

Please see the certificate of insurance booklets/summary plan descriptions incorporated through Appendix A and the Plan's Special Enrollment Notice for more information about potential special enrollment rights.

Effective Date of Coverage

Coverage for a Spouse, Domestic Partner, or Dependent shall take effect at the same time as the covered Employee. Coverage for a newborn child or a newly adopted child will begin immediately, but you must first notify the Plan Administrator within 30 days of the birth or adoption. You may also be required to increase your contributions accordingly.

WHAT BENEFITS ARE AVAILABLE UNDER THE PLAN?

The Plan provides you with the following component benefits: medical benefits; dental benefits, vision benefits; FSA, DCAP, HSA, and STD/LTD/Life/AD&D benefits.

A summary of each benefit provided under the Plan is set forth in a certificate of insurance booklet, summary plan description or other governing document. These documents are incorporated by reference through the carriers and administrators listed in Appendix A. The cost of the benefits provided through the component benefit programs will be funded in part by Employer contributions and in part by post and/or pre-tax Employee contributions. The Employer will determine and periodically communicate your share of the cost of the benefits provided through each component benefit program, and it may change that determination at any time. Discounts may be available for participation in certain wellness programs offered by the Employer.

The Employer will make its contributions in an amount that (in the Employer's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Employer will pay its contribution and your contributions to an insurance carrier. Your contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit.

With respect to component benefit plans that are group health plans, the Plan will provide benefits in accordance with the requirements of all applicable laws.

Enrollment Information

New Employees: You will receive enrollment information during your first week of employment.

Current Employees: You will receive enrollment information during the open enrollment period.

Termination of Participation

Participation in the Plan will end at the end of the month following termination of employment or a reduction in hours to a level of below 20 hours per week for any reason, unless otherwise required by law or stated within an insurance contract or other Governing Document.

REQUIRED LEGAL INFORMATION

COBRA Rights

If medical, dental, vision, or FSA coverage for you or an eligible family member ceases because of certain "qualifying events" specified in COBRA (such as termination of employment, reduction in hours, divorce, death, or a child ceasing to meet the definition of "dependent"), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time. If you have any questions about your COBRA rights, please read the Initial COBRA Notice, a copy of which has been previously furnished to you and your spouse or Domestic Partner (if covered). Please contact the Plan Administrator if you need another copy.

The Plan has enacted reasonable procedures for you to notify the Plan Administrator regarding a COBRA Election event as detailed within the Initial COBRA Notice. These reasonable procedures require you to notify the Plan Administrator in writing of any COBRA qualifying event, as detailed within applicable COBRA notice.

Covered Employees and qualified beneficiaries are responsible for providing notice of qualifying events, disability, and second qualifying events to the Plan Administrator. The notice must be provided within 60 days of the qualifying event or disability. Such notice must be provided in writing to the Plan Administrator, include a description of the qualifying event or disability and the date of the qualifying event or disability occurred.

Health Insurance Portability and Accountability Act Privacy and Security/Health Information Technology for Economic and Clinical Health (HIPAA/HITECH)

Components of the Plan required to comply with HIPAA/HITECH are subject to the following rules and policies to the extent not in conflict with a separate privacy or security policy adopted by the Employer.

(a) Permitted Uses and Disclosures of Protected Health Information.
The Plan and the Plan Sponsor may use or disclose a Participant's "protected health information" (PHI), which is defined to include individually identifiable health information that is transmitted or maintained in any form or medium—electronic, oral or written—in accordance with all uses and disclosures permitted or required under HIPAA and other relevant guidance. Such uses and disclosures include, but are not limited to:

i. Uses or disclosures necessary to facilitate "payment, treatment, and health care operations," as those terms are defined in the HIPAA regulations;
ii. Uses or disclosures that are incidental to a permitted use or disclosure, provided reasonable safeguards are in place;
iii. Uses by or disclosures to the Participant who is the subject of the information;
iv. Uses or disclosures based on and in compliance with a valid authorization given by the Participant;
v. Disclosure upon the request of a Participant to access his own PHI; and
vi. Disclosures required by the U.S. Department of Health and Human Services to verify

compliance with HIPAA.

(b) Required Uses and Disclosures of PHI.
The Plan and the Plan Sponsor may use or disclose a Participant's PHI for the following required purposes, to the extent not inconsistent with HIPAA:

i. To the extent required by any federal, state or local law, including without limitation, the provisions under HIPAA regulation 45 C.F.R. § 164.512 and the terms of any lawful judicial or administrative process; and
ii. To the extent necessary for the purpose of public health or public health oversight activities, or other governmental activities as permitted under HIPAA regulation 45 C.F.R. § 164.512.

(c) Restriction on Plan Disclosure to the Plan Sponsor.
Neither the Plan nor any insurer or "business associate" (as that term is defined under HIPAA) of the Plan will disclose PHI to the Plan Sponsor except upon the Plan's receipt of the Plan Sponsor's certification that the Plan documents have been amended to incorporate the agreements of the Plan Sponsor in accordance with the immediately following provision.

(d) Privacy Agreements of the Plan Sponsor.
As a condition for obtaining PHI from the Plan, the Plan Sponsor agrees to undertake the following activities and comply with the following restrictions with respect to any PHI (other than summary health information or enrollment or disenrollment information as provided for in 45 C.F.R. § 164.504(f)(ii) and (iii), or information that is disclosed as authorized under 45 C.F.R. § 164.508) received from the Plan (including PHI of Participants that is received from business associates acting for or on behalf of the Plan or from insurers or health maintenance organizations insuring the Plan):

i. Not to use or further disclose such PHI other than as permitted or required by paragraphs (a) or (b), above, or by the Participant's authorization;
ii. To ensure that any of its agents to whom it provides the PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;
iii. Not to use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or Employee Benefit Plan of the Plan Sponsor;
iv. To report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
v. To make the PHI of a particular Participant available for purposes of the Participant's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulations 45 C.F.R. §§ 164.524 and 164.526;
vi. To make the PHI of a particular Participant available for purposes of a required accounting of disclosures by the Plan Sponsor pursuant to the Participant's request for such an accounting in accordance with HIPAA regulation 45 C.F.R. § 164.528;
vii. To make the Plan Sponsor's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S.

Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

viii. If feasible, to return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and to retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible;

ix. To ensure that there is adequate separation between the Plan and the Plan Sponsor by implementing the following:

A. Only limited Employees and/or employment classifications under the control of the Plan Sponsor may access PHI received from the Plan.
B. The access to and use of PHI by the individuals described in (A) immediately above, is limited to Plan Administration functions as defined in HIPAA regulation 45 C.F.R. § 164.504(a) that are performed by the Plan Sponsor for the Plan.
C. If the Plan Sponsor determines that any person described in (A) immediately above, has violated any of the restrictions of these HIPAA provisions, then such individual shall be disciplined in accordance with the policies of the Plan Sponsor established for purposes of privacy compliance, up to and including dismissal from employment.

(e) HIPAA Security Standards.

In accordance with the requirements of 45 C.F.R. Part 164, Subpart C, the Plan Sponsor agrees to undertake the following activities and comply with the following restrictions with respect to any electronic PHI (other than summary health information or enrollment or disenrollment information as provided for in 45 C.F.R. § 164.504(f) or information that is disclosed as authorized under 45 C.F.R. § 164.508) received from the Plan (including electronic PHI of Plan Participants that is received from business associates acting for or on behalf of the Plan or from insurers or health maintenance organizations insuring the Plan):

i. To implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

ii. To ensure that the adequate separation required by subparagraph (d)(ix) above is supported by reasonable and appropriate security measures;

iii. To ensure that any of its agents to whom it provides this information agree to implement reasonable and appropriate security measures to protect the information;

iv. To report to the Plan any security incident of which it becomes aware. For purposes of this subparagraph, security incident shall mean successful unauthorized access, use, disclosure, modification or destruction of, or interference with, the electronic PHI; and

v. Upon request from the Plan, to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the electronic PHI to the extent such information is available to the Plan Sponsor.

Medicare Part D

In the event that a component program provides prescription drug coverage either in conjunction with a component program or as a stand-alone component program, the Plan intends to comply with the requirements of Medicare Part D and will notify you of its "Creditable Coverage" status. Such disclosure requirement will be made under separate cover.

Genetic Information Nondiscrimination Act

Notwithstanding anything to the contrary, all component programs shall comply with the Genetic Information Nondiscrimination Act. Based on GINA, in no event shall the Employer make any premium adjustments or adjustments to contributions under any component program based on genetic information; request or require genetic testing; and request, require or purchase genetic information for underwriting purposes.

Qualified Medical Child Support Orders

With respect to component benefit plans that are group health plans, the Plan will also provide benefits as required by any qualified medical child support order, or "QMCSO" (defined in ERISA § 609(a)), and will provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply in the case of dependent children who are natural children of participants or beneficiaries, in accordance with ERISA § 609(c). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of such procedures from the Plan Administrator.

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, 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 will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. Please refer to the insurance company documents incorporated through reference to the carriers and administrators in Appendix A for these deductibles and coinsurance amounts.

If you would like more information on WHCRA benefits, contact the Plan Administrator. This notice intends to meet the Notice requirements under the WHCRA.

Newborns' and Mothers' Health Protection Act

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. 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 the above periods. In any case, such 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 the above periods. These provisions are valid effective April 1, 2009, for the final regulations issued under the NMHPA.

Mental Health Parity Act/Mental Health Parity and Addiction Equity Act

All component programs subject to the MHPA/MHPAEA shall not discriminate against mental health and substance disorder as related to any medical/surgical benefits provided under a component program when such mental health, substance disorder, and medical/surgical benefits are provided. Such discrimination may not occur with regard to the component program's financial requirements or availability of out-of-network treatment under the program's terms and conditions. This provision shall not be valid in the event the Employer makes an election under the cost exemption provisions of the MHPA/MHPAEA.

Michelle's Law

The Plan shall comply with Michelle's Law. Michelle's Law requires that all full-time students, defined as Dependents in this Plan, may take a medical leave of absence from their educational institution for up to one calendar year (limited by the remaining eligibility under this Plan as defined in Dependent) and may maintain eligibility under this Plan notwithstanding anything to the contrary.

Family Medical Leave Act

Employees who are eligible to take leave under the Family Medical Leave Act (FMLA), may continue to pay for their coverage under the Plan for those benefits subject to a continuation requirement under FMLA or as otherwise called for by the Governing Documents. If the Employer pays a portion of these premiums, and the benefit is subject to a continuation requirement under FLMA or the Employer would continue to pay for a portion of the benefit during other types of leave, the Employer must continue those payments. However, if the Employee does not return from FMLA leave, he or she may be required to repay the Employer-paid portion of these premiums.

Uniformed Services Employment and Reemployment Rights Act of 1994

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

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

a. For elections made on or after December 10, 2004, the 24-month period beginning on the date that Uniformed Service leave commences;
b. The period beginning on the date that Uniformed Service leave commences and ending on the day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

A person who elects to continue Plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage. The Plan has elected reasonable procedures for you to provide notice of your election of Plan coverage under this provision. These reasonable procedures require that you provide notice of your election of Plan coverage in writing to the Plan Administrator.

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

Please contact the Plan Administrator for information concerning your eligibility for USERRA and any requirements of the Plan.

Patient Protection

To the extent a medical plan allows the designation of a primary care provider, even if selecting a PCP is not a requirement under the applicable plan:

You have the right to designate any primary care provider who participates in one of our networks and who is available to accept you or your family members. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the respective carriers or visit their websites.

For children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from the plans or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care

professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the respective carriers or visit their websites.

HOW IS THE PLAN ADMINISTERED?

Plan Administration

The administration of the Plan is under the supervision of the Plan Administrator. The specified delegate of the Employer is the person who has been designated to act on behalf of the Plan Administrator. The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of persons entitled to participate in the Plan. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, provided that such delegation is in writing, expressly identifies the delegate(s) and expressly describes the nature and scope of the delegated responsibility. The Plan Administrator has the discretionary authority to interpret the Plan in order to make eligibility and benefit determinations as it may determine in its sole discretion. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive any benefits under the Plan. The Employer will bear its incidental costs of administering the Plan.

Power and Authority of Insurance Company

Certain benefits under the Plan are fully insured or provided by contract with a Plan Administrator. The insurance companies are responsible for determining eligibility and the amount of any benefits payable under the component plans and prescribing claims procedures to be followed and proper forms to be used. The insurance companies are responsible for paying claims with respect to these programs. The Employer shares responsibility with the insurance companies for administering the program benefits.

Questions

If you have any general questions regarding the Plan, or your eligibility for, or the amount of any benefit payable under the self-funded component benefit plans, please contact the Employer, who acts on behalf of the Plan Administrator.

If you have any question regarding your eligibility for, or the amount of, any benefit payable under the fully insured component benefit plans, please contact the appropriate insurance company.

CIRCUMSTANCES WHICH MAY AFFECT BENEFITS

Denial or Loss of Benefits

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. Your benefits will also cease on termination of the Plan. Other circumstances can result in the termination, reduction, or denial of benefits. You should consult the certificate of insurance booklets, summary plan descriptions and other governing documents incorporated through reference to the carriers and administrators in Appendix A for additional information.

Amendment or Termination of the Plan

The Employer, as Plan Sponsor, has the right to amend or terminate the Plan at any time. The Plan may be amended or terminated by a written instrument duly adopted by the Employer or any of its delegates. The Employer may sign insurance contracts for this Plan on behalf of the Employer, including amendments to those contracts, and may adopt (by a written instrument) amendments to the Plan that he or she considers to be administrative in nature or advisable to comply with applicable law.

No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between you and the Employer to the effect that you will be employed for any specific period of time.

Extent of Integration

The underlying component parts of this Plan are integrated for purposes of convenience and ensuring continued compliance, but the function of combining these underlying benefits for compliance purposes in no way undermines the separateness or excepted benefits status that may otherwise exist for certain otherwise excepted benefits provided for under this Plan.

CLAIMS PROCEDURES

Claims for Insured Benefits

For purposes of the determination of the amount of, and entitlement to, benefits of the component benefit programs provided under insurance or contracts, the Plan Administrator is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a component benefit program, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign, and submit a written claim on the insurer's form. In that case, the form is available from the Plan Administrator.

The insurance company will decide your claim in accordance with its reasonable claims procedures, as required by ERISA. The insurance company has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurance company denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurance company for a review of the denied claim. The insurance company will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

See then Governing Documents for more information about how to file a claim and for details regarding the insurance company's claims procedures.

Claims for Self-Funded Benefits

For purposes of determining the amount of, and entitlement to, benefits under the component benefit programs provided through the Employer's general assets, the Plan Administrator is the named fiduciary under the Plan, with the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits from a self-funded arrangement, you must complete, execute, and submit to the Plan Administrator a written claim on the form available from the Plan Administrator. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary to decide your claim.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the Plan Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the Plan Administrator for a review of the denied claim. The Plan Administrator will decide your appeal in accordance with reasonable claims procedures, as required by ERISA. If you don't appeal on time, you will lose your right to file suit in a state or federal court, as you will not have exhausted your internal administrative appeal rights (which is generally a prerequisite to bringing a suit in state or federal court).

See Governing Documents for more information about how to file a claim and for details regarding the claims procedures applicable to your claim.

STATEMENT OF ERISA RIGHTS

Your Rights

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

Receive Information About Your Plan and Benefit

Examine, without charge, at Salem Health Hospitals & Clinics 's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

Receive a summary of the Plan's annual Form 5500, if any is required by ERISA to be prepared, in which case Salem Health Hospitals & Clinics, as Plan Administrator, is required by law to furnish each participant with a copy of this summary annual report.

COBRA Rights

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps that you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report (Form 5500), if any, 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 Salem Health Hospitals & Clinics , as Plan Administrator, to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court.

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

Assistance With Your Questions

If you have any questions about your Plan, you should contact Salem Health Hospitals & Clinics . If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or contact 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.

SALEM HEALTH HOSPITALS & CLINICS
WELFARE BENEFIT PLAN

APPENDIX A

Medical

Moda
601 SW Second Ave.
Portland, OR 97204
Phone: 888.217.2365

Dental

Moda/Delta Dental of Oregon
601 SW Second Ave.
Portland, OR 97204
Phone: 888.217.2365

Vision

VSP
3333 Quality Drive
Rancho Cordova, CA
95670
Phone: 800.877.7195

STD/LTD/LIFE/AD&D

Standard Insurance Company
900 SW Fifth Avenue Portland
Oregon 97204-1282
(503) 321-7000

HEALTH SAVINGS ACCOUNT

Optum Financial
P.O. Box 60000
Newark, NJ 07101
Phone: (877) 470-1771(HSA)

FLEXIBLE SPENDING ACCOUNT

Optum Financial
P.O. Box 60000
Newark, NJ 07101
Phone : 1-877-292-4040 (FSA)

DCAP

Optum Financial
P.O. Box 60000
Newark, NJ 07101
Phone: 1-866-234-8913

EMPLOYEE ASSISTANCE PLAN

Modern Health
650 California St Floor 7
San Francisco, CA 94108
Office 07-128
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