Employee Healthcare Plan

Effective January 1, 2022

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 ................................................................................................................. 1
  • Grandfathering .............................................................................................................................................. 2
Contacting First Choice Health .......................................................................................................................... 3
How to Obtain Health Services .......................................................................................................................... 4
  • Your ID Card ................................................................................................................................................. 4
  • Choosing a Provider .................................................................................................................................... 4
Medical Management ........................................................................................................................................ 6
  • Pre-authorization Requirements ................................................................................................................. 6
  • Notification for Emergency Admissions ..................................................................................................... 8
  • Concurrent Review and Discharge Coordination ....................................................................................... 8
  • Case Management ..................................................................................................................................... 8
Payment Provisions ........................................................................................................................................... 9
  • Highlights of Plan Provisions ..................................................................................................................... 9
  • Annual Deductible ...................................................................................................................................... 10
  • Annual Out-of-Pocket Maximum ............................................................................................................. 11
  • Benefit Maximums .................................................................................................................................... 11
Summary of Medical Benefits .......................................................................................................................... 13
Medical Plan Benefits ....................................................................................................................................... 20
  • Allergy Care ............................................................................................................................................... 20
  • Ambulance Services ................................................................................................................................. 20
  • Anesthesia .................................................................................................................................................. 20
  • Autologous Blood Donation/Blood Transfusions .................................................................................... 21
  • Chemical Dependency ............................................................................................................................... 21
  • COVID-19 .................................................................................................................................................. 21
  • Dental Trauma ........................................................................................................................................... 21
  • Diabetic Instruction and Counseling ........................................................................................................ 22
  • Diagnostic Testing .................................................................................................................................... 22
  • Dialysis ....................................................................................................................................................... 22
  • Durable Medical Equipment (DME) and Supplies .................................................................................... 22
  • Emergency and Urgent Care ...................................................................................................................... 23
  • Family Planning ....................................................................................................................................... 23
  • Foot Orthotics ............................................................................................................................................ 23
• Genetic Services ................................................................................................. 23
• Habilitative Services .......................................................................................... 24
• Hearing ................................................................................................................. 24
• Home Health Care ............................................................................................... 24
• Hospice Care ......................................................................................................... 25
• Hospital Inpatient Medical and Surgical Care ......................................................... 25
• Hospital Outpatient Surgery and Services ............................................................ 25
• Infusion Therapy .................................................................................................... 26
• Maternity and Newborn Care ............................................................................... 26
• Medication Therapy Management ........................................................................ 26
• Mental Health Care ............................................................................................... 27
• Nutritional and Dietary Formulas ......................................................................... 27
• Oral Surgery .......................................................................................................... 27
• Pharmacy .............................................................................................................. 28
• Plastic and Reconstructive Services ..................................................................... 29
• Podiatric Care ...................................................................................................... 30
• Preventive Care .................................................................................................... 30
• Professional/Physician Services .......................................................................... 30
• Rehabilitation Therapy ......................................................................................... 31
• Skilled Nursing Facility ......................................................................................... 31
• Transgender/Gender Affirming Services ............................................................... 31
• Transplants (Organ and Bone Marrow) ................................................................. 32
• Vision Care ........................................................................................................... 33

Plan Exclusions and Limitations .............................................................................. 35

Dental Benefit Plan Provisions ................................................................................. 42
• Calendar Year Dental Deductible .......................................................................... 42

Summary of Dental Benefits ...................................................................................... 43

Dental Benefits .......................................................................................................... 46
• Dental Expenses .................................................................................................... 46
• Class I - Preventive and Diagnostic Dental Services .............................................. 46
• Class II - Basic Dental Services ............................................................................ 46
• Class III - Major Dental Services ........................................................................ 47
• Class IV - Orthodontia ......................................................................................... 47

Dental Limitations and Exclusions ............................................................................. 48

Eligibility and Enrollment ......................................................................................... 50
Independent Dispute Resolution
Claim and Appeal Procedures
Other Continuation of Coverage
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
Dependents
Termination of Coverage
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)
Dependents
Other Continuation of Coverage
Claim and Appeal Procedures
Independent Dispute Resolution
Coordination of Benefits ......................................................................................................................... 70
  • Calculation of Benefit Payments ....................................................................................................... 70
  • How Do I Know Which Plan is my Primary Plan? ........................................................................... 71
  • What if I’m Covered by Medicare? .................................................................................................... 73
  • Pre-authorization when this Plan is Secondary ............................................................................... 73
  • Meaning of Plan for COB .................................................................................................................. 73
  • Claim Determination Period .............................................................................................................. 74
  • Right of Recovery ............................................................................................................................... 74
  • Facility of Payment ............................................................................................................................. 75
  • Right to Receive and Release Information ....................................................................................... 75

Subrogation, Reimbursement and Right of Recovery ............................................................................ 76
  • No application of “make whole,” “double recovery,” and “common fund” rules .............................. 76
  • Assignment of Rights (Subrogation) ................................................................................................. 76
  • Equitable Lien and Other Equitable Remedies .................................................................................. 77
  • Obligation to Assist in the Plan’s Reimbursement Activities ............................................................ 77

Health Insurance Portability and Accountability Act of 1996 ............................................................... 79
  • Privacy Rights .................................................................................................................................. 79
  • Disclosures to the Plan Sponsor ........................................................................................................ 79

Plan Benefit Information ....................................................................................................................... 80
  • Benefits, Contributions and Funding ............................................................................................... 80
  • Plan Administrator’s Power of Authority ............................................................................................ 80
  • Discretionary Authority ...................................................................................................................... 81
  • Collective Bargaining Agreements .................................................................................................... 81
  • Clerical Error .................................................................................................................................... 81

Statement of ERISA Rights .................................................................................................................. 82
  • Prudent Actions by Plan Fiduciaries ..................................................................................................... 82
  • Enforce Your Rights .......................................................................................................................... 82
  • Continue Group Health Coverage ..................................................................................................... 83
  • Assistance with Your Questions ......................................................................................................... 83

Your Rights and Protections Against Surprise Medical Bills ............................................................... 84
  • What is Balance Billing (sometimes called Surprise Billing)? ......................................................... 84

Summary Plan Description and General Information ............................................................................. 86

Plan Definitions ..................................................................................................................................... 88
Important Information about this Plan

This booklet serves as your Plan Document and Summary Plan Description for the Comprehensive Healthcare Employee Health Care Plan as of January 1, 2022. The first section of the booklet describes your coverage and payment levels under the plan(s) offered. The second section contains information on eligibility and enrollment, terminating and continuing coverage, administration, claim and appeal procedures and other legally required material applicable to each benefit plan.

Comprehensive Healthcare, 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. Comprehensive Healthcare delegates to FCH the authority to make decisions on benefit coverage, medical management, claim payment and certain other administrative services according to Comprehensive Healthcare’s policies and procedures. However, Comprehensive Healthcare retains at all times the ultimate fiduciary authority, responsibility and control over Plan assets, management and administration.

The Comprehensive Healthcare Employee Health Care 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 an out-of-network provider, you will receive the lower network level of benefits except in certain instances as outlined in the summary 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 in the How to Obtain Health Services section.

Coverage under this Plan will take effect for eligible employees and dependents when all eligibility requirements are satisfied. Comprehensive Healthcare 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 result 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 Comprehensive Healthcare.
Grandfathering

Comprehensive Healthcare believes this Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator (Comprehensive Healthcare) at 402 S 4th Avenue, Bldg. A, Yakima, WA 98902-3456. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.
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) 551-6788
Local: (206) 268-2360
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


Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (866) 551-6788.

Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijjigo holne’ (866) 551-6788.

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) 551-6788.
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) 551-6788, 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 (highest) 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:

<table>
<thead>
<tr>
<th>Networks</th>
<th>State/Area</th>
<th>Phone</th>
<th>Websites</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Health</td>
<td>All states/areas not served by FCHN</td>
<td>(800) 226-5116</td>
<td><a href="http://www.myfirsthealth.com">www.myfirsthealth.com</a></td>
</tr>
</tbody>
</table>

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

Services Received Outside 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.

Continuity of Care

When you are receiving certain types of in-network care and the treating in-network provider leaves the network, the Plan must provide 90 days of continued in-network coverage (or 90 days from the date that you are no longer a continuing care patient, whichever is earlier) and the provider cannot send you a
balance bill. A continuity of care patient is a person who is: (1) undergoing a course of treatment for a serious and complex condition from the provider or facility; (2) undergoing a course of institutional or inpatient care from the provider or facility; (3) scheduled to undergo non-elective surgery from the provider; (4) pregnant and undergoing a course of treatment for pregnancy from the provider; or (5) determined to be terminally ill and receiving treatment for such illness from the provider or facility. This requirement does not apply to for-cause terminations of a provider.
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. Emergency Services do not need to be pre-authorized. Pre-authorization is required for:

- Air Ambulance Transport - non-urgent transport
- Anesthesia for dental services
- Chimeric Antigen Receptor (CAR) T-cell therapy
- Clinical Trials (including all interventions/medications)
- Dental Trauma Services (follow-up services)
- Dialysis (all types)—for chronic kidney disease
- Durable Medical Equipment, Medical Supplies and Prosthetics
  - Bone growth and neuromuscular stimulators
  - Compression devices for home use
  - Cranial orthotic devices
  - Custom and power operated 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
  - Myoelectric components for upper limb and powered components for ankle-foot and knee Prosthetics
  - Oscillatory devices and cough stimulating devices
  - Scooters
  - Speech generating devices
  - Tumor Treating Fields for Glioblastoma
  - Vacuum Assisted Wound Therapy
- Enteral Formula, Medical Food and Associated Services
- Facet Joint Injections, Medial Branch Blocks and Neurotomies (any location)
- Genetic Testing (over $500)
- Home Health Care Services (certain home infusion drugs may still require pre-authorization. See Medical Injectables)
  - Home health visits (for wound therapy only)
  - Hospice
- Hyperbaric Oxygen Therapy
- Imaging
  - PET scans
• Inpatient Admissions
• Medical Injectables and Other Drugs, Chemotherapy and Other Drugs over $5,000/annually (Newly FDA approved medications may also require Pre-authorization. For questions, call FCH at the number above.)
  – Other Medications including
    o Blood Clotting Factors, All types, All brands
    o Select Hormone Therapy
    o Intravenous Immunoglobin Therapy- IVIG, All types, All brands
    o Botulinum Toxin, All types, All brands

• Oral Appliances for Sleep Apnea Therapy
• Organ and Bone Marrow Transplants (includes evaluation of, services for recipient and donor, and travel and lodging expenses)
• 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
  – Breast surgeries- selected (Pre-authorization is not required for breast reconstruction and nipple/areola reconstruction following mastectomy for breast cancer)
    o Implant removal
    o Mastectomy for gynecomastia
  – Cochlear implants (surgical benefit applies)
  – Cosmetic or reconstructive surgery
  – Deep brain stimulation
  – Fetal/Intrauterine surgery
  – Gender affirmation surgery
  – Implantable peripheral nerve and/or spinal cord stimulator placement (temporary and permanent) including electrodes and/or pulse generator/receiver
  – Orthognathic surgery
  – Ovarian, internal iliac and gonadal vein embolization, ablation and sclerotherapy
  – Spinal surgery (selected)
    o Artificial intervertebral disc
    o Cervical fusions
    o Lumbar fusions
    o Minimally invasive, percutaneous & endoscopic spine surgery
  – Surgical interventions for sleep apnea
  – Vagus nerve stimulation
  – Varicose vein procedures
  – Ventricular assist devices and total heart replacement

• Transcranial Magnetic Stimulation
Claims denied for lack of pre-authorization will 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. 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

- In general, your benefit coverage is greater, and your out-of-pocket costs less, when you choose a Network provider.
- If the closest network provider in the specialty you are seeking is more than 20 miles from your home zip code, you may see an out-of-network provider if there is one closer to you, and the Plan will reimburse those services at the network level. In order for your claim to be paid at the network level, you must submit an appeal according to the procedures listed under Claim and Appeal Procedures.
- If you are travelling and experience a medical Emergency (see Plan Definitions) and a network provider is not available, you may see any provider and the Plan will reimburse those services at the network level. In order for your claim to be paid at the network level, you must submit an appeal according to the procedures listed under Claim and Appeal Procedures.
- Services provided at Astria Toppenish Hospital are not covered, with the exception of the following services: inpatient and outpatient cardiac care, inpatient rehabilitative care, and emergency treatment, which are paid at the network level (generally 80%).
- Benefit payment is based on the Allowed Amounts agreed upon by Network providers.
- Services received from a Recognized Provider (see Plan Definitions) will be paid at the Network level (80%). 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. Common examples include:
  - Ambulance services
  - Anesthesiologists
  - Assistant surgeon
  - Non-contracted laboratories used by FCHN referring provider
- Services received from a Recognized No Surprises Provider (see Plan Definitions under Section II - Summary Plan Description) provided by out-of-network Emergency Departments and out-of-network providers, certain non-emergency services furnished by out-of-network providers at certain in-network facilities, and out-of-network air ambulances, the cost-sharing amount is determined by the Qualifying Payment Amount (see Plan Definitions under Section II - Summary Plan Description).
- When you receive services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most that those providers may bill you is your Plan’s lowest in-network cost-sharing amount. This applies to emergency services, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections. If you receive other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.
- For services received from out-of-network providers, you are responsible to pay the difference between the Plan payment and the provider’s actual charges.
• Certain serious and complex care treatments may apply to the Continuity of Care section. See Continuity of Care under How to Obtain Health Services for care from a provider who leaves the network.

• 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.

Summary of Annual Deductible and Out-of-Pocket Maximums:

<table>
<thead>
<tr>
<th>Calendar Year Annual Deductible</th>
<th>Network/Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$450</td>
</tr>
<tr>
<td>Family</td>
<td>$1,350</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calendar Year Annual Out-of-Pocket Maximum</th>
<th>Network/Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee only</td>
<td>$2,000</td>
</tr>
<tr>
<td>Family</td>
<td>$5,000</td>
</tr>
</tbody>
</table>

**Annual Deductible**

The annual deductible is the amount you (or your family) must pay each calendar 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 a provider is your responsibility. The network and out-of-network annual deductibles are inclusive of each other.

This Plan offers an Embedded Deductible, which means each individual will meet no more than the individual maximum, but the family will meet no more than the stated family maximum, regardless of family size. In this case, some individuals may meet less than the individual maximum amount if the family maximum is met.

Finally, if your employer replaces this Plan with another group health plan, any portion of the annual deductible that you satisfied under the previous plan will be credited to the new group health plan. This credit will occur only during the calendar year in which the new group health plan becomes effective. You may call Customer Service with questions regarding prior plan deductible credits.

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 out-of-network services as determined by FCH
• Charges that exceed any applicable benefit maximum
• First 2 preventive visits per calendar year
• Claims denied for lack of pre-authorization
• Difference in price between a brand name and generic drug
• Routine eye exams and hardware
• Routine hearing exams
• Prescription drugs
• Copayments

**Annual Out-of-Pocket Maximum**

The annual out-of-pocket maximum is the most you will need to pay in a calendar year. This Plan offers an Embedded 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 coinsurances. Also, the family will meet no more than the stated family maximum regardless of family size. The network and out-of-network calendar year out-of-pocket amounts are inclusive of each other. 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 out-of-network services as determined by FCH
• Charges that exceed any applicable benefit maximum
• Charges for claims denied for lack of pre-authorization
• Copayments
• Deductible
• Difference in price between a brand name and generic drug
• Claims denied for lack of pre-authorization
• Prescription drugs

**Benefit Maximums**

**Summary of Benefit Maximums**

<table>
<thead>
<tr>
<th>Lifetime Maximums Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Organ Transplants</strong> – Recipient</td>
</tr>
<tr>
<td>• Travel/Lodging</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Calendar Year Maximums</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hearing Exams, Aids/Appliances</strong> (Combined)</td>
</tr>
<tr>
<td><strong>Rehabilitation and Physical Therapy</strong> (Inpatient Care)</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
</tr>
<tr>
<td>Vision Care</td>
</tr>
<tr>
<td>-----------------------------</td>
</tr>
<tr>
<td><strong>Routine Vision Care</strong></td>
</tr>
<tr>
<td><strong>Lenses, Frames, Contacts</strong></td>
</tr>
</tbody>
</table>
Summary of Medical Benefits

<table>
<thead>
<tr>
<th>Service</th>
<th>Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allergy Care</strong> (testing, serum, injections)</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>FCH pre-authorization required for non-emergent air ambulance.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Anesthesia</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Autologous Blood Donation/Blood Transfusions</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Chemical Dependency</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>FCH pre-authorization required for inpatient, residential and partial hospitalization.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Dental Trauma</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>FCH pre-authorization required for follow-up services and anesthesia.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diabetic Instruction and Counseling</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Diagnostic Testing</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>(Lab and Radiology, non-routine, facility and professional services)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FCH pre-authorization required for PET Scans.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Hospital Inpatient / Outpatient</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>• <strong>Lab and X-ray Facility</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Lab or radiology services provided by an independent lab or radiology provider, group, facility or office, but billed separately from the provider of care.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• <strong>Doctor’s Office</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Office based lab or radiology service provided as part of the office visit, and billed as part of the office visit.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Services provided at Astria Regional Medical & Cardiac Center or Astria Toppenish Hospital are not covered, with the exception of inpatient and outpatient cardiac care, inpatient rehabilitative care and emergency treatment which will be paid at the Network level, generally 80%.
<table>
<thead>
<tr>
<th>Services Provided</th>
<th>Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dialysis</td>
<td></td>
<td>Covered based on place of service</td>
</tr>
<tr>
<td>FCH pre-authorization required.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Durable Medical Equipment and Supplies</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>FCH pre-authorization required for certain services (see Pre-authorization Requirements for a complete list)</td>
<td></td>
</tr>
<tr>
<td>• Durable Medical Equipment</td>
<td>80%</td>
</tr>
<tr>
<td>• Medical Supplies</td>
<td>80%</td>
</tr>
<tr>
<td>• Oral Appliances</td>
<td>80%</td>
</tr>
<tr>
<td>For treatment of obstructive sleep apnea only.</td>
<td></td>
</tr>
<tr>
<td>FCH pre-authorization required.</td>
<td></td>
</tr>
<tr>
<td>• Orthopedic Appliances/Braces</td>
<td>80%</td>
</tr>
<tr>
<td>• Prosthetic Devices</td>
<td>80%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Emergency Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emergency Department (facility services)</td>
<td>80% after $200 copay</td>
</tr>
<tr>
<td>Copay is waived if admitted.</td>
<td></td>
</tr>
<tr>
<td>• Emergency Department (professional services)</td>
<td>80%</td>
</tr>
<tr>
<td>• Urgent Care (facility and professional services)</td>
<td>80%</td>
</tr>
</tbody>
</table>

| Family Planning | 80% | 60% |
| Foot Orthotics | 80% | 60% |
| Genetic Services | 80% | 60% |
| FCH pre-authorization required for genetic testing over $500. | |
| Habilitative Services | 80% | 60% |
| Hearing (exams, aids, appliances) | |

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Comprehensive Healthcare Employee Plan 2022

14
<table>
<thead>
<tr>
<th>Services Provided</th>
<th>Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routine Hearing Exams</strong>&lt;br&gt;1 exam per calendar year.</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Medical Hearing Exams and Hearing Aids/Appliances</strong>&lt;br&gt;$1,250 per calendar year.</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td><strong>Home Health Care (HHC)</strong>&lt;br&gt;FCH pre-authorization required for wound therapy, enteral formula, medical food and associated services and home hospice.</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Hospice Care</strong>&lt;br&gt;FCH pre-authorization required.</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Hospital Inpatient Medical and Surgical Care</strong>&lt;br&gt;FCH pre-authorization required.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Facility Services</strong></td>
<td>80% after $200 copay per day up to $400 maximum</td>
<td>60% after $200 copay per day up to $400 maximum</td>
</tr>
<tr>
<td><strong>Inpatient Professional Services</strong>&lt;br&gt;(doctor, surgeon, assistant surgeon, radiologist, pathologist)</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Hospital Outpatient Surgery and Services</strong>&lt;br&gt;FCH pre-authorization required for certain outpatient services; see Pre-authorization Requirements for details.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surgical Facility Services</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Ambulatory Surgery Center (ASC)</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Outpatient Professional Services</strong>&lt;br&gt;(doctor, surgeon, assistant surgeon, radiologist, pathologist)</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>

Services provided at Astria Regional Medical & Cardiac Center or Astria Toppenish Hospital are not covered, with the exception of inpatient and outpatient cardiac care, inpatient rehabilitative care and emergency treatment which will be paid at the Network level, generally 80%.
<table>
<thead>
<tr>
<th>Services Provided</th>
<th>Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Infusion Therapy</strong> (includes infusion therapy provided in the home)</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>FCH pre-authorization required for certain infusion therapy drugs, see <em>Pre-Authorizations Requirements</em>.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Maternity and Newborn Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient Facility Services</td>
<td>80% after $200 copay per day up to $400 maximum</td>
<td>60% after $200 copay per day up to $400 maximum</td>
</tr>
<tr>
<td>• Professional Services</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Medication Therapy Management</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Mental Health Care</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>FCH pre-authorization required for inpatient, residential and partial hospitalization.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nutritional and Dietary Formulas</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Oral Surgery</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| • **Retail** (30 day supply) | | Generic: $10  
Preferred: $30  
Non-preferred: $55 |
| • **Mail Order/Online Pharmacy** (90 day supply) | | Generic: $20  
Preferred: $65  
Non-preferred: $130 |
| • **Specialty Pharmacy** (through Costco Health Solutions) | | 80% with a maximum copayment of $200 |
| **Plastic and Reconstructive Services** | 80% | 60% |
| FCH pre-authorization required. Limited benefit; see *Plastic and Reconstructive Services* for details. | | |

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<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Podiatric Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>See Podiatric Care for details on Routine Foot Care.</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>

### Preventive Care

The first two preventive visits per calendar year are paid at 100%. A visit may include: preventive exam, immunizations or routine screening tests (such as colonoscopy/sigmoidoscopy, mammogram, pap test, etc.).

### Well Baby and Child Care (children age 0 – 19)

- First 2 Visits Per Calendar Year
  - Network Providers: 100%
  - Out-of-Network Providers: 100%
- Services received After The First Two Visits
  - Network Providers: 80%
  - Out-of-Network Providers: 60%

### Adult Preventive Care (Adults age 20+)

- First 2 Visits Per Calendar Year
  - Network Providers: 100%
  - Out-of-Network Providers: 100%
- Services Received After The First Two Visits
  - Network Providers: 80%
  - Out-of-Network Providers: 60%

### Screening Tests

- **Colonoscopy** (1 every 10 years beginning at age 50 or younger if at increased risk)
  - Network Providers: 80% (100% if included in first 2 visits)
  - Out-of-Network Providers: 60% (100% if included in first 2 visits)

- **FIT-Fecal DNA**
  - FCH pre-authorization required.
  - Network Providers: 80% (100% if included in first 2 visits)
  - Out-of-Network Providers: 60% (100% if included in first 2 visits)

- **Mammograms**
  - Age 35-39 = 1 baseline test
  - Age 40-49 = 1 every 2 calendar years
  - Age 50+ = 1 per calendar year
  - Network Providers: 80% (100% if included in first 2 visits)
  - Out-of-Network Providers: 60% (100% if included in first 2 visits)

- **Sigmoidoscopy** (1 every 5 years beginning at age 50 or younger if at increased risk)
  - Network Providers: 80% (100% if included in first 2 visits)
  - Out-of-Network Providers: 60% (100% if included in first 2 visits)

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<table>
<thead>
<tr>
<th>Service Description</th>
<th>Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pap Tests, Pelvic Exams</strong> (for women 18 and/or sexually active, once per calendar year)</td>
<td>80% (100% if included in first 2 visits)</td>
<td>60% (100% if included in first 2 visits)</td>
</tr>
<tr>
<td><strong>Other Screenings</strong> (lab/x-rays, as medically necessary)</td>
<td>80% (100% if included in first 2 visits)</td>
<td>60% (100% if included in first 2 visits)</td>
</tr>
<tr>
<td><strong>Professional/Physician Services</strong> (office visits, certain telemedicine visits and office surgeries)</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>98point6 Text Based Program</strong> (Primary Care)</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td><strong>Rehabilitation Therapy</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient</strong> FCH pre-authorization required; 30 days per calendar year.</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Outpatient</strong> (includes physical, speech, cardiac, occupational, and massage therapies)</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong> FCH pre-authorization required; 30 days calendar year.</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Transgender/Gender Affirming Services</strong> FCH pre-authorization and Case Management required. Limited benefit, see Transgender/Gender Affirming Services for details.</td>
<td>Payment is based on Place of Service and Provider type.</td>
<td></td>
</tr>
<tr>
<td><strong>Transplants</strong> (Organ and Bone Marrow) FCH pre-authorization required; 12-month waiting period applies.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Recipient</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Donor</strong></td>
<td>80%</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>Travel and Lodging</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Vision Care</th>
<th>Network Providers</th>
<th>Out-of-Network Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eye Exam</strong> 1 per calendar year.</td>
<td>80%</td>
<td>Costco: 100%</td>
</tr>
<tr>
<td><strong>Hardware</strong> (lenses, frames, contacts, and extras, received at a Costco location - if the exam is through Costco) $300 benefit maximum every 2 calendar years.</td>
<td>n/a</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Hardware</strong> (lenses, frames, contacts, and extras, received through all other providers) $200 benefit maximum every 2 calendar years.</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Hardware</strong> after the above maximums of $300 or $200 have been met. (dependent children age 18 and under) (lenses, frames, contacts, and extras, received through all other providers)</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

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Comprehensive Healthcare Employee Plan 2022
Medical Plan 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, Vision and Pharmacy Benefits and Medical and Pharmacy Limitations and Exclusions for more details, along with Plan Definitions in the accompanying Summary Plan Description.

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.

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.

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:

- Six years of age or younger or,
- Is physically developmentally disabled, or
- Is an individual with a medical condition which 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.

Autologous Blood Donation/Blood Transfusions
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 approved by your physician.

Chemical Dependency
All inpatient admissions and partial hospitalization programs require FCH pre-authorization by calling (800) 640-7682. The Plan covers treatment of individuals requiring chemical dependency rehabilitation for abuse of substances such as alcohol or DEA-controlled oral, intravenous or inhaled medications and materials. 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 goal(s) must be established as determined by your provider and FCH’s medical management.

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

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 jaw bone 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 begin within 30 days of the date of the injury and be completed within 24 months. 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 Instruction and Counseling

Diabetic instruction and counseling regarding nutrition and insulin management of diabetes is covered. The instruction and counseling 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.

Dialysis

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

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:

- **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.
- **Oral Appliances** specific to the treatment of Sleep Apnea.
- **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 which 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 visits (including pre-stabilization, post-stabilization, certain ancillary services) and urgent care visits to evaluate an Emergency Medical Condition at in-network and out-of-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 gun-shot 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 out-of-network follow-up services, you must obtain a pre-authorization from FCH in order to receive the highest benefit level, unless the services are part of the post-stabilization treatment.

**Family Planning**

FDA-approved birth control methods are covered. Over-the-counter products are not covered. Oral contraceptives are covered under the pharmacy benefit.

These voluntary sterilization procedures are covered for an employee and spouse only (not dependent children):

- Essure
- Tubal ligation (not reversal)
- Vasectomy (not reversal)

Termination of pregnancy is not covered (unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result 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**

FCH pre-authorization is required for genetic testing over $500. 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.

**Hearing**

Hearing exams when needed to determine auditory deterioration, and aids and appliances as needed are covered. Covered services include exams, fittings and supplies.

**Home Health Care**

**FCH pre-authorization is required** for wound therapy. 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 Hospice benefits. 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. *Note: patients are not required to discontinue treatment or “curative care” in order to access the hospice benefit.* 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. Coverage for room and board is covered at this level.

- **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 care.
  - **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

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.
Infusion Therapy

FCH pre-authorization required for certain infusion therapy drugs, see Pre-Authorizations Requirements. 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.

Maternity and Newborn Care

Notification of a maternity admission is required within 2 business days, or as soon as possible.

Coverage for pregnancy and childbirth, for employees or his/her spouse, in a hospital or 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 and/or an advanced registered nurse practitioner (ARNP) are covered under this benefit.

There is no coverage of Pregnancy for a Dependent child, except for complications.

Coverage for newborns is provided when s/he is enrolled as a dependent under this Plan (see Enrollment section within Section II - Summary Plan Description 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.

Medication Therapy Management

This benefit covers pharmacist consultations received for a covered medical condition.
Mental Health Care

All inpatient admissions and partial hospitalization programs require FCH pre-authorization by calling (800) 640-7682. The Plan covers treatment of mental health or psychiatric conditions.

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 goal(s) as determined by your provider and FCH’s medical management.

Care may be received at a hospital, a licensed community mental health agency; a physician, or a licensed clinical psychologist, a psychological associate, licensed clinical social worker, licensed marriage and family therapist or a licensed marriage and family counselor, and/or received through residential treatment programs, partial hospital programs, and intensive outpatient programs or through group or individual outpatient services.

Family and couples counseling, and psychotherapeutic programs are covered only if related to the treatment of an approved clinical mental health diagnosis, specifically, those noted in the most 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 dietary formulas and nutritional supplements are covered 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).

Special diets, nutritional supplements and over-the-counter vitamins and minerals are not covered.

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 Costco Health Solutions, 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.

The Summary of Medical Benefits section notes the amounts for which you are responsible. To assist in keeping your out-of-pocket costs down when purchasing a prescription, it may be helpful to know that three tiers exist within the pharmacy structure:

- **Tier 1 or Generic Drugs** – The generic version of a drug has the same chemical compound as its brand counterpart. Generic drugs offer a simple, safe alternative to help reduce prescription costs.
- **Tier 2 or Preferred Brand Drugs** – This level includes preferred brand-name drugs that have no generic equivalent.
- **Tier 3 or Non-Preferred Brand Drugs** – This level includes brand drugs that are not listed in Tier 2. In most cases there are reasonable alternatives in Tier 1 or 2 for drugs found in this highest tier.

Costco customer care is available 24 hours a day 7 days a week toll free: (877) 908-6024 Closed on Christmas Day and Thanksgiving Day.

DAW Cost Sharing Penalty

Your plan encourages members to utilize generic medications when a generic is available. If your physician specifies that a brand name should be dispensed, you will pay the appropriate brand copay. If you request the brand name when a generic is available, you will pay the applicable brand copay plus the difference in cost between the brand and the generic.

Step Therapy

Step therapy is administered to help increase appropriate utilization of certain drugs and influence the process of managing costs.

Costco Health Solutions Retail Pharmacy

You may receive a 30-day supply of your prescription at a Costco Health Solutions pharmacy. Costco Health Solutions has an extensive nationwide network of retail pharmacies. You may call them directly at (800) 607-6861, or visit their website at [www.costcohealthsolutions.com](http://www.costcohealthsolutions.com) to determine if your local pharmacy is in their network.

*Important Note: You can fill prescriptions at a covered pharmacy under the Pharmacy Option copayments, however, once the same drug (maintenance drug) has been filled 3 times at the pharmacy, your 4th refill will be subject to the Mail Order copayment for only a 30-day supply.*
Costco Mail Order Pharmacy

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 may obtain a 90-day supply of ongoing medications through Costco Mail Order. Please contact Costco Mail Order at (800) 607-6861, or visit their website at www.costcohealthsolutions.com to learn more about how to obtain a 90-day supply.

Members may need to obtain new prescriptions from their physicians for a 90-day supply. If you need to start your medication immediately, or do not have a two (2) week minimum supply on hand, request two prescriptions from your physician; one for a short-term supply to fill at a local retail pharmacy and one for a 90-day supply (including refills) that can be submitted to Costco Mail Order Pharmacy.

If you have questions on how to get started using the Costco Mail Order Pharmacy please visit www.costcohealthsolutions.com or contact the pharmacy at (800) 607-6861 797-9791.

Costco Specialty Services

Costco Specialty Services is the exclusive provider for your specialty medications as part of your prescription drug plan and is mandatory at Costco Specialty Pharmacy, including your first fill of your medication. Costco Specialty Services goes beyond traditional retail pharmacy, helping you get the most from your specialty medication therapy.

Specialty Copay Card Assistance Programs are offered by drug manufacturers to eligible members. They are a direct way to lower out-of-pocket costs for specialty prescription medications. The Copay Assistance Cards allow members to afford specialty medications preferred by their physician. Any specialty drug co-pay assistance program that is paid by a drug manufacturer or other third party will be reported to the insurance with the true member out-of-pocket copay.

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 for members with peripheral vascular disease and diabetes.

Preventive Care

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

• Routine physicals
• Periodic examinations including the specific diagnostic testing/screening and laboratory services noted in the Summary of Benefits (the frequency of these examinations is determined by the age, gender, health status and medical needs of the participant)
• Adult, child and adolescent immunizations as recommended by the Centers for Disease Control (CDC).

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 recommended immunization schedules visit the CDC’s website at: www.cdc.gov/vaccines/.

Professional/Physician Services

This benefit applies to in-person, face-to-face office visits, and Telemedicine. 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.
Situations with 98point6 providers can be done online or via two-way video or telephonic. Sessions are not time-limited.

**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 or physical, occupational or 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.)

**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. 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; and, there is a 12-month waiting period for this benefit. Services directly related to organ transplants must be coordinated by your participating provider. There are no out-of-network benefits for donor services related to organ transplants. Proposed transplants will not be covered if considered experimental or investigational for the participant’s condition. 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
- 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

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

*Important 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 as any other illness 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 $5,000 per transplant episode. The maximum applies to all associated transportation, lodging and meal expenses incurred by the transplant recipient and companion(s).

Vision Care

Eye Exam

This benefit covers one routine vision exam per member each calendar year. Covered routine exam services include:

- Examination of the outer and inner parts of the eye
- Glaucoma screening
- Refraction
- Binocular balance testing
- Routine tests of color vision, peripheral vision and intraocular pressure
- Case history and recommendations
Hardware

This benefit includes vision hardware needed to correct refractory vision problems. Frames, lenses and contact lenses needed to treat or as a result of a medical condition are covered under the Durable Medical Equipment benefit.

- **Elective Contact Lenses** - Coverage is provided for elective contact lenses which are worn instead of glasses as a personal choice, versus a medical condition that prevents you from wearing glasses. A contact lens exam to ensure proper fit of your contacts, and evaluating your vision with the contacts, is also covered.

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

Hardware Extras

Additional vision hardware services (extras) including, but not limited to, scratch resistant coating, tinting, etc. are covered up to the hardware maximum noted in the *Summary of Medical Benefits* grid.

Hardware coverage can be used anywhere, however, FCHN contracted discounted amounts will apply if the provider (whether individual provider or optical hardware facility) is participating.
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 life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest. Complications of a non-covered abortion are covered.
- Acupuncture.
- Adoption or surrogacy 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 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 Therapy).
- 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.
- Benefits relating to any condition, illness, or injury for which the participant receives compensation or reimbursement through another contractual arrangement or benefit, other than employer-based disability payments, such as surrogate pregnancy.
- Biofeedback.
- Bone Anchored Hearing Aid (BAHA) devices.
- Botanical or herbal medicines, as well as other over-the-counter medications.
- Breast reduction.
• Care, treatment, supplies received outside of the U.S. if travel is for the sole purpose of obtaining medical services.

• 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.
  - Biofeedback, pain management and/or stress reduction classes.
  - Care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior.
  - 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
  - Information or referral services
  - Information schools
  - Long-term or custodial care
  - Non-substance related disorders
  - Treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required.

• Chiropractic Spinal Manipulation.

• Court ordered examinations, assessments, 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 by the Plan under the Dental Trauma benefits
  - Dental X-rays
  - Extractions of teeth, impacted or otherwise (except as covered under the Plan).
  - 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
  - Breast pumps
  - 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 primarily for sports/recreational activities
  - Oral appliances except to treat obstructive sleep apnea
- 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)
  - Wigs
- Experimental or investigational services.
- 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.
- First Responder User Fees
- Hair loss care, treatment or prescriptions.
- 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 work.
- Injuries or illnesses resulting, directly or indirectly, from an illegal act. “Illegal Act” shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence if imprisonment could be imposed. It is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the injury or illness resulted from an act of domestic violence or a medical (physical or mental) condition.
- Infertility services of any kind, and 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.
• Massage therapy (unless performed by a physical therapist as part of a rehabilitative care).

• Mental health care listed below:
  - Adventure-based and/or wilderness programs that focus primarily on education, socialization or delinquency.
  - Biofeedback, pain management, and stress reduction classes.
  - 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.
  - Developmental delay disorders
  - Family therapy, in the absence of an approved mental health diagnosis.
  - Marriage and couples counseling
  - Nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories.
  - Sensitivity training
  - Sexual dysfunctions, personality disorders, and paraphilic disorders.

• Non-compliance, specifically, all charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a hospital or skilled nursing facility against medical advice.

• 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. Complications from a non-covered abortion and complications of pregnancy for a dependent daughter are covered.

• 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

• 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:
  - Accutane over age 25
  - Retin A over age 39
  - Allergens/allergy injections
  - Contraceptive services and supplies listed below:
- Devices such as IUDs, diaphragms
- Injections such as depo-provera
- Vaginal ring (nuvaring)
- Emergency contraception such as Plan B and Preven
- Cosmetic drugs
- Fluoride preparations
- Impotency drugs such as Viagra, Cialis, Levitra, Edex, Caverject
- Miscellaneous injectable (retail)
- Miscellaneous medical supplies
- Over-the-counter (OTC) products such as Claritin OTC, Loratidine OTC, Prilosec OTC
- Tobacco cessation products
- Weight loss drugs/products
- Vitamins, in multiple or singular combinations and/or pediatric vitamins.

- 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.

- Private duty nursing.

- 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 members with peripheral vascular disease and diabetes.

- 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.

• Snoring treatment (surgical or other).

• Special diets, nutritional supplements, vitamins and minerals or other dietary formulas or supplements except as covered by the Plan.

• Specialized intraocular lenses associated with cataract surgery that correct vision disorders, such as Multifocal and Toric Intraocular lenses.

• Surrogacy (including gestational surrogacy) and any services or supplies provided in connection with a surrogate pregnancy, including maternity charges incurred by a Plan Participant acting as a surrogate parent as well as surrogacy for the Plan Participant.

• Termination of pregnancy for dependent child (unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest).

• 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 from the donation are covered as any other illness to the extent they’re not covered under the recipient’s health Plan).
  - Organ transplants not specifically listed as covered transplants.
  - Transplants considered experimental and investigational, as defined by the Plan.

- Transportation, except as covered by the Plan.

- Treatment furnished without charge or paid directly or indirectly by any government or for which a government prohibits payment of benefits, except for complications.

- Treatment of Temporomandibular Joint Dysfunction Syndrome (TMJ).

- Vision Care, the following vision benefits are not covered:
  - Non-prescription sunglasses or safety glasses.
  - 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.
  - Services or supplies received principally for cosmetic purposes other than contact lenses selected in place of eyeglasses.

- 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.

- Wigs.
Dental Benefit Plan Provisions

The benefits of this Plan are provided for covered services at the percentages specified within the *Summary of Dental Benefits* after the applicable deductible has been met. The dental benefit is a percentage of the usual, customary and reasonable (UCR) charges for those dental services and supplies that are listed in this section.

To help you budget for more expensive treatments like crowns and bridges, we recommend that you have your dentist submit a pre-estimate any time charges are expected to exceed $500.

**Calendar Year Dental Deductible**

The annual Calendar Year deductible is the amount you (or your family) must pay each Calendar Year before your employer is obligated to pay for covered services. Only covered services are applied towards the calculation of the deductible. The amount due to a provider remains your liability until your deductible is met.

**Annual Deductible and Maximum:**

<table>
<thead>
<tr>
<th>Deductible and Maximums</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible per Calendar Year</strong></td>
<td></td>
</tr>
<tr>
<td>Per Participant or Dependent</td>
<td>$50</td>
</tr>
<tr>
<td>Family</td>
<td>$100</td>
</tr>
<tr>
<td><strong>Maximum Dental Benefits per Calendar Year</strong> (applies per calendar year to all services)</td>
<td></td>
</tr>
<tr>
<td>Per Participant or Dependent</td>
<td>$1,500</td>
</tr>
<tr>
<td>Maximum Orthodontia Benefit (per Lifetime Per Dependent - child under age 19 only)</td>
<td>$1,250</td>
</tr>
</tbody>
</table>
# Summary of Dental Benefits

## Class I - Preventive and Diagnostic Dental Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Applies to Deductible</th>
<th>Children 0-18 (unless otherwise specified)</th>
<th>Adults 19+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency/Palliative treatment</td>
<td>n/a</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Fluoride, topical application</td>
<td>n/a</td>
<td>100%</td>
<td>N/A</td>
</tr>
<tr>
<td>1 per calendar year through age 14</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral evaluation of mouth, teeth and gums</td>
<td>n/a</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>2 per calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prophylaxis (cleanings)</td>
<td>n/a</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>2 per calendar year</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sealants</td>
<td>n/a</td>
<td>100%</td>
<td>N/A</td>
</tr>
<tr>
<td>Limited to permanent bicuspsids and molars for children through age 18; $100 per calendar year, $300 per Lifetime</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Space maintainers</td>
<td>n/a</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Fixed or removable</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>X-Rays</td>
<td>n/a</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>Bitewings</td>
<td>n/a</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>2 per calendar year through age 19; 1 per calendar year age 20+</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Full mouth set OR one Panorex</td>
<td>n/a</td>
<td>100%</td>
<td>80%</td>
</tr>
<tr>
<td>1 every 3 calendar years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Class I Services</td>
<td>n/a</td>
<td>100%</td>
<td>80%</td>
</tr>
</tbody>
</table>

## Class II - Basic Dental Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Applies to Deductible</th>
<th>Children 0-18</th>
<th>Adults 19+</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
- **Anesthesia** (e.g., Novocaine)
  If dental procedure requires general anesthesia within hospital setting coverage is provided under the Medical Plan, see *Anesthesia* in Medical, Vision, Pharmacy, and Dental Benefit Summary.

<table>
<thead>
<tr>
<th>Service</th>
<th>Applies to Deductible</th>
<th>Children 0-18</th>
<th>Adults 19+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Endodontics</strong></td>
<td>✓</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td><strong>Extractions</strong></td>
<td>✓</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>- Simple extraction</td>
<td>✓</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>- Surgical extraction</td>
<td>✓</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td><strong>Fillings</strong></td>
<td>✓</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td>Composite resin or amalgam (not gold)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Occlusal guard</strong> (adult/child)</td>
<td>✓</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td><strong>Oral surgery</strong></td>
<td>✓</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td><strong>Periodontics</strong></td>
<td>✓</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td><strong>Repair or recementing of Bridge, Crown, Inlay/Onlay or Dentures</strong></td>
<td>✓</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td><strong>X-rays</strong> (other than as noted in Class I section, such as periapical, occlusal, etc., as necessary)</td>
<td>✓</td>
<td></td>
<td>80%</td>
</tr>
<tr>
<td><strong>Other Class II Services</strong></td>
<td>✓</td>
<td></td>
<td>80%</td>
</tr>
</tbody>
</table>

### Class III - Major Dental Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Applies to Deductible</th>
<th>Children 0-18</th>
<th>Adults 19+</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bridges</strong> (installation)</td>
<td>✓</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Crown</strong> (installation)</td>
<td>✓</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Dentures</strong> (installation)</td>
<td>✓</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Implants</strong></td>
<td>✓</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Inlays/Onlays</strong></td>
<td>✓</td>
<td></td>
<td>50%</td>
</tr>
</tbody>
</table>
### Comprehensive Healthcare Employee Plan 2022

<table>
<thead>
<tr>
<th>Service</th>
<th>Applies to Deductible</th>
<th>Children 0-18</th>
<th>Adults 19+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Class III services</td>
<td>✓</td>
<td></td>
<td>50%</td>
</tr>
<tr>
<td><strong>Class IV - Orthodontia</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontia</td>
<td>✓</td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>For children through age 18 only; $1,250 lifetime maximum</td>
<td></td>
<td></td>
<td>50%</td>
</tr>
</tbody>
</table>
Dental Benefits

Dental Expenses
Dental expenses mean the charges for the dental services and supplies listed below which are provided by your dental professional and are in accordance with generally accepted standards of dental practice.

Class I - Preventive and Diagnostic Dental Services
Preventive and diagnostic dental expenses mean charges for the following services and supplies:

- Emergency treatment, to treat the sudden onset of severe pain, fever, swelling, bleeding, discomfort, or to prevent the imminent loss of teeth.
- Fluoride treatments for a child through age 14, limited to once per calendar year.
- Oral evaluations of the mouth and teeth, limited to twice per calendar year.
- Prophylaxis, limited to twice per calendar year.
- Sealants, limited to permanent bicuspids and molars only for children through age 19 to a maximum of $100 per calendar year and $300 per Lifetime.
- Space maintainers designed to preserve the space between the teeth caused by premature loss of a primary tooth. Can be either fixed or removable.
- The following dental x-rays:
  - Two sets of bitewing x-rays allowed per calendar year through age 19. Age 20+ one set allowed per calendar year.
  - One set of full mouth x-rays or one panorex x-ray every 3 calendar years.

Class II - Basic Dental Services
Basic dental expenses mean charges for the following services and supplies:

- Anesthesia, such as Novocain. If dental procedure requires general anesthesia within hospital setting coverage is provided under the medical plan, see Anesthesia in Medical, Vision and Pharmacy Benefit Summary booklet.
- Endodontic treatment, including pulpotomy, pulp capping, apicoectomy, retrograde filling, and root canal therapy.
- Extractions, simple or surgical extractions of one or more teeth are covered.
- Fillings include the use of materials such as amalgam or composite resin to restore teeth broken down by decay or injury. Gold fillings are not covered.
- Occlusal Guard: a removable appliance designed to minimize the effects of bruxism, or teeth grinding.
- Oral surgery, for surgical treatment or procedures needed in and about the mouth and jaw.
- Periodontal services required for treatment of disease of the gums and supportive structures of the teeth, such as root planing or subgingival curettage.
- Repair or recementing of bridge, crown, inlay/onlay, or dentures or bridgework.
• X-rays other than those noted in Class I section, for example periapical or occlusal, as necessary.

Class III - Major Dental Services

Major Dental expenses mean charges for the following services and supplies:

• Bridges, the installation of one or more artificial teeth attached by crowns to adjacent teeth. It is used to maintain space and function for missing teeth.

• Crowns and Crown Build Ups: installation of a crown (also known as ‘cap’) made of porcelain and/or metal used to cover a decayed or damaged tooth.

• Dentures, installation of dentures.

• Implants, artificial (prosthetic) tooth replacements for tooth loss.

• Inlays/Onlays: a gold, porcelain or composite custom-made filling cemented into the tooth.

Class IV - Orthodontia

Sometimes referred to as “braces,” to treat malocclusions (improper bite alignment).
Dental Limitations and Exclusions

No dental benefit will be paid for the following charges:

- Administrative costs such as completion of claim forms or reports, or for providing dental records or charges for missed appointments.
- Charges for precision or other elaborate attachments for any appliance.
- Charges for partial or full removable denture or fixed bridgework, if involving replacement of one or more natural teeth missing prior to becoming covered herein, unless the denture or fixed bridgework also includes replacement of a natural tooth which (1) is extracted while covered herein and (2) was not an abutment to a partial denture or fixed bridge installed within the immediately preceding 5 years.
- Charges for the replacement of a lost, missing or stolen prosthetic device.
- Charges which exceed the UCR for the services or supplies provided.
- Charges for services or supplies for which no charge would be made in the absence of insurance or for which you are not obligated to pay.
- Charges for services or supplies that are not generally accepted by the dental profession or are experimental or investigational.
- Charges for services or supplies that are primarily for cosmetic purposes.
- Charges for personalization of dentures.
- Charges for dental expenses for which benefits are payable under any workers compensation or similar law, or liability policy including but not limited to, an automobile policy or a homeowners’ policy.
- Charges for sterilization of materials when billed separately.
- Crowns for teeth that are restorable by other means or for the purpose of periodontal splinting.
- Dental services started prior to the date the person became eligible for services under this Plan including but not limited to charges incurred for a service to a covered person which is (1) an appliance, or modification of an appliance, for which a tooth was prepared before becoming covered herein, or (2) root canal therapy, for which the pulp chamber was opened prior to coverage herein.
- Duplicate appliances or dentures.
- Expenses covered under the Medical Plan (see Medical Benefits).
- Expenses excluded under the Medical Plan.
- Oral hygiene instruction, training or education.
- Orthognathic surgery (see Medical Benefits).
- Splinting, specifically crowns, fillings or appliances that are used to connect teeth or change or alter the way they meet, including altering the vertical dimension, restoring the bite or for cosmetic purposes.
- Treatment or services provided to correct any congenital defect or developmental malformation which does not interfere with function.
- Treatment of Temporomandibular Joint Dysfunction Syndrome (TMJ).
- Vertical dimension procedures (crowns, dentures, splinting, etc.) for the restoration or alteration of occlusions, except as covered under the medical or orthodontia benefits of this Plan.
Eligibility and Enrollment

Eligible Classes of Employees
All active, full-time Comprehensive Healthcare employees working at least 30 hours per week are eligible to enroll in the Plan after completing the Waiting Period.

For variable hour employees their eligibility date and corresponding enrollment date will be determined if they work 1560 hours in the standard 12-month measurement period.

Examples of employees that are considered non-eligible are those classified on Comprehensive Healthcare’s books or records as:

- Leased employees,
- Temporary employees that work less than 30 hours a week,
- One that is enrolled as a dependent on another Comprehensive Healthcare employee’s plan,
- One that has not completed a full first day of employment, or
- Part-time employees that work less than 30 hours a week.

Waiting Period
The waiting period is the time between the first day of employment and the first day of coverage under the Plan.

Enrollment Periods
Enrollment periods for eligible employees and dependents are:

- Within 31 days of initial eligibility, unless otherwise specified (such as for newborn dependents).
- During any open enrollment.

If a completed enrollment application is not received by the Plan Administrator within the 31 days of the employee’s initial eligibility period, the employee and their dependents cannot enroll until the next group open enrollment period.

How to Enroll
To enroll, contact the Plan Administrator for an enrollment form and instructions. It is very important that the enrollment information is complete and accurate and returned to the Plan Administrator within the 31 days of the employee’s initial eligibility period. Incomplete information will result in delayed eligibility, delayed access to benefits and non-payment of claims.

Discovery of false or misrepresented information will result in the complete nullification of coverage and you will be held financially responsible for any benefits paid. Examples of false or misrepresented information are failing to provide requested information, providing incorrect or incomplete information,
enrolling an ineligible dependent, and failing to comply with the Plan’s requirements for eligibility. It is your responsibility to notify the Plan Administrator of all dependent eligibility changes.

**Open Enrollment**

Open enrollment is a defined period when you, if an eligible employee, are allowed to enroll or make changes to your health care benefit coverage. Open enrollment occurs once each calendar year.

Under no circumstances will you be able to make changes to your benefits outside of open enrollment or any applicable special enrollment periods as described below.

**Special Enrollment Periods**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you special enrollment rights as described within this section.

**Change in Status**

If you decline Plan group health coverage and later acquire a new dependent by marriage, birth, adoption or placement, you may be eligible to enroll yourself and your dependents into the group health plan if you request enrollment within 31 days after the marriage or 60 days after the birth, adoption or placement (See also Dependents). If you decline Plan group health coverage and later experience a change in status (as described below) and become eligible to participate in a premium assistance program under Medicaid or the Children’s Health Insurance Program (CHIP) Reauthorization Act of 2009 you have 60 days to enroll in the Plan.

In addition, a special enrollment period is available if a change of status occurs.

A change in status includes:

- Marriage, divorce or legal separation.
- Death of your spouse or dependent.
- Birth, adoption, or placement for adoption of child.
- A change in employment status, such as a switch between part-time and full-time.
- Changes in your dependent’s age status or other factor affecting his or her eligibility.
- Change in your eligibility to participate in a premium assistance program under Medicaid or CHIP.

Any changes made in elections must be consistent with the change in status.

**Involuntary Loss of Other Coverage**

You may enroll for coverage under this Plan outside of open enrollment when all of the following requirements are met:

- You waived coverage under this Plan at the time this coverage was previously offered because you were already covered under another plan. (A waiver of group health plan benefits is required at open enrollment or when you become eligible for enrollment in the benefit Plan; forms are available from the Plan Administrator).
- Your coverage under the other health care plan was terminated as a result of:
- Loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or the reduction in the number of hours of employment).
- Termination of employer contributions toward such coverage.

- You were covered under COBRA at the time coverage under this Plan was previously offered and your COBRA coverage has been exhausted.
- You, or your dependent(s), were covered under Medicaid or CHIP but have since lost eligibility for either program.

The Plan Administrator must receive a completed enrollment form within 30 days of the date your prior coverage ended. Coverage under this Plan will become effective on the first of the month following loss of coverage.

Late Enrollment

Late enrollments are not accepted. An enrollment is late if it is not submitted within the timeframe set forth in the sections Enrollment Periods, Open Enrollment and Special Enrollment Periods.

Effective Date

Effective Date of Coverage for You

The employee’s coverage will become effective on the first day of the calendar month following the date that the employee has satisfied: 1) the eligibility requirement noted under Eligible Classes of Employees, and 2) the Plan is in receipt of the completed enrollment form.

Effective Date of Coverage for Your Dependents

If you have one or more eligible dependents on the date that you become covered under this Plan and you elect to insure them, they will be covered on the date your coverage becomes effective. Only dependents for which you have submitted an enrollment form and paid any required premiums will be covered. Your dependent will be considered a late enrollee if we do not receive the enrollment form and premium payment within 31 days (60 days in the case of birth, adoption or placement for adoption) of the date he or she is eligible for coverage.

Deferred Effective Date of Your Coverage or an Increase in Coverage

If you are not at work on a full-time basis on the effective date of insurance or any increase in benefits, for any reason other than a vacation day, work holiday, or scheduled non-work day, your coverage or any increase in benefits will not become effective until the date you return to full-time basis.

You will be deemed to be at work on such date only if you were at work on the day before and the day after such period of time.

Effective Date for Adding Dependents (Other than Newborn and Adopted Children)

Any dependents added after your effective date of coverage will be covered on the date they become eligible. You must submit an enrollment form to us for any such dependent and pay any required
premiums. The Plan Administrator must receive the form within 31 days of the date the dependent becomes eligible for coverage. If you do not notify us within 31 days, the dependent will be considered a late enrollee.

**Special Rule**

If an employee and spouse are each employees of Comprehensive Healthcare and are eligible for benefits, employees may not ‘double’ cover each other as dependents.

If two Comprehensive Healthcare employees are married, one may enroll as the dependent on their spouse’s employee coverage. In such a case, the employee spouse enrolled as a dependent would not be eligible for employee only coverage in addition to their dependent coverage.

If two Comprehensive Healthcare employees are married, children of those employees may enroll under only one parent.

If you are covered under a family member employed by Comprehensive Healthcare and become eligible for benefits due to your own employment status, your family member must contact the Plan Administrator to cancel your coverage within 31 days.

**Waiver of Group Health Plan Benefits**

As an eligible employee, you may elect to waive participation in the group health plan by completing the enrollment form, stating you choose to waive coverage and providing proof of other coverage. If you waive coverage, you may not enroll your dependents – a dependent is not eligible for coverage without the eligible employee also enrolled.
Dependents

Dependents become eligible for group health plan benefits on either the day you become eligible or the day you acquire your first dependent, whichever is later. Dependents can be enrolled in the group health plan only if you also are enrolled. Dependents include:

- Lawful spouse (as defined by state law where the employee permanently resides)
- Natural child, adopted child, child placed with you for legal adoption, stepchild, or other legally designated ward up to age 26 (the limiting dependent child age); or,
- Natural child, adopted child, child placed with you for legal adoption, stepchild, dependent child of or other legally designated ward that a health care professional determines is not capable of self-sustaining employment due to a physical handicap or developmental disability (see Continued Eligibility for a Child who is Disabled).

A child who loses dependent status for coverage eligibility under this provision may be eligible for continuation of coverage under COBRA (See COBRA section).

You are responsible for paying the contribution for your dependent’s group health plan benefits.

Dependents do not include:

- A spouse who is legally separated or divorced unless coverage is required by court order or decree;
- A spouse or child living outside the United States or Canada;
- A spouse or child eligible for employee coverage under the Plan;
- Any person who is on active duty in any armed forces of any country;
- You or your spouse’s natural child for whom you have given up rights through legal adoption.
- A parent of an employee or spouse; or
- The newborn child or spouse of an enrolled dependent child.

Dependents Acquired Through Marriage

If you acquire a new dependent through marriage, the Plan Administrator must receive the completed enrollment application and a copy of the marriage certificate within 31 days after the marriage for coverage to be effective, or your new dependent will not be able to enroll until the next open enrollment.

Coverage for your new dependent will become effective on the first of the month following the date of lawful marriage.

Dependent Children

An enrollment form is required to enroll any dependent child. Your dependent will not be denied based on health status. The Plan Administrator may ask for added information to establish a dependent child’s eligibility.
Natural Newborn Children

If you acquire a new dependent through birth, the Plan Administrator must receive the enrollment form within 60 days from the date of birth. In order for coverage to exist for a newborn, the child must be enrolled within this timeframe. Coverage for the facility nursery charges will be in effect until discharge from this level of care under the enrolled mother’s coverage. There is no coverage for physician services or other facility levels of care other than nursery until the newborn is enrolled. If enrolled, coverage becomes effective on the date of birth. This provision does not apply to grandchildren of the Subscriber or Spouse.

Adopted Children Acquired

Any child under age 18 you legally adopt or who is placed with you for adoption is eligible on the date of placement. A child is considered placed for adoption when you become legally obligated to support that child totally or partially before the legal adoption. If the child is placed but not adopted, all group health plan benefits stop when the placement ends and will not be continued.

If the enrollment form, with documentation to support legal guardianship, is received within 31 days of placement, coverage becomes effective on the date of placement. The Plan Administrator may request added information.

Children Acquired Through Legal Guardianship

If the enrollment form, with documentation to support legal guardianship, is received within 31 days of obtaining legal guardianship, dependent coverage becomes effective on the date of the order. The Plan Administrator may request added information.

Children Covered Under Qualified Medical Child Support Orders

If the enrollment form, with notification of the medical child support order (from you, the custodial parent or a state agency administering Medicaid) is received within 31 days of the order, coverage becomes effective on the date of the order. If received after 31 days, coverage becomes effective on the first of the month after the Plan Administrator has the enrollment information. (See Qualified Medical Child Support Orders for more information).

Dependent Children Out of Area

To receive the network level of coverage, medically necessary care for covered services must be provided by First Choice Health PPO Network (FCH) providers within Washington, Oregon, Alaska, Montana, Idaho, Wyoming, North Dakota, and South Dakota.

First Health Network is available for network benefits to:
- Participants who live outside the FCH service area due to work, COBRA or student status.
- All participants for emergency and urgent care when traveling.

(A full description of the provider networks can be found under How to Obtain Health Services.)
**Continued Eligibility for a Child who is Disabled**

Coverage may be extended beyond the dependent child limiting age if the child is:

- Incapable of self-sustaining employment due to mental or physical disability, and
- Depends primarily on you for support.

Contact the Plan Administrator for details and enrollment forms. For continued eligibility of a child who is disabled, the enrollment form must be received within 31 days of the date the child reaches the maximum dependent child age for dependent coverage. Thereafter, employees are required to resubmit proof of continued disability at reasonable intervals during the two years following initial determination of such incapacity. After such two year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a physician of the Plan Administrator’s choice, at the Plan’s expense, to determine the existence of such incapacity.

Proof may be defined as a copy of the State Disability check for the current month. If a copy of the State Disability check for the current month is not available, the provider of care must complete a physician statement to confirm the following:

- Name of dependent child;
- Dependent child’s date of birth;
- Dependent child’s Plan ID number;
- Date of onset of disabling condition;
- Description of disabling condition and functional limitations
- Expected duration of disabling condition and prognosis; and
- Signature of provider.

The participant must also submit the following:

- Signed statement that the participant provides total support for this child;
- Participant social security number; and
- Date information provided.

A child who is disabled child will continue to be eligible for coverage until the employee participant fails to submit proof of dependence due to disability, or if coverage terminates for the employee or the dependent due to any of the reasons noted under *Termination of Coverage*.

**Qualified Medical Child Support Orders**

Comprehensive Healthcare Employee Health Care Plan will provide medical and dental coverage to certain children (called alternate recipients) if directed by a Qualified Medical Child Support Order (QMCSO) (defined in ERISA §609(a)), including benefits for adopted children in accordance with ERISA §609(c). The participant, the child’s custodial parent, or a state agency administering Medicaid may submit notification.

A medical child support order:

- Is any decree, judgment, order (including approval of settlement agreement) or administrative notice from a state court or state agency with jurisdiction over the child’s support;
• Recognizes the child as an alternate recipient for plan benefits; and
• Provides for, based on a state domestic relations law (including a community property law), the child’s support or health plan coverage.

A QMCSO is a medical child support order qualified under the Omnibus Budget Reconciliation Act of 1993. A medical child support order is qualified if it creates or recognizes the existence of an alternate recipient’s right to receive plan benefits and specifies this information:

• Employee’s name and last known address;
• Each alternate recipient’s name and address (or state official/agency name and address if the order provides);
• Reasonable description of coverage the alternate recipient is entitled to receive;
• Coverage effective date;
• How long the child is entitled to coverage; and
• That the plan is subject to the order.

If the medical child support order is a QMCSO:

• The Plan Administrator notifies you and the alternate recipient of the Plan’s procedures and allows the alternate recipient to name a representative to receive copies of any QMCSO notices;
• Alternate recipient coverage begins on the first of the month after the QMCSO is received;
• If a dependent contribution is required, your specific authorization isn’t needed to establish the payroll deduction, which would be retroactive to the alternate recipient’s coverage effective date; and
• The Plan pays network providers directly for covered services; when an alternate recipient, custodial parent, legal guardian or employee pays a covered expense, the Plan reimburses the person who paid the expense.

If the medical child support order is not a QMCSO, the Plan Administrator notifies you and each alternate recipient of the specific reasons it does not qualify, along with procedures for submitting a corrected medical child support order.

The enrollment form with the notification of the medical child support order needs to be received within 31 days of the order in order for coverage to become effective on the date of the order. If the enrollment information is received after 31 days of the order, coverage will become effective on the first of the month following the date we receive the enrollment information for coverage.
Termination of Coverage

For participating employees, coverage ends at these events:

- Non-payment of a contribution that is your responsibility;
- You no longer meet eligibility requirements for coverage (see Eligibility and Enrollment);
- The employee or any participant performs an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this policy;
- The policy is materially breached; or
- The Plan Sponsor ceases to offer coverage in the group market under which this coverage is issued.

Coverage will terminate on the earliest of these dates: (1) the date the Plan is terminated, or (2) the 15th of the month for an employee who ceases to be considered eligible before the 16th of the month, and the last day of the month for an employee who ceases to be considered eligible after the 15th of the month (including death or termination of active employment).

For participating dependents, coverage ends at these events:

- The date the employee’s coverage under the Plan terminates for any reason, including death;
- The participating employee and spouse legally divorce (the Plan Administrator must receive a copy of the decree). If a spouse ceases to be eligible before the 16th of a month, the last date of coverage will be the 15th of that month; for a spouse who ceases to be eligible after the 15th of a month, the last date of coverage will be the last day of that calendar month;
- The last day of the calendar month in which a dependent child ceases to be a dependent as defined within the Eligibility section; or
- Non-payment of a contribution for dependent coverage.

Related details follow:

- If your share of the Plan contribution is paid on a pre-tax basis through a §125 Cafeteria Plan, enrollment into this Plan is a 1 year commitment. You can opt out of the Plan mid-year only as permitted under §125 regulations. Refer to your §125 Cafeteria Plan Summary Plan Description for details.
- If your share of the Plan contribution is paid on an after-tax basis (i.e., not through a §125 Cafeteria Plan), you may cancel coverage at any time during the Plan year. Coverage ends the last day of the month in which the Plan Administrator receives written notice of termination.
- The Plan requires 31 days written notice for dependent coverage termination.
- A terminated employee who is rehired will be treated as a new hire for benefit purposes and be required to satisfy all eligibility and enrollment requirements. However, if the employee is returning to work directly from COBRA coverage s/he does not have to satisfy any employment waiting period or exclusion limitation provision.

If you or your dependents lose coverage under this Plan, you may be eligible to continue coverage. For more information, read the COBRA section or ask your Plan Administrator.
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

If your coverage terminates under this group health plan, you may be eligible under COBRA to continue the same coverage you had when coverage ended, on a temporary self-pay basis. COBRA requires this continuation of coverage be made available to covered persons – called qualified beneficiaries under COBRA – on the occurrence of a qualifying event, described below.

Continuation of coverage under COBRA is not automatic; you must elect COBRA by completing and properly providing an enrollment form to your Plan Administrator. You must contact your Plan Administrator and apply for continuation of your group health plan coverage within 60 days of the termination of coverage. You will also be required to pay applicable contributions for you and/or your dependent(s) directly to the Plan.

This Plan provides no greater COBRA rights than what COBRA requires. Nothing in this Group Health Summary Plan Description is intended to expand your rights beyond COBRA’s requirements.

This section describes your COBRA coverage rights; contact the Plan Administrator for more information.

Who Is a COBRA Qualified Beneficiary?

Employees and covered dependents who participate in the Plan may be eligible for COBRA in the case of a qualifying event if they are also a qualified beneficiary. Qualified beneficiaries include:

- Employees enrolled in the Plan on or before the date of the event that causes them to lose that coverage (called the qualifying event)
- An employee’s spouse enrolled in this Plan on the day before the qualifying event
- The employee’s dependent children enrolled in this Plan on the day before the qualifying event
- Dependent children born to, or placed for adoption with, the employee while the employee has COBRA coverage
- Dependent children acquired through legal guardianship while the employee has COBRA coverage
- Dependent children covered under medical child support orders while the employee has COBRA coverage

A qualified beneficiary may choose to continue any one benefit, or all of the benefits that s/he was enrolled in prior to the qualifying event.

Certain qualified beneficiaries may have additional COBRA rights and possible tax credits if they are certified by the Department of Labor or state labor agencies as eligible under the Trade Adjustment Assistance Reform Act of 2002. (Contact the Plan Administrator for more details.)
Qualifying Events and Continuation Periods

Qualifying events and continuation periods are explained below:

- If employment terminates (voluntary or involuntary), you and your covered dependents may continue coverage under this Plan for up to 18 months unless the cause is gross misconduct;
- If your work hours are reduced, resulting in loss of group coverage, you and your covered dependents may continue coverage under this Plan for up to 18 months;
- If you and your spouse legally divorce or are legally separated, your spouse and covered dependent children may continue coverage under this Plan for up to 36 months;
- When your covered dependent child no longer meets the Plan’s definition of dependent child, the child may continue coverage under this Plan for up to 36 months;
- When you become Medicare eligible, your Medicare-ineligible covered dependents may continue coverage under this Plan for up to 36 months;
- If you die your spouse or covered dependents may continue coverage under this Plan for up to 36 months;
- If you enter into uniformed service you may elect to continue Plan coverage for up to 24 months (See also Military Leave under Other Continuation of Coverage section); or
- If while covered under COBRA you (or a COBRA-eligible dependent) become disabled, you may be eligible for a coverage extension. The 18 month COBRA coverage period may be extended another 11 months for a total of 29 months COBRA coverage. To qualify for this disability extension you must:
  - Meet the definition of disability under Title II or XVI of the Social Security Act at the time of the qualifying event or within the first 60 days of COBRA coverage; and
  - Provide the Plan Administrator with notice of the disability determination (from Social Security) on a date that is both within 60 days after the determination date and before the original 18 month coverage ends. If the disabled beneficiary is later determined by Social Security to no longer be disabled, the Plan Administrator must receive notice within 31 days of that determination date.

When COBRA Coverage Ends

COBRA coverage ends before the 18-, 29-, or 36-month period expires for any of these reasons:

- The Plan no longer provides group health coverage to any employees;
- The COBRA coverage premium is not paid within 31 days of the due date (the initial grace period is 45 days after the first COBRA election);
- The qualified beneficiary becomes covered under another group health plan with no applicable pre-existing condition exclusion or limit;
- The qualified beneficiary enrolls in Medicare; or
- If an extension from 18 to 29 months was granted due to a disability and the individual receives a final determination from the Social Security Administration stating the individual is no longer disabled the individual must notify the plan administrator within 31 days after the date of that determination. Coverage ends on the last day of the coverage period through which contribution payments have been received, so long as that date is within the first month that begins within 31 days after the final determination date, and after the initial 18-month COBRA coverage period.
Contributions have collected.]

Contribution Payment Requirements

You are required to pay any and all applicable contributions for you and your covered dependents. You must pay the first contribution for continuation of coverage within 45 days of the date you elect COBRA coverage. Contributions consist of the full cost of coverage, plus 2% (a total of 102%).

If you are eligible and receive a disability extension under Title II or XVI of the Social Security Act, your contribution will be 150% of the full cost of coverage.

If the cost for similarly situated active employees or dependents changes, the COBRA coverage premium also changes (only once a year before the Calendar Year begins).

Failure to make payments within the designated time frame will result in automatic termination of coverage to the last day of the coverage period for which a complete payment was made. Payments need to be sent directly to Comprehensive Healthcare, Human Resources Department, PO Box 959, Yakima, WA 98907. If you have COBRA related questions you may call (509) 575-3874.

Election Requirements

At the time of a qualifying event, such as termination of employment or reduction in hours, the qualified beneficiary must be notified of the right to continue coverage within 14 days of FCH receiving notice of the qualifying event from the Plan Administrator.

In the case of divorce, legal separation or the ineligibility of a dependent, the employee or qualified beneficiary is responsible for notifying the Plan Administrator within 61 days of the divorce, legal separation or ineligibility of a dependent. The Plan is not obligated to offer COBRA benefits to beneficiaries if this notification is not received within the 61 days.

What Coverage Must Be Offered When Electing COBRA?

The Plan is required to continue the following coverage for COBRA participants:

- **Identical coverage** – the qualified beneficiary must be offered the opportunity to continue the coverage received immediately before the qualifying event.

- **Independent rights** – once a qualifying event occurs each qualified beneficiary has an independent right to elect continuation coverage. For example, if an employee and family are offered COBRA coverage, each individual can make an election. Although an active employee must be covered to cover a dependent, it is possible to have COBRA coverage for a dependent when the former employee does not elect to continue coverage.

- **Open enrollment** – qualified beneficiaries must be notified of any benefit or carrier changes at open enrollment and be given the opportunity to change coverage just like active employees. Qualified beneficiaries have the same rights as active employees during open enrollment to add or drop family members, change coverages and change carriers, if available. However, if a qualified beneficiary adds a family member during open enrollment who was not previously covered, that added family member does not become a qualified beneficiary.

- **Modification of coverage** – if an employer modifies coverage for similarly situated active employees; the coverage for qualified beneficiaries must be modified similarly. Some examples of modifications include benefit enhancements, elimination of coverage and changes in carriers.
Other Continuation of Coverage

Leaves of Absence

Family Medical Leave Act of 1993 (FMLA) Leaves

The FMLA gives employees on FMLA leave the same rights and privileges as active employees. The FMLA allows an eligible employee to take 12 weeks of leave each year (during a rolling backward calendar year) for the following reasons:

- The birth or adoption of the employee’s child.
- Placement of a foster child in the employee’s care
- To care for the employee’s spouse, parent or child if suffering from a serious health condition.
- An employee’s own disabling serious health condition.
- For qualifying exigencies arising out of the fact that the employee’s spouse, parent or child is on active duty with the Armed Forces, including the National Guard or Reserves (Examples of “qualifying exigencies” include, but may not be limited to, short-notice deployment, military events and related activities, certain childcare and related activities, financial and legal arrangements, counseling, rest and recuperation, post-deployment activities and/or any other event that the employer and employee agree constitute a qualifying exigency).

The FMLA also allows an eligible employee to take 26 weeks of leave each year (during a rolling backward calendar year) for the following reasons:

- For military caregiver leave, an employee may be allowed for up to 26 weeks of leave, per service member, per injury, to care for a family member who (1) is an current member of the Armed Forces, Guard or Reserves; (2) who suffered a serious illness or injury or whose pre-existing illness or injury was aggravated in the line of duty while on active duty; and (3) is undergoing medical treatment, recuperation, therapy, outpatient care, or has been placed on the temporary disability retirement list by the military (Please note the Department of Labor (DOL) has established an order of familial priority for family members seeking this leave; your employer is within its rights to request information seeking proof and/or clarification of your relationship to the service member).

If you are granted an authorized leave of absence from work, you may choose to continue coverage under this group health plan during the approved leave time as long as you pay your required contribution. Since continuation of coverage under this provision is not extended automatically, please contact your Plan Administrator for more information. Any and all applicable monthly contributions must be paid directly to the Plan in accordance with the agreement established before the leave. Failure to make the established monthly contribution may result in the termination of group health benefits. Eligible employees will receive information about the option of continuing their health benefits on a self-pay basis under COBRA.

If your leave is a paid leave, the contribution costs will continue to come out of your paycheck as a deduction. If your leave is unpaid, you are responsible for paying your share of contribution directly.

If you lose coverage during your leave because you did not make the required contributions, you may enroll again within 31 days of returning to work. Your coverage will start on the first day of the month after you return to work and make any required contributions.
Military Leave

If you take a military leave, for active duty or training, you will be covered under the Plan’s health benefits as if you were an active employee, as long as you are in an active paid status.

If your uniformed service lasts beyond your paid time or 31 days, whichever is longer, you may continue coverage under the self-pay option for approved leaves (as described in the COBRA section) according to your rights under the Uniformed Services Employment and Reemployment Rights Act (USERRA). While continued, coverage will be what was in force on the last day you worked as an active employee. However, if benefits decrease for others in the class, yours will also decrease.

If you return to active employment promptly after your military leave, in accordance with federal law, your medical, dental, vision, pharmacy, life insurance and long-term disability coverage will be reinstated on the date you return to the active payroll. You must submit a written request for reinstatement within 90 days of your discharge from active military service, or one year following a hospitalization which continues after you are discharged from active military service.

All Leaves of Absence

If your coverage has been terminated, you must re-enroll within 31 days of returning to work in a benefit-eligible status. There is no automatic re-enrollment process. Contact the Plan Administrator if you have further questions.
Claim and Appeal Procedures

Claim

A claim means any request for a Plan benefit made by you (Claimant) or your authorized representative (an individual acting on behalf of the Claimant in obtaining or appealing a benefit claim). The authorized representative must be designated as such in writing with an approved form signed by the claimant (except for urgent care benefits or urgent care appeals). Once an authorized representative is selected, all information and notifications should be directed to that representative until the claimant states otherwise.

Note: This Plan does not consider an assignment of benefits to confer standing or assign any other rights afforded to a participant or beneficiary under ERISA, other than the payment of benefits. A Plan participant or beneficiary may not assign or transfer rights to a provider of services, other than assignment of benefit payment. A provider cannot be a designated authorized representative, but can submit additional information to support the member’s appeal.

How to File a Claim for Plan Benefits

In most cases, network providers, hospitals and licensed vision providers submit claims for you, and there are no claim forms for you to complete. If you do receive a bill for services from a provider because the provider did not file your claim for you, write your name, participant ID number and group number on the bill and send a copy to the claim address on your ID card. (Your group number can also be found on your ID card.) Any bill you submit must contain:

- Provider name
- Provider tax ID information
- Specific dates of service
- Diagnosis codes (ICD-10 codes) or description of the symptoms or a diagnosis
- Specific procedure codes (CPT codes) or description of the medical service or procedure.

It is best to submit charges as soon as possible. However, charges for covered services submitted to FCH must be received within 12 months from the date the service or supply was rendered or received, or sixty (60) calendar days after provider first receives notice that this Plan is secondary, whichever is later. Claims will not be considered for benefits if received after this timeframe. (See your ID card for the FCH claim address.) Claim forms are available from your Plan Administrator.

Claim Types

- **Pre-service claim** means any claim for a Plan benefit for which the Plan requires approval before medical care is obtained.
- **Concurrent claim** means any claim reconsidered after initial approval for an ongoing course of treatment which results in a reduced or terminated benefit.
- **Post-service claim** means any claim for a Plan benefit that is not a pre-service claim and is a request for payment or reimbursement for covered services already received.
• **Urgent care claim** means a claim for medical care or treatment that, if normal pre-service standards are applied:
  - Would seriously jeopardize the claimant’s life, health or ability to regain maximum function
  - In the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested.

### Claim Procedure

The Plan delegates to FCH the authority, responsibility and discretion to:

- Determine all questions of eligibility and status under the Plan
- Interpret and construe Plan provisions, as necessary
- Reach factually supported conclusions
- Make a full and fair review of each denied claim under ERISA requirements, as amended.

FCH will notify the claimant in writing of its decision on review.

All claims for benefits are subject to a full and fair review within a reasonable time appropriate to the medical circumstances. Payment of any benefits will be subject to the applicable deductibles, coinsurance, copays and benefit maximums.

### Adverse Benefit Determination

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

The different claim types listed in the preceding subsection have specific times for approval, payment, request for information or denial, as shown below:
### Time Table for Adverse Benefit Determinations for Claim Procedures

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>FCH Notice of Incorrectly Filed Claim – Notice to Claimant</th>
<th>FCH Notice of Incomplete Claim – Notice to Claimant</th>
<th>Initial Benefit Determination by FCH</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Claim</td>
<td>5 days</td>
<td>Not required (may be part of extension notice)</td>
<td>Reasonable period = 15 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>15-day extension with notice to claimant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reasonable period suspended up to 45 days on incomplete claim</td>
</tr>
<tr>
<td>Concurrent Claim</td>
<td>N/A</td>
<td>N/A</td>
<td>In time to permit appeal and determination before treatment ends or is reduced</td>
</tr>
<tr>
<td>Post-Service Claim</td>
<td>N/A</td>
<td>Not required (may be part of extension notice)</td>
<td>Reasonable period = 30 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>15-day extension with notice to claimant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Reasonable period suspended up to 45 days on incomplete claim</td>
</tr>
<tr>
<td>Urgent Care Claim</td>
<td>24 hours</td>
<td>24 hours</td>
<td>72 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>No extensions from claimant</td>
</tr>
</tbody>
</table>

If your claim is denied wholly or in part, you will receive a written adverse benefit determination notice that includes:

- The specific reason or reasons for the adverse benefit determination (denial);
- Reference to the specific Plan provisions on which the determination is based; and,
- Reference to any internal Plan rule, guideline, protocol or similar criterion relied upon in making the decision.

If the denial is based on medical necessity, experimental or investigational treatment or other similar exclusion or limit, the following will be provided:

- Explanation of the scientific or clinical judgment used in making the decision;
- Statement that an explanation will be provided free, upon request;
- A description of any additional material or information needed to support your claim and an explanation of why it is needed; and,
- Appropriate information on steps to take if you want to submit the claim for appeal review.
**Appeal Procedure**

FCH performs functions associated with the medical appeal process for this Plan. Pharmacy Appeals are handled by Costco Health Solutions. Comprehensive Healthcare has final authority over appeals as the appropriate named fiduciary. The plan does not provide a voluntary alternative dispute resolution option.

If your claim is denied wholly or in part, you have the right to appeal this adverse benefit determination in writing by following the appeal procedure listed below:

- You, or your authorized representative, must file your appeal within 180 days of the date you receive the adverse benefit determination or else you lose the right of appeal.
- You may submit written comments or questions, documents, records and other information including the reason you feel your claim should not have been denied.
- On request, you may obtain reasonable access to and copies of all documents, records and information relevant to your claim for benefits, free of charge.
- You may request the name of the health care expert who reviewed your claim for medical necessity or experimental or investigational care or treatment.
- You must exhaust these claim procedures before filing a civil action for benefits under ERISA §502(a)(1)(b); the civil action must be filed within 180 days from your receipt of the Plan’s final determination regarding your claim.

A time table for processing and notification of appeal procedures for each claim type follows:

<table>
<thead>
<tr>
<th>Type of Review</th>
<th>Appeal (Benefit Determination on Review and Notification to Claimant)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Service Claim</td>
<td>Reasonable period = 30 days</td>
</tr>
<tr>
<td></td>
<td>No extension from claimant</td>
</tr>
<tr>
<td>Concurrent Claim</td>
<td>Before treatment ends or is reduced</td>
</tr>
<tr>
<td>Post-Service Claim</td>
<td>Reasonable period = 60 days</td>
</tr>
<tr>
<td></td>
<td>No extension from claimant</td>
</tr>
<tr>
<td>Urgent Care Claim</td>
<td>72 hours</td>
</tr>
<tr>
<td></td>
<td>No extension from claimant</td>
</tr>
</tbody>
</table>

**Urgent care appeals will be expedited within 72 hours of receiving the appeal. The appeal may be oral or written.**

The appeal process will take into account all comments, documents, records and other information offered that relates to the claim, which may include information not offered previously. The standard appeal review will be a fresh look at your claim without considering the initial denial. The appeal review is conducted by persons who are neither involved in the initial decision nor assistants to the person who made the initial decision.

If the decision is to uphold the denial of your claim, you will receive a written notice of adverse benefit determination containing:
• The specific reason or reasons for the adverse benefit determination (denial);
• Reference to the specific Plan provisions on which the determination is based; and,
• Reference to any internal rule, guideline, protocol or similar criterion relied upon in making the decision.

On request you may obtain reasonable access to and copies of all documents, records and information relevant to your claim for benefits, free of charge.

If the denial is based on medical necessity, experimental or investigational treatment or other similar exclusion or limit, an explanation of the scientific or clinical judgment used in the decision making process will be provided.

You have a right to file a civil action for benefits under ERISA §502(a)(1)(b) after you exhaust these claim procedures; the civil action must be filed within 180 days from your receipt of the Plan’s final determination regarding your claim.

For urgent care medical appeals, you may call the Appeals Coordinator at (877) 749-2031. For all others, please use the appropriate address below to submit your written appeals:

**Medical Appeals:**
First Choice Health
Attn: Appeals Coordinator
600 University Street, #1400
Seattle, WA 98101

**Pharmacy Appeals:**
Costco Health Solutions
P.O. Box 34718
Seattle, WA 98124
Phone: 425-416-8876

**External Review**
You are entitled to external review described in this section only if you receive a final internal adverse benefit determination for a claim covered by the protections of the No Surprises Act, including claims relating to (i) out-of-network emergency services; (ii) non-emergency services performed by out-of-network providers at in-network facilities; or (iii) air ambulance services furnished by out-of-network providers of air ambulance services.
Independent Dispute Resolution

If your Plan and an out-of-network provider or facility that provided an item or service to you cannot agree on how much the provider or facility will be paid by the Plan for the item or service, then the dispute may be submitted by either the Plan or the provider to Independent Dispute Resolution (IDR). As a Plan participant, you are not involved in the IDR process (though your medical information will be shared with the certified IDR entity). Regardless of what the certified IDR entity decides, you will not have any additional cost-sharing for the affected item or service under the Plan, as your cost-sharing is limited to the in-network costs for that item or service. To the extent that you have a dispute about any adverse benefit determination you received relating to the item or service, you can appeal that decision under the Plan’s Claim and Appeal Procedures.
Coordination of Benefits

This section describes how benefits are paid when you are covered by more than one plan. Coordination of Benefits (COB) means that, when you are covered by two or more plans, one plan pays its benefits first (the Primary Plan), and the other plan pays second (the Secondary Plan). If a third plan is involved (a Tertiary Plan) that plan would pay after both the primary and secondary plans have paid.

Coordination of Benefits ensures that you do not receive more in benefits than what you would otherwise be responsible to pay for the care or treatment you receive. This Plan does not coordinate pharmacy benefits.

Calculation of Benefit Payments

The Primary Plan always pays its benefits as if you were not covered under any other plan.

The Secondary Plan pays its benefits taking into account what the Primary Plan has already paid. Similarly, a Tertiary Plan pays benefits after taking into account what the primary and secondary plans have paid. When this Plan is secondary to another plan, benefits will be calculated according to the following steps:

1. This Plan will calculate the amount it would have paid if it were your Primary Plan.
2. Next, any payment made by your Primary Plan will be subtracted from this amount. The difference remaining (if any) will be the secondary payment made by this Plan.

Example 1

<table>
<thead>
<tr>
<th>Allowed Amount</th>
<th>$150</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount this Plan would pay if primary</td>
<td>$135</td>
</tr>
<tr>
<td>- (minus) amount paid by Primary Plan</td>
<td>$100</td>
</tr>
<tr>
<td>= (equals)</td>
<td>$35  (this Plan’s secondary payment)</td>
</tr>
</tbody>
</table>

Example 2

<table>
<thead>
<tr>
<th>Allowed Amount</th>
<th>$200</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amount this Plan would pay if primary</td>
<td>$155</td>
</tr>
<tr>
<td>- (minus) amount paid by Primary Plan</td>
<td>$185</td>
</tr>
<tr>
<td>= (equals)</td>
<td>(-$30) (no payment is made by this Plan)</td>
</tr>
</tbody>
</table>
Important note: In these examples, and in most other claim situations using this calculation method, there is still a balance owed to the provider. This balance is your responsibility.

There are different ways in which a plan may calculate its benefit payment when it is the Secondary Plan. If this Plan is your Primary Plan (as determined by the rules in the following paragraphs), refer to your Secondary Plan’s Coordination of Benefits rules to find out how its benefits are calculated when secondary.

How Do I Know Which Plan is my Primary Plan?

The rules in this section determine the order in which your plans pay benefits (i.e. which plan is your Primary Plan, and which is your Secondary Plan, also known as the order of benefits). If you have Medicare coverage in addition to coverage under this Plan, refer to What if I’m Covered by Medicare? for more information. These rules are intended to be applied in the order in which they are listed (i.e., if the order of benefits can be determined by Rule 1, but Rule 3 also speaks to your situation, Rule 1 will determine the order of benefits). If you are covered by more than one secondary plan, these rules also determine the order in which the secondary plans’ benefits are determined in relation to each other.

1. Dependent or non-dependent: A plan covering a person as other than a dependent (i.e., as an active employee, retiree, member or subscriber) pays before a plan covering a person as a dependent.

   If you are a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (according the rules under What if I’m Covered by Medicare?) then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is secondary to the plan covering the person as a dependent.

2. Child covered under more than one plan:
   A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      1) The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      2) If both parents have the same birthday, the plan that has covered the parent longest is the Primary Plan.
   B. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
      1) If a court decree states that one of the parents is responsible for the dependent child’s health care expenses or health care coverage, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child’s health care expenses, but that parent’s spouse does, that parent’s spouse’s plan is the primary plan. This does not apply to any plan year during which benefits are paid or provided before the plan has actual knowledge of the court decree provision.
      2) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary.
      3) If a court decree states that both parents are responsible for the child’s health care expenses or health care coverage, or that the parents have joint custody without mentioning financial responsibility or responsibility for health care expenses, the birthday rule of the policy holders determines the order of benefits.
4) If there is no court decree allocating responsibility for the child’s health care expenses or health care coverage, the plans covering the child pay in the following order:
   a. The plan covering the custodial parent
   b. The plan covering the custodial parent’s spouse
   c. The plan covering the non-custodial parent
   d. The plan covering the non-custodial parent’s spouse
   e. For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits is determined as if those individuals were parents of the child.

5) If there is no court decree that allocates responsibility for the child’s health care expenses or that specifies a custody arrangement (for example, if the child is over 18), the birthday rule of the policy holders will determine the order of benefits.

3. **Active or inactive**: A plan covering a person as an active employee or dependent of an active employee pays before a plan covering a person as a retiree, laid-off or inactive employee or dependent of a retiree, laid-off or inactive employee.

   This rule does not apply if Rule 1 can determine the order of benefits.

4. **COBRA or State Continuation Coverage**: If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

   If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

   This rule does not apply if Rule 1 can determine the order of benefits.

5. **Length of coverage**: If none of the preceding rules establish which plan pays first, the plan that has covered the person the longest is primary. To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended. The start of a new plan does not include:
   A. A change in the amount or scope of a plan’s benefits;
   B. A change in the entity that pays, provides or administers the plan’s benefits; or
   C. A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

   A person’s length of time covered under a plan is measured from the person’s first date of coverage under that plan. If that date is not readily available, the date the person first became a member of the group must be used as the date to determine the length of time the person’s coverage under the present plan has been in force.

*Note: This Plan is always primary to TRICARE, CHAMPVA, state Medicaid programs and the Indian Health Service (IHS).*
What if I'm Covered by Medicare?

Federal rules govern coordination of benefits with Medicare. In most cases, Medicare is secondary to a plan that covers a person as an active employee or dependent of an active employee. Medicare is primary in most other circumstances.

If your Medicare entitlement is due to:

- **Age:** If you are covered under this Plan as an active employee or a dependent of an active employee and you become entitled to Medicare because of reaching age 65, this Plan will be primary. If you are covered under this Plan as a COBRA qualified beneficiary and are also entitled to Medicare based on age, Medicare is primary.

- **Disability:** If you are covered under this Plan as an active employee or dependent of an active employee and become entitled to Medicare due to disability, this Plan will be primary. Once you or your dependent is declared disabled by Social Security, the disabled individual should apply for coverage under Medicare Parts A and B. If you are covered under this Plan as a COBRA qualified beneficiary and are also entitled to Medicare based on disability, Medicare is primary.

- **End Stage Renal Disease (ESRD):** If you become entitled to Medicare on the basis of ESRD, this Plan will pay primary during the initial coordination period (refer to the Medicare Secondary Payer Manual at www.cms.gov/manuals/downloads/msp105c02.pdf for more information regarding the initial coordination period). After this initial coordination period, this Plan will pay secondary to Medicare. This is true even if you are covered under this Plan as a COBRA qualified beneficiary.

In all cases, this Plan will act in accordance with federal law when determining its status as either primary or secondary when Medicare is the other plan. Please visit the website of the Centers for Medicare and Medicaid Services at www.cms.gov for more information.

Pre-authorization when this Plan is Secondary

With the exception of transplant services (which always require pre-authorization), pre-authorization is not required if this Plan is your secondary plan. First Choice Health will honor a determination of medical necessity made by your primary plan. This means that if your primary plan determines a service to be medically necessary, this Plan will apply its normal benefit, subject to all other Plan provisions and exclusions. If your primary plan determines a service to be not medically necessary, coverage under this Plan will be denied. Benefits which are excluded by your primary plan but payable under this Plan are subject to medical review by First Choice Health.

Meaning of Plan for COB

For COB purposes, the term “plan” means any agreement for benefits or services from any of the following sources for medical or other covered health care services:

- This Plan (the Plan with a capital “P”)
- Group and non-group insurance contracts and subscriber contracts
- Uninsured arrangements of group or group-type coverage
- Group and non-group coverage through closed panel plans
• Group-type contracts (“group-type contract” means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. It does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

• The medical care components of long-term care contracts, such as skilled nursing care

• The medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts

• Medicare or other governmental benefits, as permitted by law

“Plan” does not include:

• Hospital indemnity coverage benefits or other fixed indemnity coverage

• Accident only coverage

• Specified disease or specified accident coverage

• School accident type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a “to and from school” basis

• Benefits provided in long-term care insurance policies for non-medical service, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services

• Medicare supplemental policies

• A state plan under Medicaid

• A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

If in any situation the rules contained in this section cannot determine the order of benefits, this Plan will follow the NAIC Model COB Regulation as its basis for determining the order of benefits in these extenuating circumstances.

Claim Determination Period

The claim determination period used when applying this COB provision is the calendar year, January 1 through December 31.

Right of Recovery

This provision does not reduce the benefits allowed under this agreement when this Plan is the primary plan. However, if the Plan pays in excess of the maximum necessary at the time to satisfy the intent of this COB provision, the Plan will exercise the right to recover the excess payments from any person(s), insurer(s) or other organizations, as the Plan deems appropriate.

This Plan will not seek to recover funds on any claim with a date of service that is more than 365 days prior to the date on which the Plan receives (receipt date) information regarding a participant’s other coverage.
Facility of Payment

When another plan makes payments that should have been made under this Plan and in accordance with this provision, the Plan may, at its sole discretion, elect to reimburse to the other plan the amount necessary to satisfy the intent of this COB provision. Any amount paid under this subsection will be considered benefits paid under this agreement, and the Plan will be fully discharged from liability under this agreement to the extent of those payments.

This Plan will not make any additional payment on any claim with a date of service that is more than 365 days prior to the date on which the Plan receives (receipt date) information regarding a participant’s other coverage.

Right to Receive and Release Information

The Plan Administrator and FCH may, with consent as required by law, receive or release to another insurer or organization any information concerning the participant and covered benefits deemed necessary to implement and determine the applicability of this COB provision.

The Plan Administrator and FCH have the right to require the participant to complete and return a Multiple Coverage Inquiry when primary liability is not clearly established or to verify that multiple coverage information on hand is accurate. Claim payment will be withheld until the Multiple Coverage Inquiry is complete and received by FCH.
Subrogation, Reimbursement and Right of Recovery

By enrolling in the Plan and applying for benefits from the Plan, you and your covered dependents (including minor dependents), agree and acknowledge that benefits are not payable to or on behalf of a covered person or dependent when the injury or illness occurs through an act or omission of another person, party, or entity, and any such payments made or advanced by the Plan are subject to the following terms and conditions.

No application of “make whole,” “double recovery,” and “common fund” rules

The Plan’s provisions concerning subrogation/right of recovery, equitable liens, and other equitable remedies (outlined above and more fully below) supersede the applicability of the federal common law and equitable doctrines commonly referred to as the “make whole” rule, the “double-recovery” rule and the “common fund” rule. These doctrines have no applicability to the Plan’s right of recovery hereunder.

Assignment of Rights (Subrogation)

By accepting benefits from this Plan, you and your covered dependents automatically assign to the Plan any rights you or they may have to recover all or part of the same covered expenses of the benefits paid on behalf of you and/or your covered dependents from another source, including another group health plan, insurer or individual, limited, however, to the amount of covered expenses the Plan has paid on behalf of you and/or your covered dependents. This assignment also grants the Plan a right to recover from your no-fault auto insurance carrier in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

By virtue of this assignment, the Plan is entitled to recover 100% of the amounts paid, or to be paid, by the Plan on behalf of you or your covered dependents (including minor dependents) from all recoveries by you or your covered dependents from any other party (whether by lawsuit, mediation, arbitration, settlement, award, judgment, order, insurance or otherwise) (“Recovered Funds”). This assignment includes, without limitation, the assignment to the Plan of a right to any Recovered Funds paid by any other party to you or your covered dependents (including minor dependents and wrongful death beneficiaries) or paid on behalf of you or your covered dependents (including minor dependents and wrongful death beneficiaries), or on behalf of the estate of any covered person.

You and your covered dependents are required to reimburse the Plan on a first-dollar basis (which means that the Plan will have a first priority claim to any Recovered Funds), regardless of whether the Recovered Funds amount to a full or partial recovery. Further, the Plan is entitled to recovery regardless of how the Recovered Funds are characterized (e.g., pain and suffering, punitive damages, benefits, lost wages, loss of future earnings, medical expenses, costs and/or expenses, attorneys’ fees) and regardless of whether the recovery is designated as payment for medical services or expenses. The Plan’s share of the recovery will not be reduced because you or your covered dependent (including your minor dependent) has not received the full damages claimed, unless the Plan agrees in writing to a reduction.
Any reduction is subject to prior written approval by the Plan, or agent of the Plan who administers the Plan’s subrogation, reimbursement recoveries.

This assignment also allows the Plan to pursue any claim that you or your covered dependent (including your minor dependent) may have against any third party, or its insurer, whether or not you or your covered dependent choose to pursue that claim. In the event you or your covered dependent elects not to pursue your claim(s) against a third party, the Plan shall be equitably subrogated to your (or your covered dependent’s) right of recovery.

When you, or your covered dependent – and not the Plan – pursue and obtain any Recovered Funds, you or your covered dependent shall be responsible for all expenses involved in obtaining that recovery (whether obtained by lawsuit, mediation, arbitration, settlement or, award, judgment, order, insurance or otherwise), including but not limited to, all attorneys’ fees, costs, and expenses; which fees, costs, and expenses shall not reduce the amount that you or your covered dependents (including minor dependents) are required to reimburse the Plan, and the Plan’s rights shall not be reduced due to covered person’s own negligence. For purposes of clarity, the Plan is not subject to any state laws or equitable doctrine, and the Plan’s first claim on the recovery operates on every dollar received from a third party, even those covering your or your covered dependent’s litigation costs and attorneys’ fees.

**Equitable Lien and Other Equitable Remedies**

By accepting benefits from this Plan, you agree that the Plan has established an equitable lien against any money or property you or your covered dependents (or any individual or entity acting on your or their behalf such as a legal representative or agent) recover from any other party, including but not limited to, an insurer (including but not limited to third-party, no-fault, med-pay, uninsured, or underinsured motorist), another group health plan or another individual, sufficient to reimburse the Plan in full for benefits advanced. For purposes of clarity, this equitable lien also attaches to any payment received from workers’ compensation, whether by judgment, award, settlement or otherwise, where the Plan has paid benefits prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers’ compensation insurers will be deemed to mean that such a determination has been made.

The Plan’s lien exists at the time the Plan pays benefits, and if you or your covered dependents file a petition for bankruptcy, you and your covered dependents agree that the Plan’s lien existed prior to the creation of the bankruptcy estate.

You further agree to hold any reimbursement or recovery received by you or your covered dependents (or any legal representative or agent) in trust on behalf of the Plan to cover all benefits paid by the Plan.

The Plan reserves all rights to seek enforcement of its rights hereunder, including but not limited to, the right to file a lawsuit against you or your covered dependent or any other party possessing or controlling any Recovered Funds, and the right to recoup amounts owed in any other manner prescribed by law.

**Obligation to Assist in the Plan’s Reimbursement Activities**

As a participant in this plan, the covered person is required to cooperate with efforts to recover benefits paid under the Plan. The covered person must also notify the Plan Administrator within 45 days of the notice which is given to a third party of the intention to recover damages due to the covered person’s illness or injury.

This cooperation includes providing the Plan with relevant information (including information concerning any other applicable insurance coverage that may be available such as automobile, home and other
liability insurance coverage and coverage under another group health plan), providing the identity of any other person or entity and their insurers, if applicable) that may be obligated to provide payments or benefits on account of the same illness or injury for which the Plan made payments, signing and delivering documents the Plan reasonably requests, and obtaining the Plan’s consent before releasing any party from liability. If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the Plan’s subrogation and reimbursement rights.

Failure by you or your covered dependents to cooperate with the Plan in the exercise of these rights may result, at the discretion of the Plan or the Plan Administrator, in a denial or reduction of future benefit payments available to you or your covered dependents under the Plan by an amount, up to the aggregate amount paid by the Plan that was subject to the Plan’s equitable lien, but for which the Plan was not reimbursed.
Health Insurance Portability and Accountability Act of 1996

Privacy Rights

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides you certain rights with respect to the use and disclosure of your protected health information. For details on HIPAA privacy standards, contact the Plan Administrator for a copy of the Comprehensive Healthcare Employee Health Care Plan HIPAA Privacy Notice.

Disclosures to the Plan Sponsor

The Plan may disclose your health information to Comprehensive Healthcare, the Plan Sponsor of the Plan, to carry out plan administration functions performed by the Plan Sponsor on behalf of the Plan. The plan documents have been amended in accordance with federal law to permit this use and disclosure.

The Plan may also disclose “summary health information”, if requested by the Plan Sponsor for the purpose of

1. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
2. Modifying, amending or terminating the Plan. Summary health information is information (which may be personal information) from which personal identifiers (except zip code) have been removed, and which summarizes claims history, claims expense or types of claims experienced by individuals for whom the Plan sponsor has provided health benefits under the Plan.

The Plan may also disclose to the Plan Sponsor whether an individual is participating in the Plan. The Plan will not disclose your personal information to the Plan Sponsor for purposes of employment-related decisions or actions, or in connection with any other benefit plan of the Plan Sponsor.
Plan Benefit Information

Benefits, Contributions and Funding

This Plan provides eligible employees and dependents with medical, vision, and pharmacy benefits. This Plan is an employer-sponsored self-funded group health plan with administration provided through the third party administrator (TPA), FCH. The benefits will be funded in part by the Plan Sponsor’s general assets and contributions made by Plan participants. The Plan will determine, and periodically communicate, your share of the cost for benefits under each component benefit plan, and may change that determination at any time.

The Plan will make employer contributions in an amount that, at the Plan’s sole discretion, is at least sufficient to fund the benefits or a portion of the benefits not otherwise funded by employee contributions, then use these contributions to pay benefits directly to or for participants from the Plan’s general assets. Employee contributions will be used in their entirety before using the Plan’s contributions to pay for the cost of such benefit.

The Plan will provide benefits in accordance with the requirements of all applicable laws, including but not limited to, the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns’ and Mothers’ Health Protection Act of 1996, the Women’s Health and Cancer Rights Act of 1998 and the Mental Health Parity and Addiction Equity Act of 2008.

Plan Administrator’s Power of Authority

The Plan Administrator role for this Plan rests with Comprehensive Healthcare’s Human Resources Department. The Plan Administrator is responsible for:

- Determining eligibility for and the amount of any benefits payable under the Plan, and
- Prescribing procedures to be followed and forms to be used by participants in this Plan.

The Plan Administrator may delegate any of these administrative duties among one or more entities, in writing. The written delegation must describe the nature and scope of the delegated relationship.

The Plan Administrator has the authority to amend or eliminate benefits under the Plan. The Plan Administrator also has the authority to require employees to furnish it with such information as it determines is necessary for proper administration of the Plan.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices and procedures.

An individual, or individuals, may be appointed by the Plan Sponsor to serve as Plan Administrator at the convenience of the Plan Sponsor. If a Plan Administrator resigns, dies or is otherwise removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.
Discretionary Authority

The Plan Administrator has the discretionary authority to interpret the Plan and to resolve any ambiguities under the Plan. The Plan Administrator also has the discretionary authority to make factual determinations as to whether any individual is entitled to receive benefits under this Plan and to decide questions of Plan interpretation and of fact relating to the Plan. Plan Administrator decisions will be final and binding on all interested parties.

Collective Bargaining Agreements

You may contact the Plan Administrator to determine where the Plan is maintained under one or more collective bargaining agreements. A copy is available from the Plan Administrator, upon written request, for examination.

Clerical Error

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

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains the contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount to the Plan through FCH. In the case of a Plan participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.
Statement of ERISA Rights

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

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly Pension and Welfare Benefits Administration).

- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and an updated plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report, if any is required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to obtain any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator’s control. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

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

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Group Health Summary Plan Document and the documents governing your COBRA continuation coverage rights.

Assistance with Your Questions

If you have questions about your Plan, contact the Plan Administrator. If you have any questions about your rights under ERISA or HIPAA, or if you need assistance in obtaining documents from the Plan Administrator, contact the nearest office of the Employee Benefits Security Administration, US Department of Labor, listed in your phone directory or:

    The Division of Technical Assistance and Inquiries
    Employee Benefits Security Administration, US Department of Labor
    200 Constitution Avenue NW
    Washington DC  20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.
Your Rights and Protections Against Surprise Medical Bills

What is Balance Billing (sometimes called Surprise Billing)?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that is not in your health plan’s network.

Out-of-network describes providers and facilities that have not signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called balance billing. This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

Surprise billing is an unexpected balance bill. This can happen when you cannot control who is involved in your care, like when you have an emergency or when you schedule a visit at an in-network facility, but are unexpectedly treated by an out-of-network provider.

You Are Protected from Balance Billing for Emergency Services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan’s in-network cost-sharing amount (such as copayments and coinsurance). You cannot be balance billed for these emergency services. This includes services you may get after you are in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Your plan is subject to ERISA, so in general, state balance billing laws are inapplicable to your plan, unless your plan has voluntarily opted into compliance with state balance billing laws or unless the state has an All-Payer Model Agreement with Centers for Medicare & Medicaid Services (CMS) that applies to the plan with respect to certain services at issue (e.g., in Maryland, Vermont and Pennsylvania).

You Are Protected from Balance Billing for Out-of-Network Providers

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan’s in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections not to be balanced billed.

If you get other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan’s network.
When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.

- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount on your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you have been wrongly billed under your ERISA plan, you may contact the Employee Benefits Security Administration at 1-866-444-3272 or you may call 1-800-985-3059. Visit www.dol.gov/ebsa or www.cms.gov/nosurprises for more information about your rights under federal law. If the medical service at issue was performed in a state with an All-Payer Model Agreement with Centers for Medicare & Medicaid Services (CMS), such as Maryland, Vermont and Pennsylvania, you may call that applicable state Department of Insurance for more information about your rights under applicable state law.

**Maryland:**  
Maryland Insurance Administration  
200 Saint Paul Place, Suite 2700  
Baltimore, Maryland 21202-2272  
Phone: (410) 468-2000

**Pennsylvania:**  
Pennsylvania Insurance Department  
1326 Strawberry Square  
Harrisburg, Pennsylvania 17120  
Phone: (717) 787-7000

**Vermont:**  
Vermont Department of Financial Regulation  
89 Main Street  
Montpelier, Vermont 05620-3101  
Phone: (802) 828-3301
## Summary Plan Description and General Information

<table>
<thead>
<tr>
<th>Plan Name:</th>
<th>Comprehensive Healthcare Employee Health Care Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year:</td>
<td>January 1 through December 31</td>
</tr>
<tr>
<td>Type of Plan:</td>
<td>Group health plan (a type of welfare benefit plan subject to ERISA provisions)</td>
</tr>
<tr>
<td>Plan Coverage Status:</td>
<td>This Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the ACA).</td>
</tr>
<tr>
<td>Plan Number:</td>
<td>501</td>
</tr>
<tr>
<td>Funding Medium:</td>
<td>Claims are paid directly out of the general assets of the Company. Employee contributions are placed in the general assets of the company and accounted for separately in the accounting records of the Company. Employee contributions shall only be used to pay medical or dental claims.</td>
</tr>
<tr>
<td>Source of Contributions:</td>
<td>The company bears the entire cost of this benefit Plan, minus the participants’ contribution.</td>
</tr>
<tr>
<td>Plan Sponsor’s Employer Identification Number:</td>
<td>91-1043304</td>
</tr>
</tbody>
</table>
| Name, Address & Telephone Number of Plan Sponsor/Plan Administrator | Comprehensive Healthcare  
402 S. 4th Ave/PO Box 959  
Yakima, WA 98907  
(509) 575-4084 |
| Named Fiduciary: | Comprehensive Healthcare  
402 S. 4th Ave/PO Box 959  
Yakima, WA 98907  
(509) 575-4084 |
| Agent for Service of Legal Process: | Comprehensive Healthcare  
402 S. 4th Ave/PO Box 959  
Yakima, WA 98907  
(509) 575-4084 |
| Third Party Administrator: | First Choice Health Network, Inc. d.b.a. First Choice Health  
600 University Street, Suite 1400  
Seattle, WA 98101  
(800) 430-3818/Local (206) 268-2360  
www.fchn.com |
<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Plan Description:</td>
<td>The written Plan Description required by ERISA §402 consists of this entire document plus benefit summary booklets and provider directories.</td>
</tr>
</tbody>
</table>
Plan Definitions

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

Allowed amount means the maximum amount considered for payment by the Plan for a medically necessary covered service.

For Emergency Services provided by out-of-network emergency facilities and out-of-network providers, certain non-emergency services furnished by out-of-network providers at certain in-network facilities, and out-of-network air ambulances, the cost-sharing amount is determined by the Qualifying Payment Amount (see related definition).

For services received from out-of-network providers (who are not covered under Recognized No Surprises Provider), you are responsible to pay the difference between the Plan payment and the provider’s actual charges.

Ancillary Services means services related to Emergency Services, such as radiology, anesthesiology, pathology, neonatology, laboratory, and specialty services needed to respond to unexpected complications (such as those delivered by a neonatologist or cardiologist) and also in situations where an in-network provider is not available at the in-network facility to provide the services.

Applied Behavior Analysis (ABA) is a term describing principles, techniques and interventions used in assessment and treatment to increase behaviors that are helpful, reduce behaviors that are harmful and demonstrate that the interventions employed are responsible for the improvement of behavior in individuals with autism. ABA incorporates many techniques for understanding and changing behavior and may involve a multi-disciplinary approach to increase language and communication skills, improve attention, focus, social skills and memory. ABA is flexible in that it can be adapted to meet the needs of each individual.

Approved Clinical Trials are those that meet the criteria in either Category 1 or Category 2 below. A service or supply will not be considered experimental or investigational if it is part of an approved clinical trial.

Category 1

1. The trial is a Phase III or Phase IV trial approved by the National Institutes of Health, the FDA, the Department of Veteran Affairs or an approved research center
2. The trial has been reviewed and approved by a qualified institutional review board
3. The facility and personnel have sufficient experience or training to provide the treatment or use the supplies

Category 2

1. The trial is to treat a condition too rare to qualify for approval under Category 1
2. The available clinical or preclinical data provide a reasonable expectation that the trial treatment will be at least as effective as non-investigational therapy
3. There is no therapy that is clearly superior to the trial treatment, and,
4. Criteria 2 and 3 as noted in Category 1
**Authorized representative** means an individual acting on behalf of the participant or beneficiary claimant in obtaining or appealing a benefit claim. The authorized representative must have a signed form (specified by the Plan) by the claimant except for urgent care benefits or appeals. Once an authorized representative is selected, all information and notifications should be directed to that representative until the claimant states otherwise.

**Aural therapy** is a service provided to both children and adults who have been diagnosed with hearing loss. Typically, aural therapy is an intervention that takes place following hearing aid fitting or cochlear implant hook-up. It involves working with the hearing impaired individual providing the patient with strategies to better utilize his or her listening skills. Aural therapy involves training the brain to process and understand auditory information, teaching how to monitor speech through listening, and learning to develop listening skills in each ear separately and integrated. Usually provided by a speech therapist.

**Birthing center** means any freestanding licensed health facility, place, professional office or institution, that is not a hospital or in a hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located. It must:

- Have facilities for obstetrical delivery and short-term recovery after delivery
- Provide care under the full-time supervision of a physician and either a registered nurse or a licensed nurse-midwife
- Have a written agreement with a hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

**Calendar year** means the 12-month period beginning January 1 and ending December 31 of the same year.

**Chemical Dependency Condition** means a condition characterized by a physiological or psychological abuse/dependency of a controlled substance and/or alcohol that impairs or endangers the participant’s or beneficiary’s health. It must be listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. The following conditions are either not considered Chemical Dependency Conditions or are covered under other benefits offered by this Plan (subject to all terms, limitations and exclusions):

- Conditions related to Mental Health (see **Mental Health Condition** definition)
- Nicotine Related Disorders (see **Tobacco Cessation**, if applicable to this Plan)
- Non-substance related disorders.

**Claim** means any request for a Plan benefit made by you or your authorized representative. A participant making a claim for benefits is a claimant.

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

**COVID-19** is an infectious respiratory illness caused by the virus SARS-CoV-2.

**Developmental Disabilities** is an umbrella term that can include physical, cognitive and intellectual disability that are apparent during childhood.

Some developmental disabilities are largely physical issues, such as cerebral palsy or epilepsy. Some individuals may have a condition that includes a physical and intellectual disability, for example Down syndrome or fetal alcohol syndrome.
Intellectual disability encompasses the “cognitive” part of this definition, that is, a disability that is broadly related to thought processes. Because intellectual and other developmental disabilities often co-occur, intellectual disability professionals often work with people who have both types of disabilities.

**Emergency Department (ED)** is an emergency department of a hospital, or an Independent, Freestanding Emergency Department (or a hospital, with respect to services that are included in Emergency Services).

**Emergency Medical Condition** means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

1. Jeopardy to the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child);
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition, a medical screening examination (as required under section 1867 of the Social Security Act) that is within the capability of the Emergency Department of a hospital or an Independent, Freestanding Emergency Department, including pre-stabilization services, post-stabilization services, and Ancillary Services to evaluate such an Emergency Medical Condition, and within the capabilities of the staff and facilities available at the hospital, to treat such an Emergency Medical Condition.

*Pre-stabilization services provided after the patient is moved out of the Emergency Department (ED) and admitted to a hospital, post-stabilization services and Emergency Services provided at an Independent, Freestanding Emergency Department. Emergency Service are subject to the protections of the No Surprises Act.*

*Post-Stabilization services are also subject to the protections of the No Surprises Act, unless the patient is able to travel to an in-network facility using non-medical transportation, but elects to stay at the out-of-network facility.*

**Employee contribution** is the employee portion of the costs for a benefit plan.

**ERISA** is the federal Employee Retirement Income Security Act of 1974, as amended, which governs plan administration, supervision and management.

**Essential Health Benefits** shall mean, under section 1302(b) of the Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The determination of which benefits provided under the plan are Essential Health Benefits shall be made in accordance with the benchmark plan of the State of Washington as permitted by the Departments of Labor, Treasury, and Health and Human Services.

**Experimental, investigational and unproven procedures** mean services determined to be either:

1. Not in general use in the medical community,
2. Not proven safe and effective or to show a demonstrable benefit for a particular illness or disease,
3. Under continued scientific testing and research, excepting Approved Clinical Trials (see related definition)
4. A significant risk to the health or safety of the patient, or,
5. Not proven to result in greater benefits for a particular illness or disease than other generally available services.

Family Member means a person who is a spouse, former spouse, child, stepchild, grandchild, parent, stepparent, grandparent, niece, nephew, mother-in-law, father-in-law, son-in-law, daughter-in-law, brother, sister, brother-in-law, or sister-in-law, including adoptive relationships.

Fiduciary means, under ERISA, a person who exercises discretionary authority or control over the management of an ERISA plan or its assets or has discretionary authority or responsibility in Plan administration.

First Choice Health (FCH) is the Third Party Administrator for this group health plan.

First Choice Health Network, Inc. (FCHN) is the network of providers that is used by FCH and defines the service area.

First Responder User Fee is a charge to patients who were treated or evaluated by a First Responder Unit of a municipality or other government agency that responded to a 9-1-1 call for medical services.

Independent, Freestanding Emergency Department is any health care facility that is geographically separate and distinct from a hospital, and that is licensed by a state to provide Emergency Services, even if the facility is not licensed under the term, “Independent, Freestanding Emergency Department.”

Legal Separation and/or Legally Separated shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

Levels of Care related to Mental Health and Chemical Dependency Conditions:

1. Intensive Outpatient Programs provide services for Mental Health or Chemical Dependency Conditions on an outpatient basis through planned, structured services available at least two hours per day and three days per week. Services include group, individual and when indicated family or multi-family group treatment. Medical monitoring, evaluation and adjunctive services are available. Treatment must follow a written plan of care.

2. Inpatient Psychiatric Hospitalization Programs provide around-the-clock psychiatric and nursing interventions in secure, State-licensed psychiatric facilities for individuals diagnosed with a mental health disorder. These facilities operate under the supervision of a licensed and Board eligible/certified psychiatrist who evaluates the patient within 24 hours of admission. Subsequent face-to-face visits with a psychiatrist or psychiatric ARNP occur at least once every 24 hours along with daily medication management. Treatment must follow a written plan of care and include psychosocial and substance abuse evaluations. Individual, group, and/or family therapy occurs daily. The focus of the program is stabilization of client’s psychiatric symptoms through the use of assessment, medication management, evidenced-based treatment strategies, group and individual therapy, behavior management, and active family engagement/therapy.

3. Partial Hospitalization Programs provide multi-disciplinary care for Mental Health or Chemical Dependency Condition at least 6 hours a day, 5 days a week, and schedule at least three distinct services per day. Services include individual and group therapy, medication evaluation and management, family therapy, activity therapy, occupational therapy, and
education training directed at treating the Condition. Services for Mental Health Conditions must include evaluation by a psychiatrist within 48 hours and weekly thereafter. All programs must include a substance abuse evaluation. Treatment must follow a written plan of care.

4. **Residential Treatment Programs** provide a 24-hour level of care 7 days a week for patients with long-term or severe Mental Health or Chemical Dependency Conditions. Care is medically monitored, with 24-hour medical and nursing availability. Services include treatment with a range of diagnostic and therapeutic behavioral health services that cannot be adequately provided through existing community programs. Residential care also includes family involvement in assessment, treatment and discharge planning, and offers training in the basic skills of living as determined necessary for each patient. Treatment must follow a written plan of care.

5. **Chemical Dependency Rehabilitation Programs** provide 24-hour rehabilitation treatment 7 days a week for Substance Related Conditions. Services include group, individual and when indicated family or multi-family group. The facility must offer sufficient availability of medical and nursing services to manage ancillary detoxification needs. Treatment must follow a written plan of care.

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

**Medical group** means a group or association of providers, including hospital(s), listed in the provider directory.

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

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

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

**Mental Health Condition** means a mental disorder listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association. The following conditions, although considered mental health conditions under the DSM, are not included in the Mental Health Care benefit under this Plan, and are either excluded or are covered under other benefits offered by this Plan (subject to all terms, limitations and exclusions):

1. Conditions related to Substance Related and Addictive Disorders (see Chemical Dependency definition)
2. Relational, family, and lifestyle stressors absent a primary psychiatric diagnosis
3. Sexual dysfunctions, personality disorders, paraphilic disorders.

**Network provider** means a contracted FCHN provider in Washington, Idaho, Montana, Oregon, and Alaska, or a contracted FCHN or First Health Network provider in Wyoming, North Dakota, and South
Dakota that is listed in the provider directory. Outside these states, participants must use the First Health Network for network providers.

**No Surprises Act** holds patients harmless from surprise medical bills and pre-authorization requirements. See *Your Rights and Protections Against Surprise Medical Bills*. This act:

- Bans balance billing for Emergency Services.
- Requires that patient cost-sharing, such as copayments, co-insurance, or a deductible, for Emergency Services and certain non-emergency services provided by an out-of-network provider at an in-network facility cannot be higher than if such services were provided by an in-network provider, and any cost-sharing obligation must be based on in-network provider rates.
- Prohibits out-of-network charges for items or services provided by an out-of-network provider at an in-network facility, unless certain notice and consent is given. Providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an out-of-network basis before that provider can bill the patient more than in-network cost-sharing rates.

**Open enrollment period** is a defined time when you are allowed to enroll yourself and/or your dependents for benefit coverage.

**Out-of-network provider** means a provider who delivers or furnishes health care services but is not a contracted FCHN provider in Washington, Idaho, Montana, Oregon, or Alaska. Outside these states an out-of-network provider means a provider who delivers or furnishes health care services but is not a contracted First Health Network provider.

**Out of area/out of the service area** means outside the FCHN service area as described under network provider and out-of-network provider.

**Participant** means any eligible employee or other eligible individual enrolled in the Plan.

**Plan Administrator** means the department designated by an employer group to administer a plan on behalf of participants. Usually, the Plan Administrator is your Benefits Department. (The principal duty of the Plan Administrator is to see that the Plan is carried out, in accordance with its terms, for the exclusive benefit of eligible participants and beneficiaries, without discrimination. The Plan Administrator has the power and exclusive authority necessary, at its discretion, to:

1. Construe and interpret the Plan document and to decide all questions of eligibility and participation,
2. Make all findings of fact for Plan administration, including payment of reimbursements,
3. Prescribe procedures to be followed and forms to be used by participants and beneficiaries,
4. Request and receive from all employees the information necessary for proper Plan administration, and,
5. Appoint and employ the individuals or entities to assist in Plan administration as necessary or advisable, including benefit consultants and legal counsel.

**Plan Document** means the document that describes requirements for eligibility and enrollment, covered services, limitations and exclusions, and other terms and conditions that apply to participation in this Plan.

**Post-service claim** means any claim for a Plan benefit that is not a pre-service claim and is a request for payment or reimbursement for covered services already received.
**Pre-authorization** is the process of obtaining coverage determination from FCH before receiving inpatient and certain outpatient services, as specified in the component plans’ benefit description booklets.

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

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

**Provider directory** is the listing of the network providers, hospitals, and other facilities that have agreed to provide covered services to participants or dependents of Plans contracted with FCHN and FCH for PPO and TPA services.

**Qualifying event** means, under COBRA, the triggering event that causes a loss of coverage under a group health plan, including termination of employment, reduction in hours, death or divorce. (See the COBRA section for more details.)

**Qualifying Payment Amount (QPA)** means consumer cost-sharing amounts for Emergency Services provided by out-of-network emergency facilities and out-of-network providers, certain non-emergency services furnished by out-of-network providers at certain in-network facilities, and out-of-network air ambulances that must be calculated based on one of the following amounts:

- An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
- If there is no such applicable All-Payer Model Agreement, an amount determined under a specified state law; or
- If neither of the above apply, the lesser amount of either the billed charge or the QPA, which is generally the plan’s or issuer’s median contracted rate.

**Recognized Providers** are providers acting within the scope of his/her license but for whom: 1) FCHN does not offer agreements to his/her category of providers, or 2) agreements are offered but covered participant choice is not provided. Examples of both types are outlined below:

- Ambulance services
- Anesthesiologists
- Assistant surgeon
- Blood banks
- Dental services covered by the Plan; provider types may include:
- Dentist
- Oral and Maxillofacial Surgeon
- Otolaryngologist (Ear, Nose & Throat specialist, or ENT)
- Non-contracted laboratories used by FCHN referring provider
- Ocular prosthetics (if covered by the Plan)
- PKU formula
- Services of non-contracted providers when rendering care within a network facility, except a primary surgeon for a non-emergent admission
- Suppliers of oral appliances (if covered by the Plan)
- Suppliers of wigs (if covered by the Plan)
• TMJ providers (if covered by the Plan)

For services received from out-of-network providers (not covered under Recognized No Surprises Providers), you are responsible to pay the difference between the Plan payment and the provider’s actual charges.

Recognized No Surprises Provider is a provider acting within the scope of his/her license that the No Surprises Act applies to and whom: 1) FCH does not offer agreements to his/her category of providers, or 2) agreements are offered but do not cover the particular provider at issue or no written notice and consent was provided. This includes:

- Ambulance services
- Anesthesiologists services
- Assistant surgeon services
- Emergency services
- Hospital services
- Intensivist services
- Laboratory services
- Neonatology services
- Pathology services
- Radiology services
- Services of non-contracted providers when rendering care within an in-network facility, except a primary surgeon for a non-emergent admission
- If you receive any of the services listed above, then those out-of-network providers cannot balance bill you, unless you are provided with written notice and give written consent to waive your protections against balance billing.

Special enrollment means, under HIPAA, special mid-year enrollment rights that group health plans must offer to certain unenrolled employees and dependents who experience a mid-year loss of other coverage or when there is a mid-year birth, adoption or marriage.

Surrogacy means a participant who bears a child for another person, often for pay, either through artificial insemination or by carrying until birth another participant’s surgically implanted fertilized egg.

Telemedicine Services include three types of visits: Scheduled Telephone Visits (STV), Electronic Visits (e-visits), and videoconference.

1. Scheduled Telephone Visit (STV) means a telephonic visit initiated by patient and scheduled for a specific time with a designated provider, and not related to any previous visits within 7 days.
2. Electronic Visit (e-visit) means a visit of non-urgent clinical information between a provider and a patient conducted over a secure encrypted web portal. E-visits must be scheduled with a designated provider and not be related to any visit within the last 7 days.
3. Videoconference Consultation means the use of medical information exchanged from one site to another via electronic communications.

Temporomandibular Joint (TMJ) Disorders mean disorders that have one or more of the following characteristics:

- Pain in the musculature associated with the temporomandibular joint;
• Internal derangement of the temporomandibular joint;
• Arthritic problems with the temporomandibular joint;
• An abnormal range of motion or limited motion of the temporomandibular joint.

**Third Party Administrator (TPA)** is the organization providing services to this Plan’s Administrator and Sponsor, including processing and payment of claims. FCH is the Third Party Administrator for this Plan.

**Urgent care** means services that are medically necessary and immediately required as a result of an unforeseen illness, injury or condition that is not an emergency, but it was not reasonable given the circumstances to wait for a routine appointment.

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

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

**Usual, Customary and Reasonable (UCR)** is the maximum amount that the Plan will consider for a covered health care service received from an out-of-network provider (outside of the Recognized No Surprises Providers) that is consistent with and based upon what providers in a given particular geographic area charge for a same or similar medical procedure.

The Plan’s UCR calculation is based upon the 25th percentile of the market rate for identical and similar services within a particular geographic area that has been obtained from a commercially-reasonable, independent third-party source, which is updated semi-annually. If the third party source does not have enough data to establish a UCR amount for a given medical procedure, the UCR will be calculated as a multiple of Medicare, specifically 150% of Medicare. If there is no value from the third-party source, and there is no Medicare allowed amount, and the service is deemed payable, the Plan will allow 50% of billed charges. Coinsurance, copayments, deductible or non-covered services are applied against UCR amount as patient responsibility. The provider can balance bill the member the difference between the Plan payment and providers actual charges.