First Choice Health®

Port of Tacoma, U.S.A.
and
Northwest Seaport Alliance

Non-Represented Benefit Plan Summary Plan Description

Effective April 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.

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Important Information about this Plan

This booklet describes your coverage, payment levels and how to use the benefits offered by the Port of Tacoma U.S.A. and Northwest Seaport Alliance Employee Health Care Plan as of April 1, 2022. If you need information regarding eligibility and enrollment, terminating and continuing coverage, administration, claim and appeal procedures and other legally required material, please see the accompanying Summary Plan Description.

Port of Tacoma and Northwest Seaport Alliance, 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. Port of Tacoma U.S.A. and Northwest Seaport Alliance delegates to FCH the authority to make decisions on benefit coverage, medical management, claim payment and certain other administrative services according to Port of Tacoma and Northwest Seaport Alliance' policies and procedures. However, Port of Tacoma and Northwest Seaport Alliance retains at all times the ultimate fiduciary authority, responsibility and control over Plan assets, management and administration unless stated otherwise in this document.

The Port of Tacoma U.S.A. and Northwest Seaport Alliance 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, out-of-network level of benefits.

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

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

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

These materials do not create a contract of employment or any rights to continued employment with Port of Tacoma and Northwest Seaport Alliance.

Grandfathering

Port of Tacoma and Northwest Seaport Alliance 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 (Port of Tacoma) at (253) 383-9403 or 1 Sitcum Plaza Tacoma, WA 98421. 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
(877) 572-0981
Local: (206) 268-2360
Fax: (888) 206-3092
Medical pre-authorization review: (800) 808-0450
Mental health/chemical dependency pre-authorization review: (800) 640-7682
TTY: (866) 876-5924

www.fchn.com

Spanish (Español): Para obtener asistencia en Español, llame al (877) 572-0981.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 572-0981.

Chinese（中文）：如果需要中文的帮助，请拨打这个号码(877) 572-0981.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (877) 572-0981

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 (877) 572-0981.

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 by contacting FCH Customer Service at (877) 572-0981, 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:

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

For members who reside outside Washington State, claims from Out-of-Network providers will be paid based on billed charges.

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

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.

Services Received Outside of the U.S.

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

- Participants must pay for medical services at the time of service.

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

Medical Management

Pre-Authorization Review

Pre-authorization review is recommended for all inpatient admissions and certain outpatient services and procedures, as also noted in the *Summary of Medical Benefits*. Call (800) 808-0450 for pre-authorization review 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 review is recommended for:

- **Air Ambulance Transport** - non-urgent transport
- **Anesthesia for dental services**
- **Chimeric Antigen Receptor (CAR) T-cell Therapy**
- **Dental Trauma Services** (follow-up services and anesthesia)
- **Dialysis (all types)** (for chronic kidney disease)
- **Durable Medical Equipment, Medical Supplies and Prosthetics**
  - Bone growth and neuromuscular simulators
  - Compression devices for home use
  - Cranial orthotic devices
  - Custom, power operated and manual wheelchairs and supplies
    - Standard, manual wheelchair rental for transition of care for up to 3 months does not require pre-authorization
  - Custom fabricated knee braces
  - Electrical stimulators- spinal- external
  - Myoelectric components for upper limb and powered components for ankle-foot and knee Prosthetics
  - Oscillatory devices and cough stimulating devices
  - Scooters
  - Specialized hospital beds and traction
  - 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** (pre-authorization is still recommended for certain home infusion drugs. See *Medical Injectables*)
  - Home health visits (for wound therapy only)
  - Hospice
- **Hyperbaric Oxygen Therapy**
- **Imaging**
  - PET scans
- **Inpatient Admissions**

- **Medical Injectables, 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:
    - Blood Clotting Factors, All types, All brands
    - Select Hormone Therapy
    - Intravenous Immunoglobulin Therapy- IVIG, All types, All brands
    - Botulinum Toxin, All types, All brands
- **Oral Appliances for Sleep Apnea Therapy**
- **Organ and bone marrow transplants** (includes evaluation of services for both recipient and donor)
- **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)
    - Implant removal
    - Mastectomy for gynecomastia
    - Reduction mammoplasty
  - Cosmetic or reconstructive Surgery
  - Deep brain stimulation
  - Fetal/intrauterine surgery
  - Gender affirming 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
    - Artificial intervertebral disc
    - Cervical fusions
    - Lumbar fusions
    - Minimally invasive, percutaneous & endoscopic spine surgery
  - Surgical interventions for sleep apnea
  - TMJ surgery
  - Vagus nerve stimulation
  - Varicose vein procedures
  - Ventricular assist devices and total heart replacement
- **Transcranial Magnetic Stimulation**

If you do not obtain a pre-authorization review for any of the above services, your claim may be reviewed for medical necessity post-service. If the service is determined to be medically necessary, your claim will be paid according to the benefits under this Plan. If determined to be not medically necessary, your claim will be denied.

Your provider may submit an advance request to FCH Medical Management for benefit or medical necessity determination.

Notification for Emergency Admissions

Admissions directly from the emergency department do not require pre-authorization review. However, notification is recommended 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

- Your benefit coverage is greater, and your out-of-pocket costs less, when you choose a Network provider.
- For members who reside outside Washington State, claims from Out-of-Network providers will be paid based on billed charges (see Allowed Amount under *Plan Definitions*).
- Benefit payment is based on the Allowed Amounts agreed upon by Network providers.
- Services received from a Recognized Provider (See *Plan Definitions* in this Summary Plan Description) will be paid at the In-Network level. Benefits will be based on Usual, Customary and Reasonable data or a case negotiated rate. You will be responsible for the difference (if any) between the Plan payment and the billed charges on Recognized Provider claims and this difference would not apply to your Out-of-Pocket (OOP) maximum as discussed below.
- For services received from 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.
- 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.
- 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.

Annual Deductible

Active Employees & Retirees

There is no deductible on this plan.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the most you will need to pay in a Calendar year for covered services. 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 co-insurances. Also, the family will meet no more than the stated family maximum regardless of family size. There is no out-of-pocket maximum for services received from out-of-network providers. The following do **not** apply toward the annual out-of-pocket maximum:

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 services paid by the Plan at 100%
- Allergy Testing
- Home Health Care
- Hospice Care
- Habilitative Services
- Nutritional Counseling
- Orthotics
- Outpatient Rehabilitation
- Preventive Care
- Temporomandibular Joint Disorder
- Skilled Nursing Facility
- Vision Exam

Benefit Maximums

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

Annual Deductible and Out-of-Pocket Maximums

Deductible and Out-of-Pocket Maximums	Network	Out-of-Network
Annual Deductible (per calendar year)		
Employees & Retirees	$0	

Annual Out-of-Pocket Maximum (per calendar year)		
Individual	$1,000	Unlimited
Family	$3,000	Unlimited

Summary of Benefit Maximums

Lifetime Maximum Benefits	
Hospice • Inpatient Hospice • Respite care	12-month lifetime maximum 14 days 30 days within a 12-month period
Temporomandibular Joint Disorder	$5,000
Calendar Year Maximums	
Allergy Testing	$300
Alternative Care (acupuncture, massage therapy, naturopathic care)	$1,000 (combined with Chiropractic Spinal Manipulation)
Chiropractic Spinal Manipulation	$1,000 (combined with Alternative Care)
Home Health Care	130 visits
Temporomandibular Joint Disorder	$1,000
Foot Orthotics	One pair
Preventive Care	See *Preventive Care* in the Summary of Medical Benefits below for specific age and frequency limits.
Rehabilitation Therapy • **Inpatient** • **Outpatient** (includes occupational, physical, respiratory, speech therapy, pulmonary rehabilitation, and cardiac rehabilitation)	 30 days 45 visits
Skilled Nursing Facility	100 days
Transplants – Organ and Bone Marrow • **Donor Services**	 $20,000 per transplant
Vision Exam	One exam

Summary of Medical Benefits

	Applies to Network OOP Max	Network	Out-of-Network
Allergy Care			
• **Testing** $300 per calendar year maximum	N/A	80%	60%
• **Injections**	N/A	100%	60%
Alternative Care (acupuncture, massage therapy, naturopathic care) $1,000 per calendar year maximum combined with Chiropractic Spinal Manipulation			
• **Acupuncture**	✓	80%	60%
• **Massage Therapy**	✓	80%	60%
• **Naturopathic Care**	✓	80%	60%
Ambulance Services FCH pre-authorization review is recommended for non-emergent air ambulance.	✓	80%	80%
Anesthesia	N/A	100%	100% if provided at a network facility 60% if provided at an out-of-network facility
Applied Behavior Analysis (ABA) Therapy FCH pre-authorization reviews recommended for inpatient services.	N/A	100%	60%
Autologous Blood Donation/Blood Transfusion	✓	80%	80%
Biofeedback	Not Covered		
Chemical Dependency FCH pre-authorization review is recommended for inpatient, residential and partial hospitalization.			
• **Inpatient** (facility)	✓	90%	60%

	Applies to Network OOP Max	Network	Out-of-Network
• **Inpatient** (professional)	✓	90%	60%
• **Outpatient** (facility)	N/A	100%	60%
• **Outpatient** (professional)	N/A	100%	60%
Chiropractic Spinal Manipulation ($1,000 per calendar year maximum combined with Alternative Care)	✓	80%	60%
Dental Trauma FCH pre-authorization review is recommended for follow-up services and anesthesia.			
• **Professional Services**	✓	80%	80%
• **Facility Services**	N/A	100%	100%
Diabetic Education and Diabetic Nutrition Education	N/A	80%	60%
Diagnostic Testing (Lab and Radiology Services non-routine, facility and professional services) FCH pre-authorization review is recommended for PET scans.			
• **Hospital Inpatient** (professional fees)	✓	90%	60%
• **Hospital Outpatient** (facility and professional fees)	N/A	100%	60%
• **Lab or X-Ray Facility**	N/A	100%	60%
• **Doctor's Office**	N/A	100%	60%
Dialysis FCH pre-authorization review recommended.	N/A	100%	60%
Durable Medical Equipment			
• **Durable Medical Equipment**	✓	80%	60%
• **Medical Supplies**	✓	80%	80%

	Applies to Network OOP Max	Network	Out-of-Network
• **Oral Appliances** (related to Sleep Apnea and TMJ FCH pre-authorization required when treating sleep apnea When related to TMJ, applies to the TMJ calendar year and lifetime maximums.	✓	80%	80%
• **Orthopedic Appliances**	✓	80%	80%
• **Prosthetic Devices**	✓	80%	60%
Emergency Care			
• **Emergency Department Facility**	✓	100% after $75 copay	60% after $75 copay
• **Emergency Department Professional**	N/A	100%	60%
• **Urgent Care**	✓	100% after $15 copay	60% after $15 copay
Family Planning			
• **Office Visits and Diagnostic Services**	✓	100% after $15 copay	60% after $15 copay
• **Devices, Implants and Injections**	✓	80%	80%
• **Contraceptive Diagnostic Testing**	✓	80%	80%
• **Sterilization** (covered for employee and spouse/domestic partner only)	N/A	100%	60%
• **Termination of Pregnancy**	Covered as any other medical service (for employee and spouse/domestic partner only; not covered for dependent children)		
Foot Orthotics Limit one pair per calendar year.	N/A	80%	60%
Genetic Testing/Counseling FCH pre-authorization review is recommended for Genetic Testing if over $500.	N/A	100%	60%
Habilitative Services	N/A	80%	60%
Hearing			
• **Medically Necessary Hearing Exams**	N/A	100%	60%

	Applies to Network OOP Max	Network	Out-of-Network
• **Routine Hearing Exams**	Not Covered		
• **Hearing Aids/Appliances**			
Home Health Care FCH pre-authorization review is recommended for wound therapy, enteral formula, medical food and associated services and home hospice. 130 visits per calendar year.			
• **Home Health Care**	N/A	100%	100%
• **Phototherapy** (home)	N/A	100%	100%
Hospice FCH pre-authorization review is recommended for inpatient and home hospice. 12-month lifetime maximum.			
• **Hospice Care** Inpatient Hospice is limited to 14 days	N/A	100%	100%
• **Respite Care** Limited to 30 days in a 12 month period	N/A	100%	100%
Hospital Inpatient Medical and Surgical Care FCH pre-authorization review is recommended.			
• **Facility Services**	✓	90%	60%
• **Inpatient Doctor Visits/ Consultations**	N/A	100%	60%
• **Inpatient Professional Services** (surgeon, radiologist, pathologist)	N/A	100%	60%
• **Inpatient Professional Services** (assistant surgeon)	N/A	100%	100% if provided at a network facility
			60% if provided at an out-of-network facility

	Applies to Network OOP Max	Network	Out-of-Network
Hospital Outpatient Surgery and Services FCH pre-authorization review is recommended for certain outpatient services; see *Pre-authorization Review* section for details.			
• **Surgical Facility Services**	✓	100% after $15 copay	60% after $15 copay
• **Ambulatory Surgery Center** (ASC)	✓	100% after $15 copay	60% after $15 copay
• **Outpatient Professional Services** (surgeon, radiologist, pathologist)	N/A	100%	60%
• **Outpatient Professional Services** (assistant surgeon)	N/A	100%	100% if provided at a network facility 60% if provided at an out-of-network facility
Infertility Diagnostic Services	Not Covered		
Infusion Therapy (Radiation, Chemotherapy) FCH pre-authorization review is recommended for certain infusion therapy drugs, see *Pre-Authorizations Requirements.*	N/A	100%	60%
Maternity and Newborn Care	Covered as any other medical condition.		
Mental Health Care FCH pre-authorization review is recommended for inpatient, residential and partial hospitalization.			
• **Inpatient** (facility)	✓	90%	60%
• **Inpatient** (professional)	✓	90%	60%
• **Partial Day Treatment** (PDT)	N/A	100%	60%
• **Outpatient** (facility and professional)	N/A	100%	60%
Nutritional Counseling	N/A	80%	80%

	Applies to Network OOP Max	Network	Out-of-Network
Nutritional and Dietary Formulas Limited benefit, see *Nutritional and Dietary Formulas* below.			
• **PKU Formula**	✓	80%	80%
• **Other Formulas**	✓	80%	80%
Plastic and Reconstructive Services FCH pre-authorization review is recommended. Limited benefit, see *Plastic and Reconstructive Services* for details.	N/A	100%	60%
Podiatric Care Limited benefit, see *Podiatric Care* below.	Benefit level depends on place of service.		
Preventive Care The Plan will deny claims for preventive care services outside of the age and/or frequency limits noted below.			
Immunizations Immunizations for children and adults are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention. See Preventive Care for details. Travel immunizations are not covered.			
• **Flu shots**	N/A	100%	100%
• **All Other Immunizations**	N/A	100%	60%
Periodic Exams (adult and child)			
• **Birth through age 6**	N/A	100%	60%
• **Age 7 and older**	N/A	100% after $15 copay	60% after $15 copay
• **Gynecological Exam**	N/A	100% after $15 copay	60%
Routine Screening Tests Screening tests are covered in accordance with the recommendations set forth by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See *Preventive Care* for more details.			
• **Bone Density Screening**	N/A	100%	60%

	Applies to Network OOP Max	Network	Out-of-Network
• **Colonoscopy** The first colonoscopy per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent colonoscopies in the same calendar year are covered under the applicable medical benefit, regardless of diagnosis.	N/A	100%	60%
• **Fecal Occult Blood Test** The first fecal occult blood test per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent fecal occult blood tests in the same calendar year are covered under the applicable medical benefit, regardless of diagnosis.	N/A	100%	60%
• **FIT-Fecal DNA** 1 per calendar year.	N/A	100%	60%
• **Mammogram** The first mammogram per calendar year is paid under the preventive care benefit, regardless of diagnosis. Subsequent mammograms in the same calendar year are paid under the medical benefit, regardless of diagnosis.	N/A	100%	60%
• **Pap Test**	N/A	100%	60%
• **Prostate Cancer Screening (PSA)**	N/A	100%	60%
• **Sigmoidoscopy** The first sigmoidoscopy per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent sigmoidoscopies in the same calendar year are covered under the applicable medical benefit, regardless of diagnosis.	N/A	100%	60%

	Applies to Network OOP Max	Network	Out-of-Network
• **All Other Eligible Screening Tests**	N/A	100%	60%
Professional/Physician Services (office visits)	✓	100% after $15 copay	60% after $15 copay
• **98point6 Text Based Program** (Primary Care)	N/A	100%	
Rehabilitation Therapy			
• **Inpatient** (facility and professional) FCH pre-authorization review is recommended. 30 days per calendar year.	N/A	90%	60%
• **Outpatient** (physical, speech, occupational therapy, respiratory, therapy, pulmonary rehabilitation, and cardiac rehabilitation) 45 visits per calendar year.	✓	80%	60%
Skilled Nursing Facility 100 days per calendar year.	N/A	100%	100%
Temporomandibular Joint (TMJ) Disorder FCH pre-authorization review is recommended if inpatient. $1,000 maximum per calendar year, up to $5,000 lifetime maximum.	N/A	100%	60%
Transgender/Gender Affirming Services FCH pre-authorization and Case Management recommended. Limited benefit, see *Transgender/Gender Affirming Services* for details.	Payment is based on Place of Service and Provider type.		
Transplants (organ and bone marrow) FCH pre-authorization review is recommended. 10-month waiting period applies.			
• **Recipient Services** (facility and professional)	N/A	100%	Not Covered

	Applies to Network OOP Max	Network	Out-of-Network
• **Donor Services** (facility and professional) Limited to $20,000 per transplants.	✓	80%	80%
• **Transportation and Lodging**	Not Covered		
Vision			
• **Routine Eye Exam** One exam per calendar year.	N/A	100% after $15 copay	60% after $15 copay
• **Vision Hardware**	Not Covered		
Wigs	✓	80%	80%

Medical Benefits

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

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

- The service or supply is a listed covered benefit,
- Specific benefit limits or lifetime maximums are not exhausted,
- 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.

Alternative Care

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

Ambulance Services

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

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

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

Note: Emergent Air Ambulance Transport will be reviewed retrospectively.

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

Anesthesia

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

General Anesthesia for Dental Care

Coverage is provided for general anesthesia and associated facility charges in conjunction with dental trauma (see Dental Trauma benefit), or dental care provided to a participant if such participant is:

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

Applied Behavior Analysis (ABA)

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

ABA therapy programs incorporate behavior modification, training and education.

This benefit will cover the five components of ABA:

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

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

Covered Providers

For ABA

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

- **Board Certified Behavior Analyst® (BCBA® (graduate level), BCBA-D™ (doctoral level)** – The BCBA and BCBA-D are independent practitioners who also may work as employees or independent contractors for an organization. The BCBA conducts descriptive and systematic behavioral assessments, including functional analyses, and provides behavior analytic interpretations of the results. The BCBA designs and supervises behavior analytic interventions. The BCBA is able to effectively develop and implement appropriate assessment and intervention methods for use in unfamiliar situations and for a range of cases. The BCBA seeks the consultation of more experienced practitioners when necessary. The BCBA teaches others to carry out ethical and effective behavior analytic interventions based on published research and designs and delivers instruction in behavior analysis. BCBAs supervise the work of Board Certified Assistant Behavior Analysts and others who implement behavior analytic interventions.

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

Blood Transfusions/Donation

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

Chemical Dependency

Pre-authorization review is recommended for all inpatient admissions and partial hospital programs as described under *Medical Management.* You can obtain a pre-authorization review by calling (800) 640-7682. The plan covers services provided to individuals requiring chemical dependency treatment for abuse of substances (e.g. alcohol or other drugs). Care must be medically necessary and provided at the least restrictive level of care. A clear treatment plan containing measurable progress toward a rehabilitative goal(s), including but not limited to movement to a less restrictive setting (if applicable), or other medically necessary goals must be established as determined by your provider and FCH's medical management.

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

COVID-19

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

Dental Trauma

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

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

Diabetic Education and Diabetic Nutrition Education

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

Diagnostic Testing

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

Dialysis

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

Durable Medical Equipment (DME)

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** when related to the treatment of Sleep Apnea or TMJ
- **Orthopedic appliances:** These include appliances used to support abnormal joints, limit pressure on a joint after injury to allow it to heal or correct abnormal curves in the spine.
- **Prosthetic devices:** Benefits include external prosthetic appliances that are used to replace all or part of a missing body part and are necessary for the alleviation or correction of illness, injury, or congenital defect.

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

Emergency Services 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 gunshot wounds, automobile accidents, and pain or bleeding during pregnancy. Examples of **urgent** conditions include cuts and lacerations, diarrhea, allergic reactions, sprains, urinary tract infections and vomiting.

In the case of an emergency, home or away, seek the most immediate care available. To receive the network level of benefits, you must obtain all follow-up care from network providers. If you require out-of-network follow-up services, FCH pre-authorization review is recommended, unless the services are part of the post-stabilization treatment.

Eye Exam

The eye exam includes the necessary tests to evaluate and monitor visual wellness.

Family Planning

FDA-approved birth control methods are covered. Over-the-counter products are not covered. Oral, patch and ring contraceptives are covered under the prescription drug benefit. Voluntary sterilization procedures are covered for an employee and spouse/domestic partner only.

Termination of Pregnancy

Voluntary termination of pregnancy is covered for an employee or spouse/domestic partner only.

Foot Orthotics

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

Genetic Services

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

Habilitative Services

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

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

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

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

Home Health Care

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

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

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

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

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

under this benefit and under any other benefit of this plan will be covered under the most appropriate benefit, as determined by FCH.

Hospice Care

FCH pre-authorization review is recommended for inpatient hospice and home hospice care. Hospice care is covered when prescribed by your physician and s/he has determined that life expectancy is 12 months or less and a palliative, supportive care treatment approach has been chosen. *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.
- **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

If the patient exhausts the hospice benefit maximum, limited extensions may be granted if it is determined that the treatment is medically necessary. Any charges for hospice care that qualify under this benefit, and under any other benefit of this plan, will be covered under the most appropriate benefit as determined by FCH.

Hospital Inpatient Medical and Surgical Care

Hospital inpatient and facility charges for medically necessary care are covered. **FCH pre-authorization review is recommended** 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

FCH pre-authorization review is recommended for certain outpatient surgery/procedures; please see *Pre-Authorization Review* section 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 review is recommended for certain infusion therapy drugs; please see *Pre-authorization Requirements* for details. Infusion therapy is the administration of medications using intravenous, subcutaneous, and epidural routes (into the bloodstream, under the skin, and into the membranes surrounding the spinal cord). Drug therapies commonly administered via infusion include, but are not limited to, antibiotics, chemotherapy, pain management, parenteral nutrition, and immune globulin. Diagnoses commonly requiring infusion therapy include infections that are unresponsive to oral antibiotics; cancer and cancer-related pain; gastrointestinal diseases or disorders which prevent normal functioning of the GI system; congestive heart failure; immune disorders; and more.

Maternity and Newborn Care

Coverage for pregnancy and childbirth, for employees or his/her spouse/domestic partner, 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, an advanced registered nurse practitioner (ARNP), a licensed midwife, or a certified nurse midwife (CNM) are covered under this benefit.

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

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

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

Mental Health Care

FCH pre-authorization review is recommended for all inpatient admissions and partial hospital programs 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. Facilities offering inpatient level of care must have a medical model with physician and/or nursing staff on site 24 hours each day. A clear treatment plan must be established on admission and include measurable progress toward a rehabilitative goal(s), including but not limited to movement to a less restrictive setting (if applicable), or other medically necessary goals as determined by your provider and FCH's medical management.

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

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 Counseling

Coverage provided for health services rendered by a registered dietician or other licensed professional for individuals with medical conditions that require a special diet. Some examples of such medical conditions include coronary heart disease, congestive heart failure, severe obstructive airway disease, gout, renal failure, phenylketonuria and hyperlipidemias. Nutritional counseling for diabetes is covered under the *Diabetic Education & Diabetic Nutrition Education* benefit.

Nutritional and Dietary Formulas

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

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

Plastic and Reconstructive Services

FCH pre-authorization review is recommended for reconstructive/plastic procedures 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 diabetes or peripheral vascular disease.

Preventive Care

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

- Routine physicals
- Periodic examinations including the specific diagnostic testing/screening and laboratory services 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 the recommended immunization schedules, visit the CDC's website at: https://www.healthcare.gov/prevention/

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.

Sessions 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

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

Outpatient Rehabilitation

Outpatient rehabilitation benefits are subject to the following provisions:

- You must not be confined in a hospital or other medical facility.
- Services must be billed by a hospital, physician, physical, occupational or speech therapist.

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

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

Temporomandibular Joint Syndrome (TMJ)

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

Transgender/Gender Affirming Services

FCH pre-authorization required for inpatient admissions and gender affirming services. These services are intended to provide treatment for patients with gender dysphoria. This assistance may include primary care, gynecologic and urologic care, reproductive options, mental health services (e.g., assessment, counseling, psychotherapy psychotropic medication management), and hormonal and gender affirming surgical treatments. Gender affirming surgical treatments are limited to members age 18 and older. 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 recommended 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 review is recommended for transplant service; and, there is a **10-month waiting period (from benefit enrollment date)** for this benefit. *The waiting period can be shortened by providing documentation that would show proof of coverage from your prior health Plan(s). In order to be considered eligible, coverage must be continuous without any gaps of more than 3 months. If there is a gap in coverage of 3 months or more, only the coverage after the gap will be creditable. If there is 10 or more months of creditable coverage, the waiting period will be considered satisfied.* Services directly related to organ transplants must be coordinated by your participating provider. **There are no out-of-network benefits for 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

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

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

Email:
preauthorization@fchn.com

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

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

Recipient Services

Covered transplant recipient services include:

- Medical and surgical services directly related to the transplant procedure and follow-up care
- Diagnostic tests and exams directly related to the transplant procedure and follow-up care
- Inpatient facility fees and pharmaceutical fees incurred while an inpatient
- Pharmaceuticals administered in an outpatient setting
- Anti-rejection drugs
- Private duty nursing

Donor Services

Donor expenses are covered if all criteria are met below:

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

Covered donor expenses include:

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

When both the recipient and the donor are participants under this Plan, covered charges up to the organ and bone marrow transplant lifetime maximum benefit for all covered services and supplies received by both the donor and the recipient will be payable.

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

Travel expenses

Travel and lodging expenses are not covered.

Wigs

Covered when needed as a result of chemotherapy, radiation therapy or surgery.

Medical 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:

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

- 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
  - Court-ordered or other assessments to determine the medical necessity of court-ordered treatments
  - Court-ordered treatments or treatments related to deferral of prosecution, deferral of sentencing or suspended sentencing or treatments ordered as a condition of retaining driving rights, when no medical necessity exists
  - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
  - Emergency patrol services
  - Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program
  - Information or referral services
  - Information schools
  - Long-term or custodial care
  - Non substance related disorders
  - Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs
  - Treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required
- Claims for services that are the result of any injury or illness incurred by a participant while that participant is participating in the commission of a felony, unless the injury or illness is the result of domestic violence or a physical or mental health condition
- Cochlear implants
- Court ordered examinations or treatment of any kind, except when medically necessary
- 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 X-rays
  - Extractions of teeth, impacted or otherwise (except as covered under the Plan)
  - Orthodontic treatment, appliances or services; dentures or related services
  - Orthognathic surgery regardless of origin or cause
  - Services to correct malposition of teeth
  - Oral surgery
  - Procedures in preparation for dental implants, except as covered under the Dental Trauma benefits
- DME and medical supply charges listed below:
  - Biofeedback equipment
  - Breast pumps
  - Breast milk storage/freezer bags, breastfeeding supplies, including nursing pads, nipple shields, nipple cream, and nursing bras.

  - Equipment or supplies whose primary purpose is preventing illness or injury
  - Exercise equipment
  - Items not manufactured exclusively for the direct therapeutic treatment of an illness or injured patient
  - Items used outside the home primarily for sports/recreational activities
  - Oral appliances except to treat obstructive sleep apnea and TMJ
  - 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, whirlpool baths, vaporizers, room humidifiers, hot tubs or other types of tubs, home UV or other light units (light boxes or specialized lamps or bulbs), home blood testing equipment and supplies (except diabetic equipment and supplies, and home anticoagulation meters)
- Experimental, investigational, or unproven services
- 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
- Hearing aids/appliances and routine hearing exams
- Home health care listed below:
  - Custodial care
  - Housekeeping or meal services
  - Maintenance care
  - Shift or hourly care services
- Hospice care listed below:
  - Custodial care or maintenance care, except palliative care to the terminally ill patient subject to the stated limits
  - Financial or legal counseling services
  - Housekeeping or meal services
  - Services by a participant or the patient's family or volunteers
  - Services not specifically listed as covered hospice services under the Plan
  - Supportive equipment such as handrails or ramps
  - Transportation
- Immunizations for travel
- Infertility diagnostic services or 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.
- Medication therapy management
- 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
  - Marriage and couples counseling
  - Family counseling,
  - Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program
  - Nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories
  - Sensitivity training
  - Sexual dysfunctions, personality disorders, and paraphilic disorders
  - Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs
- Non-covered services, or complications arising from non-covered services. Non-covered services include those services that would not have been covered by this Plan at the time the complication arose.
- Non-duplication of payment/coordination of benefits to prevent double coverage, benefits under this Plan will not be paid for expenses that are reimbursed by other insurance companies, medical plan, or subscriber contracts
- Non-emergent maternity services for dependent children, except as covered under the Patient Protection and Affordable Care Act (ACA)
- Orthodontia for Temporomandibular Joint Dysfunction (TMJ)
- 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
- 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
- Professional services listed below:
  - Professional services provided by fax or email

  - Follow up phone calls from providers 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 education material are also not covered
- Procedures, regardless of medical necessity, outside the scope of the provider's license, registration or certification
- 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 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
- Smoking and tobacco cessation programs, except as covered under the prescription benefits.
- Snoring treatment (surgical or other)
- Special diets, nutritional supplements, vitamins and minerals or other dietary formulas or supplements except as covered by the Plan
- Special education for the developmentally disabled
- Sterilization for a dependent child
- Surrogate mother charges, unless the surrogate mother is eligible under the Plan at the time the services were rendered, and charges are not reimbursed by any other third party
- Termination of pregnancy for a dependent child
- 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
- Transportation, except as covered by the Plan
- Transplant services listed below (Organ and Bone Marrow):
  - Animal-to-human transplants
  - Artificial or mechanical devices designed to replace human organs
  - Complications arising from the donation procedure if the donor is not a Plan participant
  - Donor expenses for a Plan participant who donates an organ or bone marrow, however, complications arising from the donation would be covered as any other illness to the extent they are not covered under the recipient's health plan.
  - Transplants considered experimental and investigational, as defined by the Plan
  - Transportation, lodging and meals
- Treatment furnished without charge or paid directly or indirectly by any government or for which a government prohibits payment of benefits
- Vision Care, the following vision benefits are not covered:
  - 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
  - Vision hardware (frames, lenses and contact lenses, including contact lens fitting fees)
- 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

Summary of Pharmacy Benefits

Prescription benefits are combined with medical benefits for Active Employees Retirees may elect prescription benefits. This Plan does not coordinate pharmacy benefits.

Pharmacy Benefits – Administered by Express Scripts				
	Applies to Deductible	Applies to Network OOP Max	Network	Non-Network
• **Express Scripts Retail Pharmacies (30-day supply)**				
– Generic Drugs (including Specialty, with a 30-day maximum)	N/A	N/A	$10 copay	$10 copay
– Preferred Brand Drugs (including Specialty, with a 30-day maximum)	N/A	N/A	$20 copay	$20 copay
– Non-Preferred Brand Drugs (including Specialty, with a 30-day maximum)	N/A	N/A	$40 copay	$40 copay
• **Express Scripts Retail 90 Pharmacy or Mail Order Prescriptions (90-day supply)**				
– Generic Drugs	N/A	N/A	$20 copay	Not Available
– Preferred Brand Drugs	N/A	N/A	$40 copay	Not Available
– Non-Preferred Brand Drugs	N/A	N/A	$80 copay	Not Available
– Specialty	Not Available			

The plan allows the participant to receive the brand over the generic without a cost penalty to the participant.

Pharmacy Benefits

Benefits will be provided as described below and as shown in the Summary of Pharmacy Benefits for state and federal approved legend drugs requiring a prescription and for other items as specifically provided, when such drug or other items are furnished by an approved pharmacy or an approved mail order supplier. Benefits will be subject to any waiting periods, limitations, and exclusions, except that prescription drug benefits will not be subject to any out of pocket maximums.

Legend Drugs are those drugs that cannot be purchased without a prescription written by a physician or other lawful prescriber.

Generic Substitutions

Over 400 commonly prescribed drug products are now available in a generic form at a lower average cost than the brand name products. This plan encourages the use of generic prescription drugs. By law, generic and brand name drugs must meet the same standards of safety, purity, strength, and effectiveness. At the same time, brand name drugs are often more expensive than generic drugs. Use of generics with this benefit will save you money and we encourage you to ask your provider to prescribe them whenever possible.

Brand Name Performance Drugs

An important element of your Express Scripts Prescription Drug Card Program is the opportunity to select drugs from the Formulary Drug List. The Formulary Drug List is a guide to the best values within select therapeutic categories that helps the provider identify products that will provide optimal clinical results at a lower cost. The Formulary Drug List undergoes a thorough review and/or revision quarterly and current versions are available on the web portal www.Express-Scripts.com or by calling Member Services. Interim changes could occur to reflect changes in the market. These changes could include entry of new products, entry of a generic option to a brand drug, or other events that alter the clinical or economic value of the products on the Formulary Drug List. Please visit the Express Scripts website address www.Express-Scripts.com for a copy of the Formulary Drug list.

Payment Schedule

A copay is payable for each prescription filled according to the amounts shown in the Summary of Pharmacy Benefits.

Drugs Covered

- Legend drugs (Exceptions: See Exclusions below)
- Insulin
- Fluoride
- Disposable needles/syringes
- Disposable blood/urine glucose/acetone testing agents (e.g. Chemstrips, Acetest tablets, Clinitest tablets, Diastix Strips and Test-Tape)

- Compounded medication of which at least one ingredient is a legend drug.
- Legend oral contraceptives and diaphragms.
- Tretinoin, all dosage forms (e.g. Retin-A), for individuals through the age of 25 years. At age 26, a clinical pre-authorization is required.
- Anabolic steroids, clinical pre-authorization is required.
- Drugs used for the treatment of sleep disorders (e.g., Ambien, Restoril, Sonata). Clinical pre-authorization is required. Quantity limits apply.
- Drugs used for the treatment of migraines (e.g., Imitrex, Migranal, Maxalt, Zomig). Clinical pre-authorization is required. Quantity limits apply.
- Growth Hormones, Covered only under the Specialty Pharmacy Program
- Sildenafil Citrate (Viagra). Clinical pre-authorization is required. Quantity limits apply.
- Prescription Pre-natal Vitamins
- Any other drug which under the applicable state law may only be dispensed upon the written prescription of a physician or other lawful prescriber

Prescription Drug Clinical Pre-Authorization

There are certain prescription drugs that need to be pre-authorized prior to dispensing for reasons of treating one or more health conditions (some of these conditions may not be covered by the medical plan such as cosmetic procedures for wrinkles), or are a controlled substance as determined by the Food and Drug Administration.

If you should receive a prescription from the physician for a drug that requires pre-authorization, this is the step-by-step process in which to have the prescription drugs pre-authorized.

1. The patient, prescriber or pharmacist must call Express Scripts at (877) 510-1011.
2. Indicate you want to start the pre-authorization process on the name of the drug requested to be dispensed. (You will need to provide the physician's name, telephone number and fax number from the prescription form you were given by the physician, and the telephone number and name of the pharmacy that will dispense the drug.)
3. After 3 days, if no PA request is received from the prescriber, then PA request is closed.
4. Once received and approved, notification is sent to prescriber and member. The pharmacy will be able to dispense the prescription for you.

Specialty Pharmacy- Accredo

Accredo, an Express Scripts specialty pharmacy, provides convenient, personal, dependable access to medications for people living with complex health conditions. Accredo's programs and services focus on injectables and medication therapies involving strict compliance requirements; specific storage, handling or delivery; complex administration methods; and education, monitoring and ongoing care management support.

Drugs that fall under this program can only be dispensed at Accredo. These specialty drugs are limited to a 30-day supply.

To receive more information, or to enroll in this program, you must call Accredo's toll-free number at (877) 895-9697. Additional information can be obtained at www.Accredo.com.

If you would like to know more information about the drug coverage policies under this program, or if you have a question or concern about your pharmacy benefit, please contact Express Scripts at (877) 510-1011.

Retail Prescription Drug Program

Express Scripts

Dispensing Limitations

The amount normally prescribed by a physician, but not to exceed a 90-day supply when filling your prescription at participating Express Scripts Preferred Pharmacy, or a 30-day supply when filling your prescription at a non-Express Scripts Preferred Pharmacy.

To locate a nearby pharmacy, call (877) 510-1011 or call your pharmacy directly. If you are registered at www.Express-Scripts.com, Express Scripts's website, click on "Pharmacy Locator" to conduct a pharmacy search.

Benefit Limitations When Not Using the Drug Card

If the prescription card is not used by the participant at the time of the prescription purchase at an in-network pharmacy, you must file a claim directly with Express Scripts using their claim form available at www.Express-Scripts.com and you will be reimbursed the prescription receipt price less the appropriate copay.

If the prescription is purchased at a non-participating pharmacy and you submit the prescription claim using a claim form the benefit will be substantially less than if you utilized an in network pharmacy. The reimbursement will be the prescription receipt price, less 50%, less the appropriate copay.

Benefits for Employees and Dependents without a Card

Prescription drugs that are eligible for reimbursement by the prescription drug card program can be submitted to Express Scripts prior to the enrollee's receipt of the card. To claim this benefit, a receipt for the paid prescription with an Express Scripts claim form must be submitted to Express Scripts.

Express Scripts will reimburse eligible claims as if the card had been used (100% reimbursement following the applicable copay).

Express Scripts Retail 90 Pharmacy Program

Express Scripts Retail 90 Pharmacy Program is a convenient way to get a 90-day supply of your maintenance medications at select retail locations. (Your doctor must authorize a 90-day supply of medication. Some medications may not be available in 90-day supplies under applicable law.) To find out more about your pharmacy benefit, including your prescription coverage, copays, generic alternatives, or to view your prescription history, visit www.Express-Scripts.com or call (877) 633-4461 with any questions you might have.

Mail Order Prescription Drug Program

Express Scripts Home Delivery Mail Service

When to Use Your Mail Order Prescription Drug Card Program

You should continue to have non-maintenance prescriptions (prescribed for urgent illness or injury) filled at the local retail pharmacy. However, if you are ordering maintenance medications (those taken on a regular or long term basis such as heart, allergy, diabetes, or blood pressure medications), use the Express Scripts Home Delivery Mail Service program.

Use the Express Scripts Home Delivery Mail Service mail order program when purchasing 90-day supply of maintenance prescriptions and pay the applicable copay.

Dispensing Limitations

The amount normally prescribed by a physician or other lawful prescriber, but not to exceed a 90-day supply.

Ordering Information

Order forms can be obtained from Express Scripts, your Group's Human Resources Department or at www.Express-Scripts.com. The physician can also phone in prescriptions to save time. Prescriptions can be reordered over the telephone with a credit card by calling (800) 763-0044. You may also reorder by using a mail service order form and pay by check or credit card.

Express Scripts Home Delivery Mail Service maintains a quick turnaround time. Orders that do not require a conversation with the participant or the physician prior to dispensing will be received within 7 to 10 days. Prescriptions that require communication with either the participant or the physician will not be filled until all questions have been answered. For this reason, please be sure to allow at least 14 days for your prescription request, to avoid running out of medication.

Pharmacy Exclusions & Limitations

- Anorectics (any drug used for the purpose of weight loss)
- Dietary supplements
- Drugs used for cosmetic purposes (i.e. Botox, Myobloc, Renova, Eldoquin, Solage)
- Fluoride preparations
- Glucose testing machines (covered under durable medical equipment under the medical plan)
- Immunization agents, biological sera, blood, or blood plasma
- Infertility medications
- Levonorgestrel (Norplant)
- Minoxidil (Rogaine) for the treatment of alopecia
- Non-legend drugs other than insulin
- Smoking Deterrent Medications containing nicotine or any other smoking cessation aids
- Vitamins, singly or in combination
- Therapeutic devices or appliances, including support garments and other nonmedical substances, regardless of intended use, except those listed above
- Charges for the administration or injection of any drug
- Prescriptions which an eligible individual is entitled to receive without charge from any Worker's Compensation Laws
- Drugs labeled Caution-limited by federal law to investigational use, or experimental drugs, even though a charge is made to the individual
- Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed medical facility, rest home, sanitarium, extended care facility, convalescent medical facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals
- Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order
- Replacement prescriptions resulting from loss, theft, or breakage
- Prescription drugs which may be obtained without charge under local, state, or federal programs
- Drugs purchased outside the U.S. that are not legal inside the U.S.

Eligibility and Enrollment

Employee Eligibility

Employees eligible for coverage under this plan are:

- All active regular full-time non-represented employees hired into budgeted positions;
- All active full-time limited duration employees who are hired into a limited duration position expected to last for at least one year;
- All active full-time limited duration Terminal Security Administrative Employees hired into a budgeted position;
- The Chief Executive Officer;
- Commissioners of the Port of Tacoma U.S.A.;
- All active regular Part-time non-represented employees working at least 30 hours per week in a budgeted position;
- All active part-time non-represented limited duration employees working at least 30 hours per week in a position expected to last at least one year.

Examples of employees who are considered non-eligible are those classified on Port of Tacoma and Northwest Seaport Alliance books or records as:

- Leased or temporary employees

Retiree Eligibility

As further defined in the Master Benefit and Salary Resolutions, retirees fall into two classes and are eligible for coverage if all of the requirements for that class are met.

All retirees and spouses or state registered domestic partners of retirees shall elect Medicare A and Medicare B as of their 65th birthday. Claims will be processed with Medicare as the primary insurer with Port of Tacoma/Northwest Seaport Alliance medical benefit as secondary.

Retiree (Port and Northwest Seaport Alliance Paid Medical)

- Retiree was covered under the non-represented benefit plan as an active employee; and
- Was hired prior to March 15, 2007 and elected not to make a one-time irrevocable decision to move to the Post-Employment Defined Contribution Plan as defined in the Master Benefit and Salary Resolutions; and
- Is eligible to retire under the Washington State Public Employees' Retirement System; and who meets the following requirements:
  - Regular Retiree – must have completed 15 years of Port/Northwest Seaport Alliance service if retiree is age 60 or older at the time of retirement; or
  - Early Retiree – must have completed 20 year of Port/Northwest Seaport Alliance service if retiree is under age 60 at the time of retirement.

Retiree may elect to purchase prescription coverage under this plan from the date active employee prescription coverage ends. Prescription coverage may not be elected at a later date.

Retiree (Retiree Paid Medical)

- Retiree was covered under the non-represented benefit plan as an active employee; and
- Was hired prior to March 15, 2007 and made a onetime irrevocable decision to move to the Post Employment Defined Contribution VEBA Plan or was hired between May 1, 2007 and April 1, 2013; and
- Retiree completed at least 20 years of Port of Tacoma/Northwest Seaport Alliance service; and
- Retiree elects to purchase benefits under this plan.

Enrollment Periods

Enrollment periods for eligible employees and dependents are:

- Within 31 days of initial eligibility, or
- During any open enrollment (except retirees).

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 Plan year. Under no circumstances will you be able to change the medical plan outside of open enrollment, without a qualifying event.

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 for adoption, 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 moving to an eligible position
- 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, or 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 31 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 Period, Open Enrollment* and *Special Enrollment Periods*.

Effective Date

Active Employees

The effective date of coverage for eligible employees is the first of the month following the date of hire, except if hired the first working day of the month. If an eligible employee is hired the first working day of the month, the employee will be eligible for coverage the first day of the month in which the employee was hired. (Example: The first working day in January is January 3; the employee is hired January 3, effective date for coverage is January 1.)

Retiree Effective Date

The effective date of coverage for eligible retirees is the first of the month following the date coverage ceases as an active Port of Tacoma and Northwest Seaport Alliance employee.

Effective Date of Coverage for Your Dependents

If the employee elects coverage for dependents during the first 31 days of eligibility, the dependents' effective date will be the same as the employee's effective date.

If the covered employee or retiree marries or forms an eligible domestic partnership, the employee must add the newly acquired dependents within 31 days of the date of marriage and the effective date of coverage is the first of the month following the date of marriage.

If the covered employee (does not apply to covered retirees) acquires a child through birth, adoption, or placement for adoption, the employee must add the child within 60 days of the date of birth, adoption or placement for adoption and the effective date of coverage for the child is the date of birth, adoption, or placement for adoption. **Late enrollments are not accepted.**

Special Rule

If an employee and spouse or domestic partner are each employees of Port of Tacoma and Northwest Seaport Alliance and are eligible for benefits, employees may double cover each other as dependents.

Children whose parents are both Port of Tacoma and Northwest Seaport Alliance employees may enroll under one or both parent.

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

Dependent Eligibility

Only dependent children of active employees are eligible to enroll. Dependent children of retirees are not eligible.

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:

- An active employee's or retiree's lawful spouse (as defined by state law where the employee/retiree permanently resides. Common law marriage is not recognized as a legal marital relationship under the Plan, even if recognized under state law where the employee/retiree resides),
- An active employee's domestic partner. Domestic partnership of the employee and his/her domestic partner must be state registered. The plan requires a copy of the Certificate of State Registered Domestic Partnership,
- A retiree's domestic partner. Domestic partnership of the retiree and his/her domestic partner must be state registered. The plan requires a copy of the Certificate of State Registered Domestic Partnership,
- An employee's or employee's spouse/domestic partner's natural child, adopted child, child placed with you for legal adoption, stepchild, or other legally designated ward up to age 26, or
- Natural child, adopted child, child placed with you for legal adoption, stepchild, or other legally designated ward that a health care professional determines is not capable of self-sustaining employment due to a physical or developmental disability. Proof of such incapacity must be furnished to the Plan Administrator within 31 days prior to the date the child reaches age 26. Thereafter, employees are required to resubmit proof of continued disability once per year.

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, Domestic Partner or child living outside the United States or Canada,
- You or your spouse's natural child for whom you have given up rights through legal adoption,
- A parent of an employee, spouse or Domestic Partner, or
- The newborn child, spouse, or Domestic Partner of an enrolled dependent child.

Special Rules for Domestic Partners

- The Domestic Partner of an enrolled dependent is not eligible for coverage.

- A Domestic Partner who loses coverage eligibility under any circumstances is not eligible for COBRA.

Dependents Acquired Through Marriage/Domestic Partnership

If you acquire a new dependent through marriage or domestic partnership, the Plan Administrator must receive the completed enrollment application and a copy of the marriage certificate/affidavit of domestic partnership within 31 days after the marriage/start of the domestic partnership 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, or the date the domestic partnership is established.

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/Domestic Partner.

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 Network (FCHN) providers within Washington.

The First Health Network is available for network benefits to:

- Participants who live outside the FCH service area
- 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 age 26 if the child is:

- Incapable of self-sustaining employment due to mental or physical disability, and
- Dependent 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 age 26. Thereafter, employees are required to resubmit proof of continued disability once per year.

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 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

Port of Tacoma and Northwest Seaport Alliance will provide medical 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. 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
- 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
- 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
- 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 reason 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 Active employees, coverage ends on the first to occur of the following events:

- Non-payment of a contribution that is your responsibility
- You no longer meet eligibility requirements for coverage (see *Eligibility and Enrollment*); coverage ends the last day of the month after the date you are no longer in a class of eligible or active employees. Employees regularly scheduled and working 80 hours in the last month of employment will continue coverage through the end of the month following termination
- 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 plan
- The plan is materially breached
- The Plan Sponsor ceases to offer coverage in the group market under which this coverage is issued

For participating Retirees (Port/Northwest Seaport Alliance Paid Medical), coverage ends on the first to occur of the following events:

- The date the Employer terminates the Plan and offers no other group health plan
- The last day of the month in which the retiree ceases to meet the eligibility requirements for the plan
- The date the retiree fails to make any required contribution when coverage is contributory
- Regular Retirees – the last day of the month in which the retiree turns 70
- Early Retirees – the last day of the month after the retiree has received 10 years of Port/Northwest Seaport Alliance paid medical coverage
- Death of the retiree

For participating Retirees (Retiree Paid Medical), coverage ends on the first to occur of the following events:

- The date the Employer terminates the Plan and offers no other group health plan
- The last day of the month in which the retiree ceases to meet the eligibility requirements for the plan
- The date the retiree fails to make any required contribution when coverage is contributory
- The last day of the month in which the retiree turns 65
- Death of the retiree

For participating dependents, coverage ends on the first to occur of the following events:

- The date the participant's coverage ends for any reason
- The last day for which any required Plan contributions are paid
- The last day of the month in which the participant dies
- The participating employee and spouse legally separate or divorce (the Plan Administrator must receive a copy of the decree's relevant pages), or a Domestic Partnership is dissolved or terminated

- The last day of the month in which the dependent child reaches age 26, unless disabled (see *Continued Eligibility for a Child who is Disabled*)

Related Details

- Coverage is automatically extended through the last day of the month of the termination, provided the applicable contribution for the coverage period has been paid. (Contact the Plan Administrator for more information.)
- 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.

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.

Coverage will not be terminated retroactively except in the case of an employee's failure to remit premiums or contribution in a timely manner or in the case of fraud or intentional misrepresentation. The Port of Tacoma and Northwest Seaport Alliance will provide 30 days' advance written notice to covered employees and dependents who will lose coverage retroactively due to an act, practice, or omission that constitutes fraud or the employee or dependent makes an intentional misrepresentation of material fact.

Upon termination of this Plan, all expenses incurred prior to the termination of this Plan, but not submitted to FCH within 75 days of the effective date of termination of this Plan, will be excluded from any benefit consideration.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

Introduction

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.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

You may have other options available to you when you lose group health coverage

For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay the entire premium for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;

- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child".

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Port of Tacoma U.S.A. and Northwest Seaport Alliance (NWSA), and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the Plan Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to FCH.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. The individual must notify the plan administrator within 31 days after the date of that determination. Coverage ends on the last day of the month 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.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

If you have questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone

numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information

Through April 30, 2022, please contact Port of Tacoma U.S.A Attn: HR Manager 1 Sitcum Plaza, P.O. Box 1837, Tacoma, WA 98421, 253-383-9403. See below for COBRA administration contact information as of May 1, 2022.

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 also 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 Plan year begins).

Failure to make payments within the designated time frame will result in automatic termination of coverage to the last day of the month for which a complete payment was made.

Effective May 1, 2022

Payments need to be sent directly to FCH at One Union Square, 600 University St, Suite 1400, Seattle, WA 98101. If you have COBRA related questions, you may call (877) 749-2032 to speak with a COBRA representative.

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" 12-month period measured backward from an FMLA leave usage) 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" 12-month period measured backward from an FMLA leave usage) 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 coincident with or next following the date 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 and pharmacy 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 that continues after you are discharged from active military service.

Leave of Absence for Non-Occupational Injuries or Disease

Leave of absences without pay shall be for a maximum of sixty (60) calendar days, but may not exceed the end of an employee's limited duration position. When Leave of Absence without pay is used intermittently, 60 calendar days are counted from the first day of the Leave of Absence Without Pay and is converted to hours to track leave usage.

Unless otherwise allowed under state or federal law, an employee must have exhausted all of his or her available paid leave and Family and Medical Leave if applicable, before qualifying for a leave of absence without pay.

Health coverage will be continued for 60 days after entry into the approved leave of absence without pay.

An employee and dependents who are being reinstated to an active status after an approved leave of absence for non-occupational injuries or diseases do not have to satisfy the initial waiting period again if it was satisfied prior to going out on the approved leave of absence. There will be no lapse in coverage for employees and dependents who have continued coverage while on the approved leave of absence. If the employee did not continue coverage while on the leave of absence for non-occupational injury or diseases, then coverage will be reinstated on the first day of the month coincident with or next following the return to active status.

An employee and any dependents who had not satisfied the waiting period prior to the approved leave of absence for occupational injuries or diseases will receive credit for the portion of the initial waiting period that was satisfied prior to the leave of absence. Coverage will begin on the first of the month following their satisfaction of any remaining eligibility waiting period.

Please contact the Group's Human Resources Department for information on how to qualify for an Approved Leave of Absence for Non-Occupational Injury or Diseases.

Approved Leave of Absence for Occupational Injuries or Diseases

If the employee is granted an approved leave of absence for an occupational injury or disease, the employee and their covered dependents will be eligible to continue coverage for up to six (6) months. If the employee's leave extends more than six (6) months the employee and their covered dependents, will be eligible to continue coverage under the (COBRA) Continuation of Coverage Provisions of the Plan. A Leave of Absence for Occupational Injuries and Diseases runs concurrently with leave mandated by federal and state law.

An employee and dependents who are being reinstated to an active status after an approved leave of absence for occupational injuries or diseases do not have to satisfy the initial waiting period again if it was satisfied prior to going out on the approved leave of absence. There will be no lapse in coverage for employees and dependents who have continued coverage while on the approved leave of absence. If the employee did not continue coverage while on the leave of absence for occupational injury or diseases, then coverage will be reinstated on the first day of the month coincident with or next following the return to active status.

An employee and any dependents who had not satisfied the waiting period prior to the approved leave of absence for occupational injuries or diseases will receive credit for the portion of the initial waiting period that was satisfied prior to the leave of absence. Coverage will begin on the first of the month following their satisfaction of any remaining eligibility waiting period.

Please contact the Group's Human Resources Department for information on how to qualify for an Approved Leave of Absence for Occupational Injury or Diseases.

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.

Please note: In addition to FMLA, this plan will allow continuation coverage in accordance with applicable state law.

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 date(s) of service
- Diagnosis codes (ICD-10 codes) or description of the symptoms or a diagnosis
- Specific medical procedure codes (CPT codes) or description of the medical service or procedure.
- Specific dental procedure codes (CDT codes) or description of the dental 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 of 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 (Port of Tacoma).

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 in the opinion of a physician with knowledge of the claimant's medical condition:
  - Seriously jeopardize the claimant's life, health or ability to regain maximum function
  - Subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested.

Claim Procedure

First Choice Health (FCH) has final authority over appeals as the appropriate named fiduciary, and the Plan delegates to FCH, as it relates to benefits issues, the authority, responsibility and discretion to:

- Interpret and construe Plan provisions, as necessary
- Reach factually supported conclusions
- Make a full and fair review of each denied claim as amended

Benefit issues include questions regarding medical necessity, health care setting, level of care, experimental or investigational treatment, cost-sharing requirements or imposition of preexisting condition exclusions or other limits on otherwise covered benefits.

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. FCH will notify the claimant in writing of the decision of claim review.

It is important to note the Plan Administrator itself holds the authority, responsibility and discretion to deny claims based on administrative issues such as questions of eligibility status for you, your spouse and your dependents; change in status; special enrollment; termination and continuation of coverage; and qualified medical child support orders. The same appeal process described below applies to administrative issues; however, such appeals are handled by the Plan Administrator, not FCH.

Adverse Benefit Determination

An adverse benefit determination means a denial, decrease or termination of a benefit. This includes a failure to provide or make payment (in whole or in part) for a benefit based on:

- A determination that a benefit is not covered by the Plan;
- A determination based on an individual's eligibility to participate in the Plan, or to receive plan benefits at time of service; (these appeals are considered administrative and handled by the Plan Administrator, see *Claim Procedure* above)
- A determination that a service is experimental, investigational or not medically necessary; and/or
- A rescission of coverage (these appeals are considered administrative and handled by the Plan Administrator, see *Claim Procedure* above).

The different claim types have specific times for approval, payment, request for information or denial, as shown below:

Time Table for Adverse Benefit Determinations for Claim Procedures			
Type of Review	**FCH Notice of Incorrectly Filed Claim – Notice to Claimant**	**FCH Notice of Incomplete Claim – Notice to Claimant**	**Initial Benefit Determination by FCH**
Pre-Service Claim	5 days	Not required (may be part of extension notice)	Reasonable period = 15 days 15-day extension with notice to claimant Reasonable period suspended up to 45 days on incomplete claim
Concurrent Claim	n/a	n/a	In time to permit appeal and determination before treatment ends or is reduced
Post-Service Claim	n/a	Not required (may be part of extension notice)	Reasonable period = 30 days 15-day extension with notice to claimant Reasonable period suspended up to 45 days on incomplete claim
Urgent Care Claim	24 hours	24 hours	72 hours No extensions from claimant

If your claim is denied wholly or in part, you will receive a written notice of adverse benefit determination. For a denial of a pre-service claim, such notice will be in the form of a letter from FCH explaining the denial. For a post-service claim, your Explanation of Benefits (EOB) will serve as your notice of adverse benefit determination. Both will include information necessary to identify the claim, such as the date of service, provider name, amount billed, as well as the reason for the denial(s), which will include:

- Reference to the specific Plan provisions on which the determination is based;
- Reference to any internal Plan rule, guideline, protocol or similar criterion relied upon in making the decision; or
- For pre-service claims, the standards for medical necessity relied upon in making the adverse benefit determination (for example, an explanation of the scientific or clinical judgment used in making the decision) if applicable.

In addition to the above information, the notice of adverse benefit determination will also include:

- A description of any additional material or information needed to support your claim and an explanation of why it is needed; and
- A description of the available appeal process (including both internal and external review processes, as also outlined below), as well as information about how to initiate the appeal process.

Appeal Procedure

FCH performs functions associated with the internal review of medical appeals for this Plan. Pharmacy Appeals are handled by Express Scripts. First Choice Health has final authority over appeals as the appropriate named fiduciary.

If your claim is denied wholly or in part, you have the right to request an internal review of an adverse benefit determination (commonly referred to as an appeal). Upon request, you may obtain free of charge reasonable access to, and copies of, all documents, records and information relevant to your claim for benefits, and relied upon in making the adverse benefit determination. You may also request the name of the health care expert who reviewed your claim for medical necessity or experimental or investigational care or treatment.

If your situation is urgent, you may call the FCH Appeals Coordinator at (877) 749-2031. An urgent care situation is one in which, in the opinion of a physician with knowledge of the claimant's medical condition, the application of the time periods for making non-urgent care determinations could seriously jeopardize the claimant's life, health, or ability to regain maximum function; or would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

For all other appeals, you may submit them in writing to the following address:

Medical Appeals:

First Choice Health
Attn: Appeals Coordinator
600 University Street, #1400
Seattle, WA 98101
Fax: (206) 268-2920

Pharmacy Appeals:

Express Scripts

877-633-4461

Internal Appeal Process

You, or your authorized representative, must file your appeal within 180 days of the date you receive the adverse benefit determination or you lose your right of appeal. The appeal must be in writing and sent to the address noted above.

The appeal should include comments, documents, records and/or other information noting the reason you feel your claim should have been approved. FCH will send a letter acknowledging receipt of your appeal within 5 calendar days.

FCH's designated Appeals Coordinator will prepare your documents and any applicable documentation from the Summary Plan Description for review and discussion by the FCH Appeals Committee or Medical Director (the individual who made the original adverse benefit determination will not be involved in the internal appeal process). The committee or Medical Director will review the information and make a recommendation to the Plan Fiduciary to either uphold or overturn the original adverse benefit determination. FCH will notify you in writing of the decision to either uphold the original denial or overturn it within 30 calendar days of pre-service claims or 60 calendar days if your appeal involves a post-service claim. If the determination is to uphold the original denial, the letter will also include information on how to initiate the next level of appeal (External Review) if the determination is based on medical judgment. If the determination is not based on medical judgment, the letter will advise you of your right to file a civil action for benefits. **Note: A decision regarding an urgent care claim will be made as soon as possible, but not later than 72 hours after receipt of a request for internal review if a delay would jeopardize the member's or their dependent's health.**

External Review

If the decision upon internal appeal review is to uphold the original denial, and such denial is based on medical judgment or rescission, this Plan offers an external review. Denials that do not involve rescission or medical judgment (i.e., denials that involve only contractual or legal

interpretation without any use of medical judgment) are not eligible for external review. You must first submit an internal appeal and receive a final internal adverse benefit determination before you may request external review. Your request for external review must be received within 125 calendar days of receipt of the final internal adverse benefit determination.

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.

Within 5 calendar days of the receipt of a request for external review, FCH will conduct a preliminary review to determine whether the claim is eligible for external review, and will send you notification if its decision within one business day thereafter. This notice will include the following:

- If your request is found ineligible for external review, the reason for its ineligibility;
- If your request is eligible for external review but not complete, a description of any additional information or materials required to complete your request;
- If your request is complete and eligible for external review, contact information for the Independent Review Organization (IRO) assigned by FCH, and details about your right to provide additional information.

If eligible for external review, FCH will forward your appeal (including all information and documentation considered in both the original denial and the internal review, as well as any additional documentation you submit) to an Independent Review Organization (IRO) within 6 business days of the receipt of a request for external review. The IRO consists of independent physicians or other specialists that are not associated with FCH or Port of Tacoma and Northwest Seaport Alliance. If applicable, they will also possess medical training specific to the appeal.

The IRO will notify you that your appeal has been received, and will allow you at least 10 business days to submit any additional information to the IRO that you wish to be considered in reviewing your appeal. The IRO will review all information submitted, make a determination, and notify both you and FCH of the results within 45 calendar days. **Note: A decision regarding an urgent care claim will be made as soon as possible, but not later than 72 hours after receipt of a request for external review if a delay would jeopardize the member or their dependent's health.**

The decision made by the IRO is the final decision of the Plan. If the IRO overturns the original adverse benefit determination, the Appeals Coordinator will forward that decision to the appropriate party for claim payment or, if a pre-service claim, approval of the request for authorization.

You have a right to file a civil action for benefits 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.

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 credit any amounts to this Plan's deductible that would have been credited if this Plan were primary.
2. This Plan will pay 100% of the Primary Plan's remaining patient liability, not to exceed the lesser of: 1) the amount this Plan would have paid as primary, or 2) the amount that, when added to the Primary Plan payment, totals 100% of this Plan's Allowed Amount.

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, the plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but the parent's spouse does, the 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 policyholders 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 custodial parent's spouse
         c. The plan covering the non-custodial parent
         d. The plan covering the non-custodial spouse

         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 policyholders 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 (excluding Domestic Partners) 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.

  If you are covered under this Plan as a Domestic Partner, a retiree or dependent of a retiree and you become entitled to Medicare because of reaching age 65, Medicare will be primary.

- **Disability:** If you are covered under this Plan as an active employee or dependent of an active employee (including Domestic Partners) 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 individual who is disabled should apply for coverage under Medicare Parts A and B.

  If you are covered under this Plan as a retiree or dependent of a retiree (including Domestic Partners) and you become entitled to Medicare due to disability, Medicare will be primary.

  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 Domestic Partner or 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

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 that 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 Port of Tacoma and Northwest Seaport Alliance Employee Health Care 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 coverage 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 organization(s), 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 Port of Tacoma and Northwest Seaport Alliance HIPAA Privacy Notice.

Disclosures to the Plan Sponsor

The Plan may disclose your health information to Port of Tacoma U.S.A., 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 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, the Mental Health Parity and Addiction Equity Act of 2008, and the Patient Protection and Affordable Care Act of 2010 (PPACA).

Plan Administrator's Power of Authority

The Plan Administrator role for this Plan rests with Port of Tacoma and Northwest Seaport Alliance'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.

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're 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 not subject to ERISA, any applicable state law that does not prevent the application of a federal requirement or prohibition on balance billing may apply, although very few states have such laws that apply to self-insured health plans, like your plan. For more information about any state balance billing protections that might apply to your situation, you should contact your state's Department of Insurance, at the contract information listed below.

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be considered 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 balance 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 in 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 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:	**Pennsylvania:**	**Vermont:**
Maryland Insurance Administration 200 Saint Paul Place, Suite 2700 Baltimore, Maryland 21202-2272 Phone: (410) 468-2000	Pennsylvania Insurance Department 1326 Strawberry Square Harrisburg, Pennsylvania 17120 Phone: (717) 787-7000	Vermont Department of Financial Regulation 89 Main Street Montpelier, Vermont 05620-3101 |Phone: (802) 828-3301

If you believe you have been wrongfully billed under a plan that is not subject to ERISA, contact your state's Department of Insurance for more information about your rights under applicable state law. **Washington: Washington State Office of the Insurance Commissioner** P.O. Box 40255 Olympia, WA 98504-0255, Phone: (360) 725-7000

Statement of Your Rights

This Plan is a governmental (sponsored) plan and as such, it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a federal law that regulates employee welfare and pension plans. Your rights as a participant in the Plan are governed by the plan documents and applicable state law and regulations. This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations.

As a participant in the Plan, you are entitled to certain rights and protection. All Plan participants shall 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. 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, certain duties are incumbent 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 the Plan.

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 the Plan, there are steps you can take to enforce the above rights. 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. In addition, if you disagree with the Plan's decision or lack thereof concerning qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim 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.

Summary Plan Description and General Information

Plan Name:	Port of Tacoma U.S.A. and Northwest Seaport Alliance (NWSA) Employee Health Care Plan
Plan Year:	April 1 to March 31
Type of Plan:	Group health plan
Plan Coverage Status:	This Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act.
Funding Medium:	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.
Source of Contributions:	The company bears the entire cost of this benefit Plan, minus the participants' contribution.
Name, address and telephone number of Plan Sponsor, Administrator and Agent for Service of Legal Process:	Port of Tacoma U.S.A 1 Sitcum Plaza Tacoma, WA 98421 253-383-9403
Named Fiduciary (Appeals Only)	First Choice Health Attn: Appeals Coordinator 600 University Street, #1400 Seattle, WA 98101 Fax: (206) 268-2920
Named Fiduciary	Port of Tacoma U.S.A and Northwest Seaport Alliance (NWSA) 1 Sitcum Plaza Tacoma, WA 98421 253-383-9403
Plan Sponsor's Employer Identification Number:	91-6001026
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
Plan Description:	The written Plan Description consists of this entire document plus benefit summary booklets and provider directories.

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. This amount is equal to one of the following:

- The contracted amount agreed to by a FCHN participating provider or a First Health participating provider
- The Usual, Customary and Reasonable (UCR) amount for services received from out-of-network providers (see related definition)
- For out-of-network emergency services, the Allowed Amount is determined annually by FCH based on federal guidelines stating the Allowed Amount must be equal to the greatest of the following amounts: 1) the median of the contracted amounts described above; 2) the Usual, Customary and Reasonable (UCR) amount (see related definition); or 3) the Medicare amount

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.

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.

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.

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; and
- 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

Domestic partner means a state registered domestic partner.

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.

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 Oregon as permitted by the Departments of Labor, Treasury, and Health and Human Services.

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

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

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, a person who exercises discretionary authority or control over the management of a 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:

- **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.
- **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.
- **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.
- **Mental Health Residential Treatment Program** provides around-the-clock behavioral health services that do not need the high level of physical security and psychiatric and nursing interventions that are available in an acute inpatient program. Care is medically monitored with on-site nursing and medical services. The focus of the program is an improvement of client's psychiatric symptoms through the use of assessment, evidenced-based treatment strategies, group and individual therapy,

behavior management, medication management and active family engagement/therapy. Treatment must follow a written plan of care. The facility must be state licensed for residential treatment. Residential settings not meeting these criteria, such as group homes, halfway houses or adult/child foster homes, are not considered to be Mental Health Residential Treatment Programs.

- **Chemical Dependency Rehabilitation/Residential** Programs provide 24-hour rehabilitation treatment 7 days a week for Substance Related Conditions. Care is medically monitored, with 24-hour medical and/or nursing availability. 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 service that is essential for the diagnosis or treatment of the patient's covered medical condition
- It is known to be effective in improving health outcomes for the patient's medical condition in accordance with sufficient scientific evidence and professionally recognized standards
- It is not furnished primarily for the convenience of the patient or provider of services
- 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 covered under other benefits offered by this Plan (subject to all terms, limitations and exclusions):

- Conditions related to Substance Related and Addictive Disorders (see Chemical Dependency definition)
- Developmental Delays/Learning Disorders (see Habilitative Services benefit)
- Relational, family, and lifestyle stressors absent a primary psychiatric diagnosis
- Sexual dysfunctions, personality disorders, paraphilic disorders.

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

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, Alaska, Wyoming,

North Dakota or South Dakota. 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.

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 area/out of the service area means outside the FCH 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:

- Construe and interpret the Plan document and to decide all questions of eligibility and participation,
- Make all findings of fact for Plan administration, including payment of reimbursements,
- Prescribe procedures to be followed and forms to be used by participants and beneficiaries,
- Request and receive from all employees the information necessary for proper Plan administration, and
- 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.

Plan Year means the twelve (12) month period beginning April 1 and ending March 31.

Post-service claim means any claim for a Plan benefit that is not a pre-authorization 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 recommends 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 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.

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.

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.

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

- **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.
- **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.
- **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-authorization 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 200% 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 provider's actual charges.