First Choice Health®

Olympia Orthopaedic Associates

Qualified High Deductible Health Plan

Effective March 1, 2021

www.fchn.com

In the event there is a discrepancy between information provided during open enrollment and the contents of this Benefits Summary, the contents herein shall prevail.

Table of Contents

Important Information about this Plan

This booklet describes your coverage, payment levels and how to use the benefits offered by the Olympia Orthopaedic Associates Medical Plan as of March 1, 2021. If you need information regarding eligibility and enrollment, terminating and continuing coverage, administration, claim and appeal procedures and other legally required material, please see the accompanying Summary Plan Description.

Olympia Orthopaedic Associates, the employer, Plan Sponsor and Plan Administrator of this self-funded Plan, delegates to First Choice Health (FCH - a division of First Choice Health Network, Inc.), a Third Party Administrator (TPA), to perform certain Plan services. Olympia Orthopaedic Associates delegates to FCH the authority to make decisions on benefit coverage, medical management, claim payment and certain other administrative services according to Olympia Orthopaedic Associates' policies and procedures. However, Olympia Orthopaedic Associates retains at all times the ultimate fiduciary authority, responsibility and control over Plan assets, management and administration.

The Olympia Orthopaedic Associates Medical Plan will be referred to within this document as the Plan. Under the Plan, you receive the higher network level of benefits when you see a network provider. If you receive care from a non-network provider, you will receive the lower, non-network level of benefits.

Please review this booklet carefully and share it with your family. If you have questions, contact the Plan's Benefits Department (Plan Administrator) or FCH. If you have questions about whether a provider is considered in-network, contact the appropriate network listed under *How to Obtain Health Services*.

Coverage under this Plan will take effect for eligible employees and dependents when all eligibility requirements are satisfied. Olympia Orthopaedic Associates fully intends to maintain this Plan indefinitely, but reserves the right to terminate, suspend, discontinue or amend the Plan at any time, for any reason. Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

The Plan will pay benefits only for expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after it terminated, even if the expenses resulted from an accident, injury or disease that occurred, began or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished. If the Plan terminates, the rights of participants and beneficiaries are limited to charges incurred before termination. No oral interpretations can change this Plan.

These materials do not create a contract of employment or any rights to continued employment with Olympia Orthopaedic Associates.

Contacting First Choice Health

You may call FCH Customer Service directly whenever you have questions or concerns at the number printed on your ID card or contact FCH by mail, fax or Internet:

First Choice Health
Customer Service Department
PO Box 12659
Seattle, WA 98111-4659
(866) 551-7358
Fax: (888) 206-3092
Medical pre-authorization: (800) 808-0450
Mental health/chemical dependency pre-authorization: (800) 640-7682
TTY: (866) 876-5924
www.fchn.com

Spanish (Español): Para obtener asistencia en Español, llame al (866) 551-7358.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (866) 551-7358.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码(866) 551-7358.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (866) 551-7358.

FCH's Customer Service Department business hours are Monday through Friday, 8:00 AM to 5:00 PM Pacific Standard Time (PST). The office is closed on New Year's Day, Memorial Day, Independence Day (4th of July), Labor Day, Thanksgiving, and the day after Thanksgiving, Christmas Eve and Christmas Day. FCH offices close at 3:00 PM on the day before Thanksgiving and on December 23rd (or on the Friday before if the 23rd falls on a weekend). 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).

You can access benefit information or your specific claim and enrollment status anytime at www.fchn.com or by calling FCH Customer Service's automated voice response system at (866) 551-7358.

How to Obtain Health Services

Your ID Card

Your ID card identifies you as a Plan participant and contains important information about your coverage and benefits. Please present your ID card each time you receive care. If you lose your ID card, you may order a new one either through contacting FCH Customer Service at (866) 551-7358, or logging into www.fchn.com. Under no circumstances should you give your ID card to another person for their use.

Choosing a Provider

To receive the network level of benefit coverage, whether living in the specific geographic location or traveling, your covered services must be obtained from providers within the following networks:

Networks	State/Area	Phone	Websites
First Choice Health	Washington, Alaska, Oregon, Idaho, Montana, Wyoming, North Dakota, South Dakota	(800) 231-6935	www.fchn.com
First Health	All states/areas not served by FCHN	(800) 226-5116	www.firsthealth.coventryhealthcare.com/

Contact the networks directly, either by phone or through the websites provided, for information on providers and/or provider directories.

Services Received Outside of the U.S.

If you are traveling outside of the United States and require treatment for an injury or medical emergency, any payments you make for medical treatment may be reimbursed, provided the following guidelines are met:

- Participants must pay for medical services at the time of service.
- Upon returning to the United States, submit an itemized statement of charges that includes diagnosis and all charges paid. The exchange rate for foreign currency must also be noted on submitted forms.
- Charges submitted must be for an Emergency or Urgent Care as defined in the Group Health Plan Summary Plan Description.
- Claims must be submitted in English.

Medical Management

Pre-authorization Requirements

All inpatient admissions and certain outpatient services and procedures **require FCH pre-authorization**, as also noted in the *Summary of Medical Benefits.* If pre-authorization is not obtained on the services noted below, your claim may be denied. Call (800) 808-0450 for pre-authorization on medical services or (800) 640-7682 for mental health or chemical dependency services. Pre-authorization is required for:

- **Air Ambulance Transport** - non-urgent transport
- **Anesthesia for dental services**
- **Chimeric Antigen Receptor (CAR) T-cell therapy**
- **Clinical trials** (any interventions provided under a clinical trial)
- **Dental trauma services** (follow-up services)
- **Dialysis – all types** (for chronic kidney disease)
- **Durable medical equipment, medical supplies and prosthetics**
  - Bone Growth Simulators
  - Compression devices for home use
  - Cranial Orthotic Devices
  - Custom, power operated and manual wheelchairs and supplies
    - Standard, manual wheelchair rental for transition of care for up to 3 months does not require pre-authorization
  - Custom Fabricated Knee Braces
  - Electrical Stimulators- Spinal- External
  - Neuromuscular Stimulators
  - Oscillatory devices and cough stimulating devices
  - Prosthetics
    - Myoelectric Prosthetic components for the upper limb
    - Powered Ankle-Foot Prosthesis, Microprocessor-Controlled Ankle-foot Prosthesis, and Microprocessor-Controlled Knee Prosthesis
  - Scooters
  - Speech Generating Devices
  - Tumor Treating Fields for Glioblastoma
- **Enteral Formula, Medical Food and Associated Services**
- **Facet joint injections, medial branch blocks and neurotomies (any location)**
- **FIT-Fecal DNA**
- **Genetic testing**
  - Over $500
- **Home health care services**
  - Home health visits (for wound therapy only)
  - Hospice
- **Hyperbaric oxygen therapy**

- **Imaging**
  - PET scans
- **Inpatient admissions**
  - Chemical dependency and mental health admissions
  - Partial Hospital Program admissions for chemical dependency or mental health
  - Inpatient hospice
  - Inpatient rehabilitation admissions
  - Long-term acute care facility
  - Medical/surgical admissions (excluding routine maternity deliveries)
  - Skilled nursing admissions
- **Medical injectables and other drugs** (List may not be all-inclusive. Newly FDA approved specialty drugs not included on the list below may also require preauthorization.)
  - Abatacept (Orencia ®)
  - Ado-trastuzumab emtansine (Kadcyla™)
  - Aflibercept (Eylea®)
  - Agalsidase Beta (Fabrazyme®)
  - Alemtuzumab (Lemtrada®)
  - Alglucosidase alfa (Lumizyme®)
  - Atezolizumab (Tecentriq®)
  - Avelumab (Bavencio®)
  - Belimumab (Benlysta®)
  - Benralizumab (Faserna®)
  - Bevacizumab (Avastin®) and Biosimilar
  - Blood clotting factors - all
  - Bortezomib (Velcade®)
  - Botulinum toxin (all types and brands)
  - Brentuximab (Adcetris®)
  - Brolucizumab-dbll (Beovu®)
  - Cerliponase alfa (Brineura™)
  - Cetuximab (Erbitux®)
  - Crizanlizumab (Adakveo®)
  - C1 Esterase inhibitors
  - Daratumumab (Darzalex®)
  - Ecallantide (Kalbitor®)
  - Eculizumab (Soliris®)
  - Edaravone (MCI-186, Radicava, Radicut®)
  - Epoprostenol (Flolan®)
  - Eteplirsen (Exondys 51™)
  - Gemtuzumab ozogamicin (Mylotarg®)
  - Infliximab (Remicade®) and Biosimilar
  - Inotuzumab Ozogamicin (Besponsa™)
  - Intravenous immunoglobulin (IVIG) therapy (all types and brands)
  - Ipilimumab (Yervoy®)
  - Lutetium Lu 177 dotatate (Lutathera®)
  - Mepolizumab (Nucala®)

- Natalizumab (Tysabri®)
- Nivolumab (Opdivo®)
- Nusinersen (Spinraza™)
- Ocrelizumab (Ocrevus™)
- Omalizumab (Xolair®)
- Onasemnogene abeparvovec-xioi (Zolgensma®)
- Palivizumab (Synagis®)
- Pembrolizymab (Keytruda®)
- Pemetrexed (Alimta®)
- Pertuzumab (Perjeta®)
- Ranibizumab (Lucentis®)
- Ravulizumab-CWVZ (Ultomiris®)
- Rituximab (Rituxan®) and Biosimilar
- Romiplostim (Nplate®)
- Sipuleucel-T (Provenge®)
- Taglicerase alfa (Eleyso™)
- Tocilizumab (Actemra®)
- Trastuzamab (Herceptin®) and Biosimilar
- Triamcinolone Acetonide Extended Release (Zilretta®)
- Ustekinumab (Stelara®)
- Vedolizumab (Entyvio™)
- Velaglucerase alfa (VPRIV®)
- Voretigene Neparvovec-Rzyl (Luxturna™)
- Ziv-aflibercept (Zaltrap®)

- **Organ and bone marrow transplants** (includes evaluation of, services for and donor, and travel and lodging expenses)
  - Notification only for evaluation
  - Pre-authorization for services or recipient and donor
  - Pre-authorization for travel and lodging
- **Peripheral nerve blocks**
- **Radiation therapy**
  - Proton Beam, Neutron Beam or Helium Ion radiation therapy
  - Stereotactic body radiation therapy (SBRT)
  - Stereotactic radiosurgery (Gamma Knife, Cyber Knife)
- **Surgery**
  - Abdominoplasty/panniculectomy
  - BAHA-Bone Anchored Hearing Aid (surgical benefit applies)
  - Breast surgeries- selected (Pre-authorization is not required for breast reconstruction and nipple/areola reconstruction following mastectomy for breast cancer)
    - Implant removal
    - Mastectomy for gynecomastia
    - Reduction mammoplasty
  - Cochlear implants (surgical benefit applies)
  - Cosmetic or reconstructive surgery
  - Deep Brain Stimulation
  - Eyelid surgery (i.e. blepharoplasty)

- Fetal/intrauterine surgery
- Gender affirming surgery
- Implantable peripheral nerve and/or spinal cord stimulator placement (trial/temporary and permanent placement of electrodes and/or generator/receiver)
- Orthognathic surgery
- Ovarian, internal iliac and gonadal vein embolization, ablation and sclerotherapy
- Rhinoplasty
- Spinal surgery - selected
    - Artificial intervertebral disc
    - Cervical fusion
    - Lumbar fusion
    - Minimally invasive, percutaneous or endoscopic spine surgery
    - Percutaneous vertebroplasty, kyphoplasty, sacroplasty and coccygeoplasty
- Surgical interventions for sleep apnea
- TMJ surgery
- Vagus nerve stimulation
- Varicose vein procedures
- Ventricular assist devices and total heart replacement

- **Transcranial Magnetic Stimulation**

Claims denied due to lack of pre-authorization do **not** apply toward your calendar year deductible or out-of-pocket maximums.

Your provider may submit an advance request to FCH Medical Management for benefit or medical necessity determinations. **Experimental and investigational services are not covered,** except as outlined under the Clinical Trials benefit. If a service could be considered experimental and investigational for a given condition, we recommend a benefit determination in advance.

Notification for Emergency Admissions

Admissions directly from the emergency department do not require pre-authorization. However, notification is required within 2 business days after the admission, or as soon as possible, unless there are extenuating circumstances (as determined by FCH). You, or your provider, may call FCH at the number on your ID card.

Concurrent Review and Discharge Coordination

Continued hospitalization is subject to periodic clinical review to ensure timely, quality care in the appropriate setting. Discharge coordination assists those transferring from the hospital to home or another facility.

Case Management

A catastrophic or chronic medical or behavioral health condition may lead to long-term, or perhaps lifetime, care involving extensive services in a facility or at home. With case management, a clinician monitors patients who need assistance and support while exploring coordination and /or alternative types of appropriate care. The case manager consults with the

patient, family and attending physician to develop an individualized plan of care that may include:

- Offering personal support to the patient
- Contacting the family for assistance and support
- Monitoring hospital or skilled nursing facility stays
- Exploring alternative care options such as pain management without narcotics
- Assisting in obtaining any necessary equipment and services
- Providing guidance and information on available resources

At times, the Case Manager may identify a customized treatment plan such as an alternative to hospitalization or other high-cost care, making more efficient use of the Plan's benefits. Such a customized plan might include services involving expenses not usually covered or an exchange of benefits. The decision to provide alternative or customized benefits is within the Plan's sole discretion. Your participation in such a treatment plan, as any through Case Management, is voluntary. You, or your legal representative, the attending physician and the Plan Administrator must all agree to any such 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.

Payment Provisions

Highlights of Plan Provisions

- Services performed at Olympia Orthopaedic Associates will receive the highest benefit. Please note that not all services can be performed at Olympia Orthopaedic associates. (For these services, your benefits will be greatest if you choose a network provider. Coverage will be at the network level.)
- Payment for certain services is based on the Medicare rate for such service. These services are noted in the *Summary of Medical Benefits*.
- In-network benefit payment is based on the Allowed Amounts agreed upon by Network providers.
- Services received from a Recognized Provider (see *Plan Definitions* in the accompanying Summary Plan Description) will be paid at the In-Network level. Benefits will be based on Usual, Customary and Reasonable data or a case negotiated rate. You will be responsible for the difference (if any) between the Plan payment and the billed charges on Recognized Provider claims and this difference would not apply to your Out-of-Pocket (OOP) maximum as discussed below.
- For services received from non-network providers, you are responsible to pay the difference between the Plan payment and the provider's actual charges.
- Claims are processed according to the diagnoses and services billed by the provider(s). Billing disputes regarding services received should be addressed with the rendering provider.

What Is a High Deductible Health Plan (HDHP)?

You must have an HDHP if you want to open a Health Savings Account (HSA). Sometimes referred to as a "catastrophic" health insurance plan, an HDHP is a health insurance plan that generally does not pay for the first few thousand dollars of health care expenses (i.e., "deductible") but will generally cover you after that.

For calendar year 2021, a HDHP is defined under § 223(c)(2)(A) as a health plan with an annual deductible that is not less than $1,400 for self-only coverage or $2,800 for family coverage, and the annual out-of-pocket expenses (deductibles, copayments, and other amounts, but not premiums) do not exceed $7,000 for self-only coverage or $14,000 for family coverage.

The Olympia Orthopaedic Associates High Deductible Health Plan is a qualifying high deductible health plan under Code §223(c)(2).

Annual Deductible

The annual deductible is the amount you (or your family) must pay each Plan year before the Plan will pay for covered services (payment for non-covered services will not be applied to the deductible). Once the deductible is satisfied, coinsurance amounts as noted in the *Summary of Medical Benefits* will be applied. Until then, the amount due to a provider is your responsibility. The network and non-network annual deductibles are inclusive of each other.

This Plan offers a True Family Deductible, which means covered expenses incurred by each person within the family accumulate and are credited toward the one "family" deductible.

The following benefits do **not** apply toward the annual deductible:

- Charges of non-covered services and treatment
- Charges for services that are denied as not medically necessary
- Charges over Usual, Customary and Reasonable (UCR) for non-network services as determined by FCH
- Charges over the Medicare rate for those benefits that are paid based on the Medicare rate
- Charges that exceed any applicable benefit maximum
- Copayments
- Difference in price between a brand name and generic drug
- Claims denied due to lack of pre-authorization
- Preventive care

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the *most* you will need to pay in a Plan year. This Plan offers a Traditional Family Out-of-Pocket (OOP) Maximum, which means once each individual within a family meets the individual maximum, s/he will not be assessed further co-insurance. Also, the family will meet no more than the stated family maximum regardless of family size. The following do **not** apply toward the annual out-of-pocket maximum:

- Charges of non-covered services and treatment
- Charges for services that are denied as not medically necessary
- Charges over Usual, Customary and Reasonable (UCR) for non-network services as determined by FCH
- Charges over the Medicare rate for those benefits that are paid based on the Medicare rate
- Charges that exceed any applicable benefit maximum
- Charges for services paid by the Plan at 100%
- Difference in price between a brand name and generic drug
- Claims denied due to lack of pre-authorization

Benefit Maximums

Your annual Plan deductible and out-of-pocket maximum, as well as your Plan year benefit maximums are noted in the tables that follow:

Annual Deductible and Out-of-Pocket Maximums

Deductible and Out-of-Pocket Maximums	Network	Non-Network
Annual Deductible (per calendar year)		
Per Individual	$2,500	
Family	$5,000	
Annual Out-of-Pocket Maximum (per calendar year)		
Per Individual	$5,000	
Family	$10,000	

Summary of Benefit Maximums

Lifetime Maximum Benefits	
Hospice Care • Hospice Care • Respite Care	12 months 30 days within 12 months
Plan Year Maximums	
Alternative Care • Acupuncture • Massage Therapy	12 visits combined
Chiropractic Spinal Manipulation	10 visits
Diabetic Education & Diabetic Nutrition Education	10 visits
Home Health Care	100 visits
Habilitative Services	60 visits combined
Rehabilitation Therapy • **Outpatient** (includes physical, speech, occupational therapies)	
Obesity Screening and Counseling	12 visits
Skilled Nursing Facility	60 days

Summary of Medical Benefits

	Applies to Deductible	Applies to OOP Max	Physician Services Performed at Olympia Orthopaedic Associates	Network Providers	Non-Network Providers
Allergy Care					
• **Testing**	✓	✓	N/A	100%	100%
• **Injections**	✓	✓	N/A	80%	60%
Alternative Care 12 visits per calendar year maximum for acupuncture and massage therapy combined.					
• **Acupuncture**	✓	✓	90%	80%	60%
• **Massage Therapy**	✓	✓	90%	80%	60%
Ambulance Services FCH pre-authorization required for non-emergent air ambulance. For ambulance (ground and air) charges exceeding $5,000, payment by this Plan will not exceed 100% of the Medicare allowance for such incurred expenses. Charges include those that relate to 1) transportation and 2) medical supplies used during transport, including those for BLS (basic life support) only services and ALS (advanced life support) services/supplies.	✓	✓	N/A	80%	80%
• **First Responder User Fees**	✓	✓	N/A	80%	80%
Anesthesia	✓	✓	N/A	80%	80% if provided at a network facility 60% if provided at a non-network facility

	Applies to Deductible	Applies to OOP Max	Physician Services Performed at Olympia Orthopaedic Associates	Network Providers	Non-Network Providers
Applied Behavior Analysis (ABA) Therapy FCH pre-authorization is required for inpatient services.	✓	✓	N/A	80%	60%
Autologous Blood Donation/Blood Transfusion	✓	✓	N/A	80%	80%
Biofeedback	✓	✓	N/A	80%	60%
Chemical Dependency FCH pre-authorization required for inpatient, residential and partial hospitalization.	Covered as any other medical service.				
Chiropractic Spinal Manipulation 10 visits per calendar year	✓	✓	N/A	80%	60%
Clinical Trials FCH Pre-authorization is required.	Covered as outlined under the Clinical Trials benefit below. Benefits depend on place of service.				
COVID-19					
• **Testing**	N/A	N/A	N/A	100%	
• **Treatment**	✓	✓	N/A	80%	60%
Dental Trauma FCH pre-authorization required for follow-up services and anesthesia.	✓	✓	N/A	80%	60%
Diabetic Education and Diabetic Nutrition Education 10 visits maximum per calendar year. First 3 nutritional counseling or diabetic nutritional counseling visits are considered preventive. This benefit applies after the preventive care visits are exhausted.	✓	✓	N/A	80%	60%
Diagnostic Services (Lab and Radiology Services. non-routine, facility and professional services)					

	Applies to Deductible	Applies to OOP Max	Physician Services Performed at Olympia Orthopaedic Associates	Network Providers	Non-Network Providers
• **Hospital inpatient** (professional fees)	✓	✓	N/A	80%	60%
• **Hospital outpatient** (facility and professional fees)	✓	✓	100%	100%	100%
• **Lab or x-ray facility**	✓	✓	100%	100%	100%
• **Doctor's office**	✓	✓	100%	100%	100%
• **MRI, CT, PET scans** (all places of services) FCH pre-authorization required for PET scans.	✓	✓	90%	80%	60%
Dialysis FCH pre-authorization required.	Covered as any other medical service.				
Durable Medical Equipment and Supplies					
• **Breast Pumps**	N/A	✓ (OON only)	N/A	100%	60%
• **Durable Medical Equipment**	✓	✓	90%	80%	60%
• **Medical Supplies**	✓	✓	90%	80%	60%
• **Contact lenses or Glasses Following Cataract Surgery** Limited to first pair of either contact lenses or glasses following cataract surgery for initial replacement of natural lenses.	✓	✓	N/A	80%	60%
• **Orthopedic Appliances/Braces**	✓	✓	90%	80%	60%
• **Prosthetic Devices**	✓	✓	90%	80%	60%
Emergency Care					
• **Emergency Department** (facility and professional)	✓	✓	N/A	80%	80%
• **Urgent Care**	✓	✓	90%	80%	60%

	Applies to Deductible	Applies to OOP Max	Physician Services Performed at Olympia Orthopaedic Associates	Network Providers	Non-Network Providers
Family Planning					
• **Female – Office Visits and Diagnostic Services**	N/A	✓ (OON only)	N/A	100%	60%
• **Male – Office Visits and Diagnostic Services**	✓	✓	N/A	80%	60%
• **Female – Contraceptive Diagnostic Testing**	N/A	✓ (OON only)	N/A	100%	60%
• **Male – Contraceptive Diagnostic Testing**	✓	✓	N/A	80%	60%
• **Female – Devices, Implants and Injections**	N/A	✓ (OON only)	N/A	100%	60%
• **Male – Devices, Implants and Injections**	✓	✓	N/A	80%	60%
• **Female – Sterilizations**	N/A	✓ (OON only)	N/A	100%	60%
• **Male – Sterilizations**	✓	✓	N/A	80%	60%
• **Termination of Pregnancy**	Not covered unless mother's life (not dependent children) is endangered if the pregnancy is carried to term, in cases of rape or incest, or involves a non-viable fetus as determined by a physician.				
Foot Orthotics 1 set of inserts every 24 months maximum.	✓	✓	90%	80%	60%
Genetic Services FCH pre-authorization required for genetic testing over $500.					
• **BRCA Testing**	N/A	N/A	N/A	100%	100%
• **All Other Genetic Testing**	✓	✓	N/A	80%	60%
• **Genetic Counseling**	✓	✓	N/A	80%	60%
Habilitative Services 60 visits per calendar year maximum, combined with outpatient rehabilitation.	✓	✓	N/A	80%	60%

	Applies to Deductible	Applies to OOP Max	Physician Services Performed at Olympia Orthopaedic Associates	Network Providers	Non-Network Providers
Hearing (routine hearing exams and hearing aids/appliances)	Routine hearing exams, hearing aids/appliances are not covered. Medically necessary hearing exams are covered as any other medical service				
Home Health Care FCH pre-authorization required for wound therapy**,** enteral formula, medical food and associated services and home hospice.					
• **Home Health Care** 100 visits per calendar year.	✓	✓	N/A	80%	60%
• **Phototherapy** (home)	✓	✓	N/A	80%	60%
Hospice FCH pre-authorization required for inpatient and home hospice. 12 months lifetime maximum.					
• **Hospice Care**	✓	✓	N/A	80%	60%
• **Respite Care** 30 days within 12 month lifetime maximum	✓	✓	N/A	80%	60%
Hospital Inpatient Medical and Surgical Care FCH pre-authorization required.					
• **Facility Services**	✓	✓	N/A	80%	60%
• **Inpatient Doctor Visits/Consultations**	✓	✓	90%	80%	60%
• **Inpatient Professional Services** (surgeon)	✓	✓	90%	80%	60%
• **Inpatient Professional Services** (assistant surgeon, radiologist, pathologist)	✓	✓	90%	80%	80% if provided at a network facility 60% if provided at a non-network facility

	Applies to Deductible	Applies to OOP Max	Physician Services Performed at Olympia Orthopaedic Associates	Network Providers	Non-Network Providers
Hospital Outpatient Surgery and Services FCH pre-authorization required for certain outpatient services; see *Pre-authorization Requirements* for details.					
• **Facility Services** Payment of non-network outpatient facility charges exceeding $50,000 will be limited to Medicare APC Reimbursement Rate.	✓	✓	N/A	80%	60%
• **Ambulatory Surgery Center (ASC)** Coverage of non-network facility charges exceeding $5,000 will be limited to the Medicare ASC Reimbursement Rate.	✓	✓	90%	80%	60%
• **Outpatient Professional Services** (surgeon)	✓	✓	90%	80%	60%
• **Outpatient Professional Services** (assistant surgeon, radiologist, pathologist)	✓	✓	90%	80%	80% if provided at a network facility 60% if provided at a non-network facility
Infertility Diagnostic Services Limited benefit, see *Infertility Diagnostic Services* below for details.	Covered as any other medical service				
Infusion Therapy (includes infusion therapy provided in the home) FCH pre-authorization required for certain infusion therapy drugs, see *Pre-Authorizations Requirements.*	✓	✓	N/A	80%	60%
Maternity and Newborn Care					

	Applies to Deductible	Applies to OOP Max	Physician Services Performed at Olympia Orthopaedic Associates	Network Providers	Non-Network Providers
• **Maternity Care** (including global fee)	✓	✓	N/A	80%	60%
• **Newborn Care**	✓	✓	N/A	80%	60%
• **Maternity office Visit** (not billed globally)	✓	✓	N/A	80%	60%
Medication Therapy Management	✓	✓	90%	80%	60%
Mental Health Care FCH pre-authorization required for inpatient, residential and partial hospitalization.					
• **Inpatient** (facility and professional)	✓	✓	N/A	80%	60%
• **Partial Day Treatment** (PDT)	✓	✓	N/A	80%	60%
• **Outpatient** (facility and professional)	✓	✓	N/A	80%	60%
Nutritional and Dietary Formulas	✓	✓	N/A	80%	60%
Oral Surgery	✓	✓	N/A	80%	80%
Pharmacy	Administered by CVS Caremark				
• **Retail** (up to 34-day supply)	✓	✓	N/A	80%	80%
• **Mail Order or Retail 90** (up to 91-day supply)	✓	✓	N/A	80%	Not covered

	Applies to Deductible	Applies to OOP Max	Physician Services Performed at Olympia Orthopaedic Associates	Network Providers	Non-Network Providers
• **Drugs considered preventive under the Patient Protection and Affordable Care Act, as well as the following "First Dollar" preventive care drugs:** – Asthma and asthma supplies – Blood-thinners – Cardiac Rx (diuretics, ACEs, ARBs, CCB, BB) – Diabetes and diabetic supplies – Lipids – Osteoporosis – Pediatric Vitamins (prescribed) – Prenatal Vitamins (prescribed)	N/A	N/A	N/A	100%	100%
Plastic and Reconstructive Services FCH pre-authorization required. Limited benefit, see *Plastic and Reconstructive Services* for details.	✓	✓	N/A	80%	60%
Podiatric Care See *Podiatric Care* for details on routine foot care.	✓	✓	N/A	80%	60%
Preventive Care					

	Applies to Deductible	Applies to OOP Max	Physician Services Performed at Olympia Orthopaedic Associates	Network Providers	Non-Network Providers
Immunizations Immunizations for children and adults are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention. See *Preventive Care* for details. Shingles vaccine is covered beginning at age 50. Covered immunizations done at a pharmacy are covered at the In Network benefit level at billed charges Travel immunizations are not covered.	N/A	N/A	N/A	100%	Not covered
Periodic Exams (adult and child)	N/A	N/A	N/A	100%	Not covered
Nutritional Counseling - first 3 visits per calendar year (any condition) Subsequent diabetes-related visits are covered under *Diabetic Education.* Subsequent non-diabetes related visits are not covered.	N/A	N/A	N/A	100%	Not covered
Obesity Screening and Counseling 12 visits per calendar year.	N/A	N/A	N/A	100%	Not covered
Screening Tests Screening tests are covered in accordance with the recommendations set forth by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See *Preventive Care* for more details. This benefit specifically does not cover executive physicals, heart scans, full body scans, CT scans, MRIs, or PET scans.					
• **Bone Density Screening** (limited to once every 5 calendar years, age 60 and older)	N/A	N/A	N/A	100%	100%

	Applies to Deductible	Applies to OOP Max	Physician Services Performed at Olympia Orthopaedic Associates	Network Providers	Non-Network Providers
• **Colonoscopy** (beginning at age 50 or younger if at increased risk) The first colonoscopy per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent colonoscopies in the same calendar year are covered under the applicable medical benefit, regardless of diagnosis.	N/A	N/A	N/A	100%	100%
• **Fecal Occult Blood Test** (beginning at age 50 or younger if at increased risk) The first fecal occult blood test per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent fecal occult blood test in the same calendar year are covered under the applicable medical benefit, regardless of diagnosis.	N/A	N/A	N/A	100%	100%
• **FIT-Fecal DNA** FCH pre-authorization required. 1 per calendar year	N/A	N/A	N/A	100%	100%
• **Mammograms** (beginning at age 40 or younger if at increased risk) The first mammogram per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent mammograms in the same calendar year are covered under the applicable medical benefit, regardless of diagnosis.	N/A	N/A	N/A	100%	100%

	Applies to Deductible	Applies to OOP Max	Physician Services Performed at Olympia Orthopaedic Associates	Network Providers	Non-Network Providers
• **Pap Test**	N/A	N/A	N/A	100%	100%
• **Prostate Cancer Screening (PSA)**	N/A	N/A	N/A	100%	100%
• **Sigmoidoscopies** (beginning at age 50 or younger if at increased risk) The first sigmoidoscopy per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent sigmoidoscopies in the same calendar year are covered under the applicable medical benefit, regardless of diagnosis.	N/A	N/A	N/A	100%	100%
All Other Screening Tests	N/A	N/A	N/A	100%	100%
Professional/Physician Services (office visits)	✓	✓	90%	80%	60%
• **Office Visits**	✓	✓	90%	80%	60%
• **Telemedicine – 98point6**	✓	✓	N/A	100%	N/A
Rehabilitation Therapy					
• **Inpatient** (facility and professional) FCH pre-authorization required.	✓	✓	N/A	80%	60%
• **Outpatient** (facility and professional) includes physical, speech, occupational and hearing therapies) 60 visits per calendar year maximum, combined with outpatient habilitative services.	✓	✓	90% (physical therapy only)	80%	60%

	Applies to Deductible	Applies to OOP Max	Physician Services Performed at Olympia Orthopaedic Associates	Network Providers	Non-Network Providers
Skilled Nursing Facility FCH pre-authorization required. 60 days per calendar year maximum.	✓	✓	N/A	80%	60%
Temporomandibular Joint (TMJ) Disorder FCH pre-authorization required if inpatient.	✓	✓	N/A	80%	60%
Tobacco Cessation Office Visits	N/A	N/A	100%	100%	60%
Tobacco Cessation Medication	Covered under Pharmacy benefits				
Transgender/Gender Affirming Services FCH pre-authorization and Case Management required. Limited benefit, see *Transgender/Gender Affirming Services* for details.	Payment is based on Place of Service and Provider type.				
Transplants (organ and bone marrow) FCH pre-authorization required.					
• **Recipient Services** (facility and professional)	✓	✓	N/A	80%	60%
• **Donor Services** (facility and professional)	✓	✓	N/A	80%	60%
• **Transportation and Lodging** $10,000 maximum per transplant episode.	✓	✓	N/A	80%	80%
Vision (routine eye exams and hardware)	Not covered.				
Wigs For hair loss resulting from the treatment of cancer. Limited to $500 every 5 calendar years.	✓	✓	N/A	80%	80%

Medical Benefits

FCH administers the benefits described in this section for the Plan participants. All benefits are subject to plan exclusions and limits. All coinsurance, deductibles and inpatient, outpatient or office visit copayments apply. See *Payment Provisions, Summary of Medical Benefits* and *Plan Exclusions and Limitations* for more details, as well as *Plan Definitions*.

Coverage is provided only when **all** these conditions are met:

- The service or supply is a listed covered benefit,
- Specific benefit limits or lifetime maximums are not exhausted,
- All pre-authorization and benefit requirements are met,
- The participant is eligible for coverage and enrolled in this plan at the time the service or supply is received, and
- The service or supply is considered Medically Necessary for a covered medical condition, as defined.

Acupuncture

Refer to *Alternative Care*

Allergy Care

Benefits include allergy tests, injections, and serums, though serum is covered only when received and administered within the provider's office. If received from a pharmacy, the serum may be covered under the pharmaceutical benefit.

Alternative Care

Benefits include services of an acupuncturist and/or massage therapist to treat a covered illness or injury. Maintenance therapy is not covered. The massage therapy benefit applies to services coded as massage therapy on the claim, which include, but are not limited to, manual lymphatic drainage, mobilization, and manual traction. These services will process to the appropriate benefit based on the codes submitted on the claim.

Ambulance Services

The plan covers medically necessary licensed ambulance transportation when the following conditions apply:

- The transportation is to the nearest available health care facility where medically necessary services can be provided;
- Other forms of transportation would likely endanger the participant's health.

Air ambulance transport services require pre-authorization for non-urgent transport.

Note: Emergent Air Ambulance Transport will be reviewed retrospectively.

Transportation for personal or convenience reasons is deemed to be not medically necessary.

Anesthesia

Benefits for anesthesia are covered if and when required for certain procedures or surgeries. Anesthesia must be administered within a hospital or ambulatory surgical center.

General Anesthesia for Dental Care

Coverage is provided for general anesthesia and associated facility charges in conjunction with dental care provided to a participant if such participant is:

- Age six or younger or,
- Is physically developmentally disabled, or
- Is an individual with a medical condition that his/her physician determines will place the person at undue risk if the procedure is performed in a dental office. The covered participant's physician must approve the procedure.

Applied Behavior Analysis (ABA)

This benefit will provide coverage for behavioral interventions based on the principles of Applied Behavior Analysis (ABA).

ABA therapy programs incorporate behavior modification, training and education.

This benefit will cover the five components of ABA:

- Initial assessment
- Direct clinical treatment
- Program development
- Treatment planning
- Supervision of the providers of direct service

Coverage will be provided for medically necessary services to develop, maintain, and/or restore the functioning of an individual with a diagnosis listed above. Duplicate services, provider training and group classes are not covered.

Covered Providers

For ABA:

ABA services are provided by a state certified behavior health facility that has ABA services overseen by a BCBA- BCBA-D or provided directly by them as independent practitioners. Qualified network providers can be located using the FCH provider search at www.fchn.com, by selecting "other facilities" and then "Applied Behavior Analysis Facility."

- **Board Certified Behavior Analyst® (BCBA® (graduate level), BCBA-D™ (doctoral level)** – The BCBA and BCBA-D are independent practitioners who also may work as employees or independent contractors for an organization. The BCBA conducts descriptive and systematic behavioral assessments, including functional analyses, and provides behavior analytic interpretations of the results. The BCBA designs and supervises behavior analytic interventions. The BCBA is able to effectively develop and implement appropriate assessment and intervention methods for use in unfamiliar

situations and for a range of cases. The BCBA seeks the consultation of more experienced practitioners when necessary. The BCBA teaches others to carry out ethical and effective behavior analytic interventions based on published research and designs and delivers instruction in behavior analysis. BCBAs supervise the work of Board Certified Assistant Behavior Analysts and others who implement behavior analytic interventions.

- **Board Certified Assistant Behavior Analyst® (BCaBA®)** – The BCaBA conducts descriptive behavioral assessments and is able to interpret the results and design ethical and effective behavior analytic interventions for clients. The BCaBA designs and oversees interventions in familiar cases (e.g., similar to those encountered during their training) that are consistent with the dimensions of applied behavior analysis. The BCaBA obtains technical direction from a BCBA for unfamiliar situations. The BCaBA is able to teach others to carry out interventions and supervise behavioral technicians once the BCaBA has demonstrated competency with the procedures involved under the direct supervision of a BCBA. The BCaBA may assist a BCBA with the design and delivery of introductory level instruction in behavior analysis. It is mandatory that each BCaBA practice under the supervision of a BCBA. Governmental entities, third-party insurance plans and others utilizing BCaBAs must require this supervision.
- **Registered Behavior Technician™ (RBT™) or Therapy Assistant (TA)** – The RBT/TA is a paraprofessional who practices under the close, ongoing supervision of a BCBA or BCaBA ("Designated therapy supervisor"). The RBT/TA is primarily responsible for the direct implementation of skill-acquisition and behavior-reduction plans developed by the supervisor. The RBT/TA may also collect data and conduct certain types of assessments (e.g., stimulus preference assessments). The RBT/TA does not design intervention or assessment plans. It is the responsibility of the therapy supervisor to determine which tasks an RBT/TA may perform as a function of his or her training, experience, and competence. The therapy supervisor is ultimately responsible for the work performed by the RBT/TA and bills for their services.

Blood Transfusions/Donation

Autologous blood donations are those in which the blood being transfused was donated by the patient during surgery. Blood transfusions are the replacement of blood or one of its components, depending on the condition being treated. Coverage for either is provided when ordered by your physician.

Biofeedback

Biofeedback, a training program designed to develop one's ability to control the involuntary nervous system, is covered.

Chemical Dependency

All inpatient admissions and partial hospitalization programs **require FCH pre-authorization** by calling (800) 640-7682. Emergency admissions require notification as described under *Medical Management*. The plan covers services provided to individuals requiring chemical dependency treatment for abuse of substances, (e.g. alcohol or other drugs.) Care must be medically necessary and provided at the least restrictive level of care. A clear treatment plan containing measurable progress toward a rehabilitative goal(s), including but not limited to movement to a

less restrictive setting (if applicable), or other medically necessary goals must be established as determined by your provider and FCH's medical management.

Care may be received at a hospital, a chemical dependency facility, and/or received through residential treatment programs, partial hospital programs and intensive outpatient programs or through group or individual outpatient services.

Chiropractic Spinal Manipulation

Coverage includes chiropractic manipulation of the spine when performed within the scope of the provider's license.

Clinical Trials

This benefit covers routine patient costs for members who choose to participate in an approved clinical trial (as outlined below), and the member's participation in the clinical trial has been pre-authorized. Services such as those identified as Experimental and/or Investigational in the clinical trial are not covered. Refer to "Costs Not Covered" below for details.

An approved clinical trial is:

- Pre-authorization for clinical trial participation has been granted.
- The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening disease or condition. A "life-threatening condition" is a disease or condition likely to result in death unless the disease or condition is interrupted. The principal purpose of the trial intervention must be the therapeutic intent to potentially improve health outcomes.
- The clinical trial intervention must be intended for a condition covered by the health plan.
- The approved clinical trial must be classed as one of the following:
  - A federally funded or federally approved trial.
  - A clinical trial conducted under a U.S. Food and Drug Administration (FDA) investigational new drug application.
  - A drug trial that is exempt from the requirement of an FDA investigational new drug application.
- The clinical trial must be conducted under a written research protocol approved by an appropriate Institutional Review Board (IRB). This protocol must demonstrate that the trial is in compliance with Federal regulations relating to the protection of human subjects.
- The clinical trial must provide a thorough informed consent document to the participating member, and this document must be signed by the member.
- All applicable plan limitations for coverage of out-of-network care along with all applicable plan requirements for precertification, registration, and referrals will apply to any costs associated with member participation in the trial. The plan may require a qualified member to use an in-network provider participating in a clinical trial if the provider will accept the member as a participant. A member participating in an approved clinical trial conducted outside the state of the member's residence will be covered if the plan otherwise provides out-of-network coverage for routine patient costs.

- A “qualified member” is a group health plan member or beneficiary who is eligible, according to the trial protocol, to participate in the approved clinical trial for the treatment of disease and either:
  - The referring health care professional is a participating provider and has concluded that the member’s or beneficiary’s participation in the clinical trial would be appropriate; or
  - The member or beneficiary provides medical and scientific information establishing that the individual’s participation in the clinical trial would be appropriate.

Costs associated with clinical trial participation may be covered as follows:

Costs Covered:

- Routine Patient Costs defined as follows-
  - Items or services that are typically provided under the plan for a participant not enrolled in a clinical trial. (e.g., usual care/standard care.).
  - Items, services, or tests that are required to safely provide the investigational intervention to include clinically appropriate monitoring of the effects of the intervention.
  - Medically necessary diagnosis and treatment for conditions that are medical complications resulting from the member’s participation in the clinical trial.

Costs Not Covered:

- Investigational items, services, tests, or devices that are the object of the clinical trial.
- Interventions, services, tests, or devices provided by the trial sponsor without charge.
- Data collection or record keeping costs that would not be required absent the clinical trial; this exclusion extends to any activity (e.g. imaging, lab tests, biopsies) necessary only to satisfy the data collection needs of the trial.
- Services or interventions clearly not consistent with widely accepted and established standards of care for the member’s particular diagnosis.
- Interventions associated with treatment for conditions not covered by the Plan.

COVID-19

The plan covers medically necessary diagnostic and treatment services related to COVID-19.

Dental Trauma

Not intended as dental coverage, this benefit coverage is provided for repair of sound natural teeth and/or implants of sound natural teeth, and repair of the jawbone or supporting tissues, due to accidental injury. After the initial examination by your dentist, a pre-authorization for further services is required by FCH. All services related to the repair must be completed within 24 months of the date of the injury. Any services received after 24 months have elapsed, or after you become disenrolled from this Plan regardless of whether 24 months have elapsed or not, are not covered. Anesthesia related to the accidental injury is covered within 24 months.

Injury due to biting or chewing is not covered, and is not considered an accidental injury. 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 and Diabetic Nutrition Education

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.

Diagnostic Testing

The plan covers testing such as lab and radiology for diagnostic purposes when medically necessary and ordered by a qualified health care provider.

Durable Medical Equipment (DME) and Supplies

DME is medical equipment that can withstand repeated use, is not disposable, is used for a medically therapeutic purpose, is generally not useful in the absence of sickness or injury and is appropriate for use in the home. DME may be rented or purchased (at FCH's discretion) and total cost for rental must not exceed the purchase price. Repair or replacement is only covered when needed due to normal use, a change in the patient's physical condition or the growth of a child. Duplicate items are not covered. When more than one option exists, benefits will be limited to the least expensive model or item appropriate to treat the patient's covered condition.

Examples of DME include, but are not limited to:

- Crutches
- Oxygen and equipment for administering oxygen
- Walkers
- Wheelchairs

This benefit also covers:

- **Breast Pumps**
- **Diabetic monitoring equipment,** such as the initial cost of an insulin pump and blood glucose monitor (including supplies related to such equipment). Diabetic supplies such as insulin, syringes, needles, lancets, etc., are covered under the pharmacy benefit.
- **Medical supplies** needed for the treatment or care of an appropriate covered condition, including but not limited to compression garments, mastectomy supplies and ostomy supplies. Supplies available over-the-counter are excluded.
- **Orthopedic appliances/braces:** These include appliances used to support abnormal joints, limit pressure on a joint after injury to allow it to heal or correct abnormal curves in the spine.
- **Prosthetic devices:** Benefits include external prosthetic appliances that are used to replace all or part of a missing body part and are necessary for the alleviation or correction of illness, injury, or congenital defect.

Surgically implanted devices may be covered under the appropriate surgical benefit and are not considered DME. Benefits for durable medical equipment are determined by the type of device and its intended use, and not by the entity that provides or bills for the device.

Emergency and Urgent Care

The Plan covers emergency department and urgent care visits in network and non-network facilities.

Emergency (or emergent) means the sudden and acute onset of a symptom(s), including severe pain, that would lead a person, acting reasonably, to believe 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 severe pain, difficulty breathing, deep cuts or severe bleeding, poisoning, drug overdose, broken bones, unconsciousness, stab or gunshot wounds, automobile accidents, and pain or bleeding during pregnancy. Examples of **urgent** conditions include cuts and lacerations, diarrhea, allergic reactions, sprains, urinary tract infections and vomiting.

In the case of an emergency, home or away, seek the most immediate care available. To receive the network level of benefits, you must obtain all follow-up care from network providers. If you require non-network follow-up services, you must obtain a pre-authorization from FCH in order to receive your best benefit.

Dialysis

Benefits are provided for kidney dialysis treatment including drugs and supplies used during the treatment.

Family Planning

Voluntary sterilization procedures and FDA-approved birth control methods are covered. Over-the-counter products are not covered, except certain drugs required under the Patient Protection and Affordable Care Act. Oral, patch and ring contraceptives are covered under the prescription drug benefit.

Termination of Pregnancy

Voluntary termination of pregnancy is not covered unless the mother's life (not dependent children) is endangered if the pregnancy is carried to term, the fetus is non-viable as determined by a physician, or in cases of rape or incest.

Foot Orthotics

Custom-designed foot orthotics, when prescribed by a physician and required for all normal, daily activities are covered by the Plan.

Genetic Services

Genetic testing, counseling, interventions, therapy and other genetic services are covered when determined to be an essential component of medically necessary care or treatment of a covered condition, or a medically necessary precursor to obtaining prompt treatment of a covered condition.

Habilitative Services

Benefits are provided for habilitative services when medically necessary and related to a Developmental Disability. These services must be recognized by the medical community as efficacious:

- For partial or full development;
- For keeping and learning age appropriate skills and functioning within the individual's environment; and
- To compensate for a progressive physical, cognitive, and emotional Illness.

Covered Services include Speech, occupational, physical and aural therapy services.

Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational and custodial services are not covered.

Home Health Care

FCH pre-authorization is required for wound therapy**,** enteral formula, medical food and associated services and home hospice. Home health care is covered when prescribed by your physician. The patient must be homebound (except for lactation and perinatal services) and require skilled care services (as defined by the Plan). Benefits are limited to intermittent visits by a licensed home health care agency.

For this benefit, a visit is a time-limited session or encounter with any of the following home health agency providers:

- Nursing services (RN, LPN)
- Licensed or registered physical, occupational or speech therapist (or an assistant working under the supervision of one of these providers)
- Home health aide working directly under the supervision of one of the above providers
- Licensed as a social worker - masters prepared
- Registered dietician

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

This benefit is not intended to cover care in the home when FCH determines care in a skilled nursing facility or a hospital is more cost-effective. 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 FCH.

Hospice Care

FCH pre-authorization is required for inpatient hospice and home hospice care. Hospice care is covered when prescribed by your physician and s/he has determined that life expectancy is 12 months or less and a palliative, supportive care treatment approach has been chosen. This benefit includes acute, respite, and home care to meet the physical, psychosocial, and special needs of a patient-family unit during the final stages of illness and dying. Hospice care is provided at a variety of levels to meet the individual needs of the patient-family unit. Levels offered are:

- **Intermittent in-home visits** are provided on an as needed basis by the hospice team, which includes health care professionals, support staff, and a twenty-four (24) hour a day “on-call” registered nurse. This level of care does not cover room and board while a member resides in a skilled nursing facility, adult family home, or assisted living facility.
- **Inpatient Hospice** care is needed when care cannot be managed where the patient resides. The care will be provided at an inpatient facility until the patient’s condition stabilizes.
- **Respite Care**
    - **Continuous home care** is provided when a medical crisis occurs where the patient resides and care can be provided at the residence. During such periods, the hospice team can provide around-the-clock.
    - **Inpatient respite care** is available to provide the patient’s caregiver a rest. This acknowledges that caring for a dying person can be difficult. Care for the patient is provided at an inpatient facility and includes room and board costs.

When provided within the above-defined levels of care, additional covered expenses include:

- Approved medications and infusion therapies furnished and billed by an approved hospice agency
- Durable Medical Equipment
- Supplies required for palliative care

If the patient exhausts the hospice benefit maximum, limited extensions may be granted if it is determined that the treatment is medically necessary. 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 FCH.

Hospital Inpatient Medical and Surgical Care

Hospital inpatient and facility charges for medically necessary care are covered. **FCH pre-authorization is required** for all non-emergency inpatient admissions to a hospital or facility. Covered inpatient care includes room and board, operating room and anesthesia, radiology, lab and pharmacy services furnished by and used while in the hospital.

Hospital Outpatient Surgery and Services

Certain outpatient surgery/procedures **require FCH pre-authorization**; please see *Pre-authorization Requirements* for details. Covered outpatient care includes outpatient surgery, procedures and services, operating room and anesthesia, radiology, lab and pharmacy services furnished by and used while at a hospital or ambulatory surgical center.

Infertility Diagnostic Services

Coverage is provided for the initial evaluation and diagnosis of infertility only. Examples of covered services for the initial diagnosis of infertility include endometrial biopsy, hysterosalpingography, reproductive screening services, or sperm count. A pre-authorization must be obtained from FCH if care is provided inpatient. Treatments and procedures for the purposes of producing a pregnancy are not covered.

Infusion Therapy

FCH pre-authorization required for certain infusion therapy drugs; please see *Pre-authorization Requirements* for details. Infusion therapy is the administration of medications using intravenous, subcutaneous, and epidural routes (into the bloodstream, under the skin, and into the membranes surrounding the spinal cord). Drug therapies commonly administered via infusion include, but are not limited to, antibiotics, chemotherapy, pain management, parenteral nutrition, and immune globulin. Diagnoses commonly requiring infusion therapy include infections that are unresponsive to oral antibiotics; cancer and cancer-related pain; gastrointestinal diseases or disorders which prevent normal functioning of the GI system; congestive heart failure; immune disorders; and more. Nursing visits associated with infusion therapy are covered under this benefit, regardless of whether the patient is home bound.

Massage Therapy

Refer to *Alternative Care.*

Maternity and Newborn Care

Coverage for pregnancy and childbirth, for employees or his/her spouse/domestic partner (not dependent children, unless provided for a life threatening condition), in a hospital birthing center is provided on the same basis as any other medical condition, as are complications of pregnancy. Medically necessary screening(s) and diagnostic procedures during pregnancy for prenatal diagnosis of congenital disorders of the fetus are covered. The services of a licensed physician, an advanced registered nurse practitioner (ARNP), a licensed midwife, or a certified nurse midwife (CNM) are covered under this benefit.

Coverage for newborns is provided automatically for the first 21 days following birth when no other coverage is in effect during the first 21 days of life. In order for coverage to continue beyond the first 21 days, the child must be enrolled as a dependent under this Plan (see Eligibility and Enrollment for details). Benefits are subject to the newborn child's own coinsurance and deductible requirements.

Newborn care includes inpatient hospital services and professional care (including circumcision) performed during the initial period of hospitalization immediately following birth. Any services performed after the baby is discharged from this level of care are covered under the benefit applicable to the services billed, and are not considered newborn care. Circumcisions are covered up to 28 days following birth. Circumcisions performed after 28 days must be medically necessary as determined by FCH.

Newborns' and Mothers' Health Protection Act of 1996 *This Act states that group health plans may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than these periods. In any case, the Plan may not, under federal law, require that a provider obtain authorization from the Plan or the insurance issuer or TPA for prescribing a length of stay not in excess of these periods.*

Mental Health Care

All inpatient admissions, partial hospitalization programs **require FCH pre-authorization** by calling (800) 640-7682. Emergency admissions require notification as described under *Medical Management.* The plan covers treatment of mental health or psychiatric conditions.

Care must be medically necessary and provided at the least restrictive level of care. Facilities offering inpatient level of care must have a medical model with physician and/or nursing staff on site 24 hours each day. A clear treatment plan must be established on admission and include containing measurable progress toward a rehabilitative goal(s), including but not limited to movement to a less restrictive setting (if applicable), or other medically necessary goals as determined by your provider and FCH's medical management.

Care may be received at a hospital or treatment facility, and/or received through residential treatment programs, partial hospital programs, and intensive outpatient programs or through group or individual outpatient services.

Family counseling and psychotherapeutic programs are covered only if related to the treatment of an approved clinical mental health diagnosis, specifically, those noted in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Nutritional and Dietary Formulas

Coverage for nutritional and dietary formulas is provided when medically necessary. The following conditions must be met:

- The formula is a specialized formula for treatment of a recognized life-threatening metabolic deficiency such as phenylketonuria **or**
- The formula is the significant source of a patient's primary nutrition or is administered in conjunction with intravenous nutrition **and**
- The formula is administered through a feeding tube (nasal, oral or gastrostomy).

Oral Surgery

Coverage for oral surgery is offered when a medical diagnosis is present. Oral Surgery required for a dental diagnosis such as periodontal disease is not covered. Examples of covered services include:

- The reduction or manipulation of fractures of facial bones
- Excision of lesions, cysts, and tumors of the mandible, mouth, lip or tongue
- Incision of accessory sinuses, mouth salivary glands or ducts
- Extraction of teeth damaged due to radiation therapy that occurred while under this Plan

Pharmacy

Prescription drug benefits for Plan participants are administered by CVS Caremark, a separate provider not affiliated with FCH. Covered medications must meet these requirements:

- Prescribed by a licensed physician,
- Approved by the Food and Drug Administration (FDA), and
- Must be warranted to treat a covered condition.

You may order up to a 34-day supply from a retail network pharmacy. Alternatively, you may order up to a 91-day supply through the CVS Caremark Mail Service or any retail pharmacy participating in our Retail 90 program. If you, or a family member, regularly take medication for chronic, long-term conditions, you may receive up to a 91-day supply of these maintenance medications. If you use the mail order service, you pay the 91-day coinsurance even if your prescription is written for less than a 91-day supply. See “Filling a Prescription” below for more detailed information on how and where you can obtain your prescription drugs.

The *Summary of Medical Benefits* section notes the amounts for which you are responsible.

If you select a brand name drug 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 coinsurance. If a brand name drug is prescribed by your physician because s/he feels it is medically necessary and a generic equivalent drug is available, you will not have to pay the difference in cost. Your out-of-pocket expense will never exceed the cost of the drug.

In addition to the coinsurance, you are responsible for the cost of any prescription not covered under your pharmacy benefit and for any prescription purchased without presenting your medical benefit ID card.

Filling a Prescription

Following are details for filling a prescription through the retail network pharmacy or mail order. Contact CVS Caremark for any questions on filling a prescription. If you need assistance in determining if your local, independent pharmacy is part of the CVS Caremark network of retail pharmacies or part of the Retail 90 program, you may call CVS Caremark directly at (866) 818-6911. They are available 24 hours a day, 7 days a week.

CVS Caremark guarantees that all prescriptions will meet the highest pharmaceutical standards for safety, quality and effectiveness. A record of your prescriptions is maintained by CVS Caremark to monitor for adverse reactions with other prescriptions you may receive from the retail network pharmacy or the mail order service. A pharmacist will contact you or your doctor before dispensing a medication if there is a concern for possible drug interactions or adverse reactions.

Retail Network Pharmacy

With the retail pharmacy program, you may receive up to a 34-day supply of medication.

An extensive nationwide network of pharmacies has agreed to dispense covered prescription drugs to Plan participants at a discounted cost and not to bill you for any amounts over the coinsurance. All major chain pharmacies and most independent pharmacies participate in the CVS Caremark network. Please refer to the website or contact customer service for a complete list of participating pharmacies. A partial list includes:

- Albertsons
- Bartell Drug
- Costco
- CVS
- Fred Meyer
- Kmart
- Rite Aid
- Safeway
- Target
- Walgreens
- Wal-Mart

Mail Order Service and Retail 90

If you, or a covered family member, regularly take medication for chronic, long-term conditions such as diabetes, arthritis, high blood pressure, heart conditions, etc., you have two options for obtaining a 91-day supply of ongoing medications. The prescription will be delivered directly to your home.

1. **Mail Order** You may obtain a 91-day supply of medication through a mail order program with CVS Caremark.

   How to get started with the Mail Order Program

   Online

   a. Go to Caremark.com/mailservice
   b. Register or Sign In and have your Prescription Benefit Card ready
   c. Follow the guided steps to request a prescription. Once the information is submitted, CVS Caremark will contact the doctor for a 90-day prescription of your current medicine.

   Phone

   a. Call (866) 818-6911
   b. Be ready with your prescription ID card, list of long-term medications, doctor's information and payment method
   c. Your physician can also call in your prescription with the information from your ID card along with your date of birth and mailing address

   To obtain additional details about the mail order pharmacy benefit, please contact CVS Caremark at (866) 818-6911, or www.caremark.com/mailservice.

2. **Retail 90** You can also obtain a 91-day supply of medication through the Retail 90 program. Retail 90 is CVS Caremark's retail-based program that allows you to obtain up to a 91-day supply of ongoing medication. To obtain a complete list of pharmacies participating in the Retail 90 program you may contact CVS Caremark directly at (866) 818-6911; they are available 24 hours a day, 7 days a week. You can also find the information by visiting www.caremark.com.

Non-network Pharmacy

If necessary, you may obtain your prescription through a non-network pharmacy, however you would need to pay full price and obtain reimbursement through CVS Caremark. CVS Caremark will reimburse you their cost of the drug, minus the applicable co-insurance amount noted in the *Summary of Medical Benefits.* There may be a difference between their cost and the non-network pharmacy's cost; any difference would also be your responsibility. Please contact CVS Caremark directly at (866) 818-6911 for instructions on how to obtain reimbursement. They are available 24 hours a day, 7 days a week.

Specialty Pharmacy

Specialty Pharmacy is a special pharmacy management program for high cost or complex self-injectable or oral drug therapies. These Specialty Pharmacy medications must be filled through the CVS Caremark Specialty program. To obtain additional details about the Specialty Pharmacy benefit, please contact CVS Specialty at (800) 237-2767 or visit www.CVSspecialty.com.

Plastic and Reconstructive Services

Reconstructive/plastic procedures **require FCH pre-authorization** and are covered when performed to correct or repair abnormal structures of the body caused by congenital defects, trauma, infection, tumors, disease, accidental injury or prior surgery (if the prior surgery would be covered under this Plan). Specific criteria follow:

- Services performed to correct congenital defects of a child must be completed before the child's 18th birthday
- In the case of accidental injury, services must be completed within 12 months of the initial injury

Women's Health and Cancer Rights Act of 1998 *The federal law titled "Women's Health and Cancer Rights Act of 1998" states group health plans that are providing medical and surgical benefits for mastectomy resulting from disease, illness or injury must also cover, for those affected participants:*

- Reconstruction of the breast on which the mastectomy was performed
- Reconstruction of the other breast to produce a symmetrical appearance
- Internal or external prostheses
- Treatment of physical complications in all stages of post-mastectomy reconstruction, including lymphedema

Podiatric Care

Coverage is provided for certain surgical podiatric services, including incision and drainage of infected tissue of the foot, removal of lesions of the foot, removal or debridement of infected toenails, and treatment of fractures and dislocations of bones of the foot. Routine foot care, such as the treatment of corns, calluses, non-surgical care of toenails, fallen arches and other symptomatic complaints of the feet are not covered, except in the treatment of a peripheral-vascular disease and diabetes.

Preventive Care

Coverage is provided by or under the supervision of your provider, including:

- Routine physicals
- Periodic examinations including the specific diagnostic testing/screening and laboratory services as recommended by the US Preventive Services Task Force and the Health Resources and Services Administration)
- Adult, child and adolescent immunizations as recommended by the Centers for Disease Control (CDC). Shingles vaccine is covered beginning at age 50.

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

For more information on the recommendations of the CDC, US Preventive Services Task Force, and the Health Resources and Services Administration, visit the following website:

www.healthcare.gov/prevention/

Professional/Physician Services

This benefit applies to in-person, face-to-face office visits, and Telemedicine from Doctors on Demand and 98point6 only. Telemedicine includes videoconferences, scheduled telephone visits and electronic visits (e-Visits).

Telemedicine visits must be initiated by the patient. Scheduling and medical record documentation of these visits, as well as creation of a claim, follows the same standard as in-person office visits. Please review this with your provider before receiving services to ensure your telephonic or e-visit meets the requirements above.

98point6 Text Based Program

98point6 provides the following benefits:

- A Participant has access to an online interactive platform (including related iOS and Android applications) for continuity of care, including access to his or her diagnoses and treatment plans.
- A Participant may also use the platform to access non-urgent primary care via the 98point6 website or mobile application. The provider network is available at www.98point6.com.
  - Primary care services available through 98point6 include evaluation, diagnosis, and development of a treatment plan with respect to non-urgent primary care issues, including (as appropriate) referrals or orders for prescriptions or lab services.
  - Sessions with 98point6 providers can be done online or via two-way video or telephonic. Sessions are not time-limited.

The member pays the cost in full until the out-of-pocket is satisfied.

Rehabilitation Therapy

Coverage for disabling conditions is provided through inpatient and outpatient rehabilitation therapy. Examples of such therapies include, but are not limited to, physical therapy, speech therapy, and occupational therapy. The following conditions must be met:

- Services are to restore and significantly improve function that was previously present but lost due to acute injury or illness,
- Services are not for palliative, recreational, relaxation or maintenance therapy, and
- Loss of function was not the result of a work-related injury.

Coverage for cardiac rehabilitation requires that participants have experienced a cardiac event in the preceding twelve (12) month period, such as myocardial infarction, chronic stable angina, heart transplants or heart and lung transplants.

Inpatient Rehabilitation

Inpatient rehabilitation requires FCH pre-authorization and must be furnished and billed by a rehabilitative unit of a hospital or by another approved rehabilitation facility. When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day the care becomes primarily rehabilitative. Inpatient care includes all room and board, services provided and billed by the inpatient facility and therapies performed during the rehabilitative stay.

Outpatient Rehabilitation

Outpatient rehabilitation benefits are subject to the following provisions:

- You must not be confined in a hospital or other medical facility.
- Services must be billed by a hospital, physician, physical, occupational or speech therapist. Hearing therapy is covered when performed by a speech therapist.

Speech therapy is covered only when required as a result of brain or nerve damage secondary to an accident, disease or stroke.

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

Skilled Nursing Facility

Inpatient skilled nursing facility care **requires FCH pre-authorization.** Benefits include room and board and ancillary services. The care must be therapeutic or restorative and require in-facility delivery by licensed professional medical personnel, under the direction of a physician, to obtain the desired medical outcome. (Neither maintenance care nor custodial care are covered.)

Temporomandibular Joint Syndrome (TMJ)

FCH pre-authorization is required for inpatient admissions related to TMJ. Medical, dental, surgical and related hospital services are covered for the treatment of TMJ including the correction of malocclusion of the jaw or any dental treatment for dental conditions involved in temporomandibular joint pain dysfunction, syndrome or disease collectively referred to as Temporomandibular Joint Dysfunction (TMJ). Orthodontia for TMJ is not a covered benefit.

Transgender/Gender Affirming Services

FCH pre-authorization required for inpatient admissions and gender affirming services. These services are intended to provide treatment for patients with gender dysphoria. This assistance may include primary care, gynecologic and urologic care, reproductive options, mental health services (e.g., assessment, counseling, psychotherapy, psychotropic medication management), and hormonal and gender affirming surgical treatments. Gender affirming surgical treatments are limited to members age 18 and older. The services are provided as any other benefit (cost shares are indicated in the *Summary of Benefits*). Transportation and lodging are not covered. FDA approved medications for support and treatment of transgender related services are covered through the *Pharmacy Benefit.*

Case Management is a mandatory requirement and is free to the member. To enroll, call FCH Case Management at (800) 808-0450. The Case Manager will provide support and clinical guidance through this complex process.

Transplants, Organ and Bone Marrow

FCH pre-authorization is required for transplant service. Services directly related to organ transplants must be coordinated by your participating provider. **Proposed transplants will not be covered if considered experimental or investigational for the participant's condition, except as outlined under the Clinical Trials benefit.** FCH pre-authorization approval for transplants is based on these criteria:

- A written recommendation with supporting documentation received from your provider
- The request for the transplant is based on medical necessity
- The requested procedure and associated protocol is not considered experimental or investigational treatment for your condition, except as outlined under the Clinical Trials benefit
- The procedure is performed at a facility, and by a provider, approved by FCH
- Upon evaluation, you are accepted into the approved facility's transplant program and comply with all program requirements

Please Note: *Corneal transplants are not considered an organ transplant and are covered under the medical-surgical benefit, and not under the transplant benefit.*

Have your provider send a request, prior to evaluation, to:

Email:
preauthorization@fchn.com

Written:
FCH Medical Management
600 University St., Suite 1400
Seattle, WA 98101

Fax:
(833) 227-4256 or (833) 227-4259

Recipient Services

Covered transplant recipient services 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
- Pharmaceuticals administered in an outpatient setting
- Anti-rejection drugs

Donor Services

Donor expenses are covered if all criteria are met below:

- FCH approves the transplant procedure
- The recipient is enrolled in this plan
- Expenses are for services directly related to the transplant procedure
- Donor services are not covered under any other health plan or government program

Covered donor expenses include:

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

When both the recipient and the donor are participants under this Plan, covered charges for all covered services and supplies received by both the donor and the recipient will be payable.

Please Note: *If you, as a participant, choose to donate an organ or bone marrow, donor expenses are not covered under this Plan unless the recipient is also enrolled in this Plan. However, complications arising from the donation would be covered to the extent that they are not covered under the recipient's health plan.*

Travel expenses

Travel and lodging expenses for approved transplants and associated pre-transplant evaluations are available for the recipient and his/her guardian/caregiver and the donor. **Travel and lodging expenses require FCH preauthorization**; and if authorized, are paid up to a maximum of$10,000 per transplant episode if the recipient is required to travel 30 miles or more his or her home zip code for the medically necessary services related to an approved transplant, or if the facility requires the patient to remain within a certain distance of the facility during the transplant process. The maximum applies to all associated transportation, lodging and meal expenses incurred by the transplant recipient, companion(s) and donor(s).

Wigs

Wigs are covered for hair loss resulting from the treatment of cancer.

Plan Exclusions and Limitations

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

- Abortion (termination of pregnancy) unless the mother's life (not dependent children) is endangered if the pregnancy is carried to term, in cases of rape or incest, or the fetus is non-viable as determined by a physician.
- Adoption expenses
- Amounts over and above UCR, as defined by the Plan
- Amounts for which the covered person has no obligation to pay
- Any charges by a facility owned or operated by the United States or any state or local government unless the participant is legally obligated to pay (excluding: (i) covered expenses rendered by a medical facility owned or operated by the United States Veteran's Administration when the services are provided to a participant for a non-service related illness or injury, and (ii) covered expenses rendered by a United States military medical facility to participants who are not on active military duty)
- Any condition resulting from participation in declared or undeclared acts of terrorism, war, military service, participation in a riot or civil disobedience
- Any service not medically necessary for the diagnosis, treatment or prevention of injury or illness, even if it is not specifically listed as an exclusion (except for specific services offered through the Preventive Care benefit)
- Any service received before the participant's effective date of coverage or after the coverage termination date
- Applied Behavior Analysis (ABA)- the following are not covered:
  - Providers accompanying children or family members to health care appointments that are not part of the direct provision of ABA services
  - Services by more than one program manager for each child/family (program development, treatment planning, supervision)
  - Training of therapy assistants and family members (as distinct from supervision)
  - Parent training or classes, except for one-on-one or one-on-two direct training of the parents of one identified patient
  - Services provided in a home school, or public/private school environment that are part of a child's schooling as distinct from specific ABA treatment services (e.g. acting as the "Teacher's Aide," or helping a child with homework
- Aromatherapy
- Athletic training, body-building, fitness training or related expenses
- Autopsies
- Bariatric surgery, prescription drugs for weight loss, gym memberships, prescription or non-prescription nutritional and/or food supplements including weight loss shakes, exercise programs and equipment, other surgical procedures primarily for reduction of adipose tissue, abdominoplasty and other cosmetic surgery/liposuction

- Botanical or herbal medicines, as well as other over-the-counter medications. This exclusion does not apply to over-the-counter medications required under the Patient Protection and Affordable Care Act (such medications are covered under the pharmacy benefits when prescribed by a licensed provider)
- Charges for failure to keep a scheduled visit, for the copying of medical records or for the completion of a claim or administrative forms
- Chemical Dependency treatments listed below:
  - Alcoholics Anonymous or other similar chemical dependency programs or support groups
  - Care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior
  - Court-ordered or other assessments to determine the medical necessity of court-ordered treatments
  - Court-ordered treatments or treatments related to deferral of prosecution, deferral of sentencing or suspended sentencing or treatments ordered as a condition of retaining driving rights, when no medical necessity exists
  - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
  - Emergency patrol services
  - Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program
  - Information or referral services
  - Information schools
  - Long-term or custodial care
  - Non substance related disorders
  - Pain management and/or stress reduction classes
  - Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs
  - Treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required
- Claims for services that are the result of any injury or illness incurred by a participant while that participant is participating in the commission of a felony, unless the injury or illness is the result of domestic violence or a physical or mental health condition
- Compensation, wage, or profit expenses relating to an illness or injury when the participant receives a profit or wage (other than employer based disability payments)
- Court ordered examinations or treatment of any kind, except when medically necessary
- Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational and custodial services are not covered.
- Dental, oral surgery or orthodontic related services, such as (but not limited to) those listed below (unless accident related or otherwise specifically covered by the Plan):
  - Care of the teeth or dental structures
  - Tooth damage due to biting or chewing
  - Dental implants, except as covered under the Dental Trauma benefits
  - Dental X-rays
  - Extractions of teeth, except removal of total bony impacted teeth
  - Orthodontia

  - Procedures in preparation for dental implants, except as covered under the Dental Trauma benefits
  - Services to correct malposition of teeth
- Developmental delay treatment or services, except as covered by the Plan
- DME and medical supply charges listed below:
  - Biofeedback equipment
  - Equipment or supplies whose primary purpose is preventing illness or injury
  - Exercise equipment
  - Items not manufactured exclusively for the direct therapeutic treatment of an illness or injured patient
  - Items used outside the home primarily for sports/recreational activities
  - Oral appliances for any diagnosis
  - Over-the-counter items (except medically necessary crutches, walkers, standard wheelchairs, diabetic supplies and ostomy supplies are covered)
  - Personal comfort items including but not limited to air conditioners, lumbar rolls, heating pads, diapers or personal hygiene items
  - Phototherapy devices related to seasonal affective disorder
  - Supportive equipment/environmental adaptive items including, but not limited to, hand rails, chair lifts, ramps, shower chairs, commodes, car lifts, elevators, and modifications made to the patient's home, place of work, or vehicle.
  - The following medical equipment/supplies: standard car seats or strollers, push chairs, air filtration/purifier systems or supplies, water purifiers, allergenic mattresses, orthopedic or other special chairs, pillows, bed-wetting training equipment, corrective shoes, whirlpool baths, vaporizers, room humidifiers, hot tubs or other types of tubs, home UV or other light units (light boxes or specialized lamps or bulbs), home blood testing equipment and supplies (except diabetic equipment and supplies, and home anticoagulation meters)
- Experimental, investigational, or unproven services, except as outlined under the Clinical Trials benefit
- FDA-approved drugs, medications or other items for non- approved indications, except when an FDA-approved drug has been proven clinically effective to treat such indication and is supported in peer-reviewed scientific medical literature
- Home births
- Home health care listed below:
  - Custodial care
  - Housekeeping or meal services
  - Maintenance care
  - Shift or hourly care services
- Hospice care listed below:
  - Custodial care or maintenance care, except palliative care to the terminally ill patient subject to the stated limits
  - Financial or legal counseling services
  - Housekeeping or meal services
  - Services by a participant or the patient's family or volunteers
  - Services not specifically listed as covered hospice services under the Plan
  - Supportive equipment such as handrails or ramps
  - Transportation
- Immunizations for travel

- Infertility treatments to achieve pregnancy (regardless of the cause) including but not limited to:
  - Artificial insemination
  - In vitro fertilization (IVF)
  - Gamete intra-fallopian transplant (GIFT)
- Lab and/or radiology services not ordered by a qualified health care provider
- Learning disabilities and related services, educational testing or associated training.
- Mental health care listed below:
  - Adventure-based and/or wilderness programs that focus primarily on education, socialization or delinquency
  - Court-ordered assessments
  - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
  - Marriage and couples counseling
  - Family therapy, in the absence of an approved mental health diagnosis
  - Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program
  - Nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories
  - Pain management and/or stress reduction classes
  - Sensitivity training
  - Sexual dysfunctions, personality disorders, and paraphilic disorders
  - Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs
- Non-covered services or complications arising from non-covered services. Non-covered services include those services that would not have been covered by this Plan at the time the complication arose
- Non-duplication of payment/coordination of benefits to prevent double coverage, benefits under this Plan will not be paid for expenses that are reimbursed by other insurance companies, medical plan, or subscriber contracts
- Non-emergent maternity services for dependent children, except as covered under the Patient Protection and Affordable Care Act (ACA)
- Nutritional counseling, other than as specifically covered under the Preventive Care or Diabetic Education benefits
- Orthodontia for Temporomandibular Joint Dysfunction (TMJ)
- Orthodontic treatment, appliances or services; dentures or related services
- Over-the-counter products, except as covered by the Plan
- Personal, convenience or comfort services, supplies, house cleaning, house call home visits from a doctor, or items including but not limited to phones, TVs, guest services, deluxe or suite hospital room, air conditioners, diapers or hygiene items
- Pharmacy services listed below:
  - Anorectics (any drug used for the purpose of weight loss
  - Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order
  - Charges for the administration or injection of any drug
  - Diagnostic tests

- Drugs labeled “Caution: Limited by federal law to investigational use” or experimental drugs, even though a charge is made to the individual
- Drugs used for cosmetic purposes, including but not limited to drugs such as Botox, Minoxidil (Rogaine), Tretinoin (Retin A, covered through age 25)
- Immunological agents, biological sera, blood or blood plasma, except flu, pneumonia and zoster (shingles) vaccines as recommended by the Centers for Disease Control and Prevention (CDC) Shingles vaccine is covered beginning at age 50.
- Infertility medications
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed medical facility, rest home, sanitarium, extended care facility, convalescent medical facility, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Non-legend drugs other than insulin. This exclusion does not apply to over-the-counter medications required under the Patient Protection and Affordable Care Act (such medications are covered when prescribed by a licensed provider)
- Non-systemic contraceptives and implants, such as diaphragms, IUDs, cervical caps which would be covered through the medical benefits; or condoms which are over-the-counter
- Nutritional supplements
- Prescriptions which an eligible individual is entitled to receive without charge from any Workers’ Compensation laws
- Renova
- Replacement of lost or stolen medications/items
- Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, except those listed above
- Vitamins, singly or in combination, except prenatal and federal legend vitamins to treat covered medical conditions

- Physical examinations, reports or related services for the purpose of obtaining or maintaining employment, insurance, or licenses or permits of any kind, school admission, school sports clearances, immigration, foreign travel, medical research, camps, or government licensure, or other reasons not related to medical needs.
- Plastic and reconstructive services such as those listed below:
  - Abdominoplasty/panniculectomy
  - Complications resulting from non-covered services
  - Cosmetic services, supplies or surgery to repair, modify or reshape a functioning body structure for improvement of the patient’s appearance or self-esteem (except for gender affirmation surgery);
  - Dermabrasion, chemical peels or skin procedures to improve appearance or to remove scars or tattoos
- Procedures, regardless of medical necessity, outside the scope of the provider’s license, registration or certification
- Professional services listed below:
  - Professional services provided by fax or email.
  - Follow up phone calls from provider for test results, referrals, prescription refills or reminders that occur within 7 days of an in-person office visit
  - Calls to nurse line or to obtain educational material are also not covered
- 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 covered by the Plan
- Reversal of sterilization
- Routine foot care, except as covered by the Plan for treatment of peripheral vascular disease and diabetes
- Routine hearing exams (except as required by law) and hearing aids/appliances
- Services beyond the specified Plan Benefit Maximums
- Services for any condition, illness or injury that arises 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 or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation
- Services or supplies payable under a contract or insurance for uninsured or underinsured (UIM) coverage, motor vehicle, motor vehicle no-fault, or personal injury protection (PIP) coverage, commercial premises or homeowner's medical premise coverage or other similar type of contract or insurance
- Services or supplies received without charge from a medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar group
- Services or supplies required by an employer as a condition of employment
- Services provided by a family member (spouse, parent or child)
- Services provided by a spa, health club or fitness center, except covered medically necessary services provided within the scope of the provider's license
- Services provided by clergy
- Services provided in a school setting (such as early learning and K-12)
- Smoking and Tobacco cessation programs, except as covered under the pharmacy benefit
- Snoring treatment (surgical or other)
- Special diets, nutritional supplements, vitamins and minerals or other dietary formulas or supplements except as covered by the Plan
- Special education for the developmentally disabled
- Specialized intraocular lenses associated with cataract surgery that correct vision disorders, such as Multifocal and Toric intraocular lens.
- Surrogate mother charges (any service rendered to a surrogate mother for the purposes of childbirth)
- Tooth damage due to biting or chewing
- Transportation, except as covered by the Plan
- Transgender/Gender Affirming Services
  - Services that are considered cosmetic (including but not limited to):
    - Abdominoplasty
    - Blepharoplasty
    - Breast augmentation
    - Calf Implants

    - Cheek/malar implants
    - Chin augmentation (reshaping or enhancing the size of the chin)
    - Collagen injections
    - Cryothyroid approximations (voice modification surgery)
    - Electrolysis (hair removal)
    - Face-lift
    - Facial bone reduction
    - Forehead lift
    - Hair transplantation
    - Laryngoplasty (reshaping of laryngeal framework/voice modification surgery)
    - Lip reductions/enhancement (decreasing/increase lip size)
    - Liposuction
    - Mastopexy (breast lift)
    - Neck tightening
    - Pectoral implants
    - Reduction thyroid chondroplasty (trachea shave)
    - Rhinoplasty
  - Travel and lodging
- Transplant services listed below (Organ and Bone Marrow):
  - Animal-to-human transplants
  - Artificial or mechanical devices designed to replace human organs
  - Complications arising from the donation procedure if the donor is not a Plan participant
  - Donor expenses for a Plan participant who donates an organ or bone marrow, however complications arising from the donation would be covered as any other illness to the extent they are not covered under the recipient's health plan.
  - Transplants considered experimental and investigational, as defined by the Plan, except as outlined under the Clinical Trials benefit
- Treatment furnished without charge or paid directly or indirectly by any government or for which a government prohibits payment of benefits
- Vision Care, the following vision benefits are not covered:
  - Routine eye exams
  - Vision hardware (frames, lenses and contact lenses, including fitting) Frames, lenses, and contact lenses needed to treat a medical condition, or needed as a result of a medical condition are covered under the Durable Medical Equipment benefit
  - Radial keratotomy, Lasik or any other refractive surgery, orthoptics, pleoptics, visual therapy, visual analysis therapy or training related to muscular imbalance of the eye; optometric therapy
- Vitamin B-12 injections except to treat Vitamin B-12 deficiency
- Vocational rehabilitation, work hardening or training programs regardless of diagnosis or symptoms that may be present, or for non-medically necessary education
- Weight management programs