First Choice Health™

Healthy Employees. Healthy Companies.™

CONSUMER DRIVEN HEALTH PLAN (CDHP)

Group 1

Plan Year effective September 1, 2006 – August 31, 2007

Administered by

First Choice Health Administrators

TABLE OF CONTENTS

PLAN DEFINITIONS

Active Employee is an employee who is on the regular payroll of First Choice Health Network, Inc. and is scheduled to perform the duties of his or her job on a full-time or part-time basis.

Accidental Injury means physical harm caused by a sudden and unforeseen event at a specific time and place.

Adverse Benefit Determination means a denial, decrease, or ending of a benefit. This includes a failure to provide or make payment (in whole or in part) for a benefit including claims based on medical necessity or experimental and investigational exclusions.

Agreement means the Services Agreement, Plan Document, Summary of Benefits, attachments, and any endorsements or amendments to the agreement approved by the Plan Administrator.

Allowed Amount means the maximum amount paid by the Plan for a medically necessary covered service. Generally, this is an amount agreed to contractually by the Plan and participating providers. The allowable amount paid by the Plan for services from non-participating providers and for out-of-area providers is based on usual, customary and reasonable (UCR) rates.

Ambulatory Surgical Facility means a licensed facility that is used mainly for performing outpatient surgery.

Benefit Administrator or Plan Administrator means the department designated by your employer group to administer the Plan on behalf of the group's employees.

Case Management means a program whereby a case manager monitors these patients and explores and discusses coordinated and/or alternative types of appropriate medically necessary care.

Certificate of Creditable Coverage means a certificate issued by a health Plan which describes a person's prior period(s) of creditable health care coverage as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Chemical Dependency means an illness characterized by a physiological or psychological dependency, or both, on a controlled substance and/or alcohol, which impairs or endangers the participant or dependents' health.

Child (or Children) An unmarried natural child, adopted child, a child placed with the participant for the purposes of legal adoption, a stepchild, or other legally designated ward who is not older than the maximum dependent child age unless meeting full time student status requirements or physically handicapped.

Claim means any request for a Plan benefit, made by you or your authorized representative. A participant making a claim for benefits is a "claimant" under ERISA regulations.

Coinsurance means a cost-sharing requirement that requires a participant or dependent to pay a percentage of the cost of specified covered services.

Concurrent claim means any claim that is reconsidered after an initial approval for ongoing course of treatment was made and results in a reduced or terminated benefit.

Copayment means a set amount that a participant or dependent is responsible to pay at the time of service. Copayments are paid in addition to membership contribution.

Custodial Care is care designed primarily to assist in activities of daily living, including institutional care that serves primarily to support self-care and provide room and board. Custodial care includes, but is not limited to, bathing, dressing, walking assistance, help with getting in and out of bed, feeding, preparation of special diets, and supervision of medications that are ordinarily self-administered.

Deductible means the amount the participant or dependant must pay each Plan year before your employer is obligated to pay for covered services. Only covered services are applied towards the calculation of the Plan year deductible.

Dental Professional: means any of the following who is acting within the scope of the license

- A doctor of dental medicine (D.M.D.);
- A doctor of dental surgery (D.D.S.);
- A dental hygienist; or
- A denturist.

Dental Services refer to services by any provider which are related to natural and unnatural teeth or structures and tissues contiguous to teeth (whether or not teeth are actually present). Dental services also include any associated service, such as, but not limited to anesthesia, laboratory, pathology, supplies, appliances, x-ray, or facility support.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent means an employee's legal spouse, domestic partner or child.

Developmental disability means a condition which meets all of the following:

- A condition defined as mental retardation, cerebral palsy, epilepsy, autism, or another neurological or other condition;
- Originates before the individual reaches eighteen years of age;
- Is expected to continue indefinitely; and
- Results in a substantial handicap.

Domestic partners mean 2 individuals, either opposite or same sex, who each meet all the following criteria:

- Must be 18 or older; and
- Must have a close personal relationship of mutual caring and are each other's sole domestic partner and are responsible for each other's common welfare; and
- Have been domestic partners for the last consecutive 12 months; and
- Were mentally competent to consent to contract when our domestic partnership began; and
- Currently share the same regular and permanent residence; and
- Must be financially interdependent and are jointly responsible for "basic living expenses" and
- Neither partner can be married or legally separated from any other person or involved in another domestic partner relationship; and
- Partners must not be blood relatives of a degree of closeness that would prohibit marriage in the State in which they reside; and

- The partners must complete during the enrollment process the Affidavit of Domestic Partnership (and be responsible for keeping a copy of the original and providing copies when requested by the Plan Administrator).

Note: The domestic partner of an enrolled dependent is not eligible for coverage.
Children of domestic partners are not eligible for health Plan coverage.
A domestic partner who loses coverage eligibility under any circumstances is not eligible for COBRA or a continuation of coverage.

Durable Medical Equipment (DME) is medical equipment which can withstand repeated use, is not disposable, is used to serve a medically therapeutic purpose, is generally not useful to a person in the absence of a sickness or injury, and is appropriate for use in the home.

Emergency (Medical Emergency, Emergent) means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson acting reasonably to believe that a health condition exists that requires immediate medical attention, and that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Employee means a person who is an active, regular employee of First Choice Health Network, Inc. in an employee/employer relationship.

Employee Contribution is the employee portion of the costs for this benefit Plan.

Employer Group means the employer entity that sponsors the group health Plan.

Experimental and Investigational Procedures means services which are determined to be:

- Not in general use in the medical community;
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- Not proven safe & effective or to show a demonstrable benefit for a particular illness or disease;
- Under continued scientific testing and research;
- A significant risk to the health or safety of the patient; or
- Not proven to result in greater benefits for a particular illness or disease than other generally available services.

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

FCH means First Choice Health, an abbreviation for FCHN, Inc.

FCHA means First Choice Health Administrators, a division of FCHN, Inc.

FCHN, Inc. means First Choice Health Network, Inc.

Full-time means an employee who works a minimum of 35 hours per week.

Full-time Student means a dependent child age 22 or younger, who is enrolled at an accredited school or other institution of higher education and is taking a minimum of twelve (12) credit hours each grading period during at least through three (3) quarters or two (2) semesters per academic year. A full-time course load is determined by the individual institution. In general, most colleges and universities consider a full-time course load to be a minimum of 12 credits.

HIPAA means the Health Insurance Portability and Accountability Act of 1996.

Generic Drug is identical or the bio-equivalent to a brand name drug in dosage form, safety, strength, route of administration, quality, performance characteristics and intended use.

Health Savings Account (hereinafter "HSA") is an account that allows you to pay for certain medical expenses on a tax-free basis. HSA contributions can be made by FCH as your employer, by you, or both.

Incur, Incurs, Incurred and Incurred Date mean, with respect to a dental expense, the date the services or supplies are provided to you, except:

- Bridgework, a crown, or onlay work is incurred on the date the tooth or teeth are seated;
- Placement or modification of a full or partial denture is incurred on the date the impression is made; and
- Root canal therapy is incurred on the date the pulp chamber is opened.

Initial Eligibility means the date an eligible employee or dependent is first eligible for coverage under this Plan.

Lifetime is a reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does lifetime mean during the lifetime of the participant or dependant.

Maximum Child Age is eighteen (18) years old, unless meeting full-time student status requirements.

Medical Group means a group or association of providers, including hospital(s), listed in the Provider Directory.

Medically Necessary is a medical service or supply that meets all the following criteria:

- It is required for the treatment or diagnosis of a covered medical condition;
- It is the most appropriate supply or level of service that is essential for the diagnosis or treatment of the patient's covered medical condition;
- It is known to be effective in improving health outcomes for the patient's medical condition in accordance with sufficient scientific evidence and professionally recognized standards;
- It is not furnished primarily for the convenience of the patient or provider of services; and
- It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the patient.

The fact that a service or supply is furnished, prescribed, or recommended by a physician or other provider does not, of itself, make it medically necessary. A service or supply may be medically necessary in part only.

Non-participating Provider means a provider who delivers or furnishes health care services but who is not a contracted FCHN, Inc. provider.

Notification for Emergent Admissions or Childbirth means if you are admitted to a non-participating hospital or facility you must call the Plan Customer Service phone number listed on your ID card within two business days after the admission.

Open Enrollment Period is a defined period of time in which you are allowed to enroll yourself and/or your dependents for health care benefit coverage through your employer group.

Part-time employee means an employee who works any combination of hours less than 35 hours per week.

Participant means any eligible employee or other eligible individual who is enrolled in this employer group Plan, and who is not a dependent.

Participating Pharmacy means those contracted outpatient pharmacies listed in the Provider Directory.

Participating Provider means a contracted provider in the Plan service area and listed in the Provider Directory.

Participating Specialist means a contracted provider in the Plan service area and listed in the Provider Directory.

Periodontal Splint means any appliance designed to retain teeth in position, and includes multiple abutments for fixed bridgework.

Personal Representative means an individual acting on behalf of the claimant in obtaining or appealing a benefit claim. The authorized representative must have a signed form (specified by the Plan) by the claimant except for urgent care benefits or appeals. Once an authorized representative is selected, all information and notifications should be directed to that representative until the claimant states otherwise.

Plan Document means the instrument or instruments that set forth and govern the duties of Plan Sponsor and eligibility and benefit provisions of the Plan which provide for the payment or reimbursement of covered services.

Plan Year means the twelve (12) month period beginning September 1 and ending August 31 of the same year.

Post-Service claim means any claim for a Plan benefit under the Plan that is not a pre-service claim and is a request for payment or reimbursement for covered services already received.

Precertification is the process of obtaining coverage determination from the Plan Administrator prior to obtaining certain inpatient and outpatient services, which are specifically indicated in this document.

Pre-Service claim means any claim for a Plan benefit for which the Plan requires approval before medical care is obtained.

Primary Care Provider (PCP) means a participating provider who manages and coordinates the health care needs of the patient. A PCP may be in general practice, family practice, internal medicine or general pediatrics, an advanced registered nurse practitioner (ARNP) or an allopathic or osteopathic physician specializing in general practice.

Prosthetic devices are artificial substitutes which generally replace missing parts of the human body, such as a limb, bone, joint, eye, tooth, or other organ or part thereof, and materials which become ingredients or components of prostheses.

Provider means any person, organization, health facility or institution licensed to deliver or furnish health care services.

Provider Directory is the listing of participating providers, hospitals, and other facilities that have agreed to provide covered services to Plan participants or dependents.

Referral means a request for benefit coverage when a PCP refers a patient to another practitioner or facility other than the PCP location.

Skilled Care Services may include skilled nursing and skilled rehabilitation services which meet all the following criteria: 1) Must be delivered or directly supervised by licensed professional medical personnel in order to obtain the specific medical outcome, 2) are ordered by a physician, and 3) are medically necessary for the treatment of the sickness, injury or medical condition. Of note, determination of benefits for skilled care services is based on both the skilled nature of the specific service and the need (medical necessity) for physician-directed medical management. The absence of a caregiver to perform an unskilled service does not cause the service to become "skilled".

Skilled Nursing Facility means a qualified facility designated by FCHA which has the staff and equipment to provide skilled nursing care as well as other related services.

Spouse means an individual who is living in a marital relationship with the participant. The marital relationship must be recognized as lawful by the laws of the State in which the participant resides.

Standard Reference Compendia means the American Hospital Formulary Service-Drug Information; the American Medical Association Drug Evaluation; the United States Pharmacopoeia-Drug Information; or other authoritative compendia as identified by the Federal Secretary of Health and Human Services regarding the effective use of prescription medication.

Summary Plan Description (SPD) means the ERISA required summary of benefit plan terms that must be furnished to participants and describes the terms and conditions under which the Plan operates and the requirements for eligibility and enrollment, covered services, limitations and exclusions, and other terms and conditions that apply to participation in the Plan.

Temporomandibular Joint Disorders (TMJ) means those disorders which have one or more of the following characteristics: (i) pain in the musculature associated with the Temporomandibular Joint, (ii) internal derangement of the Temporomandibular Joint, (iii) arthritic problems with the Temporomandibular Joint, or (iv) an abnormal range of motion or limitation of motion of the Temporomandibular Joint.

Third Party Administrator (TPA) is the organization providing services to this employer group in connection with the operation of this Plan, as may be delegated to it, including processing and payment of claims.

Urgent Care means services which are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition and it was not reasonable given the circumstances to obtain the services through your PCP or regular provider office.

Urgent Care Claim means a claim for medical care or treatment that if normal pre-service standards are applied:

- Would seriously jeopardize the claimant's life, health or ability to regain maximum function; or
- In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested.

Usual, Customary and Reasonable (UCR) is the allowable paid by FCHA for services from non-participating providers and out-of-area providers as designated by an independent entity for the applicable geographical location.

First Choice Health Network, Inc. (FCHN) is the employer and Plan Sponsor of this self-funded employee group health Plan (herein after referred to as the "Plan.") First Choice Health Administrators (FCHA), a division of FCHN, provides services required to administer the Plan including decisions regarding benefit coverage, medical management, and claim payment (herein after referred to collectively as "FCH"). FCH maintains the ultimate authority, responsibility and control over the assets, management and administration of the Plan.

For the purpose of this document, the term "you" is meant to include all eligible participants and dependents covered under the Plan.

HOW TO CONTACT FIRST CHOICE HEALTH ADMINISTRATORS

You may call FCHA Customer Service directly whenever you have questions or concerns. The number for your Customer Service department is printed on your ID card. You may also contact them by mail, fax or via the Internet at the addresses listed below:

First Choice Health Administrators
Customer Service Department
PO Box 12659
Seattle, WA 98111-4659
(800) 430-3818 (statewide)
Fax: (888) 206-3092
www.fchadmin.com

FCHA business hours are Monday through Friday, 8:00 AM to 5:00 PM (Pacific Standard Time) during which time you may speak to a Customer Service Representative. The office is closed on the following holidays: New Year's Day, President's Day, Memorial Day, Independence Day (4th of July), Labor Day, Thanksgiving Day, the day after Thanksgiving Day, Christmas Eve Day and Christmas Day. If the holiday falls on a Saturday, the office is closed on Friday. If the holiday falls on Sunday, the office is closed Monday (the holiday is recognized during the same calendar week in which the holiday falls).

For your convenience, you may access your specific claim and enrollment status information via the Internet or by telephonic automated voice response system 24 hours a day.

YOUR ID CARD

Your ID card identifies you as an FCH Plan participant and contains important information about your coverage and benefits. We recommend that you present your ID card each time you receive care. If you lose your ID card, please notify Customer Service immediately and a representative will assist you in obtaining a new card. Under no circumstances should you give your ID card to another person for their use.

WAITING PERIODS

There is a twelve (12) month waiting period for Organ and Bone Marrow Transplants. Please see section COVERED SERVICES AND RELATED SUPPLIES, subsection ORGAN AND BONE MARROW TRANSPLANT SERVICES (Page 27) for specific information regarding the organ transplant waiting period.

PARTICIPANT REIMBURSEMENT LIABILITY

You are always responsible for the following costs associated with your health care:

- Plan year deductible, if applicable;
- Copayments, if applicable;
- Coinsurance, if applicable;
- The difference between a non-participating provider's charge for a service and FCHA's allowed amount for that service (see section DEFINITIONS under UCR);
- Any costs for care you receive after your benefit limits have been exhausted;
- Any costs for non-covered services; and
- Any cost for services that require precertification that were not obtained.

CLERICAL ERROR

Any clerical error by FCHA, the Plan Administrator, or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made if the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains the contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money to FCH via FCHA, the third party administrator which is defined in section DEFINITIONS.

FINDING A PROVIDER

First Choice Health Network (FCH) is the provider network for this Plan. In order to receive the network level of benefit coverage, medically necessary care for covered services must be provided by First Choice Health Network (FCH) participating providers. Please reference the Provider Directory for a complete list of participating providers.

The Healthcare Direct network is available and defined as in-network for those enrollees who live or work in Oregon or dependants with active full time student status in Oregon. You may access an up to date list of providers at the websites listed below. The Healthcare Direct network is also available to all participants for urgent or emergent care when traveling in Oregon.

The Beech Street Provider Network is available and defined as in-network for those enrollees who live or work outside of the FCH or Healthcare Direct network service areas including dependants with active full time student status outside of the FCH and Healthcare Direct service areas. The Beech Street Provider Network is also available to all participants for urgent or emergent care when traveling.

Networks by State/Area:	**State/Area:**	**Phone**	**Websites**
First Choice Health Network	Washington, Alaska, Montana, Idaho	1-800-430-3818	www.1stchoiceadmin.com
Healthcare Direct of Oregon	Oregon	7-877-287-2922	www.hcdirect.net
Beech Street Network	All other states areas not served by FCH or Healthcare Direct	1-800-877-1444, ext.2	www.beechstreet.com

If you receive care from a non-network provider, your benefits will be at the lower non-network level.

MENTAL HEALTH/CHEMICAL DEPENDENCY CARE

You may access Mental Health or Chemical Dependency care directly.

For assistance finding a provider specific to your Mental Health or Chemical Dependency needs, you may call the EAP phone number listed on your ID card (1-800-777-4114). Ask for a FCH participating provider.

NOTIFICATION FOR EMERGENT ADMISSIONS OR CHILDBIRTH

Admissions directly from the Emergency Room or for childbirth do not require precertification. However, notification is required within two business days after the admission. If you are admitted, you or your provider are responsible for notifying FCHA by calling the Customer Service phone number listed on your ID card within the 2 business days stated above. **Failure to notify FCHA of an emergent admission will result in a denial of benefits.**

CASE MANAGEMENT

A catastrophic medical condition may require long-term, perhaps lifetime care involving extensive services in a facility or at home. Case Management is a program whereby a nurse monitors such cases and explores and discusses coordinated and/or alternative types of appropriate medically necessary care. The case manager consults with the patient, family and attending physician.

A Plan of care is developed which may include some or all of the following:

- Personal support to the patient;
- Contacting the family to offer assistance and support;
- Monitoring hospital or skilled nursing facility stays;
- Addressing alternative care options; and
- Assisting in obtaining any necessary equipment and services.

Case management may identify a custom treatment Plan, if it would be beneficial to both the patient and the Plan. The Plan Administrator, the patient or designated representative and the attending physician must all agree to any custom treatment Plan.

Once agreement is reached, the specific medically necessary services stated in the treatment Plan will be reimbursed, subject to all Plan terms and conditions.

Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis. The final decision on the course of treatment rests with patients and their providers.

24/7 NURSELINE

Questions about your health, symptoms, and conditions can come up at anytime. Registered Nurses are available to you 24/7 through the nurseline to offer reliable and timely information.

The Nurseline provides:

- A valuable resource to assist you with timely health care information;
- Assistance to you in evaluating health lifestyle choices;

MATERNITY PROGRAM

MaternaLink is a free, voluntary program that is available to covered employees and their spouses/domestic partners. It is designed to help screen for potential risk factors associated with pregnancy and to provide ongoing education. The program includes comprehensive educational materials, access to a 24- hour BabyLine and a free electronic OB newsletter. In the event you develop problems during your pregnancy, a maternity RN is available to assist in the coordination of your care with your health care provider. You are encouraged to call 1-800-395-BABY (2229) when your pregnancy is confirmed to register with MaternaLink.

DISEASE MANAGEMENT

The free, voluntary Disease Management program is designed for people with chronic conditions with the goal of reducing the severity of health problems and minimizing complications. It provides proactive programs via mailings, telephonic nurse management, Internet programs, and hand-held biometric devices. Programs for the following chronic conditions are available: congestive heart failure, coronary artery disease, asthma, diabetes, and musculoskeletal. You are encouraged to call FCHA Medical Management at 1-800-808-0450 to obtain more information or to self-refer to a program.

CDHP/HSA Plan	CDHP PPO with Health Savings Account network	 out-of-network
Annual Deductible		
Employee	$1,400	$2,800
Employee + 1	$2,100	$4,200
Employee + 2 or more	$2,800	$5,600
Coinsurance	90%	70%
Out-of-Pocket Maximum		
Employee Only	$2,500	$5,000
Employee + 1	$3,750	$7,500
Employee + 2 or more	$5,000	$10,000
Lifetime Maximum	$2,000,000	
Office Visit	90% after deductible	70% after deductible
Emergency Room	90% after deductible	70% after deductible
Preventive Care	100% to $400/mem	70%
Prescription Drugs (Retail)	90% after deductible Includes Generic, Formulary and Non-Formulary	No Coverage
Prescription Drugs (mail-order) and/or Choice 90 Program – • Walgreens Pharmacy • Kroger (Fred Meyer & QFC)	100% after deductible	No Coverage
Contributions (Premium)		
Self Only	$ 0.00	
Employee & Spouse/Domestic Partner	$165.00	
Employee & Child(ren)	$121.00	
Family	$325.00	

- The benefits of this Plan are provided for medically necessary covered services at the percentages specified below after the applicable deductible has been met.
- Benefit payment is based on the allowed amount. Your benefit coverage is greater and out-of-pocket costs are less when your care is provided by a participating provider (Network Benefit Level).
- When the Plan year out-of-pocket maximum has been reached, the Plan will provide benefits for many covered services at 100% of the allowed amount for the remainder of the Plan year. Exceptions are noted.
- Certain services and procedures require precertification (see page 15 for more information.)
- Benefit visit and dollar maximums listed in this section apply to the Network benefit level and Out-of-Network benefit level options combined.

EMPLOYER HEALTH SAVING ACCOUNT CONTRIBUTIONS

First Choice Health will provide employer health saving account contributions based on a percentage of your deductible and your annual base salary.

HSA Funding Levels	Percentage of Deductible	Family Size	Salary Level
Level A Income	100%	Single / Family	Less than $30,000 / $40,000
Level B Income	90%	Single / Family	Less than $40,000 / $50,000
Level C Income	80%	Single / Family	Less than $50,000 / $60,000
Level D Income	70%	Single / Family	Less than $60,000 to $100,000
Level E Income	50%	Single / Family	Greater than $100,000
Longevity Benefit (over 7 years)	100%	Single / Family	100% funded

The "Level" of employer health saving account contribution is established based on your salary level and family size at the time of open enrollment and is only subject to change based on a qualifying event, or the longevity benefit, as set forth in the Plan Document. The annual employer contribution amount will be prorated and deposited **monthly** into the employee's HSA account.

Contribution Level	Employer HSA Contribution
Level A HSA Contribution	Annually
EE Only	$1,400
EE+Sp/DP or EE+Ch(ren)	$2,100
Family	$2,800
Level B HSA Contribution	Annually
EE Only	$1,260
EE+Sp/DP or EE+Ch(ren)	$1,890
Family	$2,520
Level C HSA Contribution	Annually
EE Only	$1,120
EE+Sp/DP or EE+Ch(ren)	$1,680
Family	$2,240
Level D HSA Contribution	Annually
EE Only	$980
EE+Sp/DP or EE+Ch(ren)	$1,470
Family	$1,960
Level E HSA Contribution	Annually
EE Only	$700
EE+Sp/DP or EE+Ch(ren)	$1,050
Family	$1,400

PLAN YEAR DEDUCTIBLE

The Plan year deductible is the amount you (and/or your family) must pay each Plan year before your employer is obligated to pay for covered services. The deductible must be met in full before any coinsurance applies. Only covered services are applied towards the calculation of the Plan year deductible. If your Plan year deductible has not been met, the amount due a provider is your liability until the deductible has been satisfied. The network and non-network Plan year deductibles are inclusive of each other. The following benefits do **not** apply toward the Plan year deductible: Preventive care up to $400 and vision and vision copays. Penalty fees do not apply toward the Plan year deductibles.

Prior Plan Deductible: If FCH replaces this Plan with another employer group Plan, any portion of the Plan Year deductible that you satisfied under the previous Plan will be credited to the new group Plan. This credit will occur only during the Plan year in which the new group Plan becomes effective. You may call Customer Service with questions regarding prior Plan deductible credits.

PLAN YEAR OUT-OF-POCKET MAXIMUM

Vision copayments and preventive care do **not c**ount toward the Plan year out-of-pocket maximum. Penalty fees do not apply toward the Plan year out-of pocket maximum. The network and non-network Plan year out-of-pocket maximums are inclusive of each other.

LIFETIME MAXIMUM

The lifetime maximum level of benefits is $2,000,000 per participant or dependent. Each Plan year of your continuous coverage, FCH will restore up to $50,000 per participant or dependent per Plan year of your lifetime maximum that has been paid by FCH but not previously restored. This restoration occurs regardless of your health. The Plan year restoration does not apply to benefits with separate lifetime maximums such as organ transplants, TMJ disorders, and the twenty-four (24) month maximum for chemical dependency.

ACCRUAL OF BENEFIT MAXIMUMS

Benefits with Plan year and lifetime maximums accrued under your previous FCH employer group Plan will be transferred and applied to the corresponding benefit maximum(s) of this Plan, if applicable.

PRECERTIFICATION REQUIREMENTS

All inpatient admissions and certain outpatient services and procedures require precertification from FCHA.

Precertification is required for:

- Bariatric Surgery
- Dental trauma services (follow-up services);
- Durable medical equipment and prosthetics if purchase exceeds $1000 or $250 per month rental;
- Eyelid surgery (blepharoplasty, etc);
- Home health services/home infusion therapy;
- Hospice care;
- Inpatient hospital admissions*;*
- Inpatient rehabilitation admissions ;
- Inter-facility transport via ambulance;
- Organ transplants;
- PET scans;
- Reconstructive and/or cosmetic surgery;
- Removal of breast implants;
- Rhinoplasty
- Skilled nursing facility admissions;
- Stereotactic radiosurgery (ie gamma knife)
- Surgical interventions for sleep apnea;
- Unproven, investigational or experimental services (unless specifically and completely excluded); and
- Varicose Vein Procedures.

For any of these procedures, you're responsible for obtaining pre-certification directly from FCHA. You may have your provider contact FCHA for you, but you are ultimately responsible. The medical pre-certification number is 800-808-0450.

Your provider may submit an advance request to FCHA Medical Management for benefit or medical necessity determinations. If a service could be considered experimental and investigational for a given condition, we recommend a benefit determination in advance, since those services are typically not covered.

If you receive care from a non-participating provider for services that require precertification without obtaining the necessary approval, you will be assessed a financial penalty: $400 for inpatient care and $200 for outpatient care, or up to the billed amount, whichever is less. Penalty amounts **do not** apply toward your Plan year deductible or out of pocket maximums.

BENEFIT DESCRIPTION	NETWORK BENEFIT LEVEL	OUT-OF-NETWORK BENEFIT LEVEL
	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Acupuncture - maximum 12 visits per Plan year (Maintenance therapy is not covered)	90%	Not covered
AMBULANCE - maximum $2,000 per Plan year • Non-emergent inter-facility transport via ambulance requires FCHA precertification	90%	
BARIATRIC SURGERY • Facility & Professional Services	90%♦	70%♦
CHEMICAL DEPENDENCY TREATMENT – maximum $13,500 every 24 months for inpatient and outpatient combined	70%	
CHIROPRACTIC – Limited to 12 visits per Plan year (Maintenance therapy is not covered)	90%	70%
DIABETIC EDUCATION & DIABETIC NUTRITION EDUCATION	90%	
DIETICIAN VISITS - maximum 3 visits per Plan year	90%	70%
DURABLE MEDICAL EQUIPMENT & PROSTHETIC DEVICES - maximum of $10,000 combined for DME and Prosthetic Devices per Plan year		
• Durable Medical Equipment - precertification required if exceeds $1000 purchase or $250 per month rental	90% ♦	70%♦
• Prosthetic Devices - precertification required if exceeds $1000 purchase	90% ♦	70%♦
• Wigs as a result of medically necessary treatments	$1000 lifetime maximum benefit	
• Oral Appliances - lifetime maximum $300, for treatment of obstructive sleep apnea only	90%	
HOME HEALTH CARE - maximum 130 home health agency visits per Plan year	90% ♦	70%♦
HOSPICE CARE	90% ♦	70%♦
HOSPITAL FACILITY SERVICES ♦ Certain out-patient procedures require precertification		
• Inpatient care	90% ♦	70%♦
• Outpatient hospital surgery and services - certain out-patient procedures require precertification	90% ♦	70%♦
• Outpatient laboratory & radiology services	90%	70%
• Ambulatory surgical centers - certain out-patient procedures require precertification	90% ♦	70%♦
• Hospital Emergency Room	90%	70%

BENEFIT DESCRIPTION	NETWORK BENEFIT LEVEL	OUT-OF-NETWORK BENEFIT LEVEL
	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
MEDICAL SUPPLIES	90%	70%
MENTAL HEALTH CARE		
• Inpatient care - maximum 10 days per Plan year	90%	
• Outpatient therapy - maximum 20 visits per Plan year. (Office visits for medication checks will not accrue towards your outpatient visit maximum)	70%	
• Day treatment - each day counts as ½ day toward the inpatient benefit maximum	90%	
NATUROPATHIC CARE	90%	Not covered
NEURODEVELOPMENTAL THERAPY - maximum $1,000 per Plan year	90%	70%
ORGAN AND BONE MARROW TRANSPLANT SERVICES - Subject to 12-month organ transplant waiting period. Lifetime maximums: Recipient - $250,000, Donor - $25,000	90% ♦	Not covered
PRESCRIPTION DRUGS AND MEDICATIONS - RETAIL	90**%** after deductible (See benefit)	**Not covered**
PRESCRIPTION DRUGS AND MEDICATIONS – MAIL ORDER Choice90 Program: • Walgreens Pharmacy • Kroger (Fred Meyer & QFC)	100**%** after deductible (See benefit)	**Not covered**
PROFESSIONAL / PHYSICIAN SERVICES ♦ Certain out-patient procedures require precertification		
• Office visits	90%	70%
• Preventive care visits – does not apply toward the Plan year deductible - Pediatric & adult immunizations - Screening services such as: o Mammograms o Colonoscopy o Flex Sigmoidoscopy	100% up to $400 per participant per Plan year	70%
• Laboratory & radiology services	90%	70%
• Hospital visits	90%	70%
• Surgery and anesthesia services	90%	70%

BENEFIT DESCRIPTION	NETWORK BENEFIT LEVEL	OUT-OF-NETWORK BENEFIT LEVEL
	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
REHABILITATION THERAPY		
• Inpatient care - maximum $30,000 per Plan year	90% ♦	70%♦
• Outpatient therapy - maximum 20 visits per Plan year for all therapies combined	90%	70%
SKILLED NURSING FACILITY - maximum 60 days per Plan year (Maintenance care and custodial care are not covered)	90% ♦	70%♦
SMOKING CESSATION - lifetime maximum $250	90%	
TEMPOROMANDIBULAR JOINT (TMJ) DISORDER SERVICES -maximum $1,000 per Plan year; lifetime maximum $5,000	90%	Not covered
URGENT CARE CENTER	90%	
WOMEN'S HEALTH CARE/MATERNITY CARE	Covered as any other medical condition	

COVERED SERVICES AND RELATED SUPPLIES

FCHA administers the services and benefits described to eligible persons enrolled in the FCH group health Plan. Please refer to the **BENEFIT SUMMARY** section for deductibles, copayments, coinsurance, and benefit maximum information.

Note: For all covered services described in this section: deductible, inpatient, outpatient, and office visit copayments and/or coinsurance will apply.

Please be aware that medical necessity alone does not determine coverage of the services you receive. As the Plan Sponsor, FCH reserves the right to interpret the provisions contained herein. If there is a dispute or other question concerning coverage, FCH has sole authority to determine the eligibility of benefits received under this Plan.

All services and benefits are subject to the exclusions or limitations of the Plan. Coverage is provided only when all of the following conditions are met:

- The service or supply is a listed covered benefit;
- The service or benefit is not specifically excluded from coverage;
- Specific benefit limitations or lifetime maximums have not been exhausted;
- All precertification and benefit requirements have been met;
- The participant or dependent is eligible for coverage and enrolled in this Plan at the time the service or supply is provided; and
- The service or benefit is considered to be medically necessary for a covered medical condition, as outlined below:

  A **medically necessary** service or supply, as determined by FCHA, is a medical service or supply which meets all the following criteria:

  - It is required for the treatment or diagnosis of a covered medical condition;
  - It is the most appropriate supply or level of service that is essential for the diagnosis or treatment of the patient's covered medical condition;
  - It is known to be effective in improving health outcomes for the patient's medical condition in accordance with sufficient scientific evidence and professionally recognized standards;
  - It is not furnished primarily for the convenience of the patient or provider of services; and
  - It represents the most economically efficient use of medical services and supplies that may be provided safely and effectively to the patient.

AMBULANCE

The use of approved ground or air ambulance transportation services are covered in an emergency situation to the nearest hospital where emergency health services can be rendered if the following conditions apply:

- Use of a less intensive form of transportation would likely endanger the participant's or dependent 's health; and
- Use of such transportation is not for personal or convenience reasons.

A non-emergent interfacility transport is covered in full when medically necessary and precertified by FCHA.

ACUPUNCTURE

Coverage for acupuncture is covered when furnished by a participating provider for the medically necessary treatment of a covered illness or condition. Maintenance therapy is not covered.

BARIATRIC SURGERY

All Bariatric surgeries are subject to FCHA pre certification.

Gastrointestinal surgery for obesity, also called bariatric surgery, alters the digestive process by closing off parts of the stomach to make it smaller. Surgeries that only reduce stomach size are known as "restrictive operations" because they restrict the amount of food the stomach can hold. Some surgeries combine stomach restriction with a partial bypass of the small intestine. These procedures create a direct connection from the stomach to the lower segment of the small intestine, literally bypassing portions of the digestive tract that absorb calories and nutrients. These are known as malabsorptive operations.

Coverage for bariatric surgery must be medically necessary and may be subject to medical review and case management. This benefit is revocable at any time per the Plan Administrator's discretion. The bariatric surgery coverage applies to the actual surgery and other **inpatient costs** associated or related to that specific stay. Any pre or post services are applied to the applicable medical benefits.

CHEMICAL DEPENDENCY TREATMENT

Inpatient, outpatient, and professional services benefits are available for covered illnesses characterized by a physiological and/or psychological dependency on a controlled substance and/or alcohol. For assistance finding a provider specific to your Mental Health or Chemical Dependency needs, you may call the EAP phone number listed on your ID card (1-800-777-4114). Ask for a FCH participating provider.

Coverage for chemical dependency treatment includes:

- A maximum of $13,500 every 24 months for inpatient and outpatient combined.
- Medically necessary services and supplies of a participating provider, facility, or approved program for both inpatient and outpatient care;

- Detoxification, supportive services, and approved prescription drugs prescribed by the participating provider or facility.

Coverage under this provision is limited to the specific services listed above and **does not** include:

- Alcoholics Anonymous or other similar chemical dependency programs or support groups;
- Court-ordered assessments or other assessments to determine the medical necessity of court order treatments;
- Court-ordered treatment and/or treatment related to the deferral of prosecution, deferral of sentencing or suspended sentencing, or treatment ordered as a condition of retaining motor vehicle driving rights, when no medical necessity exists;
- Emergency patrol services;
- Information and referral services;
- Information schools;
- Long term or residential custodial care; or
- Smoking cessation treatment.

CHIROPRACTIC CARE

Manipulation of the spine is covered when furnished by a chiropractor for the medically necessary treatment of a covered illness or condition. Maintenance therapy is not covered. Coverage includes diagnosis and treatment of musculoskeletal disorders that are within the scope of the chiropractor.

Chiropractic care is limited to 12 visits per Plan year and includes medically necessary diagnostic radiology.

DENTAL TRAUMA SERVICES

Benefit coverage is provided under this medical Plan for the repair, but not the replacement, of a sound natural tooth which becomes damaged as a result of a traumatic injury. **After the initial examination by your dentist, a precertification for further services is required by FCHA**. All services related to the repair must be completed within six (6) months of the date of the injury. Any services received after six (6) months have elapsed, or after you become disenrolled from this group Plan regardless of whether six (6) months have elapsed or not, are not covered. Damage due to biting or chewing is not covered.

For the purposes of this coverage, a "sound natural tooth" is a tooth that is (i) free of active or chronic clinical decay, (ii) contains at least fifty percent (50%) bony structure, (iii) is functional in the arch, and (iv) has not been excessively weakened by multiple dental procedures.

DIABETIC EDUCATION & DIABETIC NUTRITION EDUCATION

Medically necessary diabetic education regarding nutrition and insulin management of diabetes is covered. The education may take place in classes through approved diabetic courses or as individual instruction.

DIETICIAN AND NUTRITIONIST SERVICES

The services of a registered dietician or certified nutritionist are covered at a maximum of 3 visits per Plan year for the medically necessary treatment of a covered illness, injury, or condition.

DURABLE MEDICAL EQUIPMENT (DME) & PROSTHETIC DEVICES

Durable medical equipment that exceeds $1000 purchase or $250 per month rental and prosthetic devices that exceed $1000 purchase require precertification by FCHA in order to be covered. A maximum limit of $10,000 is available for combined DME and Prosthetic Devices per Plan year. Benefits for DME and Prosthetic Devices are subject to stated definitions, benefit limitations and exclusions of this Plan.

Durable medical equipment (DME) is medical equipment which can withstand repeated use, is not disposable, is used to serve a medically therapeutic purpose, is generally not useful to a person in the absence of a sickness or injury, and is appropriate for use in the home. Benefits will be provided for the purchase or rental (not to exceed the purchase price) of durable medical equipment when it is medically necessary and prescribed by a physician for therapeutic use in direct treatment of a covered illness or injury. Repair of covered medically necessary equipment due to normal use, change in physical condition, or growth of a child is eligible for coverage. Duplicate items are not covered. Purchase (vs. rental) is at the discretion of FCHA.

Examples of durable medical equipment are:

- Walkers
- Crutches
- Standard manual wheelchairs
- Standard manual hospital beds
- Oxygen and equipment for administering oxygen

DIABETIC DME AND SUPPLIES

Coverage for diabetic equipment includes medically necessary diabetic monitoring equipment and the initial cost of a medically necessary insulin pump. Repair of covered medically necessary equipment due to normal use is eligible for coverage. When medically necessary, foot care appliances for prevention of complications associated with diabetes are covered.

Coverage for diabetic supplies is limited to insulin, syringes, and needles for diabetic injections, lancets, urine and blood glucose testing reagents (including visual strips). This benefit is only available under section **PRESCRIPTION DRUG BENEFIT**.

PROSTHETIC DEVICES

Prosthetic devices are covered when medically necessary for the treatment of an appropriate covered condition. Standard artificial limbs and eyes for the replacement of body parts lost as a result of an illness or injury are covered. Coverage is limited to the initial purchase and subsequent repair costs necessitated by physical growth or normal use. Duplicate items are not covered. In addition to limitations and exclusions listed elsewhere, FCHA will not provide coverage for items primarily for use during or to enable sports and/or recreational activities.

Exclusions for Durable Medical Equipment, Prosthetic Devices, and Medical Supplies

In addition to limitations and exclusions listed elsewhere in this document, the Plan will not provide coverage for:

- Biofeedback equipment;
- Computer-controlled or microprocessor-controlled prosthetic devices;
- Electronic and/or keyboard communication devices;
- Exercise equipment;
- Equipment or supplies whose primary purpose is preventing illness or injury;
- Items that are not manufactured exclusively for the direct therapeutic treatment of an ill or injured patient; and
- Items that can be or are available over the counter, except for medically necessary crutches, walkers, standard wheelchairs, diabetic supplies, and ostomy supplies;
- Items primarily designed to assist a person caring for the patient;
- Items primarily for comfort, convenience, recreational purposes, or use outside the participant or dependent's residence;
- Items primarily for use during or to enable sports and/or recreational activities;
- Oral appliances, except for the medically necessary treatment of obstructive sleep apnea;
- Personal comfort items including, but not limited to, air conditioners, lumbar rolls, heating pads, diapers, and personal hygiene items;
- Regular or special car seats, regular or special strollers, push chairs, air filtration systems or supplies, orthopedic or other special chairs, pillows, prone standers, three-wheeled scooters, adjustable beds, bed wetting training equipment, corrective shoes, whirlpool baths, vaporizers, room humidifiers, hot tubs or other types of tubs, home UV or other light units, home blood testing equipment and supplies (except as indicated under this section, subsection DURABLE MEDICAL EQUIPMENT (DME) & PROSTHETIC DEVICES, AND MEDICAL SUPPLIES, Diabetic DME and Supplies), and humidifiers;
- Supportive equipment/environmental adaptive items including, but not limited to, handrails, chair lifts, ramps, shower chairs, commodes, car lifts, elevators, car and home modifications.

EMERGENCY CARE

Coverage for emergency conditions includes medically necessary emergency room visits in participating and non-participating facilities.

Emergency (Medical Emergency, Emergent) means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent layperson, acting reasonably, to believe that a health condition exists that requires immediate medical attention, and that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Examples of emergent conditions include but are not limited to severe pain, difficulty breathing, deep cuts or severe bleeding, poisoning, drug overdose, broken bones, unconsciousness, stab or gun shot wounds, automobile accidents, and pain or bleeding during pregnancy.

In the case of a life-threatening emergency, whether at home or away from home, you should seek the most immediate care available. To receive the highest level of benefit coverage, all follow-up care to emergency treatment must be provided by FCH participating providers. Specialty care services require approval for the highest level of benefit coverage. If you do not obtain the necessary precertification, your benefits will be substantially reduced or denied.

If you are admitted to a non-participating hospital or facility, you are responsible for notifying FCHA within two (2) business days. See page 9, section HOW TO OBTAIN HEALTH CARE, subsection NOTIFICATION FOR EMERGENT ADMISSIONS OR CHILDBIRTH. FCHA may arrange for your transfer to a participating hospital as soon as your condition permits at no cost to you.

FAMILY PLANNING

The following voluntary sterilization and birth control procedures are covered:

- IUD insertion
- Tubal ligation
- Vasectomy
- Diaphragm
- Cervical Cap
- Norplant

Over-the-counter products are not covered. Oral contraceptives are covered under section PRESCRIPTION DRUG BENEFIT.

Termination of Pregnancy

Voluntary termination of pregnancy within the first trimester is covered.

Infertility Services

The treatment of infertility is not a covered benefit. The following services are covered for the initial diagnosis of infertility:

- Endometrial biopsy
- Hysterosalpingography
- Reproductive screening services
- Sperm count

HOME HEALTH CARE

Home health care services are covered when prescribed by your physician has been precertified. Refer to page 9, section HOW TO OBTAIN HEALTHCARE, subsection PRECERTIFICATION REQUIREMENTS. Home health care is covered when the patient must be homebound and when the care provided is medically necessary skilled care services. Skilled care services are services that must be delivered or supervised by licensed professional medical personnel in order to obtain the specified medical outcome. Benefits are limited to intermittent visits provided by a licensed home health care agency and include medically necessary home infusion services. A precertification request from your provider and an approval by FCHA are required to receive coverage. Any charges for home health care that qualify under this benefit and under any other benefit of this Plan will be covered under the most appropriate benefit, as determined by FCHA.

A visit is defined as one time-limited session or encounter with any of the following home health agency providers of care. A maximum of 130 Home Health agency visits are available per Plan year.

- Nursing services (Registered Nurse, Licensed Practical Nurse);
- Licensed or registered physical, occupational or speech therapist;
- Home health aid working directly under the supervision of one of the above employees; or a
- Medical Social Worker (M.S.W.)

Private duty nursing, shift or hourly care services, custodial care, maintenance care, housekeeping services, respite care, and meal services are not covered.

The Home Health Care benefit is not intended to cover care in the home when care in a skilled nursing facility or a hospital is determined by FCHA to be more cost-effective.

HOSPICE CARE

Hospice care services are covered when the provider has determined that life expectancy is six (6) months or less and you have obtained FCHA pre certification. In order to receive the highest level of benefit coverage, care must be provided by a participating provider. Hospice care must be part of a written Plan of care prescribed and approved by a physician in order to be covered.

Coverage for hospice care includes:

- Medically necessary services and supplies in a hospice facility approved by FCHA;
- Intermittent in-home visits when provided by a registered nurse, licensed practical nurse, medical social worker, physical, occupational, or speech therapist, or a home health aide;
- One period of continuous home care provided by a registered nurse, licensed practical nurse, or home health aid under the supervision of a registered nurse. This type of care is provided only during a period of crisis, which would otherwise require hospitalization in an acute care facility. Continuous care is covered for four (4) or more hours per day for a period not to exceed five (5) days, or seventy-two (72) hours, whichever comes first;
- Respite care is covered in the home in order to continue necessary care activities in the absence of a primary care giver. Coverage is limited to a maximum of one

hundred twenty (120) hours during each three (3) month period of hospice care, beginning with the first day of covered hospice care;

- Approved prescription drugs furnished and billed by an approved hospice facility or home health agency; and
- Durable medical equipment (see subsections **DURABLE MEDICAL EQUIPMENT (DME) & PROSTHETIC DEVICES, AND MEDICAL SUPPLIES.**)

Coverage for hospice care does **not** include the following:

- Any service excluded under this Plan;
- Financial or legal counseling services;
- Housekeeping or meal services;
- Services not specifically listed as covered hospice services under this Plan;
- Services provided by participant or dependents of the patient's family or by volunteers;
- Spiritual or bereavement counseling;
- Supportive equipment such as handrails or ramps;
- Transportation; and
- Custodial care or maintenance care, except that benefits will be provided for palliative care to the terminally ill patient subject to the stated limits.

Any charges for hospice care that qualify under this benefit and under any other benefit of this Plan will be covered under the most appropriate benefit, as determined by FCHA.

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HOSPITAL/ FACILITY SERVICES

Hospital and facility charges for medically necessary covered care are paid at the highest level when the hospital or facility are participating providers and precertification from your provider has been approved by FCHA. Precertification is required for all non-emergent inpatient admissions to a hospital or facility and for outpatient surgery. Standard maternity care and emergency admissions require notification. See page 9, section HOW TO OBTAIN HEALTHCARE, subsections PRECERTIFICATION and NOTIFICATION FOR EMERGENT ADMISSIONS OR CHILDBIRTH for specific requirements.

Inpatient Medical & Surgical Care

Coverage for inpatient hospital care includes semi-private room and board, operating room and anesthesia services, radiology, laboratory and pharmacy services furnished by and used while in the hospital.

Outpatient Hospital Surgery and Services

Coverage for outpatient hospital care includes outpatient surgery, procedures and services, operating room and anesthesia services, radiology, laboratory and pharmacy services furnished by and used while at a hospital or ambulatory surgical center.

MEDICAL SUPPLIES

Medical supplies are covered when medically necessary for the treatment or care of an appropriate covered condition. See DME limitations and exclusions page 23 of this document.

MENTAL HEALTH CARE

Inpatient, outpatient, and professional services benefits are available for covered mental or psychiatric conditions. A maximum of 10 days for Inpatient Care and 20 visits for Outpatient Therapy are available per Plan year. (Office visits for medication checks will not accrue towards your outpatient visit maximum). A day treatment counts as ½ day toward the inpatient benefit maximum.

You may access Mental Health or Chemical Dependency care directly. For assistance finding a provider specific to your Mental Health or Chemical Dependency needs, you may call the EAP phone number listed on your ID card (1-800-777-4114). Ask for a FCH participating provider.

There is no coverage under this provision for the following:

- Behavioral therapy
- Chemical dependency
- Developmental delay disorders
- Marriage and family therapy, in the absence of a mental health diagnosis
- Court-ordered assessments
- Sexual dysfunction
- Sensitivity training
- Chronic pain management, including biofeedback
- Residential treatment

NATUROPATHIC CARE

The services of a participating naturopathic physician are covered for the medically necessary treatment of a covered illness, injury, or condition. These services include standard diagnostic medical procedures and therapies.

NEURODEVELOPMENTAL THERAPY

Coverage is available for the restoration and improvement of function in neurodevelopmentally disabled children, age six (6) and under up to $1000 per Plan year. Children seven (7) years of age and older are not covered. The therapy must be a part of a formal written treatment Plan prescribed by a physician. The following services are included:

- Outpatient physical, occupational and speech therapy;
- Ongoing maintenance in cases where serious significant deterioration would result without ongoing treatment; and
- Neurological and psychological testing, evaluations and assessments

Once the benefit under this provision is exhausted, coverage may not be extended by using the benefits under any other provision.

ORAL SURGERY

Coverage for oral surgery includes:

- The reduction or manipulation of fractures of facial bones;
- Excision of lesions, cysts, and tumors of the mandible, mouth, lip or tongue; and
- Incision of accessory sinuses, mouth salivary glands or ducts.

This coverage does not include care of the teeth or dental structures, dental implants, extractions of impacted teeth, services related to malocclusion, services to correct malposition of the teeth, or orthognathic surgery, regardless of the origin.

ORGAN AND BONE MARROW TRANSPLANT SERVICES

Provided the criteria for a transplant procedure are met, the following transplants are covered:

- Heart
- Heart/lung
- Intestinal
- Islet Cell
- Lung
- Kidney
- Kidney/pancreas
- Liver
- Living donor liver transplant
- Multi-visceral (liver, stomach, jejunum, ileum, pancreas, and /or colon
- Certain autologous and allogenic bone marrow transplants (including peripheral stem cell rescue)

For the purpose of this program, the term "transplant" does not include cornea transplantation. Coverage for cornea transplantation is available under other benefits of this program.

Services directly related to organ transplants must be coordinated by your participating provider. A precertification request from your participating provider and approval by FCHA is required. There is no out-of-network benefit for organ transplants. All inpatient, outpatient, and office coinsurance apply. Such approval is based on the following criteria:

- Your provider submits a written recommendation and supporting documentation;
- Your medical condition requires the requested transplant based on medical necessity;
- The requested procedure is not considered to be an experimental or investigational treatment for your condition;
- The procedure is performed at a facility and by a provider approved by FCHA; and
- You are accepted into the approved facility transplant program and comply with all program requirements.

Please have your provider send a written request to FCHA for precertification of your transplant prior to your inpatient admission. The request must include the results of the transplant evaluation. Send the requests to:

Medical Director

C/O Medical Management

First Choice Health Administrators

600 University Street Ste. 1400

Seattle, WA 98101

Transplant Waiting Period

You are eligible for coverage for organ transplants after you have been continuously covered under this group Plan for a period of twelve (12) consecutive months from your date of enrollment. The twelve (12) month organ transplant waiting period does not apply to an organ transplant performed prior to your date of enrollment.

There are no waiting periods under the following conditions:

- If the transplant is necessary as a result of abrupt unforeseen damage to a previously non-diseased organ;
- If the transplant is necessary as a result of an accident or injury which occurs after you enroll;
- If the transplant is necessary to correct a congenital defect for a child who has been continuously covered under this employer group Plan since birth.

Recipient Services

Covered recipient transplant services are available up to a maximum of $250,000 and include:

- Medical and surgical services directly related to the transplant procedure and follow-up care;
- Diagnostic tests and exams directly related to the transplant procedure and follow-up care;
- Inpatient facility fees and pharmaceutical fees incurred while an inpatient;
- Medically necessary services and supplies directly related to the transplant procedure;
- Pharmaceuticals administered in an outpatient setting; and
- Travel and lodging expenses for the recipient and his/her family when the recipient is required by FCHA to travel thirty (30) or more miles outside of the service area for medically necessary services related to an approved transplant. Travel and lodging benefits are paid up to a maximum of $2,500 per transplant episode and must be precertified by FCHA.

Donor Services

Donor expenses are covered up to a maximum of $25,000 **only if** all the following conditions are met:

- The transplant procedure is approved by FCHA;
- The **recipient** is enrolled in the group Plan;
- The expenses are for services directly related to the transplant procedure; and
- The donor services are not covered under any other health Plan or government program.

Covered donor expenses include:

- Donor typing, testing, and counseling; and
- Donor organ selection, removal, storage, and transportation of the surgical/harvesting team and/or the donor organ or bone marrow.

Organ donor expenses apply toward the recipient's lifetime maximum benefit.

Transplant Exclusions

In addition to the limitations and exclusions contained in this document, the following transplant services are **not** covered:

- Complications arising from the donation procedure if the donor is not an participant or dependent;
- Animal-to-human transplants;
- Artificial or mechanical devices designed to replace human organs;
- Prescription drugs dispensed after the recipient has been discharged from the transplant facility, except as may be covered under section PRESCRIPTION DRUG BENEFIT;
- Meals and lodging (except for lodging as otherwise specified above);
- Organ transplants not specifically listed as covered transplants; and

- Transplants which are considered to be experimental or investigational, as defined in this document, for the condition. See section DEFINITIONS for definition of experimental or investigational.

Note: If you, as a participant, choose to donate an organ or bone marrow, donor expenses are not covered under this Plan. However, complications arising from the donation are covered as any other illness to the extent that they are not covered under the recipient's health Plan.

PLASTIC AND RECONSTRUCTIVE SERVICES

Plastic and reconstructive services and procedures are covered only for the following conditions and are subject to any applicable inpatient, outpatient, and copayments and/or coinsurance:

- To correct a functional deficit resulting from a congenital disease or anomaly;
- For a prompt repair of an accidental injury that occurred while the participant or dependent is covered under this employer group Plan. The repair must be performed within twelve months of the initial injury;
- To correct a functional physical disorder resulting from disease;
- To correct a functional physical disorder resulting from a prior surgery, provided the prior surgery would be eligible for coverage under this Plan; or
- For reconstructive breast surgery following a mastectomy which resulted from disease, illness, or injury. Coverage is also available for internal or external breast prosthesis. A breast reconstruction on the non-diseased or non-injured breast is covered to make the healthy breast equivalent in size to the reconstructed breast.

Coverage does **not** include:

- Cosmetic services, supplies, or surgery to repair, modify, or reshape a functioning body structure for the improvement of the patient's appearance or self esteem;
- Complications resulting from non-covered services;
- Orthognathic surgery, regardless of origin or cause; or
- Dermabrasion, chemical peels, and/or skin procedures used to improve appearance or to remove scars or tattoos.

PREVENTIVE CARE

The CDHP provides 100% preventive care coverage up to the first $400 per participant per Plan year. Notice 2004-23 provides a CDHP safe harbor for preventive care benefits including physicals, immunizations, well child care and screening services such as mammogram, colonoscopy and flex sigmoidoscopy. The notice also clarifies that preventive care generally does not include the treatment of existing conditions.

The FCH CDHP preventive care benefit includes coverage for routine physicals and routine childhood immunizations, and vaccinations for participants and dependents who are nineteen (19) years of age or older limited to influenza, pneumococcus, and tetanus boosters. Coverage determinations are based on current recommendations from the American Academy of Pediatrics, the American Academy of Family Physicians, and the Report of the U.S. Preventive Services Task Force - Guide to Clinical Preventive Services, and are subject to change periodically. Travel and work-related immunizations are not covered.

Preventive care does not include diagnostic treatment, lab, or x-ray, or follow-up care or maintenance care of existing conditions or chronic disease.

PROFESSIONAL SERVICES

Your care must be provided by a FCH participating provider in order to receive the highest level of benefit coverage. Coverage applies to in-person visits only. Charges for care provided by phone, fax, electronic mail, Internet and telemedicine are not covered.

REHABILITATION THERAPY

Coverage for physical therapy, speech therapy, occupational therapy, massage therapy, and biofeedback for disabling conditions other than neurodevelopmental disabilities (see this section**,** subsection **NEURODEVELOPMENTAL THERAPY** below) is provided on an inpatient and outpatient basis when all of the following conditions are met:

- The services are medically necessary to restore and significantly improve function that was previously present but was lost due to an acute injury or illness;
- The services are not for palliative, recreational, relaxation, or maintenance therapy;
- The loss of function was not the result of a work-related injury; and
- The therapy is provided by, or prescribed by, your physician.

Inpatient Rehab Care

Inpatient rehabilitation services are covered up to $30,000 per plan year and must be furnished and billed by a rehabilitative unit of a hospital, or be furnished and billed by another rehabilitation facility approved by FCHA. When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day that the care becomes primarily rehabilitative. Inpatient care includes all room and board, all services provided and billed by the inpatient facility, and therapies performed during the rehabilitative stay. A precertification request including an approved treatment Plan and approval by FCHA is required prior to services being rendered for all inpatient treatment.

Outpatient Rehab Care

Benefits for outpatient rehabilitation care are subject to the following provisions:

- You must not be confined in a hospital or other medical facility;
- The therapy must be part of a formal written treatment Plan prescribed by your physician; and
- Services must be furnished and billed by a hospital, by a physician, or by a physical, occupational, speech, or massage therapist.

Coverage for outpatient rehabilitative services is limited to those services that are reasonably expected to result in significant self-sustaining functional improvement (not dependent on maintenance therapy) within ninety (90) days of initiation. Speech therapy is only covered when required as a result of brain or nerve damage secondary to an accident, disease, or stroke.

All therapies combined accrue toward the outpatient visit maximum and are limited to 20 visits per Plan year.

Once the benefits under this provision have been exhausted, coverage may not be extended by using the benefits under any other provision.

SKILLED NURSING FACILITY

Medically necessary care in a skilled nursing facility for skilled care services is covered up to a maximum of 60 days per plan year when a precertification is obtained by FCHA. Coverage for a skilled nursing facility includes semi-private room and board and medically necessary ancillary services. The care provided must be therapeutic or restorative in nature and require the in-facility delivery of care by licensed professional medical personnel, under the direction of a physician, in order to obtain the desired medical outcome. Maintenance care and custodial care are not covered. Please see the LIMITATIONS AND EXCLUSIONS section.

TOBACCO CESSATION

This benefit (up to a $250 lifetime maximum) requires participation in and proof of completion of an approved smoking cessation program. To find a program, call the Washington State Department of Health Washington Quit Line at 1-877-270-STOP or your county health district, or check with your local FCH preferred provider hospital.

Certain smoking cessation pharmacy products are covered when purchased in association with an approved smoking cessation program. You must pay the cost of any drugs received under this benefit and submit your claim to FCHA for reimbursement. The cost of the drugs will be subject to your tobacco cessation lifetime benefit.

For reimbursement, send a copy of your proof of completion along with your receipts to FCHA Claims Department, PO Box 12659, Seattle, WA 98111-4659.

TEMPOROMANDIBULAR JOINT (TMJ) DISORDER

Medical, surgical, and related hospital services are covered specifically for the treatment of temporomandibular joint disorders up to $1000 per Plan year and $5000 lifetime maximum. All inpatient admissions to a hospital or facility for the treatment of TMJ require a precertification request from your participating provider and approval by FCHA. If you self-refer for specialty care to a non-participating provider, your care will not be covered. Medical and surgical services are those which are:

- Reasonable and appropriate for the treatment of a disorder of the temporomandibular joint;
- Effective for the control or elimination of one or more of the following conditions caused by a disorder of the temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing food;
- Not experimental or investigational as determined by FCHA according to definition contained in this document; and
- Not primarily for cosmetic purposes.

URGENT CARE

Urgent Care means services that are medically necessary and immediately required as a result of an unforeseen illness, injury, or condition and it was reasonable, given the circumstances, to obtain the services through an Urgent Care Facility.

Examples of urgent conditions include but are not limited to cuts and lacerations, diarrhea, fever, minor allergic reactions, sinus infections, sprains, strains, urinary tract infections, and vomiting.

Outside the Service Area: If an urgent situation occurs while you are traveling or visiting outside the service area, seek care immediately. To receive the highest level of benefit coverage, all follow-up care to urgent treatment must be provided by participating providers.

MATERNITY CARE

Coverage for pregnancy and childbirth in a hospital or birthing center is provided on the same basis as any other medical condition. Medically necessary prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy is covered. The services of a licensed physician (M.D. or D.O.), an advanced registered nurse practitioner (A.R.N.P.), a licensed midwife, or a certified nurse midwife (CNM) are covered under this benefit.

Mandated maternity inpatient stays are up to forty-eight (48) hours for routine deliveries or up to ninety-six (96) hours for cesarean sections. In all cases, the attending provider, in consultation with the mother, will make the decision regarding length of stay based upon accepted standard medical practice.

Notification to FCHA is required within 2 business days for the following:

- All emergency childbirth admissions. **Failure to notify FCHA of an emergent admission will result in a denial of benefits**
- Exceeding the mandated maternity inpatient stays timeline(s) listed above
- Admission to an out-of-network hospital or facility

See this section and section HOW TO OBTAIN HEALTHCARE, subsections PRECERTIFICATION, NOTIFICATION FOR EMERGENT ADMISSION OR CHILDBIRTH (Page 10).

Coverage for Newborns

Coverage for a newborn child is provided when enrolled as a dependent under this group Plan (see your Summary Plan document for details). Benefits for newborns are subject to the newborn child's own coinsurance and deductible requirements.

- Newborn care includes:
- Inpatient hospital care, including inpatient care separate from the maternity admission;
- Circumcision (for up to six (6) months following birth for an enrolled dependent);
- Outpatient and emergency care for the medically necessary treatment of an illness or injury; and
- Professional care and medically appropriate follow-up care.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 DISCLOSURE

The Women's Health and Cancer Rights Act of 1998 requires FCHA to disclose the following benefit statement to Plan participants:

Health plans that provide medical and surgical benefits with respect to mastectomy shall provide, in a case of a participant who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with such mastectomy, coverage for the following services in a manner determined in consultation with the physician and the participant:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications in all stages of mastectomy, including lymphedemas.

PRESCRIPTION DRUG BENEFIT

FCH contracts with MedImpact for the services required to administer the prescription drug benefit. FCH delegates to MedImpact the authority to make decisions regarding the prescription drug benefit according to policies and procedures.

You must use MedImpact Pharmacies or the Mail Order Pharmacy benefit. There is no coverage if you use any other pharmacy.

This Plan uses a formulary. A formulary is an established list of preferred drugs based on an evaluation of a drug's effectiveness, cost and safety relative to alternative drugs which treat the same condition(s). The determination of formulary versus non-formulary drugs is performed by pharmacists based on extensive research. Every non-formulary drug has an equivalent drug, which is on the formulary.

- All prescriptions must be dispensed through a participating pharmacy.
- All prescriptions must be ordered by a licensed provider.
- All prescriptions must be warranted to treat a covered condition.
- If a brand name drug is selected when a generic equivalent drug is available, you will be responsible for paying the difference in price between the brand-name drug and the generic, plus the applicable brand-name coinsurance. Your out-of-pocket expense will never exceed the cost of the drug.
- When a generic equivalent is available, but your physician requests the brand name product because s/he believes the brand name product to be medically necessary, then you are responsible for the brand name coinsurance amount.

NOTE: Tier 2 and 3 may include drugs that have prior authorization, quantity dispensing limitations, or step-therapy requirements. (Step-Therapy drugs require a previous trial of specific agent(s) before coverage is available.)

The following benefit summary outlines the coverage available under this Plan and identifies the deductible or coinsurance amounts for which the participant or dependent is responsible. The three-tier formulary drug benefit consists of three levels designed to help manage your prescription drug costs:

- **Tier 1 (Generic)** includes most generic drugs.
- **Tier 2 (Preferred Brand Drugs)** includes preferred brand-name drugs that have no generic equivalent.
- **Tier 3 (Non-Preferred Brand Drugs)** includes brand drugs that are not listed in tier 2. In most cases there are reasonable alternatives in tier 1 or 2 for drugs found in this highest tier.

RETAIL PHARMACY BENEFIT	**A thirty (30) day supply 90% after deductible**
MAIL ORDER PHARMACY BENEFIT (Also see Choice90)	**Up to a ninety (90) day supply 100% after deductible**

CHOICE 90 AND MAIL ORDER PROGRAMS FOR ONGOING MEDICATIONS

You will have two options for obtaining a 90-day supply of ongoing medications.

1. Mail Order. You may obtain a 90-day supply of medication through a mail order program with Walgreens.

HOW TO USE THE MAIL ORDER PROGRAM

a) Complete the mail order Patient Profile/Order Form.

b) Attach your prescription for a 90-day supply of medication to the Patient Profile/Order Form and include your payment.

c) Mail all documents to the address below.

Please place your order for a refill by mail 3 weeks before your current supply runs out and allow 14 days for delivery of your medication. Your coinsurance can be made by check or credit card. Do not send cash. Mail all documents to:

Walgreens Healthcare Plus

P.O. Box 188

Beaverton, OR 97075-0188

To obtain additional details about the mail order pharmacy benefit, please contact Walgreens Healthcare Plus at:

1-800-635-3070

www.whphi.com

2. Choice 90. You can also obtain a 90-day supply of medication through the Choice90 program. Choice90 is MedImpact's retail-based program that allows you to obtain up to a 90-day supply of ongoing medication through your local Walgreens.

Refills by phone call: 1-800-797-3345

For a copy of the Quick Reference Guide, please contact Customer Service at 1-800-430-3818.

COVERED DRUGS

- Any other drug which, under applicable state law, may only be dispensed by means of a written prescription from a physician or other lawful prescriber, and which is (i) medically necessary to treat the condition of the patient and (ii) not otherwise limited or excluded;
- Compound medications in which at least one ingredient is a legend prescription drug (prior authorization may be required);
- Diabetic supplies, including disposable needles/syringes, blood testing agents (e.g. Chemstrips, AccuCheck, One Touch) and lancets;
- Insulin and disposable needles/syringes. Needles/syringes must be dispensed in quantities corresponding to the amount of insulin prescribed and at the same time in order to be included under the same coinsurance with the insulin;
- Insulin;
- Legend (prescription) drugs, including fluoride supplements (oral tablets or drops only) and prenatal vitamins. (See this section, subsection **EXCLUSIONS** below for exceptions); and
- PKU formulas (e.g. Lofenalac, Phenex-2, Phenyl-Free, PKU 2, PKU 3).

EXCLUSIONS

- Anabolic steroids, unless specifically pre-authorized;
- Anorectics (any drug used for the purpose of weight loss);
- Anti-wrinkle agents in all dosage forms (e.g. Retin A, Renova, tretinoin);
- Any prescription dispensed from a non-participating pharmacy unless dispensed resulting from an emergent condition;
- Botanicals and herbal medicines;
- Charges for the administration or injection of any drug;
- Dietary formulas and supplements, including minerals (e.g. Phoslo, Potaba), except PKU formulas;
- Drugs available without a prescription or for which there is a nonprescription equivalent available;
- Immunization agents, blood or blood plasma;
- Infertility medications (e.g. Clomid, Metrodin, Pergonal, Profasi);
- Injectable drugs that are not normally self administered;
- Investigational or experimental drugs, including drugs labeled "Caution: Limited by federal law to investigational use", even if there is a retail or wholesale charge for such drugs;
- Levonorgestrel (Norplant), coverage is provided under section COVERED SERVICES AND RELATED SUPPLIES, subsection WOMEN'S HEALTH CARE / MATERNITY CARE, Family Planning;
- Lost, stolen, spilled or replacement prescriptions;
- Minoxidil (Rogaine) or any other medications used for the treatment of alopecia (hair loss);

- Non-approved medications;
- Non-legend drugs and over-the-counter (OTC) products;
- Prescription medications for the treatment of a non-covered condition;
- Products used for cosmetic purposes;
- Refills dispensed after one (1) year from the date of the prescription order, any refill in excess of the quantity specified by the physician, unauthorized refills of any medication;
- Retin-A for individuals over the age of 25;
- Tobacco deterrent medications and tobacco cessation aids (except when purchased in association with an approved smoking cessation program);
- Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, unless covered as diabetic supplies (see above);
- Travel immunizations;
- Use of FDA approved drugs, medications, and other items for non-approved indications, except when an FDA approved drug has been proven clinically effective for the treatment of such indication and is supported in peer-reviewed scientific medical literature; and
- Vitamins and fluoride, singularly or in combination, except generic legend prescription prenatal vitamins and legend fluoride supplements (oral tablets or drops only) are covered. (Connie, does this have to be generic?)

The following vision benefit summary outlines the coverage available under this Plan and identifies the deductible, copayment or coinsurance amounts for which the participant or dependent is responsible. A referral is not required.

BENEFIT DESCRIPTION	COVERAGE / LIMITATIONS
Eye Examination - every 12 months from your last date of service.	
The eye exam includes the necessary tests to evaluate and monitor visual wellness.	Covered in full after $10 copay
Hardware - every 12 months from your last date of service.	
The hardware benefit includes coverage for the following items, covered up to the Plan allowance. • Frames • Basic Spectacle Lenses - (Single Vision, Bifocal, Trifocal, Lenticular) • Elective Contact Lenses • Contact Lens Exam (fitting and evaluation)	Plan allowance: $150
Medically Necessary Contact Lenses	Covered in full

For questions regarding your specific Plan allowance, assistance with choosing a provider or finding a retail outlet near you, please call the Customer Service number listed on your ID Card.

Spectacle Lenses - Several cosmetic lens options are available at cost-controlled prices under the Plan.

Contact Lens Exam - The contact lens exam is a special exam in addition to your routine eye exam for ensuring proper fit of your contacts and evaluating your vision with the contacts.

Elective Contact Lenses - Contact lenses are considered to be elective if you elect to wear contacts instead of glasses as a personal choice, versus a medical condition that prevents you from wearing glasses.

Medically Necessary Contact Lenses - Contact lenses are furnished when the participating provider secures prior approval for any of the following conditions: a) following cataract surgery; b) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses; c) under certain conditions of Anisometropia and d) Keratoconus. If the request is approved, the contact lenses are fully covered, after any applicable copays, when services are obtained from a participating provider.

VISION LIMITATIONS

- Benefits renew every 12 months from your last date of service;
- Coverage for eye exam is only available through a participating provider;
- Hardware allowance can be used anywhere. However, contract discount will apply if the providers is a participating FCH preferred Optical Hardware Facility; and
- You are responsible for the coinsurance amount, office visit copayment, and/or additional costs not covered under this benefit.

Covered services are limited to the diagnosis, therapeutic care or treatment, and prevention of disease, sickness or injury as described in this document. Coverage is specifically excluded for each of the following items and any related services and charges:

- Abdominoplasty/panniculectomy;
- Aromatherapy;
- Artificial insemination, in vitro fertilization, gamete intra-fallopian transplant (GIFT), and any other treatments for infertility (regardless of the cause), including any direct or indirect complications or after effects, other than pregnancy;
- Athletic training, body-building, fitness training or related expenses;
- Botanical and herbal medicines, as well as other over-the-counter medications;
- Charges for care provided by phone, fax, electronic mail, Internet, and telemedicine;
- Charges for services or supplies that are over and above UCR;
- Charges for services related to injuries while under the influence of a controlled substance and/or alcohol unless prescribed by a physician;
- Cognitive therapy;
- Cosmetic services (surgical and non-surgical), including treatment for complications thereof, except as otherwise specifically stated under section **COVERED SERVICES AND RELATED SUPPLIES**, subsection **PROFESSIONAL SERVICES**, **Plastic and Reconstructive Services**;
- Custodial care, Domiciliary care, Housekeeping services, and Rest cures;
- Dental services including, but not limited to, associated anesthesia and facility charges, except as specified under section **COVERED SERVICES AND RELATED SUPPLIES**, subsection **PROFESSIONAL SERVICES**, **Dental Trauma Services**;
- Experimental, investigational, and unproven services;
- Eyeglasses and contact lenses unless specifically stated herein;
- Genetic testing, counseling, interventions, and other genetic services, unless it is an essential component of a covered and medically necessary treatment or it is a medically necessary precursor to obtaining a prompt and covered treatment;
- Hair analysis;
- Hearing aids (unless specifically stated herein) and cochlear implants;
- Implants including, but not limited to, penile prosthesis;
- Infertility treatments (regardless of the cause);
- Laser Assisted Uvuloplasty (LAUP); Laser Assisted Uvulopalatoplasty (LAUPP); Somnoplasty;
- Liposuction and other procedures for removal of adipose tissue;
- Maintenance Care;

- Marriage and family counseling, unless specifically stated herein;
- Non-covered services and complications arising from non-covered services;
- Non-surgical treatment, programs, or supplies intended to result in weight reduction, regardless of diagnosis;
- Occupational injuries or diseases;
- Oral appliances, except for the medically necessary treatment of obstructive sleep apnea;
- Orthodontic appliances and services; Dentures and related services;
- Orthognathic (jaw) surgery, regardless of the origin or cause, including any complications or after effects thereof; treatment of malocclusion; upper and lower jaw bone surgery except for direct treatment of acute traumatic injury or cancer;
- Orthotics, orthotic shoe inserts, orthotic services, and orthotic casting associated with care of the feet, except for prevention of complications associated with diabetes, corrective shoes;
- Over-the-counter products, except as specifically noted under section COVERED SERVICES AND RELATED SUPPLIES, subsection DURABLE MEDICAL EQUIPMENT (DME), PROSTHETIC DEVICES, AND MEDICAL SUPPLIES;
- Personal, convenience, or comfort services, supplies, or items including, but not limited to, telephones, televisions, guest services, private hospital room, air conditions, and hygiene items;
- Physical exams for the express purpose of obtaining or continuing employment, insurance, governmental licensure or participation in sports activities;
- Prescription medications, except as expressly allowed as a covered benefit;
- Preventive care and screening, except as specifically referenced under section COVERED SERVICES AND RELATED SUPPLIES, subsection PROFESSIONAL SERVICES, Preventive Care;
- Private duty nursing;
- Procedures, regardless of medical necessity, which are outside of the scope of the provider's license, registration or certification;
- Radial keratotomy, Lasik or any other refractive surgery, orthoptics, pleoptics, visual analysis therapy or training related to muscular imbalance of the eye, and optometric therapy;
- Reduction mammoplasty (breast reduction surgery) except as part of a reconstructive procedure following a mastectomy which resulted from disease, illness or injury (see section COVERED SERVICES AND RELATED SUPPLIES, subsection PROFESSIONAL SERVICES, Plastic and Reconstructive Services);
- Repair or replacement of items not used in accordance with manufacturer's instructions or recommendations;
- Replacement of lost or stolen items, such as, but not limited to, prescription drugs, prostheses, or DME;
- Respite care except as detailed under section COVERED SERVICES AND RELATED SUPPLIES, subsection HOSPICE CARE;
- Reversal of sterilization;

- Rhinoplasty;
- Routine eye exams unless specifically stated herein;
- Routine foot care, including non-surgical treatment of deformities of the toes and feet, except when such care is directly related to the treatment of diabetes;
- Services and supplies to the extent that benefits are payable under the terms of a contract or insurance offering for: uninsured or underinsured (UIM) coverage; motor vehicle, motor vehicle no-fault, or personal injury protection (PIP) coverage; or commercial premises or homeowner's medical premise coverage, or other similar type of contract or insurance;
- Services for any condition, illness or injury that arise from or during the course of work for wages or profit that is covered by State Insurance Workers' Compensation and Federal Act or similar law;
- Services for any condition for which the Veterans' Administration, federal, state, county or municipal government or any of the armed forces is responsible or provides treatment, except as required by law;
- Services for any condition resulting from declared or undeclared acts of terrorism, war or military service;
- Services for mental health, except as may be specified herein;
- Services for the treatment of sexual dysfunction;
- Services for which there is a referral, precertification or coordination of care requirement, but it has not been obtained;
- Services furnished outside the service area, except as described under section COVERED SERVICES AND RELATED SUPPLIES, subsections EMERGENCY CARE and URGENT CARE;
- Services provided by a family member (spouse, domestic partner, parent, or child);
- Services provided by or that could be provided by a spa, health club, fitness center, or a weight loss clinic;
- Services which are not medically necessary for the diagnosis, treatment, or prevention of injury or illness, even though such services are not specifically listed as exclusions;
- Services which are received prior to the participant or dependent's effective date of coverage or after the coverage termination date;
- Sex change operations or treatment for transsexualism;
- Special diets, enteral formulas, nutritional supplements, electrolyte formulas, vitamins & minerals, and other dietary formulas or supplements (except PKU formula for the treatment of phenylketonuria (PKU), which is covered at 100%);
- Special education;
- Surgery for gynecomastia;
- Surgical or other treatment for snoring;
- Transportation, except as specified under section COVERED SERVICES AND RELATED SUPPLIES, subsections AMBULANCE and ORGAN AND BONE MARROW TRANSPLANT SERVICES;

- Travel or work related immunizations and medications;
- Treatment of dyslexia;
- Treatment of learning disabilities;
- Use of FDA approved drugs, medications, and other items for non-approved indications, except when an FDA approved drug has been proven clinically effective for the treatment of such indication and is supported in peer-reviewed scientific medical literature;
- Vitamin B-12 injections except for the treatment of Vitamin B-12 deficiency; and
- Vocational rehabilitation.