First Choice Health®

High Deductible Health Plan and Fairway PPO Plan Medical, Vision and Pharmacy Benefits

Effective September 1, 2022

www.fchn.com

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

Table of Contents

Important Information about the Plan 6

Contacting Customer Service 7

How to Obtain Health Services 8

- Your ID Card 8
- Choosing a Provider 8
- Continuity of Care 9
- Services Received Outside the U.S. 9

Medical Management 10

- Pre-authorization Requirements 10
- Notification for Emergency Admissions 12
- Concurrent Review and Discharge Coordination 12
- Case Management 12
- Maternity Management Program 13
- Tobacco Cessation 13

Payment Provisions – HDHP Plan 14

- Highlights of Plan Provisions 14
- Annual Deductible 15
- Annual Out-of-Pocket Maximum 15
- What Is a High Deductible Health Plan (HDHP)? 16
- Benefit Maximums – HDHP Plan 17
- Annual Deductible and Out-of-Pocket Maximums 17
- Summary of Benefit Maximums 18
- Participant Reimbursement Liability 18

Summary of Medical Benefits – HDHP 19

Payment Provisions – Fairway PPO Plan 32

- Highlights of Plan Provisions 32
- Annual Deductible 33
- Annual Out-of-Pocket Maximum 33
- Benefit Maximums – Fairway PPO Plan 34
- Summary of Benefit Maximums 34

Summary of Medical Benefits – Fairway PPO Plan 36

Medical Benefits – All Plans 52

- Acupuncture 52
- Allergy Care 52
- Alternative Care 52
- Ambulance Services 52
- Anesthesia 53
- Applied Behavior Analysis (ABA) 53
- Autologous Blood Donation/Blood Transfusions 54
- Biofeedback 54
- Chemical Dependency 54
- Chiropractic Spinal Manipulation 55
- Clinical Trials 55
- Dental Trauma 56
- Diabetic Education and Diabetic Nutrition Education 56
- Diagnostic Testing 56
- Dialysis 57
- Durable Medical Equipment (DME) and Supplies 57
- Emergency Services and Urgent Care 58
- Family Planning 58
- Foot Orthotics 58
- Genetic Services 58
- Habilitative Services 58
- Hearing Exams 59
- Hearing Aids/Appliances 59
- Hip Replacement 59
- Home Health Care 59
- Hospice Care 60
- Hospital Inpatient Medical and Surgical Care 61
- Hospital Outpatient Surgery and Services 61
- Infertility Diagnostic Services 61
- Infusion Therapy 61
- Knee Replacement 61
- Massage Therapy 62
- Maternity and Newborn Care 62
- Mental Health Care 62
- Nutritional Counseling 63

- Nutritional and Dietary Formulas 63
- Oral Surgery 63
- Organ and Bone Marrow Transplants 63
- Plastic and Reconstructive Services 65
- Podiatric Care 65
- Preventive Care 66
- Professional/Physician Services 66
- Rehabilitation Therapy 66
- Skilled Nursing Facility 67
- Temporomandibular Joint Syndrome (TMJ) 67
- Transgender/Gender Affirming Services 67
- Vision 68
- Wigs 68

Summary of Pharmacy Benefits 69

Pharmacy Benefits 70

- Preventive Drug Benefit 70
- 'First Dollar' Preventive Drug Pharmacy Benefit 71
- Filling a Prescription 71
- Retail Network Pharmacy 71
- Mail Order 71
- Specialty Pharmacy Program 72
- Non-network Pharmacy 72

Plan Exclusions and Limitations 73

Eligibility and Enrollment 81

- Eligible Classes of Employees 81
- Enrollment Periods 81
- How to Enroll 81
- Open Enrollment 81
- Special Enrollment Periods 82
- Late Enrollment 83
- Effective Date 83
- Special Rule 83
- Waiver of Group Health Plan Benefits 84

Dependents 85

- Dependent Eligibility - Medical Plan 85

- Additional Information Applicable to All Plans 85
- Special Rules for Domestic Partners 85
- Dependents Acquired Through Marriage 86
- Dependent Children 86
- Dependent Children Out of Area 87
- Continued Eligibility for a Child who is Disabled 87
- Qualified Medical Child Support Orders 88

Termination of Coverage 89

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) 90

- Who Is a COBRA Qualified Beneficiary? 90
- Qualifying Events and Continuation Periods 91
- When COBRA Coverage Ends 91
- Contribution Payment Requirements 92
- Election Requirements 92
- What Coverage Must Be Offered When Electing COBRA? 92

Other Continuation of Coverage 93

- Leaves of Absence 93

Claim and Appeal Procedures 95

- Claim 95
- How to File a Claim for Plan Benefits 95
- Claim Types 95
- Claim Procedure 96
- Adverse Benefit Determination 96
- Appeal Procedure 98

Independent Dispute Resolution 101

Coordination of Benefits 102

- Calculation of Benefit Payments 102
- How Do I Know Which Plan is my Primary Plan? 103
- What if I'm Covered by Medicare? 104
- Pre-authorization when this Plan is Secondary 105
- Meaning of Plan for COB 105
- Claim Determination Period 106
- Right of Recovery 106
- Facility of Payment 106
- Right to Receive and Release Information 107

Subrogation, Reimbursement, and Right of Recovery 108
- No application of "make whole," "double recovery," and "common fund" rules 108
- Assignment of Rights (Subrogation) 108
- Equitable Lien and Other Equitable Remedies 109
- Obligation to Assist in the Plan's Reimbursement Activities 109

Health Insurance Portability and Accountability Act of 1996 111
- Privacy Rights 111
- Disclosures to the Plan Sponsor 111

Plan Benefit Information 112
- Benefits and Contributions 112
- Special Rights 112

Plan Administration 113
- Funding 113
- Plan Administrator's Power of Authority 113
- Discretionary Authority 113
- Collective Bargaining Agreements 114
- Clerical Error 114

Statement of ERISA Rights 115
- Prudent Actions by Plan Fiduciaries 115
- Enforce Your Rights 115
- Continue Group Health Coverage 115
- Assistance with Your Questions 116

Your Rights and Protections Against Surprise Medical Bills 117
- What is Balance Billing (sometimes called Surprise Billing)? 117

Summary Plan Description and General Information 119

Plan Definitions 121

Important Information about the Plan

This booklet describes your coverage and payment levels under the First Choice Health Network, Inc. Health and Welfare Plan as of September 1, 2022 and how to use your benefits. For information on eligibility and enrollment, terminating and continuing coverage, administration, claim and appeal procedures, definitions and other details, see the Health and Welfare Plan Summary Plan Document.

First Choice Health Network, Inc. (FCH), 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.

The FCH Health and Welfare Plan will be referred to within this document as the "Plan." Under the Plan, you receive the higher network level of benefits when you see a network provider. If you receive care from an out-of-network provider, you will receive the lower network level of benefits.

Please review this booklet carefully and share it with your family. If you have questions, contact the FCH Benefits Department (Plan Administrator) or FCH. If you have questions about whether a provider is considered 'in-network', contact the appropriate network listed on page 3.

Coverage under this Plan will take effect for eligible employees and dependents when all eligibility requirements are satisfied. FCH 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.

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

This Medical, Vision and Pharmacy Benefit Summary booklet, combined with the Health and Welfare Plan Summary Plan Document, comprise the Plan document and summary plan description. These materials do not create a contract of employment or any rights to continued employment with FCH.

Contacting Customer Service

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
(888) 324-8356
Fax: (888) 206-3092
Medical pre-authorization: (800) 808-0450
Mental health/chemical dependency pre-authorization: (800) 640-7682
www.fchn.com

Spanish (Español): Para obtener asistencia en Español, llame al (888) 324-8356.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (888) 324-8356.

Chinese（中文）： **如果需要中文的帮助**，请拨打这个号码 (888) 324-8356.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (888) 324-8356.

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, President's Day, Memorial Day, Independence Day (4th of July), Labor Day, Thanksgiving, and the day after Thanksgiving, Christmas Eve and Christmas Day.

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 (888) 324-8356.

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. We recommend presenting your ID card each time you receive care. If you lose your ID card, you may order a new one either through contacting FCH Customer Service at (888) 324-8356, 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:

PPO Plan

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

HDHP Plan

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

Remember: To ensure you receive the highest level of benefits, confirm provider participation with one of the above networks prior to seeking care.

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 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 Health and Welfare Plan Summary Plan Document.
- Claims in a foreign language must be submitted in English.

Medical Management

Pre-authorization Requirements

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

- **Air Ambulance Transport** - non-urgent transport
- **Anesthesia for dental services**
- **Chimeric Antigen Receptor (CAR) T-cell Therapy**
- **Clinical Trials** (including all interventions/medications)
- **Dental Trauma Services** (follow-up services 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 fabricated knee braces
  - 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
  - Electrical stimulators- spinal- external
  - Myoelectric components for upper limb and powered components for ankle-foot and knee Prosthetics
  - Oscillatory devices and cough stimulating devices
  - Scooters
  - Speech generating devices
  - Tumor Treating Fields for Glioblastoma
  - Vacuum Assisted Wound Therapy
- **Enteral Formula, Medical Food and Associated Services**
- **Facet Joint Injections, Medial Branch Blocks and Neurotomies (any location)**
- **Genetic Testing**
  - Over $500
- **Home Health Care Services** (certain home infusion drugs may still require pre-authorization. See *Medical Injectables*)
  - Home health visits (for wound therapy only)
  - Hospice
- **Hyperbaric Oxygen Therapy**
- **Imaging**
  - PET scans

- **Inpatient admissions**
- **Medical Injectables, 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, and travel and lodging expenses)
- **Peripheral Nerve Blocks**
- **Radiation Therapy**
  - Proton beam, neutron beam or helium ion radiation therapy
  - Stereotactic body radiation therapy (SBRT)
  - Stereotactic radiosurgery (Gamma Knife, Cyber Knife)
- **Surgery**
  - BAHA-bone anchored hearing aid (surgical benefit applies)
  - Breast surgeries- selected (Pre-authorization is not required for breast reconstruction and nipple/areola reconstruction following mastectomy for breast cancer)
    - Implant removal
    - Mastectomy for gynecomastia
    - Reduction mammoplasty
  - Cochlear implants (surgical benefit applies)
  - Cosmetic or reconstructive surgery
  - Deep brain stimulation
  - Fetal/Intrauterine surgery
  - Gender affirming surgery
  - Hip replacement
  - Implantable peripheral nerve and/or spinal cord stimulator placement (temporary and permanent) including electrodes and/or pulse generator/receiver
  - Knee replacement
  - 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**

As noted above, if you neglect to obtain pre-authorization for services which require it, your claim(s) may be denied. Claims denied for lack of pre-authorization do **not** apply toward your Plan year deductible or out-of-pocket maximums.

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

Notification for Emergency Admissions

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

Concurrent Review and Discharge Coordination

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

Case Management

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

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

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

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

Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment is individually tailored to a specific patient and should not be seen

as appropriate or recommended for any other patient, even one with the same diagnosis. The final decision on the course of treatment rests with patients and their providers.

Maternity Management Program

Expecting a baby? First Choice Health offers the Maternity Management Program through a vendor relationship, which provides pre- and post-natal education to help mothers carry their babies to term. To enroll, or if you want additional information, call (800) 756-7751.

Tobacco Cessation

The American Lung Association **Freedom From Smoking** program gives you options, resources and support to quit using tobacco products. This telephonic coaching program helps you to develop a plan of action and support to remain tobacco free. Contact your Human Resources Department for more information about how to enroll.

Payment Provisions – HDHP Plan

Highlights of Plan Provisions

- The benefits of this Plan are provided for medically necessary covered services at the percentages specified in the *Summary of Medical Benefits*, after you meet the applicable deductible.
- Benefit payment is based on the allowed amount under the plan. Your benefit coverage is greater and your out-of-pocket costs are less when you choose a network provider.
- When your annual out-of-pocket maximum is reached, the plan will provide benefits for many covered services at 100% of the allowed amount for the remainder of that Plan year.
- Certain services and procedures require pre-authorization.
- Benefit visit and dollar maximums listed in this section apply to network benefits and out-of-network benefits combined.
- Services received from a Recognized Provider (See "Plan Definitions" within accompanying Health and Welfare Plan Summary Plan Document) 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

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

- Charges of non-covered services and treatment
- Charges for services that are denied as not medically necessary
- Charges over Usual, Customary and Reasonable (UCR) for Out-of-Network services as determined by FCH
- Charges that exceed any applicable benefit maximum
- Charges for claims denied for lack of pre-authorization
- Difference in price between a brand-name and generic drug
- Preventive care
- Preventive care pharmacy benefit
- Vision and vision copays

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

Non-Embedded Family Deductible: With a Non-Embedded Family deductible, covered expenses incurred by each person in family coverage accumulate and are credited toward the one "family" deductible.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the most you will need to pay in a Plan year for covered services. The network and out-of-network Plan year out-of-pocket maximums are inclusive of each other. 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.

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 being medically necessary
- Charges over Usual, Customary and Reasonable (UCR) for out-of-network provider services as determined by FCH
- Charges for claims denied for lack of pre-authorization
- Charges that exceed any applicable benefit maximum
- Difference in price between a brand-name and generic drug

What Is a High Deductible Health Plan (HDHP)?

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

For calendar year 2022, a HDHP is defined under § 223(c)(2)(A) as a health plan with an annual deductible that is not less than $1,400 for self-only coverage or $2,800 for family coverage (both unchanged from 2021), and the annual out-of-pocket expenses (deductibles, copayments, and other amounts, but not premiums) do not exceed $7,050 for self-only coverage or $14,100 for family coverage. For calendar year 2023, a HDHP is defined under § 223(c)(2)(A) as a health plan with an annual deductible that is not less than $1,500 for self-only coverage or $3,000 for family coverage, and the annual out-of-pocket expenses (deductibles, copayments, and other amounts, but not premiums) do not exceed $7,500 for self-only coverage or $15,000 for family coverage.

The First Choice Health and Welfare Plan is a qualifying high deductible health plan under Code §223(c)(2).

Benefit Maximums – HDHP Plan

Your annual deductible, annual out-of-pocket maximum and lifetime maximum amounts under the Plan follow:

Annual Deductible and Out-of-Pocket Maximums

Annual Deductible (per Plan Year)		
Deductible and Out-of-Pocket Maximums	**Network**	**Out-of-Network**
Employee	$1,400	$2,800
Employee + 1	$2,800	$4,800
Employee + 2 or more	$2,800	$5,600
Annual Out-of-Pocket Maximum (per Plan Year)		
Annual Out-of-Pocket Maximum (per Plan Year)	**Network**	**Out-of-Network**
Employee Only	$5,000	$14,000
Employee + 1		
– Individual	$6,900	$21,000
– Family	$8,000	$21,000
Employee + 2 or more		
– Individual	$6,900	$28,000
– Family	$10,000	$28,000

Summary of Benefit Maximums

Lifetime Maximum Benefits – HDHP Plan	
Wigs	$1,000
Plan Year Maximums – HDHP Plan	
Alternative Care (Acupuncture, Massage Therapy)	12 visits
Chiropractic Spinal Manipulation	12 visits
Foot Orthotics	1 pair per Plan year up to $400
Hip Replacement (facility charge without complications)	$35,000 per occurrence
Home Health Care	130 visits
Knee Replacement (facility charge without complications)	$35,000 per occurrence
Nutritional Counseling	6 visits
Obesity Screening and Counseling	12 visits
Rehabilitation Therapy • Outpatient Cardiac, Speech, Occupational and Physical Therapies	30 visits
Skilled Nursing Facility	60 days
Vision Care • Routine Vision Care • Vision Appliances (hardware)	1 routine eye exam $250

Participant Reimbursement Liability

Remember, your care must be from network providers to be covered at the network level. You are always responsible for the following health care costs:

- Annual deductible, if applicable;
- Coinsurance, if applicable;
- Difference between an out-of-network provider's charge for a service and FCH's allowed amount for that service;
- Care you receive after your benefit limits are exhausted; and
- Non-covered services

Summary of Medical Benefits – HDHP

First Choice Health Network, Inc. Health and Welfare Plan – HDHP				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Out-of-network Providers**
Allergy Care	✓	✓	80%	60%
Alternative Care Maximum 12 visits combined specialties per Plan year.				
• **Acupuncture**	✓	✓	80%	Not Covered
• **Massage Therapy**	✓	✓	80%	Not Covered
Ambulance Services FCH pre-authorization required for non-emergent air ambulance.	✓	✓	80%	80%
• **First Responder User Fees**	✓	✓	80%	80%
Ambulatory Surgery Center (ASC) FCH pre-authorization required for certain outpatient services.	✓	✓	80%	60%
Applied Behavior Analysis (ABA) Therapy FCH pre-authorization is required for inpatient services.	✓	✓	80%	60%
Anesthesia				
• **Anesthesia** (in general)	✓	✓	80%	60%
• **Anesthesia Related to Dental Services** (Limited benefit, see *Anesthesia* for details. FCH pre-authorization required for follow-up services and anesthesia)	✓	✓	80%	60%
Autologous Blood Donation/Blood Transfusions	✓	✓	80%	80%

First Choice Health Network, Inc. Health and Welfare Plan – HDHP				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Out-of-network Providers**
Biofeedback	✓	✓	80%	60%
Chemical Dependency FCH pre-authorization required for inpatient, residential, and partial hospitalization.				
• **Inpatient**	✓	✓	80%	60%
• **Outpatient**	✓	✓	80%	60%
Chiropractic Spinal Manipulation Maximum 12 visits per Plan year.	✓	✓	80%	60%
Clinical Trials	Covered as specifically outlined under the Clinical Trials Benefit in the *Summary of Medical Benefits*			
Dental Trauma FCH pre-authorization required for follow-up services and anesthesia.				
– Professional	✓	✓	80%	80%
– Facility	✓	✓	80%	60%
Diabetic Education & Diabetic Nutrition Education First 3 visits per calendar year are covered under Preventive Care.	✓	✓	80%	80%
Dialysis FCH pre-authorization required.	Covered based on place of service			
Diagnostic Testing Lab and Radiology Services, Non-routine, facility and professional services				
• **Hospital Inpatient** (professional fees)	✓	✓	80%	60%

First Choice Health Network, Inc. Health and Welfare Plan – HDHP				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Out-of-network Providers**
• **Hospital Outpatient** (facility and professional fees)	✓	✓	80%	60%
• **Lab and X-ray Facility** Lab or radiology services provided by an independent lab or radiology provider, group, facility or office. Billed separately from the provider of care.	✓	✓	80%	60%
• **Doctor's Office** Office based lab or radiology service provided as part of the office visit, and billed as part of the office visit.	✓	✓	80%	60%
Durable Medical Equipment and Supplies				
• **Breast Pumps**	N/A	✓	100%	60%
• **Durable Medical Equipment**	✓	✓	80%	60%
• **Medical Supplies**	✓	✓	80%	60%
• **Prosthetic Devices**	✓	✓	80%	60%
• **Oral Appliances** For treatment of obstructive sleep apnea only, FCH pre-authorization required.	✓	✓	80%	80%
• **Orthopedic Appliances/Braces**	✓	✓	80%	60%
Emergency Care				
• **Emergency Department** – Facility and Professional Services	✓	✓	80%	80%

First Choice Health Network, Inc. Health and Welfare Plan – HDHP				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Out-of-network Providers**
• **Urgent Care –** Facility and Professional Services	✓	✓	80%	80%
Family Planning (contraceptive services, pregnancy terminations)				
• **Female Contraceptive Management Office Visits and Diagnostic Testing**	N/A	✓	100%	60%
• **Male Contraceptive Management Office Visits and Diagnostic Testing**	✓	✓	100%	60%
• **Contraceptive Supplies, Devices, Implants and Injections**	N/A	✓	100%	60%
• **Sterilization**				
– Female Sterilization	N/A	✓	100%	60%
– Male Sterilization	✓	✓	100%	60%%
• **Voluntary Termination of Pregnancy**	✓	✓	80%	60%
Foot Orthotics 1 pair per Plan year up to $400.	✓	✓	80%	60%
Genetic Services Pre-authorization required for Genetic Testing if over $500.				
• **BRCA Testing**	N/A	✓	100%	60%
• **All other Genetic Testing/Counseling**	✓	✓	80%	60%
Habilitative Services	✓	✓	80%	60%

First Choice Health Network, Inc. Health and Welfare Plan – HDHP				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Out-of-network Providers**
Hearing				
• **Hearing Exams** (1 per Plan year)	N/A	✓	100%	60%
• **Hearing Aids & Appliances** Maximum of $2,000 every 3 Plan years.	✓	✓	80%	60%
Hip Replacement				
• **Inpatient Facility Services** (without complications) Maximum of $35,000 per occurrence.	✓	✓	80%	60%
• **Outpatient Facility Services** (without complications) Maximum of $35,000 per occurrence.	✓	✓	80%	60%
• **Plan-authorized Bundled Payment Program**	✓	✓	$1,500 Copay then 100%	N/A
• **Inpatient Facility Services** (with complications)	✓	✓	80%	60%
• **Outpatient Facility Services** (with complications)	✓	✓	80%	60%
• **Professional Services**	✓	✓	80%	60%
• **Travel and Lodging** Pre-authorization required $3,500 per Plan year.	✓	✓	100%	
Home Health Care (HHC) FCH pre-authorization required for wound therapy, enteral formula, medical food and associated services and home hospice.				

First Choice Health Network, Inc. Health and Welfare Plan – HDHP				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Out-of-network Providers**
• **Home Health Care** 130 visits per Plan year maximum.	✓	✓	80%	60%
• **Phototherapy** (home)	✓	✓	80%	60%
• **Infusion Therapy** (as part of HHC)	✓	✓	80%	60%
Hospice Care FCH pre-authorization required.	✓	✓	80%	60%
Hospital Inpatient Medical and Surgical Care FCH pre-authorization required.				
• **Facility Services**	✓	✓	80%	60%
• **Inpatient Doctor Visits/Consultations**	✓	✓	80%	60%
• **Inpatient Professional Services**	✓	✓	80%	60%
Hospital Outpatient Surgery and Services FCH pre-authorization required for certain outpatient services; refer to *Pre-authorization Requirements*.				
• **Surgical Facility Services**	✓	✓	80%	60%
• **Ambulatory Surgery Center** (ASC)	✓	✓	80%	60%
• **Outpatient Professional Services**	✓	✓	80%	60%

First Choice Health Network, Inc. Health and Welfare Plan – HDHP				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Out-of-network Providers**
Infertility Diagnostic Services FCH pre-authorization required for inpatient care. Infertility treatments such as IVF, GIFT, etc. are not covered. See page *Infertility Diagnostic Services* for details.	✓	✓	80%	60%
Infusion Therapy (separate from Home Health Care) FCH pre-authorization required for certain infusion therapy drugs, see *Pre-Authorizations Requirements.*	✓	✓	80%	60%
Knee Replacement				
• **Inpatient Facility Services** (without complications) Maximum of $35,000 per occurrence.	✓	✓	80%	60%
• **Outpatient Facility Services** (without complications) Maximum of $35,000 per occurrence.	✓	✓	80%	60%
• **Plan-authorized Bundled Payment Program**	✓	✓	$1,500 Copay	N/A
• **Inpatient Facility Services** (with complications)	✓	✓	80%	60%
• **Outpatient Facility Services** (with complications)	✓	✓	80%	60%
• **Professional Services**	✓	✓	80%	60%
• **Travel and Lodging** Pre-authorization required $3,500 per Plan year.	✓	✓	100%	
Maternity and Newborn Care				
• **Maternity Care**	✓	✓	80%	60%

First Choice Health Network, Inc. Health and Welfare Plan – HDHP				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Out-of-network Providers**
• **Newborn Care**	✓	✓	80%	60%
Mental Health Care FCH pre-authorization required for inpatient, residential, and partial hospitalization.				
• **Inpatient**	✓	✓	80%	60%
• **Partial Day Treatment** (PDT)	✓	✓	80%	60%
• **Outpatient**	✓	✓	80%	60%
Nutrition and Dietary Formulas	✓	✓	80%	60%
Nutritional Counseling 6 visit maximum per Plan year. First 3 visits per calendar year are covered under Preventive Care, any subsequent visits are covered under this benefit up to the 6 visit maximum.	✓	✓	80%	60%
Oral Surgery Limited benefit; covered when medical diagnosis present, see *Oral Surgery* for details.				
– Professional	✓	✓	80%	80%
– Facility	✓	✓	80%	60%
Organ and Bone Marrow Transplants FCH pre-authorization required; benefit subject to 12-month waiting period. Travel and Lodging maximum: $2,500 per episode.	✓	✓	80%	Not Covered
Plastic and Reconstructive Services FCH pre-authorization required. Limited benefit; please see *Plastic and Reconstructive Services* for details.	✓	✓	80%	60%

First Choice Health Network, Inc. Health and Welfare Plan – HDHP				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Out-of-network Providers**
Podiatric Care See *Podiatric Care* for details on Routine Foot Care.	✓	✓	80%	60%
Preventive Care Preventive care services are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention, US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive services (this is not meant to be an all-inclusive list). See *Preventive Care* for more details.				
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 more information. Covered immunizations done at a pharmacy are covered at the in network benefit level at billed charges	N/A	✓	100%	60%
Office Visits				
• **Well Baby and Child Care** (children age 0 – 18)				
– Newborn through end of 23rd month	N/A	✓	100%	60%
– Age 2 through 18 (1 visit per Plan year)	N/A	✓	100%	60%
• **Adult Preventive Care** (Age 19 and over)				
– Periodic Preventive Visit (1 visit per Plan year)	N/A	✓	100%	60%
– Nutritional Counseling (first 3 visits per Plan year)	N/A	✓	100%	60%

First Choice Health Network, Inc. Health and Welfare Plan – HDHP				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Out-of-network Providers**
– For visits 4 and beyond, refer to *Nutritional Counseling or Diabetic Education.*				
• **Obesity Screening and Counseling** 12 visits per calendar year.	N/A	✓	100%	60%
Screening Tests 1 visit per plan year unless otherwise indicated:				
• **Abdominal Aortic Aneurysm Ultrasound Screening** (for current or prior male tobacco users between 65 years and 75 years old; 1 test per lifetime.)	N/A	✓	100%	60%
• **Cholesterol/Lipid**	N/A	✓	100%	60%
• **Colonoscopy** (beginning at age 50 – or younger, if at increased risk) First colonoscopy per plan year is paid under the Preventive Care benefit, regardless of diagnosis. Subsequent colonoscopies in the same plan year are paid under the medical benefits.	N/A	✓	100%	60%
• **Fecal Occult Blood Tests** (beginning at age 50 – or younger, if at increased risk) First fecal occult blood test per plan year is paid under the Preventive Care benefit, regardless of diagnosis. Subsequent fecal occult blood tests in the same plan year are paid under the medical benefits.	N/A	✓	100%	60%
• **FIT-Fecal DNA** 1 per Plan year.	N/A	✓	100%	60%

First Choice Health Network, Inc. Health and Welfare Plan – HDHP				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Out-of-network Providers**
• **HIV Screening**	N/A	✓	100%	60%
• **Lead Level Tests** (1 test for children, age 2 or under)	N/A	✓	100%	60%
• **Mammograms** (beginning at age 40 – or younger, if at increased risk) First mammogram per plan year is paid under the Preventive Care benefit, regardless of diagnosis. Subsequent mammograms in the same plan year are paid under the medical benefits.	N/A	✓	100%	60%
• **Pap Tests, Pelvic Exams**	N/A	✓	100%	60%
• **Periodic Blood Glucose Testing**	N/A	✓	100%	60%
• **Periodic Bone Density Screening** (1 test every other plan year, women beginning at age 65, or at age 60 for those with increased risk for osteoporotic fractures)	N/A	✓	100%	60%
• **Prostate Cancer Screening** (PSA) (for men, beginning at age 50)	N/A	✓	100%	60%
• **Sexually Transmitted Disease Screening** (Chlamydia, Gonorrhea, etc.)	N/A	✓	100%	60%

First Choice Health Network, Inc. Health and Welfare Plan – HDHP				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Out-of-network Providers**
• **Sigmoidoscopy** (beginning at age 50 – or younger, if at increased risk) First sigmoidoscopy per plan year is paid under the Preventive Care benefit, regardless of diagnosis. Subsequent sigmoidoscopies in the same plan year are paid under the medical benefits.	N/A	✓	100%	60%
• **All Other Screening Tests**	N/A	✓	100%	60%
Professional/Physician Services (office visits, certain telemedicine visits and office surgeries)				
• **Office Visits and Related Services**	✓	✓	80%	60%
• **98point6 Text Based Program** (Primary Care) The member pays the cost in full until the out-of-pocket is satisfied.	✓	✓	N/A	0%
Rehabilitation Therapy				
• **Inpatient** FCH pre-authorization required.	✓	✓	80%	60%
• **Outpatient** (includes cardiac, physical, speech and occupational therapies) 30 visit max per plan year; all therapies combined.	✓	✓	80%	60%
Skilled Nursing Facility FCH pre-authorization required. 60 days Plan year maximum; maintenance and custodial care are not covered.	✓	✓	80%	60%

First Choice Health Network, Inc. Health and Welfare Plan – HDHP				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Out-of-network Providers**
Sleep Apnea FCH pre-authorization required for surgical intervention.	✓	✓	80%	60%
Temporomandibular Joint Syndrome (TMJ)	✓	✓	80%	80%
• Professional	✓	✓	80%	80%
• Facility	✓	✓	80%	60%
Tobacco Cessation Office Visits - Children and Adolescents age 18 & Under.	N/A	✓	100%	60%
Transgender/Gender Affirming Services FCH pre-authorization required. Limited benefit, see *Transgender/Gender Affirming Services* for details.	Payment is based on Place of Service.			
Vision Care				
• **Vision Exam** 1 exam per Plan year.	N/A	✓	100% after $10 copay	Not Covered
• **Vision Hardware** (eyeglasses and contacts, includes contact lens fitting and evaluation) $250 max per Plan year.	N/A	N/A	100% up to $250 per Plan Year	
Wigs Coverage if needed as a result of medically necessary treatment. $1,000 lifetime maximum.	✓	✓	80%	80%

Payment Provisions – Fairway PPO Plan

Highlights of Plan Provisions

- Your benefit coverage is greater, and your out-of-pocket costs less, when you choose a Fairway preferred provider (Tier 1 Network).
- You will receive the second-highest benefit coverage if you receive services within the First Choice Health Network of providers (Tier 2 In-Network).
- Your benefit coverage will be lowest if you receive services from an out-of-network provider (Tier 3 Out-of-Network).
- Benefit payment is based on the Allowed Amounts agreed upon by Network providers.
- Services received from a Recognized Provider (see *Plan Definitions*) will be paid at the In-Network level. An Allowed Amount will be obtained through Usual, Customary and Reasonable data or a negotiated rate. If neither is available or appropriate, billed charges may be used as the Plan payment. You will be responsible for the difference (if any) between the Allowed Amount 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, you are responsible to pay the difference between the Plan payment and the provider's actual charges.
- 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

The annual deductible is the amount you (or your family) must pay each Plan year before the Plan will pay for covered services (payment for non-covered services will not be applied to the deductible). Once the deductible is satisfied, coinsurance amounts as noted in the *Summary of Medical Benefits* will be applied. Until then, the amount due to a provider is your responsibility. The Tier 2 and Tier 3 annual Deductibles are inclusive of each other.

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

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

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

- Charges of non-covered services and treatment
- Charges for services that are denied as not medically necessary
- Charges over Usual, Customary and Reasonable (UCR) for out-of-network services as determined by FCH
- Charges that exceed any applicable benefit maximum
- Charges for claims denied for lack of pre-authorization
- Copayments (except for the Hip/Knee Replacement Bundled Payment Program copay)
- Pharmacy charges for branded product when a generic equivalent (branded generic) is available
- Preventive care
- Preventive care pharmacy
- Vision and related vision copays

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the most you will need to pay in a Plan 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. The Tier 1, Tier 2, and Tier 3 annual Out-of-Pocket maximums are inclusive of each other.

The following do not apply toward the annual out-of-pocket maximum:

- Charges of non-covered services and treatment
- Charges for services that are denied as not medically necessary
- Charges over Usual, Customary and Reasonable (UCR) for out-of-network services as determined by FCH
- Charges that exceed any applicable benefit maximum
- Charges for claims denied for lack of pre-authorization
- Charges for services paid by the Plan at 100%
- Pharmacy charges for branded product when a generic equivalent (branded generic) is available

Benefit Maximums – Fairway PPO Plan

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

Annual Deductible and Out-of-Pocket Maximums

Deductible and Out-of-Pocket Maximum	Tier 1 Fairway	Tier 2 In-Network	Tier 3 Out-of-Network
Annual Medical and Pharmacy Deductible (per Plan year)			
Employee only	$0	$400	$800
Family	$0	$800	$1,600
Annual Medical and Pharmacy Out-of-Pocket Maximum (per Plan year)			
Employee Only Coverage			
Employee only	$3,500	$5,000	$14,000
Family Coverage (EE + 1 or more)			
Individual	$5,000	$6,900	$28,000
Family	$7,000	$10,000	$28,000

Summary of Benefit Maximums

Lifetime Maximum Benefits – Fairway PPO	
Wigs	$1,000

Plan Year Maximums – Fairway PPO	
Alternative Care (Acupuncture, Massage Therapy)	12 visits
Chiropractic Spinal Manipulation	12 visits
Foot Orthotics	1 pair per Plan year up to $400
Hearing Aids	$2,000 every 3 Plan years
Hip Replacement (facility charge without complications)	$35,000 per occurrence
Home Health Care	130 visits
Knee Replacement (facility charge without complications)	$35,000 per occurrence

Nutritional Counseling	6 visits
Obesity Screening and Counseling	12 visits
Rehabilitation Therapy • Outpatient Cardiac, Speech, Occupational, and Physical Therapies	30 visits
Skilled Nursing Facility	60 days
Vision Care • Routine Vision Care • Vision Appliances (hardware)	1 routine eye exam $250

Summary of Medical Benefits – Fairway PPO Plan

First Choice Health Network, Inc. Health and Welfare Plan – Fairway PPO Plan					
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Fairway**	**Tier 2 In-Network**	**Tier 3 Out-of-Network**
Allergy Care					
• **Injections**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Testing**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Alternative Care 12 visits maximum combined per Plan year.					
• **Acupuncture**	✓ (Tier 2 only)	✓	$25 copay then 100%	$25 copay then 75%	Not Covered
• **Massage Therapy**	✓ (Tier 2 only)	✓	$25 copay then 100%	$25 copay then 75%	Not Covered
Ambulance Services FCH pre-authorization required for non-emergent air ambulance.	✓ (Tier 2 and 3 only)	✓	80%	80%	80% (Tier 2 deductible and out-of-pocket apply)
• **First Responder User Fees**	✓ (Tier 2 and 3 only)	✓	80%	80%	80% (Tier 2 deductible and out-of-pocket apply)
Ambulatory Surgery Center (ASC) FCH pre-authorization required for certain outpatient services.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%

First Choice Health Network, Inc. Health and Welfare Plan – Fairway PPO Plan					
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Fairway**	**Tier 2 In-Network**	**Tier 3 Out-of-Network**
Applied Behavior Analysis (ABA) FCH pre-authorization is required for inpatient services.					
• **Inpatient**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Outpatient**	✓ (Tier 2 and 3 only)	✓	$25 copay then 100%	$25 copay then 75%	$25 copay then 60%
Anesthesia					
• **Anesthesia** (in general)	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Anesthesia Related to Dental Services** (Limited benefit, see *Anesthesia* for details. FCH pre-authorization required for follow-up services and anesthesia.)	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Autologous Blood Donation/Blood Transfusions	✓ (Tier 2 and 3 only)	✓	80%	75%	75% (Tier 2 deductible and out-of-pocket apply)
Biofeedback	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Chemical Dependency FCH pre-authorization required for inpatient, residential, and partial hospitalization.					
• **Inpatient**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Outpatient**	✓ (Tier 2 and 3 only)	✓	$25 copay then 100%	$25 copay then 75%	$25 copay then 60%

First Choice Health Network, Inc. Health and Welfare Plan – Fairway PPO Plan					
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Fairway**	**Tier 2 In-Network**	**Tier 3 Out-of-Network**
Chiropractic Spinal Manipulation 12 visits maximum per Plan year.	✓ (Tier 2 and 3 only)	✓	$25 copay then 100%	$25 copay then 75%	$25 copay then 60%
Clinical Trials	Covered as specifically outlined under the Clinical Trials Benefit in the *Summary of Medical Benefits*				
Dental Trauma FCH pre-authorization required for follow-up services and anesthesia.					
• **Facility**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Professional**	✓ (Tier 2 and 3 only)	✓	80%	75%	75% (Tier 2 deductible and out-of-pocket apply)
Diabetic Education & Diabetic Nutrition Education First 3 visits per plan year covered under Preventive Care.	✓ (Tier 2 and 3 only)	✓	80%	75%	75%
Dialysis FCH pre-authorization required.	Covered based on place of service.				
Diagnostic Testing Lab and Radiology Services (Non-routine, facility and professional services)					
• **Hospital Inpatient** (professional fees)	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Hospital Outpatient** (facility and professional fees)	✓ (Tier 2 and 3 only)	✓	80%	75%	60%

First Choice Health Network, Inc. Health and Welfare Plan – Fairway PPO Plan					
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Fairway**	**Tier 2 In-Network**	**Tier 3 Out-of-Network**
• **Lab and X-ray Facility** Lab or radiology services provided by an independent lab or radiology provider, group, facility or office. Billed separately from the provider of care.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Doctor's Office** Office based lab or radiology service provided as part of the office visit, and billed as part of the office visit.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Durable Medical Equipment and Supplies					
• **Breast Pumps**	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Durable Medical Equipment**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Medical Supplies**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Prosthetic Devices**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Oral Appliances** (for treatment of obstructive sleep apnea only) FCH pre-authorization required	✓ (Tier 2 and 3 only)	✓	80%	75%	75% (Tier 2 deductible and out-of-pocket apply)
• **Orthopedic Appliances/Braces**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Emergency Care					

First Choice Health Network, Inc. Health and Welfare Plan – Fairway PPO Plan					
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Fairway**	**Tier 2 In-Network**	**Tier 3 Out-of-Network**
• **Emergency Department** – Facility and Professional Services	✓ (Tier 2 and 3 only)	✓	80%	80%	80% (Tier 2 deductible and out-of-pocket apply)
• **Urgent Care –** Facility and Professional Services	✓ (Tier 2 and 3 only)	✓	80%	80%	60%
Family Planning (contraceptive services, pregnancy terminations)					
• **Female Contraceptive Management Office Visits and Diagnostic Testing**	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Male Contraceptive Management Office Visits and Diagnostic Testing**	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Contraceptive Supplies, Devices, Implants and Injections**	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Female Sterilization**	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Male Sterilization**	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Voluntary Termination of Pregnancy**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Foot Orthotics 1 pair per Plan year up to $400.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Genetic Services FCH pre-authorization required for Genetic Testing over $500.					
• **BRCA Testing**	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%

First Choice Health Network, Inc. Health and Welfare Plan – Fairway PPO Plan					
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Fairway**	**Tier 2 In-Network**	**Tier 3 Out-of-Network**
• **All other Genetic Testing/Counseling**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Habilitative Services					
• **Inpatient**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Outpatient**	✓ (Tier 2 and 3 only)	✓	$25 copay then 100%	$25 copay then 75%	$25 copay then 60%
Hearing					
• **Hearing Exams** 1 exam maximum per Plan year.	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Hearing Aids & Appliances** $2,000 maximum every 3 Plan years.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Hip Replacement					
• **Inpatient Facility Services** (without complications) $35,000 maximum per occurrence.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Outpatient Facility Services** (without complications) $35,000 maximum per occurrence.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Plan-authorized Bundled Payment Program**	✓ (Tier 2 only)	✓ (Tier 2 only)	N/A	$1,500 Copay then 100%	N/A

First Choice Health Network, Inc. Health and Welfare Plan – Fairway PPO Plan					
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Fairway**	**Tier 2 In-Network**	**Tier 3 Out-of-Network**
– **Travel and Lodging** (for use with the Plan-authorized Bundled Payment Program only) FCH pre-authorization required. $3,500 maximum per Plan year.	N/A	N/A	100%	100%	100%
• **Inpatient Facility Services** (with complications)	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Outpatient Facility Services** (with complications)	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Professional Services**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Home Health Care (HHC) FCH pre-authorization required for wound therapy**,** enteral formula, medical food and associated services and home hospice.					
• **Home Health Care** 130 visits maximum per Plan year.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Phototherapy** (home)	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Infusion Therapy** (as part of HHC)	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Hospice Care FCH pre-authorization required.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Hospital Inpatient Medical and Surgical Care FCH pre-authorization required.					

First Choice Health Network, Inc. Health and Welfare Plan – Fairway PPO Plan					
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Fairway**	**Tier 2 In-Network**	**Tier 3 Out-of-Network**
• **Facility Services**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Inpatient Doctor Visits/Consultations**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Inpatient Professional Services**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Hospital Outpatient Surgery and Services FCH pre-authorization required for certain outpatient services; refer to *Pre-authorization Requirements*.					
• **Surgical Facility Services**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Ambulatory Surgery Center** (ASC)	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Outpatient Professional Services**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Infertility Diagnostic Services FCH pre-authorization required for inpatient care. Infertility treatments such as IVF, GIFT, etc. are not covered. See page *Infertility Diagnostic Services* for details.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Infusion Therapy (separate from Home Health Care) FCH pre-authorization required for certain infusion therapy drugs, see *Pre-Authorizations Requirements.*	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Knee Replacement					

First Choice Health Network, Inc. Health and Welfare Plan – Fairway PPO Plan					
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Fairway**	**Tier 2 In-Network**	**Tier 3 Out-of-Network**
• **Inpatient Facility Services** (without complications) $35,000 maximum per occurrence.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Outpatient Facility Services** (without complications) $35,000 maximum per occurrence.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Plan-authorized Bundled Payment Program**	✓ (Tier 2 only)	✓ (Tier 2 only)	N/A	$1,500 Copay then 100%	N/A
– **Travel and Lodging** (for use with the Plan-authorized Bundled Payment Program only) FCH pre-authorization required. $3,500 maximum per Plan year.	N/A	N/A	100%	100%	100%
• **Inpatient Facility Services** (with complications)	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Outpatient Facility Services** (with complications)	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Professional Services**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Maternity and Newborn Care					
• **Maternity Care**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Newborn Care**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%

First Choice Health Network, Inc. Health and Welfare Plan – Fairway PPO Plan					
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Fairway**	**Tier 2 In-Network**	**Tier 3 Out-of-Network**
Mental Health Care FCH pre-authorization required for inpatient, residential, and partial hospitalization.					
• **Inpatient**	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Partial Day Treatment** (PDT)	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Outpatient**	✓ (Tier 2 and 3 only)	✓	$25 copay then 100%	$25 copay then 75%	$25 copay then 60%
Nutrition and Dietary Formulas	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Nutritional Counseling 6 visits maximum per Plan year. (First 3 visits per plan year are covered under Preventive Care; subsequent visits are covered under this benefit up to the 6-visit maximum.)	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Oral Surgery Limited benefit; covered when medical diagnosis present, see *Oral Surgery* for details.	✓ (Tier 2 and 3 only)	✓	80%	75%	75%
Organ and Bone Marrow Transplants FCH pre-authorization required; subject to 12-month waiting period.					
• **Organ and Bone Marrow Transplants**	✓ (Tier 2 only)	✓	80%	75%	Not Covered
• **Travel and Lodging** FCH pre-authorization required. $2,500 maximum per episode.	N/A	N/A	100%	100%	100%

First Choice Health Network, Inc. Health and Welfare Plan – Fairway PPO Plan					
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Fairway**	**Tier 2 In-Network**	**Tier 3 Out-of-Network**
Plastic and Reconstructive Services FCH pre-authorization required. Limited benefit; please see *Plastic and Reconstructive Services* for details.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Podiatric Care See *Podiatric Care* for details on Routine Foot Care.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Preventive Care Preventive care services are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention (CDC), US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive services (this is not meant to be an all-inclusive list). See *Preventive Care* for more details.					
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 more information. Covered immunizations done at a pharmacy are covered at the in network benefit level at billed charges	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
Office Visits					
• **Well Baby and Child Care** (Children age 0 – 18)					
– Newborn through end of 23rd month	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
– Age 2 through 18 (1 visit per Plan year)	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Adult Preventive Care** (Age 19 and over)					

First Choice Health Network, Inc. Health and Welfare Plan – Fairway PPO Plan					
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Fairway**	**Tier 2 In-Network**	**Tier 3 Out-of-Network**
– Periodic Preventive Visit (1 visit per Plan year)	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
– Nutritional Counseling (first 3 visits per Plan year) – For visits 4 and beyond, refer to *Nutritional Counseling or Diabetic Education.*	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Obesity Screening and Counseling** 12 visits per plan year.	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
Screening Tests 1 visit per plan year unless otherwise indicated.					
• **Abdominal Aortic Aneurysm Ultrasound Screening** (for current or prior male tobacco users between 65 years and 75 years old; 1 test per lifetime.)	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Cholesterol/Lipid**	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Colonoscopy** (beginning at age 50 – or younger, if at increased risk) First colonoscopy per plan year is paid under the Preventive Care benefit, regardless of diagnosis. Subsequent colonoscopies in the same plan year are paid under the medical benefits.	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%

First Choice Health Network, Inc. Health and Welfare Plan – Fairway PPO Plan					
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Fairway**	**Tier 2 In-Network**	**Tier 3 Out-of-Network**
• **Fecal Occult Blood Tests** (beginning at age 50 – or younger, if at increased risk) First fecal occult blood test per plan year is paid under the Preventive Care benefit, regardless of diagnosis. Subsequent fecal occult blood tests in the same plan year are paid under the medical benefits.	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **FIT-Fecal DNA** 1 per Plan year.	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **HIV Screening**	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Lead Level Tests** (1 test per lifetime for children age 2 or younger)	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Mammograms** (beginning at age 40 – or younger, if at increased risk) First mammogram per plan year is paid under the Preventive Care benefit, regardless of diagnosis. Subsequent mammograms in the same plan year are paid under the medical benefits.	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Pap Tests, Pelvic Exams**	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Periodic Blood Glucose Testing**	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Periodic Bone Density Screening** (1 test every other plan year, women beginning at age 65, or at age 60 for those with increased risk for osteoporotic fractures)	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%

First Choice Health Network, Inc. Health and Welfare Plan – Fairway PPO Plan					
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Fairway**	**Tier 2 In-Network**	**Tier 3 Out-of-Network**
• **Prostate Cancer Screening** (PSA) (for men, beginning at age 50)	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Sexually Transmitted Disease Screening** (Chlamydia, Gonorrhea, etc.)	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **Sigmoidoscopy** (beginning at age 50 – or younger, if at increased risk) First sigmoidoscopy per plan year is paid under the Preventive Care benefit, regardless of diagnosis. Subsequent sigmoidoscopies in the same plan year are paid under the medical benefits.	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
• **All Other Screening Tests**	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
Professional/Physician Services (office visits, certain telemedicine visits and office surgeries)					
• **Office Visits** (Primary Care)	✓ (Tier 2 and 3 only)	✓	$25 copay then 100%	$25 copay then 75%	$25 copay then 60%
• **Office Visit Related Services and Surgeries** (Primary Care)	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Office Visits** (Specialist)	✓ (Tier 2 and 3 only)	✓	$40 copay then 100%	$40 copay then 75%	$40 copay then 60%
• **Office Visit Related Services and Surgeries** (Specialist)	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **98point6 Text Based Program** (Primary Care)	N/A	N/A	100%		
Rehabilitation Therapy					

First Choice Health Network, Inc. Health and Welfare Plan – Fairway PPO Plan					
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Fairway**	**Tier 2 In-Network**	**Tier 3 Out-of-Network**
• **Inpatient** FCH pre-authorization required.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• **Outpatient** (includes cardiac, physical, speech and occupational therapies) 30 visits maximum per plan year; all therapies combined.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Skilled Nursing Facility FCH pre-authorization required. 60 days maximum per Plan year; maintenance and custodial care are not covered.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Sleep Apnea FCH pre-authorization required for surgical intervention.	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
Temporomandibular Joint Syndrome (TMJ)	✓ (Tier 2 and 3 only)	✓	80%	75%	75%
• Facility	✓ (Tier 2 and 3 only)	✓	80%	75%	60%
• Professional	✓ (Tier 2 and 3 only)	✓	80%	75%	75% (Tier 2 deductible and out-of-pocket apply)
Tobacco Cessation Office Visits - Children and adolescents age 18 and under.	✓ (Tier 3 only)	✓ (Tier 3 only)	100%	100%	60%
Transgender/Gender Affirming Services FCH pre-authorization required. Limited benefit, see *Transgender/Gender Affirming Services* for details.	Payment is based on Place of Service.				
Vision Care					

First Choice Health Network, Inc. Health and Welfare Plan – Fairway PPO Plan					
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Fairway**	**Tier 2 In-Network**	**Tier 3 Out-of-Network**
• **Vision Exam** 1 exam per Plan year	N/A	✓	N/A	$10 copay then 100%	Not Covered
• **Vision Hardware** (eyeglasses and contacts, includes contact lens fitting and evaluation) $250 maximum per Plan year	N/A	N/A	N/A	100% up to $250 per Plan Year	
Wigs Coverage if needed as a result of medically necessary treatment. $1,000 lifetime maximum.	✓ (Tier 2 and 3 only)	✓	80%	75%	75% (Tier 2 deductible and out-of-pocket apply)

Medical Benefits – All Plans

FCH administers the benefits described in this section for the FCH's Plan participants. All benefits are subject to plan exclusions and limits. All coinsurance, deductibles and inpatient, outpatient or office visit copays apply. See *Payment Provisions*, *Summary of Medical Benefits*, and *Plan Exclusions and Limitations* for more details, along with definitions in the Health and Welfare Plan Summary Plan Document.

Coverage is provided only when all these conditions are met:

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

Acupuncture

Refer to *Alternative Care*.

Allergy Care

Benefits include allergy tests, injections, and serums. Coverage is provided when administered by a physician, allergist or specialist. Serum is covered only when received and administered within the provider's office. If received from a pharmacy, the serum may be covered under the pharmaceutical benefit.

Alternative Care

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

Ambulance Services

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

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

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

Note: Emergent Air Ambulance Transport will be reviewed retrospectively.

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

Anesthesia

Anesthetics cause the partial or complete loss of sensation, with or without consciousness. Benefits for anesthesia are covered if and when required for certain procedures or surgeries.

General Anesthesia for Dental Care

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

- Six years of age or younger or is physically or developmentally disabled; or
- An individual who has a medical condition that the person's 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.

Anesthesia must be administered within a hospital or ambulatory surgical center.

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® (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.

Autologous Blood Donation/Blood Transfusions

Autologous blood donations are those in which the blood being transfused was donated by the patient during surgery. Blood transfusions are the replacement of blood or one of its components, depending on the condition being treated.

Biofeedback

Biofeedback is a training program designed to develop one's ability to control the involuntary nervous system. After learning the technique, the patient may be able to control heart rate, blood pressure, and skin temperature or to relax certain muscles. The patient learns by using monitoring devices that sound a tone when changes in pulse, blood pressure, brain waves, and muscle contraction occur. Then the patient attempts to reproduce the conditions that caused the desired changes.

Chemical Dependency

All inpatient admissions and partial hospitalizations require FCH pre-authorization 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.

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

Chiropractic Spinal Manipulation

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

Clinical Trials

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

An approved clinical trial is:

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

- The member or beneficiary provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

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

Costs Covered:

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

Costs Not Covered:

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

Dental Trauma

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

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

Diabetic Education and Diabetic Nutrition Education

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

Diagnostic Testing

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

Dialysis

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

Durable Medical Equipment (DME) and Supplies

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

Examples of DME include, but are not limited to:

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

This benefit also covers:

- **Breast pumps:** Benefits include electric, hospital grade, or manual breast pumps, as well as replacements of tubing, power adapters, breast shields, caps for breast pump bottles, polycarbonate bottles, and locking ring. Breast milk storage/freezer bags, breastfeeding supplies, including nursing pads, nipple shields, nipple cream, and nursing bras are not covered.
- **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, FCH pre-authorization required
- **Orthopedic appliances/braces:** These include appliances used to support abnormal joints, limit pressure on a joint after injury to allow it to heal
- **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 prudent layperson, 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, at home or away from home, seek the most immediate care available. To receive the network level of benefits, you must obtain all follow-up care from network providers. If you require out-of-network follow-up services, you must obtain a pre-authorization from FCH in order to receive your best benefits, unless the services are part of the post-stabilization treatment.

If you are admitted to an out-of-network hospital or facility, you are responsible for notifying FCH within 2 business days or as soon as reasonably possible (see the Medical Management section). FCH may arrange for your transfer to a network hospital, as soon as your condition permits, at no cost to you.

Family Planning

Voluntary sterilization procedures and FDA approved birth control methods are covered. Over-the-counter products are not covered (except as required under Healthcare reform through the prescription drug benefit). Oral and patch contraceptives are covered under the prescription drug benefit.

Termination of Pregnancy

Voluntary termination of pregnancy is covered for an employee or spouse only, not a dependent child.

Foot Orthotics

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

Genetic Services

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

Habilitative Services

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

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

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

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

Hearing Exams

Hearing exams to detect and/or prevent auditory deterioration are covered for employees and their dependents.

Hearing Aids/Appliances

Hearing aids and appliances are covered when needed for auditory deterioration. Costs for these device(s), repairs and other related services are all subject to the limit(s) noted within the Summary of Medical Benefits for Hearing Aids/Appliances.

Hip Replacement

Hip replacements are covered under this Plan, and *require FCH pre-authorization.* The facility charge is limited to a maximum of $35,000 per occurrence. It is very important that you confirm the actual cost with the facility prior to your surgery.

Please contact First Choice Health Customer Service at (888) 324-8356 for information regarding contracted facilities and providers for the Plan-authorized Bundled Payment Program. Contact the contracted facility or provider of your choice to confirm which services are covered in their Plan-authorized Bundled Payment Program.

Travel Benefit

Travel and lodging expenses for approved hip replacements are available for the member and his/her companion(s). **Travel and lodging expenses require FCH preauthorization**; and if authorized, are paid up to a maximum of $3,500 per Plan year. The maximum applies to all associated transportation, lodging and meal expenses incurred by the member and companion(s).

Home Health Care

FCH pre-authorization is required for wound therapy only, enteral formula, medical food and associated services. 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 and home infusion services.

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

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

This benefit is not intended to cover care in the home when FCH determines care in a skilled nursing facility or a hospital is more cost-effective. Any charges for home health care that qualify under this benefit and under any other benefit of this plan will be covered under the most appropriate benefit, as determined by FCH.

Hospice Care

FCH pre-authorization is required for inpatient and home hospice benefits. Hospice care is covered when prescribed by your physician and s/he has determined that life expectancy is 12 months or less and a palliative, supportive care treatment approach has been chosen. *Note: patients are not required to discontinue treatment or "curative care" in order to access the hospice benefit.* This benefit includes acute, respite, and home care to meet the physical, psychosocial, and special needs of a patient-family unit during the final stages of illness and dying. Hospice care is provided at a variety of levels to meet the individual needs of the patient-family unit. Levels offered are:

- **Intermittent in-home visits** are provided on an as needed basis by the hospice team, which includes health care professionals, support staff, and a twenty-four (24) hour a day "on-call" registered nurse. This level of care does not cover room and board while a member resides in a skilled nursing facility, adult family home, or assisted living facility.
- **Inpatient Hospice care** is needed when care cannot be managed where the patient resides. The care will be provided at an inpatient facility until the patient's condition stabilizes.
- **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 is required* (for all non-emergency inpatient admissions to a hospital or facility). Out-of-network maternity care and emergency admissions require notification to FCH within 48 hours as described under Medical Management.

Covered inpatient care includes room and board, operating room and anesthesia, radiology, lab and pharmacy services furnished by and used while in the hospital.

Hospital Outpatient Surgery and Services

Certain outpatient surgery/procedures *require FCH pre-authorization*; please refer to the list on page 5 for details. Covered outpatient care includes outpatient surgery, procedures and services, operating room and anesthesia, radiology, lab and pharmacy services furnished by and used while at a hospital or ambulatory surgical center.

Infertility Diagnostic Services

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

Infusion Therapy

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

Knee Replacement

Knee replacements are covered under this Plan, and *require FCH pre-authorization.* The facility charge is limited to a maximum of $35,000 per occurrence. It is very important that you confirm the actual cost with the facility prior to your surgery.

Please contact First Choice Health Customer Service at (888) 324-8356 for information regarding contracted facilities and providers for the Plan-authorized Bundled Payment Program. Contact the contracted facility or provider of your choice to confirm which services are covered in their Plan-authorized Bundled Payment Program.

Travel Benefit

Travel and lodging expenses for approved knee replacements are available for the member and his/her companion(s). **Travel and lodging expenses require FCH preauthorization**; and if authorized, are paid

up to a maximum of $3,500 per Plan year. The maximum applies to all associated transportation, lodging and meal expenses incurred by the member and companion(s).

Massage Therapy

Refer to *Alternative Care*.

Maternity and Newborn Care

First Choice Health offers the Maternity Management Program through a vendor relationship that provides prenatal education to help mothers carry their babies to term. To enroll, or if you want additional information, call (800) 756-7751.

Coverage for pregnancy and childbirth, for employees or his/her spouse (not dependents), 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 *Enrollment* section within the accompanying *Health and Welfare Plan Summary Plan Document* for details). Benefits are subject to the newborn child's own coinsurance and deductible requirements.

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

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

Mental Health Care

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

Care must be medically necessary and provided at the least restrictive level of care. Facilities offering inpatient level of care must have a medical model with physician and/or nursing staffing on site 24 hours each day.

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

Family and couples counseling is 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 covered under "Diabetic Education & Diabetic Nutrition Education" benefit.

Nutritional and Dietary Formulas

FCH pre-authorization required. Coverage for dietary formulas and nutritional supplements are covered when medically necessary. The following conditions must be met:

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

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

Oral Surgery

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

- The reduction or manipulation of fractures of facial bones;
- Excision of lesions, cysts, and tumors of the mandible, mouth, lip or tongue; and
- Incision of accessory sinuses, mouth salivary glands or ducts; and,
- Extraction of teeth when related to radiation therapy for head and/or neck cancer.

Organ and Bone Marrow Transplants

FCH pre-authorization is required for transplant service; and, there is a 12-month waiting period for this benefit. The waiting period can be offset by providing documentation that would show proof of coverage from your prior health Plan(s). The waiting period will be reduced by the number of months of prior coverage, as long as it did not occur before a significant break in coverage of more than 63 days. 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**,** except as outlined under the *Clinical Trials* Benefit. FCH pre-authorization approval for transplants is based on these criteria:

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

Note: Corneal transplants are covered under the medical-surgical benefit, and not under the transplant benefit.

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

Email:
preauthorization@fchn.com

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

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

Recipient Services

Covered transplant recipient services include:

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

Donor Services

Donor expenses are covered if all criteria are met below:

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

Covered donor expenses include:

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

When both the recipient and the donor are participants under this Plan, covered charges 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. The covered donor and recipient will each be eligible to receive the organ and tissue transplant lifetime benefit maximum.

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 covered under this Plan. However, complications arising from the donation would be covered as any other illness to the extent that they are not covered under the recipient's health plan.

Travel expenses

Travel and lodging expenses for approved transplants and associated pre-transplant evaluations are available for the recipient and his/her guardian/caregiver and the donor. **Travel and lodging expenses require FCH preauthorization**; and if authorized are paid up to a maximum of $2,500 per transplant episode, if the recipient is required to travel 30 miles or more from his or her home zip code for the medically necessary services related to an approved transplant, or if the facility requires the patient to remain within a certain distance of the facility during the transplant process. The maximum applies to all associated transportation, lodging and meal expenses incurred by the transplant recipient and companion(s).

Plastic and Reconstructive Services

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

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

Women's Health and Cancer Rights Act of 1998

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

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

Podiatric Care

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

Preventive Care

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

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

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

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

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.

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

Rehabilitation Therapy

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

- Services are to restore and significantly improve function that was previously present but lost due to acute injury or illness;

- Services are not for palliative, recreational, relaxation or maintenance therapy; and,
- Loss of function was not the result of a work-related injury.

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

Inpatient Rehabilitation

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

Outpatient Rehabilitation

Outpatient rehabilitation benefits are subject to the following provisions:

- You must not be confined in a hospital or other medical facility, and

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

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

Skilled Nursing Facility

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

Temporomandibular Joint Syndrome (TMJ)

FCH pre-authorization is required for inpatient admissions related to TMJ. Orthodontia for TMJ is not a covered benefit. Medical and surgical services are those which are:

- Reasonable and appropriate for the treatment of a disorder of the Temporomandibular joint;
- Effective for the control or elimination of one or more of the following conditions caused by a disorder of the Temporomandibular joint: pain, infection, disease, difficulty in speaking, or difficulty in chewing or swallowing;
- Not experimental or investigational as determined by FCH**,** except as outlined under the *Clinical Trials* Benefit; and
- Not primarily for cosmetic purposes.

Transgender/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), and hormonal and gender affirming surgical treatments. Gender affirming surgical treatments are limited to members age 18 and older. The services are provided as any other benefit (cost shares are indicated in the *Summary of Benefits*). Transportation and lodging are not covered. FDA approved medications and/or therapies for support and treatment of transgender related services are covered through the *Pharmacy Benefit.* **Pre-authorization is required for any gender affirmation surgery and inpatient admission.**

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

Vision

Eye Exam

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

Hardware

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

- **Elective Contact Lenses -** Coverage is provided for elective contact lenses and are covered up to the hardware maximum noted in the Summary of Medical Benefits grid. A contact lens exam, a special exam in addition to your routine eye exam for ensuring proper fit of your contacts and evaluating your vision with the contacts, is also covered, subject to the hardware maximum.
- **Spectacle Lenses** – Single vision, progressive, bifocals, etc. are covered up the hardware maximum noted in the Summary of Medical Benefits grid.

Hardware Extras

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

Hardware allowance can be used anywhere, however, FCHN contracted discounted amounts will apply if the provider (whether individual provider or optical hardware facility) is participating.

Wigs

Coverage for wigs is provided if needed due to chemotherapy, radiation therapy or surgery.

Summary of Pharmacy Benefits

First Choice Health Network, Inc. Health and Welfare Plan – Pharmacy Please see "Filling a Prescription" for details on where and how to obtain your prescription drugs whether through retail, pharmacy or specialty pharmacy.			
	Applies to Deductible	**Applies to OOP Max**	**Benefit Coverage**
Pharmacy	Administered by Prescryptive		
• Network Pharmacy (retail 30- or 90-day supply)	Yes	Yes	Generic: 90% Preferred: 80% Non-preferred: 50%
• Mail order through Prescryptive mail order partner	Yes	Yes	Generic: 90% Preferred: 80% Non-preferred: 50%
• Specialty pharmacy (30-day supply only)	Yes	Yes	80% Maximum copay for generics only: $100
• ACA mandated immunizations and medications at 100% coverage (retail 30- or 90-day supply)	N/A	N/A	100%
Selected Maintenance Medications Benefit (Generics/Preferred Brands only) *Available at formulary tier at "First Dollar" prior to meeting deductible*	Healthy Values Medications List Administered by Prescryptive		
• Anti-coagulants • Anti-convulsants • Anti-depressants • Anti-psychotics • Asthma/COPD • Blood thinners • Cardiac Rx (diuretics, ACEs, ARBs, CCB, BB, Nitrates, Digoxin) • Diabetes and diabetic supplies • Lipids • Osteoporosis	N/A	Yes	Generic: 90% Preferred: 80%

Pharmacy Benefits

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

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

You may order up to a 90-day supply from a retail network pharmacy. Alternatively, you may order a 90-day supply through Walmart Mail Order service. If you use the mail order service, you pay the 90-day copay even if your prescription is written for less than a 90-day supply. See "Filling a Prescription" below for more detailed information on how and where you can obtain your prescription drugs.

The *Summary of Pharmacy Benefits* notes the coinsurance amounts for which you are responsible. To assist in keeping your out-of-pocket costs down when purchasing a prescription, it may be helpful to know what is included in your drug formulary:

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

You are encouraged to choose a generic drug when available. A generic drug is a drug that is the pharmaceutical equivalent with the same active ingredient to one or more brand name drugs. Such generic drugs have been approved by the Food and Drug Administration as meeting the same standards of safety, purity, strength and effectiveness as the brand name drug. As Generic drugs generally cost less than the Brand Drug, your cost share will be less than if you filled the Brand Drug.

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

Preventive Drug Benefit

Certain generically available medications are covered at a $0 copay for members as required by the Affordable Care Act (ACA). These medications are identified as Tier 0 drugs in the preferred drug list and are provided at no cost if the member has a valid prescription.

The following is a summary of Tier 0 Preventive Medications. Find a full list of Preventive Medications at www.prescryptive.com/member.

- Generic low dose aspirin
- Fluoride
- Folic acid
- Iron
- Prescription contraceptives
- Breast cancer prevention
- Non-travel related vaccines not covered by medical benefit

- Bowel preparations for colorectal cancer screening
- Statins at doses used to prevent heart attack and stroke
- Smoking cessation

'First Dollar' Preventive Drug Pharmacy Benefit

The Plan offers first dollar coverage on certain preventive Safe Harbor medications needed to manage conditions such as hypertension, high cholesterol, diabetes, asthma or osteoporosis. Members can receive certain maintenance medications at their benefit co-insurance prior to meeting their deductible. A list of these medications, called the Healthy Values Medications List, can be found at the member portal: www.prescryptive.com/member.

Filling a Prescription

Following are details for filling a prescription through the retail network pharmacy or mail order. Contact Prescryptive Health, Inc. for any questions on filling a prescription. If you need assistance in determining if your local pharmacy is part of the Prescryptive pharmacy network, you may call Prescryptive Member Services anytime at (206) 686-9016, or log in to your pharmacy member portal at www.prescryptive.com/member.

Prescryptive guarantees that all prescriptions will meet the highest pharmaceutical standards for safety, quality and effectiveness. A record of your prescriptions is maintained by Prescryptive.

Retail Network Pharmacy

With the retail pharmacy program, you may receive up to a 30-day or 90-day supply of medication.

An extensive nationwide network of pharmacies has agreed to dispense covered prescription drugs to the FCH's Plan participants at a discounted cost and not to bill you for any amounts over the copays. Many chain and independent pharmacies participate in the Prescryptive retail network. Please refer to your pharmacy member portal at www.prescryptive.com/member or contact Prescryptive member services. A partial list includes:

- Albertsons
- Bartell Drug
- Bi-Mart
- Sam's Club
- Fred Meyer
- Kroger
- QFC
- Safeway
- Costco
- Walgreens
- Wal-Mart

Mail Order

If you, or a covered family member, regularly take medication for chronic, long-term conditions such as diabetes, arthritis, high blood pressure, heart conditions, etc., you can choose to have your 90-day supply mailed to you by Prescryptive's mail order pharmacy partner, Walmart Mail Order. You can sign up for this mail order service with 3 simple steps. Set up an account with Walmart Mail Order by calling (800) 273-3455. Ask your physician to send your prescription electronically to Walmart Mail Order.

Specialty Pharmacy Program

This program supports patients with complex health conditions who are taking injectable medications or other medications with strict compliance requirements or special storage needs. To receive these drugs, you now must purchase them through Amber Pharmacy. You may receive your medications via delivery to your home, workplace, physician's office, or any other designated location. For additional information, please contact Amber Pharmacy at (206) 413-9371.

Non-network Pharmacy

If necessary, you may obtain your prescription through a non-network pharmacy. The coinsurance would be the same as a retail pharmacy coinsurance, however you would need to pay full price and obtain reimbursement through Prescryptive. Prescryptive will reimburse you their cost of the drug, minus the applicable coinsurance amount. There may be a difference between their cost and the non-network pharmacy's cost; any difference would also be your responsibility. To obtain reimbursement, you may fill out the Direct Member Reimbursement form and submit it to Prescryptive. The Direct Member Reimbursement form can be found at www.prescryptive.com/member. Please contact Prescryptive Member Services at (206) 686-9016 with any questions.

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. This does not apply to covered expenses rendered by a medical facility owned or operated by the United States Veterans Administration when the services are provided to a participant for a non-service related illness or injury. The exclusion also does not apply to covered expenses rendered by a United States military medical facility to participants who are not on active military duty.
- Any condition resulting from declared or undeclared acts of terrorism, war, military service, participation in a riot or civil disobedience.
- Any service not medically necessary for the diagnosis, treatment or prevention of injury or illness, even if it is not specifically listed as an exclusion.
- Any service received before the participant's effective date of coverage or after the coverage termination date.
- Applied Behavior Analysis (ABA) Therapy - 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, including but not limited to:
  - Replacement of a gastric band, regardless of whether the initial placement was covered under this Plan. (**However, gastric band adjustments will be covered for members whose gastric band placement was covered under this Plan**)
  - A second bariatric surgical procedure or revision of bariatric surgery, regardless of whether the initial procedure was covered under this Plan.

  - Complications related to any type of bariatric surgery, unless the surgery was covered under this Plan
- Benefits relating to any condition, illness, or injury for which the participant receives compensation or reimbursement through another contractual arrangement or benefit, other than employer-based disability payments, such as surrogate pregnancy.
- Botanical or herbal medicines, as well as other over-the-counter medications unless otherwise covered as required by Healthcare Reform Regulations.
- Care provided by phone, fax, e-mail, or Internet except telemedicine (see *Plan Definitions* in the accompanying Health and Welfare Plan Summary Plan Document).
- 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
  - Any care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior
  - Chemical dependency benefits not specifically listed
  - Court-ordered or other assessments to determine the medical necessity of court-ordered treatments
  - Court-ordered treatments or treatments related to deferral of prosecution, deferral of sentencing or suspended sentencing or treatments ordered as a condition of retaining driving rights, when no medical necessity exists
  - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
  - Emergency patrol services
  - Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program
  - Information or referral services
  - Information schools
  - Long-term or custodial care
  - Non substance related disorders
  - Pain management and/or stress reduction classes
  - Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs
  - Treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required
- Claims for services that are the result of any injury or illness incurred by a participant while that participant is participating in the commission of a felony, unless the injury or illness is the result of domestic violence or a physical or mental health condition. Actively participating does not include being at the scene of a violent disorder or riot while performing his or her official duties.
- Court ordered examinations or treatment of any kind, except when medically necessary.
- Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational and custodial services are not covered.
- Dental, oral surgery or orthodontic related services, such as (but not limited to) those listed below (unless accident related or otherwise specifically covered by the Plan):
  - Care of the teeth or dental structures

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

  - Custodial care or maintenance care, except palliative care to the terminally ill patient subject to the stated limits
  - Financial or legal counseling services
  - Housekeeping or meal services
  - Services by a participant or the patient's family or volunteers
  - Services not specifically listed as covered hospice services under the Plan
  - Supportive equipment such as handrails or ramps
  - Transportation
- Immunizations for travel or work, except those specifically noted as being covered.
- Infertility treatments to achieve pregnancy (regardless of the cause) including but not limited to:
  - Artificial insemination
  - In vitro fertilization (IVF)
  - Gamete intra-fallopian transplant (GIFT)
- Lab and 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
  - 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
  - Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program
  - Marriage and family therapy, in the absence of an approved mental health diagnosis
  - Nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories
  - Pain management and/or stress reduction classes
  - Sensitivity training
  - Sexual dysfunctions, personality disorders, and paraphilic disorders
  - Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs
- Non-covered services or complications arising from non-covered services. Non-covered services include those services that would not have been covered by this Plan at the time the complication arose.
- Non-duplication of payment/coordination of benefits to prevent double coverage, benefits under this Plan will not be paid for expenses that are reimbursed by other insurance companies, medical plan, or subscriber contracts
- Non-emergent maternity services for dependent children, except as covered under the Patient Protection and Affordable Care Act (ACA)
- Orthodontia for Temporomandibular Joint Dysfunction (TMJ).
- Orthodontic treatment, appliances or services; dentures or related services.
- Organ and Bone Marrow Transplant services listed below:
  - Animal-to-human transplants;
  - Artificial or mechanical devices designed to permanently replace human organs;
  - Complications arising from the donation procedure if the donor is not a Plan participant;

- Donor expenses for a Plan participant who donates an organ or bone marrow (however, complications from the donation are covered as any other illness to the extent they're not covered under the recipient's health plan);
- Transplants considered experimental and investigational.

- Orthodontic treatment, appliances or services; dentures or related services.
- Over-the-counter products, except as covered by the Plan.
- Personal, convenience or comfort services, house cleaning, house call home visits from a doctor, supplies, or items including but not limited to phones, TVs, guest services, deluxe or suite hospital room, air conditioners, diapers or hygiene items.
- Pharmacy, the following items are not covered under the Prescryptive pharmacy benefit:
  - Anabolic steroids, unless specifically pre-authorized;
  - Anoretics (any drug for the purpose of weight loss);
  - Anti-wrinkle agents, in all dosage forms, for cosmetic purposes (e.g. Retin A, Renova, tretinoin);
  - Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order;
  - Botanicals and herbal medicines;
  - Charges for the administration or injection of any drug, except immunizations specifically covered by the Plan;
  - FDA Approved High Dollar Non-Essential Drugs: New drug formulations and derivatives of similar agents already marketed, or combinations of agents that provide no additional clinical benefit to the currently available medications.
  - High dollar kits and non-FDA approved patches;
  - Immunization agents, blood or blood plasma, except those immunizations specifically covered by the Plan;
  - Infertility medications (e.g. Clomid, Metrodin, Pergonal, Profasi);
  - Injectable drugs that are not normally self-administered;
  - Investigational or experimental drugs, including drugs labeled "Caution-limited by Federal law to investigational use", even if there is a retail or wholesale charge for such drugs;
  - Lost, stolen, spilled or replacement prescriptions;
  - Medical foods
  - Minoxidil (Rogaine) or any other medications used for the treatment of alopecia (hair loss);
  - Non-approved medications;
  - Non-Federal Legend Drugs and over-the-counter (OTC) products and/or drugs available without a prescription, or for which there is a nonprescription equivalent available, except certain over-the-counter medications required by the Patient Protection and Affordable Care Act, (when prescribed);
  - Over-the-counter-equivalent medications;
  - Over-the-counter contraceptive methods and supplies (for example, jellies, creams, foams, condoms or devices) without a prescription even if used in conjunction with covered equipment or supplies;
  - Prescription medications for the treatment of a non-covered condition;
  - Products used for cosmetic purposes;
  - Refills dispensed after one (1) year from the date of the prescription order, any refill in excess of the quantity specified by the physician, unauthorized refills of any medication;
  - Retin-A for individuals over the age of 25;
  - Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, unless covered as diabetic supplies (see above);
  - Travel immunizations;

  - Use of FDA approved drugs, medications, and other items for non-approved indications, except when an FDA approved drug has been proven clinically effective for the treatment of such indication and is supported in peer-reviewed scientific medical literature; and
  - Vitamins and fluoride, singularly or in combination, except generic legend prescription prenatal vitamins and legend fluoride supplements (oral tablets or drops only) are covered or legend vitamins used for treatment of a documented medical condition/ deficiency.
- 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 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, examples include but are not limited to: rhinoplasty; implants, penile or otherwise; liposuction or other procedures for the removal of adipose tissues; or,
  - Dermabrasion, chemical peels or skin procedures to improve appearance or to remove scars or tattoos.
- Procedures, regardless of medical necessity, outside the scope of the provider's license, registration or certification.
- 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 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; or,
- Services provided by a family member (spouse, parent or child).
- Services provided by a spa, health club or fitness center, except covered medically necessary services provided within the scope of the provider's license.
- Services provided by clergy.

- Services provided in a school setting (such as early learning and K-12).
- Snoring treatment (surgical or other).
- Special diets, nutritional supplements, vitamins and minerals or other dietary formulas or supplements, except as covered by the Plan.
- Special education for the developmentally disabled.
- Specialized intraocular lenses associated with cataract surgery that correct vision disorders, such as Multifocal and Toric intraocular lens.
- Surgery, non-surgical treatment, programs or supplies intended to result in weight reduction, regardless of diagnosis, except as covered by the plan.
- Surrogate mother charges, unless the surrogate mother is eligible under the plan at the time the services were rendered.
- Tobacco Cessation programs (except the American Lung Association Freedom from Smoking program)
- Tooth damage due to biting or chewing.
- Transgender/Gender Affirming Services
  - Services that are considered cosmetic (including but not limited to):
    - Abdominoplasty
    - Blepharoplasty
    - Calf Implants
    - Cheek/malar implants
    - Chin augmentation (reshaping or enhancing the size of the chin)
    - Collagen injections
    - Cryothyroid approximations (voice modification surgery)
    - 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
    - Rhinoplasty
  - Travel and lodging
- Transportation, except as covered by the plan.
- Treatment furnished without charge or paid directly or indirectly by any government or for which a government prohibits payment of benefits.
- Vision, the following vision benefits are not covered:
  - Non-prescription sunglasses or safety glasses;
  - Radial keratotomy, Lasik or any other refractive surgery, orthoptics, pleoptics, visual therapy, visual analysis therapy or training related to muscular imbalance of the eye; optometric therapy;
  - Services or supplies received principally for cosmetic purposes other than contact lenses selected in place of eyeglasses;
- Vitamin B-12 injections except to treat Vitamin B-12 deficiency.

- Vocational rehabilitation, work hardening or training programs regardless of diagnosis or symptoms that may be present, or for non-medically necessary education.
- Weight management programs.

Eligibility and Enrollment

Eligible Classes of Employees

All active FCH employees who work a minimum of 20 hours per week are eligible to enroll in the Plan. Active part-time employees who are scheduled to work between 20 and 32 hours per week pay an additional premium expense due to their part-time status. In order to be considered eligible, you must have worked 1 full day.

Examples of employees that are considered non-eligible are those classified on FCH's books or records as:

- Leased or temporary employees;
- One that is enrolled as a dependent on another FCH employee's plan; or,
- One that has not completed a full first day of employment.

Enrollment Periods

Enrollment periods for eligible employees and dependents are:

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

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

How to Enroll

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

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

Open Enrollment

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

Under no circumstances will you be able to change the medical plan outside of open enrollment.

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

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

A change in status includes:

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

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

Involuntary Loss of Other Coverage

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

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

The Plan Administrator must receive a completed enrollment form within 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."

If an individual loses eligibility for coverage as a result of terminating employment or a general suspension of coverage under this Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a late enrollee.

Effective Date

Effective Date of Coverage for You

The employee's coverage will become effective on the first day of the calendar month following the date that the employee has satisfied: 1) the eligibility requirement noted under "Eligible Classes of Employees" on page 3 and, 2) the Plan is in receipt of the completed enrollment form.

Effective Date of Coverage for Your Dependents

If you have one or more eligible dependents on the date that you become covered under this Plan and you elect to insure them, they will be covered on the date your coverage becomes effective. Only dependents for which you have submitted an enrollment form and paid any required premiums will be covered. Your dependent will be considered a late enrollee if we do not receive the enrollment form and premium payment within 31 days (61 days in the case of birth, adoption or placement for adoption) of the date he or she is eligible for coverage. Late enrollments are not accepted.

Deferred Effective Date of Your Coverage or an Increase in Coverage

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

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

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

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

Special Rule

If an employee and spouse or domestic partner are both employees of FCH and are eligible for benefits, employees may not "double' cover each other as dependents.

If two FCH employees are married, one may enroll as the dependent on their spouse's/domestic partner's employee coverage. In such a case, the employee spouse/domestic partner enrolled as a dependent would not be eligible for employee only coverage in addition to their dependent coverage. Also, s/he would not be eligible to take advantage of the "Waiver of Group Health Benefits" cash-out option mentioned below.

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

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

If your spouse/domestic partner is eligible for other medical coverage and chooses to be covered under this First Choice Health Group Health Plan, you must pay a surcharge each month of $200. This monthly surcharge will be waived if your spouse/domestic partner is not eligible for other medical coverage.

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.

FCH provides a cash-out benefit of $250 a month to employees who opt to waive benefits. If two FCH employees are married or in a domestic partnership, and one opts to enroll as a dependent on their spouse's/domestic partner's employee coverage, this cash-out option is not available. If an employee waives medical coverage, the employee is still eligible for dental coverage.

Dependents

Dependent Eligibility - Medical Plan

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

- Lawful spouse "Lawful spouse (as defined by state law where the employee permanently resides)";
- Domestic Partner (same or opposite sex) who meets the criteria for eligibility (with a signed affidavit regarding eligibility of the Domestic Partner), see Plan Definitions;
- Unmarried or married natural child, adopted child, child placed with you for legal adoption, stepchild, or other legally designated ward through age 25; or,
- Unmarried or married natural child, adopted child, child placed with you for legal adoption, stepchild, dependent child of or other legally designated ward that a health care professional determines is not capable of self-sustaining employment due to a physical or developmental disability. Proof of such incapacity must be furnished to the Plan Administrator within 31 days of the date the child reaches the maximum dependent child age or the maximum full-time student age for dependent coverage. Thereafter, employees are required to resubmit proof of continued disability every two years.

Additional Information Applicable to All Plans

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;
- A spouse, Domestic Partner or child eligible for employee coverage under the Plan;
- Any person who is on active duty in any armed forces of any country;
- Your 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

- Domestic Partners who qualify for coverage under the terms and conditions of this Plan may only enroll during the open enrollment period.
- The Domestic Partner of an enrolled dependent is not eligible for coverage.
- Children of Domestic Partners are not eligible for Plan coverage.

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

Dependents Acquired Through Marriage

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

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

Dependent Children

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

Children of married FCH employees may enroll under only one (1) parent (see *Special Rule*).

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 details.)

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, Oregon, Alaska, Idaho, Montana, North Dakota, South Dakota, and Wyoming.

First Health Network is available for network benefits to:

- Participants who live outside the FCH care area due to work, COBRA or student status.
- All participants for emergency and urgent care when traveling.

(A full description of the provider networks is in your Medical, Vision and Pharmacy Benefits booklet under How to Obtain Health Services.)

Continued Eligibility for a Child who is Disabled

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

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

Contact the Plan Administrator for details and enrollment forms. For continued eligibility of a child who is disabled, the enrollment form must be received within 31 days of the date the child reaches the maximum dependent child age or the maximum full-time student age for dependent coverage. Thereafter, employees are required to resubmit proof of continued disability every two years.

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

FCH 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 in accordance with ERISA §609(c). The participant, the child's custodial parent, or a state agency administering Medicaid may submit notification.

A medical child support order:

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

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

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

If the medical child support order is a QMCSO:

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

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

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

Termination of Coverage

For participating employees, coverage ends at these events:

- Non-payment of a contribution that is your responsibility; coverage ends the last day for which you have made any required contributions.
- 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.
- The employee or any participant performs an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this policy.
- The policy is materially breached.
- The Plan Sponsor ceases to offer coverage in the group market under which this coverage is issued.

For participating dependents, coverage ends at these events:

- The date the participant's coverage ends for any reason.
- The last day for which any required Plan contributions are paid.
- The participant dies.
- The participating employee and spouse legally divorce (the Plan Administrator must receive a copy of the decree).
- 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 Document 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.
- 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.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

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

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

This Plan provides no greater COBRA rights than what COBRA requires. Nothing in this Health and Welfare Plan Summary Plan Document is intended to expand your rights beyond COBRA's requirements.

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

Who Is a COBRA Qualified Beneficiary?

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

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

Please note: Domestic Partners are not eligible for COBRA or other continuation of coverage.

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

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

Qualifying Events and Continuation Periods

Qualifying events and continuation periods are explained below:

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

When COBRA Coverage Ends

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

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

Note: Once COBRA coverage ends, it cannot be reinstated.

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 102% 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. Payments need to be sent directly to FCH, 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.

Election Requirements

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

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

What Coverage Must Be Offered When Electing COBRA?

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

- **Identical coverage** – the qualified beneficiary must be offered the opportunity to continue the coverage received immediately before the qualifying event.
- **Independent rights** – once a qualifying event occurs each qualified beneficiary has an independent right to elect continuation coverage. For example, if an employee and family are offered COBRA coverage, each individual can make an election. Although an active employee must be covered to cover a dependent, it is possible to have COBRA coverage for a dependent when the former employee does not elect to continue coverage.
- **Open enrollment** – Qualified beneficiaries must be notified of any benefit or carrier changes at open enrollment and be given the opportunity to change coverage just like active employees. Qualified beneficiaries have the same rights as active employees during open enrollment to add or drop family members, change coverages and change carriers, if available. However, if a qualified beneficiary adds a family member during open enrollment who was not previously covered, that added family member does not become a qualified beneficiary.
- **Modification of coverage** – if an employer modifies coverage for similarly situated active employees, the coverage for qualified beneficiaries must be modified similarly. Some examples of modifications include benefit enhancements, elimination of coverage and changes in carriers.

Other Continuation of Coverage

Leaves of Absence

Family Medical Leave Act of 1993 (FMLA) Leaves

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

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

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

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

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

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

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

Personal Leave of Absence

Plan benefits will continue to the end of the month you receive pay from vacation accruals as long as you have vacation time remaining and are receiving a paycheck. Benefits will then terminate at the end of the month for which you receive your last paycheck. (You will receive information about the option of continuing health benefits on a self-pay basis under COBRA.)

Medical Leave of Absence

Plan benefits will continue to the end of the month you receive pay from your sick and annual leave/vacation accruals. Once you exhaust all paid time (sick and vacation), benefits will terminate at the end of the month for which you receive your last paycheck. Eligible employees will receive information about the option of continuing health benefits on a self-pay basis under COBRA.

Military Leave

If you take a military leave, for active duty or training, you will be covered under FCH 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, vision, pharmacy, life insurance and long-term disability coverage will be reinstated on the date you return to the active payroll. You must submit a written request for reinstatement within 90 days of your discharge from active military service, or one year following a hospitalization which continues after you are discharged from active military service.

All Leaves of Absence

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

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 a 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 (First Choice Health Network, Inc.).

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

The Plan Sponsor (First Choice Health Network, Inc.) has final authority over appeals as the appropriate named fiduciary, however 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 under ERISA requirements, 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 pre-existing 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 (an ERISA mandated 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, and 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.
- 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 and pharmacy appeals for this Plan. First Choice Health Network, Inc. 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 and Pharmacy Appeals:

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

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 Health and Welfare Plan Summary Plan Document 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). FCH will provide you with any new or additional evidence or rationale and any other information and documents used in the appeal review of your claim without regard to whether such information was considered in the initial determination. Any such new or additional evidence or rationale and information will be provided to you sufficiently in

advance of the date a final decision on appeal is made in order to give you a chance to respond. 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, and such recommendation will be sent to the Plan Administrator (First Choice Health Network, Inc.) for a final decision. 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 under ERISA §502(a)(1)(b). **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 First Choice Health Network, Inc. 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 under ERISA §502(a)(1)(b) after you exhaust these claim procedures; the civil action must be filed within 180 days from your receipt of the Plan's final determination regarding your claim.

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.

Calculation of Benefit Payments

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

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

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

Example 1

Allowed Amount	**$150**
Amount this Plan would pay if primary	$135
- (minus) amount paid by Primary Plan	$100
= (equals)	$35 (this Plan's secondary payment)

Example 2

Allowed Amount	**$200**
Amount this Plan would pay if primary	$155
- (minus) amount paid by Primary Plan	$185
= (equals)	(-$30) (no payment is made by this Plan)

Important note: In these examples, and in most other claim situations using this calculation method, there is still a balance owed to the provider. This balance is your responsibility.

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

How Do I Know Which Plan is my Primary Plan?

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

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

   If you are a Medicare beneficiary, and Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (according the rules under *What if I'm Covered by Medicare?*) then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is secondary to the plan covering the person as a dependent.
2. Child covered under more than one plan:
   A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
      1) The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      2) If both parents have the same birthday, the plan that has covered the parent longest is the Primary Plan.

   B. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:
      1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This does not apply to any plan year during which benefits are paid or provided before the plan has actual knowledge of the court decree provision.
      2) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary
      3) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, or that the parents have joint custody without mentioning financial responsibility or responsibility for health care expenses, the birthday rule of the policy holders determines the order of benefits.
      4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the plans covering the child pay in the following order:
         a. The plan covering the custodial parent
         b. The plan covering the custodial parent's spouse

c. The plan covering the non-custodial parent

d. The plan covering the non-custodial parent's spouse

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits is determined as if those individuals were parents of the child.

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

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

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

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

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

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

5. **Length of coverage**: If none of the preceding rules establish which plan pays first, the plan that has covered the person the longest is primary. To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended. The start of a new plan does not include:

   A. A change in the amount or scope of a plan's benefits;

   B. A change in the entity that pays, provides or administers the plan's benefits; or

   C. A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

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

Note: This Plan is always primary to TRICARE, CHAMPVA, state Medicaid programs and the Indian Health Service (IHS).

What if I'm Covered by Medicare?

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

If your Medicare entitlement is due to:

- **Age:** If you are covered under this Plan as an active employee or a dependent of an active employee (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 Domestic Partner or COBRA qualified beneficiary and are also entitled to Medicare based on age, Medicare is primary
- **Disability:** If you are covered under this Plan as an active employee or dependent of an active employee (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 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

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

Meaning of Plan for COB

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

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

- The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts
- Medicare or other governmental benefits, as permitted by law

"Plan" does not include:

- Hospital indemnity coverage benefits or other fixed indemnity coverage
- Accident only coverage
- Specified disease or specified accident coverage
- School accident type coverages that cover students for accidents only, including athletic injuries, either on a twenty-four-hour basis or on a "to and from school" basis
- Benefits provided in long-term care insurance policies for non-medical service, for example, personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services
- Medicare supplemental policies
- A state plan under Medicaid
- A governmental plan, which, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

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

Claim Determination Period

The claim determination period used when applying this COB provision is the Plan year, September 1 through August 31.

Right of Recovery

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

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

Facility of Payment

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

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

Right to Receive and Release Information

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

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

Subrogation, Reimbursement, and Right of Recovery

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

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

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

Assignment of Rights (Subrogation)

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

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

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

Any reduction is subject to prior written approval by the Plan, or agent of the Plan who administers the Plan's subrogation, reimbursement recoveries.

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

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

Equitable Lien and Other Equitable Remedies

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

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

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

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

Obligation to Assist in the Plan's Reimbursement Activities

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

This cooperation includes providing the Plan with relevant information (including information concerning any other applicable insurance coverage that may be available such as automobile, home and other liability insurance coverage and coverage under another group health plan), providing the identity of any other person or entity and their insurers, if applicable) that may be obligated to provide payments or benefits on account of the same illness or injury for which the Plan made payments, signing and delivering documents the Plan reasonably requests, and obtaining the Plan's consent before releasing any

party from liability. If you enter into litigation or settlement negotiations regarding the obligations of other parties, you must not prejudice, in any way, the Plan's subrogation and reimbursement rights.

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

Health Insurance Portability and Accountability Act of 1996

Privacy Rights

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

Disclosures to the Plan Sponsor

The Plan may disclose your health information to First Choice Health, Inc., 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

6. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
7. 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 and Contributions

This Plan provides eligible employees and dependents with medical, vision and pharmacy benefit plans.

The cost of benefits provided through the component benefit plans will be funded in part by FCH contributions and in part by employee contributions. FCH 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.

FCH will make employer contributions in an amount that, at FCH'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 FCH's general assets. Employee contributions will be used in their entirety before using FCH's contributions to pay for the cost of such benefit.

The Plan will provide benefits in accordance with the requirements of all applicable laws, such as Consolidated Omnibus Budget Reconciliation Act of 1985, Health Insurance Portability and Accountability Act of 1996, Newborns' and Mothers' Health Protection Act of 1996 (see below) and Women's Health and Cancer Rights Act of 1998 (see below).

Special Rights

Newborns' and Mothers' Health Protection Act of 1996

Group health plans generally may not, under the federal law titled "Newborns' and Mothers' Health Protection Act of 1996", 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.

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; and,
- Treatment of physical complications in all stages of post-mastectomy reconstruction, including lymphedema.

Plan Administration

Funding

This Plan provides eligible employees and dependents with medical, vision, and pharmacy benefits.

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

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

The Plan will provide benefits in accordance with the requirements of all applicable laws, including but not limited to, the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996 , the Women's Health and Cancer Rights Act of 1998, 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 FCH's Human Resources Department. The Plan Administrator is responsible for:

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

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

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

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

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

Discretionary Authority

The Plan Administrator has the discretionary authority to interpret the Plan and to resolve any ambiguities under the Plan. The Plan Administrator also has the discretionary authority to make factual

determinations as to whether any individual is entitled to receive benefits under this Plan and to decide questions of Plan interpretation and of fact relating to the Plan. Plan Administrator decisions will be final and binding on all interested parties.

Collective Bargaining Agreements

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

Clerical Error

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

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

Statement of ERISA Rights

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, filed by the Plan with the US Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly Pension and Welfare Benefits Administration).
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report (Form 5500 Series) and an updated plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any is required by ERISA to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Continue Group Health Coverage

You may continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such

coverage. Review this Health and Welfare Plan Summary Plan Document and the documents governing your COBRA continuation coverage rights.

Assistance with Your Questions

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

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

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

Your Rights and Protections Against Surprise Medical Bills

What is Balance Billing (sometimes called Surprise Billing)?

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

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

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

You Are Protected from Balance Billing for Emergency Services

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

Your plan is subject to ERISA, so in general, state balance billing laws are inapplicable to your plan, unless your plan has voluntarily opted into compliance with state balance billing laws or unless the medical service at issue was performed in a state that has an All-Payer Model Agreement with Centers for Medicare & Medicaid Services (CMS), such as Maryland.

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

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **cannot** balance bill you and may **not** ask you to give up your protections not to be 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 on your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

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

Maryland:

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

Summary Plan Description and General Information

Plan Name:	First Choice Health Network, Inc.
Plan Year:	September 1 – August 31
Type of Plan:	Group health plan (a type of welfare benefit plan subject to ERISA provisions)
Plan Coverage Status:	This is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act.
Plan Number:	1
Original Effective Date:	June 1, 1985
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 claims.
Source of Contributions:	The company bears the entire cost of this benefit Plan, minus the participants' contribution.
Plan Sponsor:	First Choice Health Network, Inc. 600 University Street Ste. 1400 Seattle, WA 98101 (206) 292-8255
Plan Sponsor's Employer Identification Number:	91-1272766
Named Fiduciary:	First Choice Health Network, Inc. 600 University Street Ste. 1400 Seattle, WA 98101 / (206) 292-8255
Name, Address and Telephone Number of Plan Administrator:	First Choice Health Network, Inc. 600 University Street Ste. 1400 Seattle, WA 98101 / (206) 292-8255 Attn: HR/Plan Administrator

Third Party Administrator:	First Choice Health Network, Inc. d.b.a. First Choice Health 600 University Street, Suite 1400 Seattle WA 98101 (888) 324-8356 / Local: (206) 268-2360 www.fchn.com
Agent for Service of Legal Process:	Jaja Okigwe, President & CEO First Choice Health Network, Inc. 600 Union Street, Suite 1400 Seattle WA 98101
Plan Description:	The written Plan Description required by ERISA §402 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.

Care System means an organized group of providers, clinics and facilities who work together to coordinate the delivery of a patient's care.

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.

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

- Must be 18 or older;
- Must have an intimate, committed relationship of mutual caring that has existed for at least 12 months;
- Must be financially interdependent and share the same residence;
- Neither partner can be married or legally separated from any other person or involved in another domestic partner relationship;
- Partners must not be blood relatives of a degree of closeness that would prohibit marriage; and,

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Plan-authorized Bundled Payment Program is a contract with an established network of healthcare professionals and facilities to provide certain bundled medical procedures and services with separate rate agreements.

Plan Administrator means the department designated by an employer group to administer a plan on behalf of participants. For this Plan, Plan Administrator means the FCH 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 FCH plans 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 September 1 and ending August 31 of the next year.

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

Pre-authorization is the process of obtaining coverage determination from FCH before receiving inpatient and certain outpatient services, as specified in the component plans' benefit description booklets.

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

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

Provider directory is the listing of the network providers, hospitals, and other facilities that have agreed to provide covered services to FCH participants or dependents.

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 starting on page 3 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 member 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); and,
- 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 means the use of medical information exchanged from one site to another via both synchronous and asynchronous electronic communications.

- **Synchronous** communication includes the use of audio and video equipment permitting two-way, real time interactive communication between the patient and provider at a distant site (example: videoconference).
- **Asynchronous** (or "store and forward") communication includes the use of audio and video equipment that records and stores information to be sent to a provider at a distant site to be interpreted at a later time.

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; or,
- An abnormal range of motion or limited motion of the temporomandibular joint.

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

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

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

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

Usual, Customary and Reasonable (UCR) is the 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 400% 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.