First Choice Health®

MultiCare

MultiCare Health System
Flexible Benefits Program

Medical and Pharmacy Benefits

Standard PPO Plan
MyConnected Care Plan
High Deductible PPO Plan

Effective January 1, 2024

www.fchn.com

Puget Sound Region benefits

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

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Table of Contents

Important Information about this Plan

This booklet describes your coverage and payment levels, claim and appeal procedures, continuation coverage, definitions and how to use your benefits under the Standard PPO Plan, MyConnected Care Plan, and High Deductible PPO Plan – medical plan options offered under the MultiCare Health System Flexible Benefits Program (Plan) as of January 1, 2024. For information on eligibility and enrollment, terminating, administration, definitions and other details of the Welfare Benefit Plan, see the Flexible Benefits Program Summary Plan Description (SPD).

MultiCare Health System (MultiCare), 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), responsibility and authority to perform certain Plan services. However, MultiCare maintains the ultimate fiduciary authority, responsibility and control over Plan assets, management, and administration. First Choice Health Network, Inc. is not a fiduciary with respect to making claims determinations or interpreting terms of the Plan.

The benefit plan includes provider networks. The network tier structure is listed from least expensive to you to most expensive to you (out-of-network). Your out-of-pocket costs are lowest when you choose to get care from a Tier 1 MultiCare Connected Care Clinically Integrated Network (MCC CIN) provider. If you receive care from an out-of-network provider, you will receive the lowest level of benefits and your out-of-pocket costs are greatest.

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

Coverage under this Plan will take effect for eligible employees and dependents when all eligibility requirements are satisfied. MultiCare Health System expects 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 is amended or terminated, the rights of participants and beneficiaries are limited to charges incurred before amendment or termination. No oral interpretations can change this Plan.

This Medical and Pharmacy Benefits booklet is part of and should be read in conjunction with the MultiCare Health System Flexible Benefits Program Summary Plan Description (SPD). A copy of the SPD and, if desired, the formal legal document for the Plan, known as the MultiCare Health System Flexible Benefits Program plan document, is available from the MultiCare Human Resources Benefits Department. These materials do not create a contract of employment or any rights to continued employment with MultiCare Health System.

Contacting FCH Member Services

You may call FCH Member Services 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
Member Services Department
PO Box 12659
Seattle, WA 98111-4659
Toll free: (888) 889-1112

Local: (206) 268-2360
Fax: (888) 206-3092
Medical pre-authorization: (800) 808-0450
Mental health/chemical dependency pre-authorization: (800) 640-7682

TTY: (866) 876-5924
www.fchn.com

Spanish (Español): Para obtener asistencia en Español, llame al (888) 889-1112.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (888) 889-1112.

Chinese（中文）： 如果需要中文的帮助，请拨打这个号码 (888) 889-1112.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (888) 889-1112.

FCH's Member Services Department business hours are Monday through Friday, 8:00 AM to 5:00 PM Pacific Standard Time (PST).

You can access benefit information or your specific claim and enrollment status anytime at www.fchn.com or by calling FCH's Member Services automated voice response system at (888) 889-1112.

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 Member Services at (888) 889-1112, or logging into www.fchn.com. Under no circumstances should you give your ID card to another person for their use.

Choosing a Provider

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

Standard PPO Plan

Networks	State/Area	Phone	Website
MultiCare Connected Care Clinically Integrated Network (MCC CIN) (Tier 1)	Washington	(800) 231-6935	www.fchn.com/ProviderSearch
First Choice Health (except those noted in Tier 2 below) (Tier 1 – FCHN)	Washington, Alaska, Oregon, Idaho, Montana, Wyoming, North Dakota, South Dakota	(800) 231-6935	www.fchn.com/ProviderSearch
First Health (Tier 1 – FHN)	All states/areas not served by FCHN	(800) 226-5116	www.myfirsthealth.com/
Providence, Swedish, Virginia Mason Franciscan Health, Pacific Medical Center providers and facilities (Prov/Swed/VMFH/PacMed) (Tier 2)	Washington	(800) 231-6935	www.fchn.com/ProviderSearch
Out-of-Network (Tier 3)	Facilities/providers who are not contracted in any of the networks previously noted above.	N/A	N/A

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

MyConnected Care Plan and High Deductible PPO Plan

Networks	State/Area	Phone	Website
MultiCare Connected Care Clinically Integrated Network (MCC CIN) (Tier 1)	Washington	(800) 231-6935	www.fchn.com/ProviderSearch
First Choice Health (except those noted in Tier 3 below) (Tier 2 – FCHN)	Washington, Alaska, Idaho, Oregon, Montana, Wyoming, North Dakota, South Dakota	(800) 231-6935	www.fchn.com/ProviderSearch
First Health (Tier 2 – FHN)	All states/areas not served by FCHN	(800) 231-6935	www.myfirsthealth.com/
Providence, Swedish, Virginia Mason Franciscan Health, Pacific Medical Center providers and facilities (Prov/Swed/VMFH/PacMed) (Tier 3)	Washington	(800) 231-6935	www.fchn.com/ProviderSearch
Out-of-Network (Tier 4)	Facilities/providers who are not contracted in any of the networks previously noted above.	N/A	N/A

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

Contact First Choice Health directly for information on providers and/or provider directories.

MultiCare and the MultiCare Connected Care Clinically Integrated Network (MCC CIN) may not be able to offer all services required for your care. Each service you receive is paid based on the applicable network tier, and no exceptions are made if a service cannot be provided within a particular network (except Recognized Providers and Recognized No Surprises Providers).

Services Received Outside the U.S.

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

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

Continuity of Care

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

Medical Management

Pre-authorization Requirements

All inpatient admissions and certain outpatient services and procedures **require FCH pre-authorization**, unless noted as a benefit exclusion in your Summary Plan Document. If pre-authorization is not obtained on the services noted below, your claim may be denied. Submit requests via our Provider Portal at www.fchn.com/Providers#PreAuthorization or via fax to (888) 272-3289. For questions, call FCH at (800) 808-0450. *Emergency Services* do not need to be pre-authorized. Pre-authorization is required for:

- **Ambulance**
  - Air Ambulance Transport - non-urgent transport
  - Non-emergent ground or air ambulance transport to a MultiCare Health facility
- **Anesthesia for Dental Services**
- **Clinical Trials** (including all interventions/medications)
- **Dental Trauma Services** (follow-up services)
- **Durable Medical Equipment, Medical Supplies and Prosthetics**
  - Bone growth stimulators
  - Compression devices for home use
  - Custom and power operated wheelchairs and supplies
    - Standard, manual wheelchair rental for transition of care for up to 3 months does not require pre-authorization
  - 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
- **Enteral Formula, Medical Food and Associated Services**
- **Facet Joint Injections, Medial Branch Blocks and Neurotomies** (any location)
- **Gene, Immune, and CAR T-Cell Therapy**
- **Genetic Testing**
- **High Dose Rate Electronic Brachytherapy**
- **Hyperbaric Oxygen Therapy**
- **Imaging**
  - PET scans
- **Inpatient Admissions**
- **Medical Injectables, Chemotherapy and Other Drugs over $5,000/annually** (The following list includes drugs that may require pre-authorization and/or may require use of a designated specialty pharmacy provider, regardless if covered under Medical or Pharmacy Benefit. This list is not all inclusive. Newly FDA-approved drugs not included

on the list below may also require pre-authorization. For questions, call FCH at the number above.)

- Biosimilar or alternative comparable biologics (eg. Renflexis, Ogivri, Mcasi, Truxima) are preferred over originator biologics (eg. Remicade, Herceptin, Avastin, Rituxan) unless the patient has had an inadequate response or intolerance to biosimilars or alternative comparable biologics.
- Botulinum toxin A (Xeomin® is plan preferred for covered medical indications, cosmetic is not covered)
- 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

- **Organ and Bone Marrow Transplants** (covered only at qualified Centers of Excellence)
- **Peripheral Nerve Blocks** (except Occipital and Cranial)
- **Radiation Therapy**
  - Proton beam, neutron beam or helium ion radiation therapy
  - Stereotactic body radiation therapy (SBRT)
  - Stereotactic radiosurgery (Gamma Knife, CyberKnife)
- **Surgery**
  - BAHA-bone anchored hearing aid (surgical benefit applies)
  - Bariatric surgery (No benefit on the Standard PPO Plan)
  - Breast surgeries- selected (Pre-authorization is not required for breast reconstruction and nipple/areola reconstruction following mastectomy for breast cancer)
  - Cochlear implants (surgical benefit applies)
  - Cosmetic or reconstructive surgery
  - Deep brain stimulation
  - Fetal/Intrauterine surgery
  - Gender affirming surgery
  - Implantable peripheral nerve and/or spinal cord stimulator placement (temporary and permanent)
  - Leadless Pacemaker Placement & Removal
  - 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
- **Select Bioengineered Skin/Amniotic and Soft Tissue Products**

- **Transcranial Magnetic Stimulation**

The medical pre-authorization number is (800) 808-0450 and the mental health and chemical dependency pre-authorization number is (800) 640-7682.

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.

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

Notification for Emergency Admissions

Admissions directly from the emergency department do not require pre-authorization. However, notification is required within two (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.

Care Management

Care Management services are provided by PSW Care Management. Case Management services for Organ and Bone Marrow Transplants are provided by First Choice Health (see *Transplants (Organ and Bone Marrow)* in the Medical Benefits section).

Enrolling in any MultiCare medical plan allows you and your covered dependents access to a Nurse Care Manager (NCM). We have partnered with PSW Care Management, a population health company to provide this service. The philosophy of PSW Care Management is to collaborate with you and your family to be a resource for coordinating care and services to support your needs and goals for health and well-being. The care management team serves as a catalyst to support you across the care continuum to improve health outcomes. Your Nurse Care Manager is employed by PSW Care Management, so all of your personal health information is completely confidential.

If you or a covered dependent have a sudden onset acute medical condition, are living with a chronic health condition, have an upcoming surgery or are starting a new treatment, your NCM can help. Your NCM works with you and your current providers to support your plan of care. This coordination of care can enhance decision-making related to your treatment plan in support of making your treatment more effective and less expensive for you. As a registered nurse who specializes in care management and in helping those with acute or chronic health conditions, your Nurse Care Manager is your expert resource for:

- Guidance when navigating the healthcare system
- Coordinating your healthcare providers to reduce the stress associated with management of a new diagnosis

- Phone outreach following emergency room visits or inpatient stays
- Making sure you get the right tests and treatment for your condition
- Helping you set personal goals for improving your health
- Answering any questions you may have about your condition, medication or treatment
- You can reach the PSW Care Management Team at (360) 786-8690, option 2.

Care management is a voluntary service. There is no reduction of benefits or penalty if you choose not to participate. Each treatment is individually tailored 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 you and your providers.

Payment Provisions

Standard PPO 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 will vary by network tier, but generally, your out-of-pocket costs are less when you choose a MultiCare Connected Care, First Choice Health, or First Health Network network provider (Tier 1 Network).
- Your benefit coverage will be lowest if you receive services from Prov/Swed/VMFH/PacMed or out-of-network providers (Tier 2 and Tier 3).
- When your annual out-of-pocket maximum is reached, the Plan will provide benefits for covered services at 100% of the allowed amount for the remainder of that Plan year.
- Certain services and procedures require pre-authorization.
- The Network facilities and providers may not be able to offer all services required for your care. Each service you receive is paid based on the applicable network tier of the provider or facility, and no exceptions are made if a service cannot be provided within a particular network (except Recognized Providers, as described below).
- Services received from a Recognized Provider (see *Plan Definitions*) will be paid at the appropriate tier or 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 amount paid by the Plan 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).
- 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.
- 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.

Annual Deductible – Standard PPO Plan

The annual deductible is the amount you (or your family) must pay each Plan year (January 1 – December 31) 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 Tier 1 annual deductible is exclusive of the Tier 2 and 3 annual deductible. Tiers 2 and 3 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
- Copayments
- Pharmacy
- Difference in price between a brand name and generic drug
- In Network Routine hearing exams; and
- In Network Tier 1 and 2 Preventive Care.

Deductible Carry-over: Covered expenses incurred during the last three months of a calendar year and applied to the deductible may also be applied to the next calendar year's deductible.

Prior Plan Deductible: If your employer replaces this Plan with another employer group plan during the plan year, 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 Member Services with questions regarding prior plan deductible credits.

Embedded Deductible: Each individual will meet no more than the individual deductible, but the family will meet no more than the stated family deductible amount (regardless of family size). In this case, some individuals may meet less than the individual deductible amount, if the family deductible is met.

Annual Out-of-Pocket Maximum – Standard PPO Plan

The annual out-of-pocket (OOP) maximum is the most you will need to pay in a Plan year. Once you have met the out-of-pocket maximum indicated, the Plan will provide benefits at 100%

of the allowed amount for the remainder of the Plan year. Tiers 1, 2, and 3 are inclusive of each other.

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

- Benefits paid at 100% (such as routine hearing exams);
- Claims denied for lack of required pre-authorization;
- 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 that exceed any applicable benefit maximum;
- Difference in price between a brand name and generic drug;
- Pharmacy out-of-pocket maximum; and
- Pharmacy coinsurances.

Embedded Out-of-Pocket Maximum: Each individual will meet no more than the individual out-of-pocket maximum, but the family will meet no more than the stated family out-of-pocket maximum amount (regardless of family size). In this case, some individuals may meet less than the individual out-of-pocket maximum amount, if the family out-of-pocket is met.

Annual Pharmacy Out-of-Pocket Maximum

The annual pharmacy out-of-pocket (OOP) maximum is the most you will need to pay in a Plan year. Once you have met the pharmacy out-of-pocket maximum indicated, the Plan will provide pharmacy benefits at 100% of the allowed amount for the remainder of the Plan year.

Benefits are not available through out-of-network pharmacies; the Pharmacy OOP maximum noted refers to prescriptions received through Network pharmacies only. Pharmacy expenses (coinsurances, etc.) do not apply to the medical deductible or out-of-pocket maximums.

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

Deductible and Out-of-Pocket Maximums	MultiCare Connected Care Network (MCC CIN) / First Choice Health Network (FCHN) / First Health Network (FHN) Tier 1	Prov/Swed/ VMFH/PacMed Tier 2	OON Tier 3
Annual Deductible (per Plan Year)			
Individual only	$600	$1,500	
Family	$1,800	$3,000	
Annual Out-of-Pocket Maximum (per Plan Year)			
Individual only	$3,200	$4,850	
Family	$8,300	$12,500	
Annual Pharmacy Out-of-Pocket Maximum (per Plan Year)			
Individual only	$1,500	N/A	
Family	$3,000	N/A	

Payment Provisions

MyConnected Care Plan

Provider Referral Waivers are available to MyConnected Care plan members when services are not available within MultiCare or the MultiCare MyConnected Care Clinically Integrated Network. This must be initiated proactively to the services by your MultiCare/MCC referring provider. All Provider Referral Waivers are reviewed by the MCC Medical Director for approval. Members will receive a determination letter for each Provider Referral Waiver. Provider Referral Waivers are not approved retrospectively.

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 will vary by network tier, but generally, your out-of-pocket costs are less when you choose a MultiCare Connected Care network provider (MCC CIN -Tier 1).
- You will receive the second-highest benefit coverage if you receive services within the First Choice Health or First Health Network (Tier 2 Network).
- Your benefit coverage will be lowest if you receive services from Prov/Swed/VMFH/PacMed or out-of-network providers (Tier 3 and Tier 4).
- When your annual out-of-pocket maximum is reached, the Plan will provide benefits for covered services at 100% of the allowed amount for the remainder of that Plan year.
- Certain services and procedures require pre-authorization.
- MultiCare and the MultiCare Connected Care Clinically Integrated Network (MCC CIN) may not be able to offer all services required for your care. Each service you receive is paid based on the applicable network tier of the provider or facility, and no exceptions are made if a service cannot be provided within a particular network (except Recognized Providers and Recognized No Surprises Providers).
- Services received from a Recognized Provider (see *Plan Definitions*) will be paid at the appropriate tier or 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).

- 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.
- 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.

Annual Deductible – MyConnected Care Plan

The annual deductible is the amount you (or your family) must pay each Plan year (January 1 – December 31) 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 MCC CIN deductible in Tier 1, is exclusive of the Tier 2, 3, and 4 annual deductibles. The Tier 2, 3, and 4 deductibles are inclusive of each other, so depending upon how you access care, you may be accumulating annual deductible expenses in two benefit tiers.

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;
- Pharmacy;
- Difference in price between a brand name and generic drug;
- In Network Routine hearing exams; and
- In Network Tiers 1, 2, and 3 Preventive Care.

Prior Plan Deductible: If your employer replaces this Plan with another employer group plan during the plan year, 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 Member Services with questions regarding prior plan deductible credits.

Embedded Deductible: Each individual will meet no more than the individual deductible, but the family will meet no more than the stated family deductible amount (regardless of family size). In this case, some individuals may meet less than the individual deductible amount, if the family deductible is met.

Annual Out-of-Pocket Maximum – MyConnected Care Plan

The annual out-of-pocket (OOP) maximum is the most you will need to pay in a Plan year. Once you have met the out-of-pocket maximum indicated, the Plan will provide benefits at 100% of the allowed amount for the remainder of the Plan year. The Tiers 1, 2, 3, and 4 out-of-pocket and coinsurance maximums are inclusive of each other.

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

- Benefits paid at 100% (such as routine hearing exams);
- Claims denied for lack of required pre-authorization;
- Charges for 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 that exceed any applicable benefit maximum;
- Difference in price between a brand name and generic drug;
- Pharmacy out-of-pocket maximum; and
- Pharmacy coinsurance.

Embedded Out-of-Pocket Maximum: Each individual will meet no more than the individual out-of-pocket maximum, but the family will meet no more than the stated family out-of-pocket maximum amount (regardless of family size). In this case, some individuals may meet less than the individual out-of-pocket maximum amount, if the family out-of-pocket is met.

Annual Pharmacy Out-of-Pocket Maximum

The annual pharmacy out-of-pocket (OOP) maximum is the most you will need to pay in a Plan year. Once you have met the pharmacy out-of-pocket maximum indicated, the Plan will provide pharmacy benefits at 100% of the allowed amount for the remainder of the Plan year.

Benefits are not available through out-of-network pharmacies; the Pharmacy OOP maximum noted refers to prescriptions received through Network pharmacies only. Pharmacy expenses (coinsurances, etc.) do not apply to the medical deductible or out-of-pocket maximums.

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

Deductible and Out-of-Pocket Maximums	MCC CIN Tier 1	FCHN/FHN Tier 2	Prov/Swed/ VMFH/PacMed Tier 3	OON Tier 4
Annual Deductible (per Plan Year)				
Individual only	$0 for services with MCC $500 for Emergency Care only	$1,500	$2,000	
Family	$0 for services with MCC $1,000 for Emergency Care only	$4,500	$6,000	
Annual Out-of-Pocket Maximum (per Plan Year)				
Individual only	$3,100	$6,500		
Family	$6,200	$15,000		
Annual Pharmacy Out-of-Pocket Maximum (per Plan Year)				
Individual only	$1,500		N/A	
Family	$3,000		N/A	

You receive the highest level of benefit coverage for care at the MultiCare Connected Care network (MCC CIN).

Payment Provisions

High Deductible PPO 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 will vary by network tier, but generally, 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 covered services at 100% of the allowed amount for the remainder of that Plan year.
- Certain services and procedures require pre-authorization.
- Services received from a Recognized Provider (see *Plan Definitions*) will be paid at the appropriate tier or 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 amount paid by the Plan 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.
- The Network facilities and providers may not be able to offer all services required for your care. Each service you receive is paid based on the applicable network tier of the provider or facility, and no exceptions are made if a service cannot be provided within a particular network (except Recognized Providers, as described below).
- 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).
- 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.
- 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.

The MultiCare Health System High Deductible PPO Plan is a qualifying high deductible health plan under Code §223(c)(2). It is eligible to be paired with a Health Savings Account (HSA).

Annual Deductible – High Deductible PPO Plan

The annual deductible is the amount you (or your family) must pay each Plan year (January 1 – December 31) 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 Tiers 1, 2, 3, and 4 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;
- In Network Routine hearing exams; and
- In Network Tier 1 & 2 Preventive Care.

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. When only one member is covered by the Plan, only the "employee only" deductible amount indicated in the grid above needs to be met. The deductible must be met in full before any coinsurance applies. The network and out-of-network Plan year deductibles are inclusive of each other.

Annual Out-of-Pocket Maximum – High Deductible PPO Plan

The annual out-of-pocket (OOP) maximum is the most you will need to pay in a Plan year. Once you have met the out-of-pocket maximum indicated, the Plan will provide benefits at 100% of the allowed amount for the remainder of the Plan year. Tiers 1, 2, 3, and 4 annual out-of-pocket maximums are inclusive of each other.

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

- Benefits paid at 100% (such as routine hearing exams);
- Claims denied for lack of required pre-authorization;
- 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; and
- Charges that exceed any applicable benefit maximum.
- Difference in price between a brand name and generic drug.

Embedded Out-of-Pocket Maximum: Each individual will meet no more than the individual out-of-pocket maximum, but the family will meet no more than the stated family out-of-pocket maximum amount (regardless of family size). In this case, some individuals may meet less than the individual out-of-pocket maximum amount, if the family out-of-pocket is met.

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

Deductible and Out-of-Pocket Maximums	MCC CIN Tier 1	FCHN/FHN Tier 2	Prov/Swed/ VMFH/PacMed Tier 3	OON Tier 4
Annual Deductible (per Plan Year)				
Individual only	$1,600		$2,500	
Family	$3,200		$5,000	
Annual Out-of-Pocket Maximum (per Plan Year)				
Individual only	$3,500		$6,500	
Family	$6,850		$13,000	

You receive the highest level of benefit coverage for care at the MultiCare Connected Care Network (MCC CIN).

Benefit Maximums – All Plans

Below is a summary of benefit and Plan Year maximums applicable to the Standard PPO Plan, MyConnected Care Plan, and High Deductible PPO Plan. Note the High Deductible PPO Plan is referred to as HDHP within the Benefit Summary tables, except where a difference is indicated. Benefit visit and dollar maximums listed in this section apply to network benefits and out-of-network benefits combined.

Lifetime Maximum Benefits	
Bariatric Surgery	$50,000 (This benefit available for MCC and HDHP Plans only. Benefit exclusion on Standard PPO Plan.)
Organ Transplants Benefit subject to 6-month waiting period. • Transportation/Lodging	$3,000 per episode
Calendar Year Maximums	
Acupuncture	12 visits
Chiropractic Spinal Manipulation	16 visits
Hearing Aid and Appliances	$2,000 every 3 Calendar years
Hearing Exams	1 exam
Home Health Care	130 visits
Hospice • **Hospice Care** • **Respite Care** (minimum of 4 hours per day)	14 inpatient days per 12-month period 30 day maximum within 12-month period
Massage Therapy	20 visits
Obesity Counseling, visits 1- 12	12 visits
Obesity Counseling, visits 13 – 20	8 visits (This benefit available for MCC and HDHP Plans only. Benefit exclusion on Standard PPO Plan.)
Out of Network (OON) Inpatient Admissions	10 admissions

Rehabilitation Therapy • **Inpatient** • **Outpatient/Cardiac Rehabilitation** (Speech, Occupational, and Physical)	30 days (spinal cord injuries are allowed an additional 15 days) 45 visits
Skilled Nursing Facility	90 days
Wigs	1 per Plan year

Participant Reimbursement Liability

Remember, for the MyConnected Care and High Deductible PPO Plans, your care must be from network providers from Tiers 1, 2, or 3 to be covered at the Tiers 1, 2, or 3 network levels. For the Standard PPO Plan, your care must from network providers from Tiers 1 or 2 to be covered at the Tiers 1 or 2 network levels. 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 service.

Summary of Medical Benefits

Tier	MyConnected Care Plan and HDHP Plan Networks
Tier 1	MultiCare Connected Care Clinically Integrated Network (MCC CIN)
Tier 2	First Choice Health and First Health Network providers and facilities (FCHN/FHN)
Tier 3	Providence, Swedish, Virginia Mason Franciscan Health, Pacific Medical Center providers and facilities within the State of Washington (Prov/Swed/VMFH/PacMed)
Tier 4	Out-of-Network (OON)

Tier	Standard PPO Plan Networks
Tier 1	MultiCare Connected Care Clinically Integrated Network (MCC CIN), First Choice Health and First Health Network providers and facilities (FCHN/FHN)
Tier 2	Providence, Swedish, Virginia Mason Franciscan Health, Pacific Medical Center providers and facilities within the State of Washington (Prov/Swed/VMFH/PacMed)
Tier 3	Out-of-Network (OON)

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
Allergy Care	✓	✓	90%	50%			80%	50%		90%	70%	50%	
Alternative Care	***** MyConnected Care Plan "Network" Benefits apply to Tier 1 Out-of-Pocket. No deductible.												
• **Acupuncture*** Maximum 12 visits per Plan year.	✓ *	✓ *	90%		50%		80%	50%		90%		50%	
• **Massage Therapy*** Maximum 20 visits per Plan year.	✓ *	✓ *	90%		50%		80%	50%		90%	70%	50%	

Providence, Swedish, Virginia Mason Franciscan Health, and Pacific Medical Center is for any of their providers or facilities within Washington State.
Any Out-of-Network Inpatient Admissions are limited to 10 per calendar year combined.
Reminder: The High Deductible PPO Plan is referred to within the table as "HDHP."

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
Ambulance Services FCH pre-authorization required for non-emergent air ambulance.													
• **Ambulance services** (transfers from a MultiCare Health Facility to a non-MultiCare facility will process under the Tier 2 FCHN Benefit level on MyConnected Care plan and HDHP Plan. On the Standard PPO plan, they will process under the Tier 1 Benefit)	✓	✓	90%				80%			90%			
• **Ground ambulance transfers to a MultiCare Health Facility** (non-emergent requires FCH pre-authorization)	✓	✓	100%				100%			100%			
Anesthesia													
• **Anesthesia** (in general)	✓	✓	90%				80%			90%			
• **Anesthesia related to dental services** (Limited benefit, see Anesthesia for details)	✓	✓	90%				80%			90%			

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
Applied Behavior Analysis (ABA) Therapy Inpatient/Outpatient (facility or professional) -- * *MyConnected Care Plan "Network" Benefits apply to Tier 1 Out-of-Pocket. No deductible.* FCH pre-authorization required for inpatient.	✓ *	✓ *	90%		50%		80%	50%		90%		50%	
Autologous Blood Donation/Blood Transfusions	✓	✓	90%	80%			80%			80%			
Chemical Dependency FCH pre-authorization required for inpatient, residential and partial hospitalization.	*MyConnected Care Plan "Network" Benefits apply to Tier 1 Out-of-Pocket. No deductible.*												
• **Facility Services**	✓ *	✓ *	90%		50%		80%	50%		90%		50%	
• **Professional Services**	✓ *	✓ *	90%		50%		80%	50%		90%		50%	
Chiropractic Spinal Manipulation 16 visits per calendar year. Maintenance therapy is not covered. * *MyConnected Care Plan "Network" Benefits apply to Tier 1 Out-of-Pocket. No deductible.*	✓ *	✓ *	90%		50%		80%	50%		90%		50%	
Clinical Trials	Covered as specifically outlined under *Clinical Trials* in the Medical Benefits section below.												

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
Cochlear Implants	Covered based on place of service												
Dental Trauma FCH pre-authorization required for follow-up services and anesthesia.	✓	✓	80%										
Diabetic Education & Diabetic Nutrition Education The first 3 Diabetic Nutrition Education visits or Nutritional Counseling visits per calendar year are considered preventive. This benefit applies after the first 3 visits per calendar year are exhausted.	✓	✓	90%	50%			80%	50%		90%	70%	50%	
Diagnostic Testing Lab and Radiology Services. Non-routine, facility and professional services FCH pre-authorization required for PET scans.													
• **Hospital Inpatient** (professional fees)	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Hospital Outpatient** (facility fees)	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Hospital Outpatient** (professional fees)	✓	✓	90%	50%			80%	50%		90%	70%	50%	

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Reminder: The High Deductible PPO Plan is referred to within the table as "HDHP."

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
• **Independent Facility** Diagnostic Testing provided by an independent diagnostic testing provider, group, facility or office. Billed separately from the provider of care.	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Doctor's Office - Primary Care Provider** Office based lab or radiology service provided as part of the office visit, and billed as part of the office visit. Office Visit copay will be assessed for the office visit portion of the visit.	✓ (N/A for MyConnected Care Plan)	✓	100%	50%			100%	50%		90%	70%	50%	
• **Doctor's Office - Specialist** Office based lab or radiology service provided as part of the office visit, and billed as part of the office visit. Office Visit copay will be assessed for the office visit portion of the visit.	✓	✓	100%	50%			100%	50%		90%	70%	50%	

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Any Out-of-Network Inpatient Admissions are limited to 10 per calendar year combined.
Reminder: The High Deductible PPO Plan is referred to within the table as "HDHP."

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
• **High Dose Electronic Brachytherapy**	✓	✓	90%	50%			80%	50%		90%	70%	50%	
Dialysis End Stage Renal Disease (ESRD/Dialysis)	Covered based on place of service.												
Durable Medical Equipment and Supplies	** MyConnected Care Plan "Network and Out-of-Network" Benefits apply to Tier 1 Out-of-Pocket. No deductible.*												
• **Breastfeeding Supplies and Equipment**	N/A	N/A	100%										
• **Durable Medical Equipment***	✓ *	✓ *	90%	50%			80%	50% (Tier 1 deductible and OOP max apply)		90%	50% (Tier 1 deductible and OOP max apply)		
• **Medical Supplies***	✓ *	✓ *	90%	50%			80%	50% (Tier 1 deductible and OOP max apply)		90%	50% (Tier 1 deductible and OOP max apply)		
• **Oral Appliances*** For treatment of obstructive sleep apnea only. Oral appliances for Temporomandibular Joint Syndrome fall to the *Temporomandibular Joint Syndrome* benefit	✓ *	✓ *	90%	50%			80%	50% (Tier 1 deductible and OOP max apply)		90%	50% (Tier 1 deductible and OOP max apply)		

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Any Out-of-Network Inpatient Admissions are limited to 10 per calendar year combined.
Reminder: The High Deductible PPO Plan is referred to within the table as "HDHP."

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
• **Orthopedic Appliances/Braces***	✓ *	✓ *	90%		50%		80%	50% (Tier 1 deductible and OOP max apply)		90%		50% (Tier 1 deductible and OOP max apply)	
• **Prosthetic Devices***	✓ *	✓ *	90%		50%		80%	50% (Tier 1 deductible and OOP max apply)		90%		50% (Tier 1 deductible and OOP max apply)	
Emergency Care													
• **Emergency Department** – facility services Copay is waived if admitted. On MyConnected Care plan, Tier 1 separate $500 individual/ $1,000 family ER deductible applies across all Tiers. On Standard PPO Plan and HDHP Plan, Tiers 1 & 2 deductible applies across all Tiers.	✓	✓	Visits 1 & 2 $250 Copay				Visits 1 & 2 $250 Copay			90%	70%	70% (Tier 1 and 2 ded applies)	
			Visits 3 & 4 $350 Copay				Visits 3 & 4 $350 Copay						
			Visits 5+ $500 Copay				Visits 5+ $500 Copay						

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Reminder: The High Deductible PPO Plan is referred to within the table as "HDHP."

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
• **Emergency Department** – professional On MyConnected Care plan, Tier 1 separate $500 individual/ $1,000 family ER deductible applies across all Tiers. On Standard PPO Plan and HDHP Plan, Tiers 1 & 2 deductible applies across all Tiers.	✓	✓	100%				100%			90%	70%	70% (Tier 1 and 2 ded applies)	
• **Urgent Care**	✓	✓	$20 copay	50%			$20 copay	50%		90%	70%	50%	
Family Planning													
• **Office Visits – Female**	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Office Visits – Male**	✓	✓	100%			50%	100%		50%	100%			50%
• **Diagnostic Testing – Female**	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Diagnostic Testing – Male**	✓	✓	100%			50%	100%		50%	100%			50%

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
• **Contraceptive Services – Supplies, Devices, Implants** (oral contraceptives covered under Pharmacy)	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Sterilization – Female**	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Sterilization – Male**	✓	✓	100%			50%	100%		50%	100%			50%
Termination of Pregnancy Covered for employees or their spouse/domestic partner only. Dependent children are not covered.													
• **Termination of Pregnancy** – facility services	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Termination of Pregnancy** – Professional services	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Termination of Pregnancy** – Outpatient													

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
– Primary Care Physician	✓	✓	$20 copay then 100%	50%			$20 copay then 100%	50%		90%	70%	50%	
– Specialist	✓	✓	$35 copay then 100%	50%			$35 copay then 100%	50%		90%	70%	50%	
Foot Orthotics	✓	✓	90%	50%			80%	50%		90%	70%	50%	
Genetic Services FCH pre-authorization required for genetic testing.													
• **BRCA Testing**	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Genetic Testing** FCH pre-authorization required.	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Genetic Counseling** FCH pre-authorization required.	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **All other Genetic Testing/Counseling**	Refer to *Diagnostic Testing*												
Habilitative Services	✓	✓	90%	50%			80%	50%		90%	70%	50%	

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Reminder: The High Deductible PPO Plan is referred to within the table as "HDHP."

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
Hearing	** MyConnected Care Plan "Network" Benefits apply to Tier 1 Out-of-Pocket. No deductible.*												
• **Routine Hearing Exams** 1 per Plan year maximum.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Medically Necessary Hearing Exams**	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Hearing Aids and Appliances*** $2,000 every 3 Plan years.	✓*	✓*	90%		50%		80%	50%		90%		50%	
Home Health Care (HHC) FCH pre-authorization required for enteral formula, medical food and associated services.													
• **Home Health Care** 130 visits combined plan year maximum.	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Phototherapy** (home)	✓	✓	90%	50%			80%	50%		90%	70%	50%	
Hospice Care FCH pre-authorization required for inpatient.													

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Any Out-of-Network Inpatient Admissions are limited to 10 per calendar year combined.
Reminder: The High Deductible PPO Plan is referred to within the table as "HDHP."

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
• **Hospice Care** Maximum 14 inpatient days per 12-month period.	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Respite Care** 30-day maximum within 12-month period.	✓	✓	90%	50%			80%	50%		90%	70%	50%	
Hospital Inpatient Medical and Surgical Care FCH pre-authorization required.													
• **Facility Services**	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Inpatient Doctor Visits or Consultations**	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Inpatient Professional Services** (surgeon, assistant surgeon, radiologist, pathologist)	✓	✓	90%	50%			80%	50%		90%	70%	50%	
Hospital Outpatient Surgery and Services FCH pre-authorization required for certain outpatient services; see Pre-authorization Requirements for details. Dialysis claims received by a Network Provider pay at the MCC Network benefit level.													

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
• **Surgical Facility Services**	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Ambulatory Surgery Center** (ASC)	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Outpatient professional services** (surgeon, radiologist, pathologist)	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Pre-admission Outpatient Testing**	Refer to *Diagnostic Testing*												
Infertility Services (IVF, GIFT, fertility drugs, etc.) Coverage for evaluation only at Professional Service coinsurance levels.	Not Covered												
Infusion Therapy (includes infusion therapy provided in the home) FCH pre-authorization required for certain infusion therapy drugs, see *Pre-Authorizations Requirements.*	✓	✓	90%	50%			80%	50%		90%	70%	50%	
Lab and Radiology Services	**Refer to *Diagnostic Testing***												

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Reminder: The High Deductible PPO Plan is referred to within the table as "HDHP."

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
Maternity and Newborn Care Covered for employees or their spouse/domestic partner only. (Dependent maternity is not covered)													
• **Maternity/Newborn care** – inpatient facility	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Maternity/Newborn care** – inpatient professional	✓	✓	90%	50%			80%	50%		90%	70%	50%	
Medication Therapy Management	✓ (waived for all Tiers except HDHP Tier 1 when billed as non-preventive)	N/A	100%	Not Covered			100%	Not Covered		100%	Not Covered		
Mental Health Care FCH pre-authorization required for inpatient, residential and partial hospitalization. *MyConnected Care Plan "Network" Benefits apply to Tier 1 Out-of-Pocket. No deductible.*													

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	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
• **Inpatient and Outpatient** - facility services	✓ *	✓ *	90%		50%		80%	50%		90%		50%	
• **Inpatient and Outpatient** - professional services	✓ *	✓ *	90%		50%		80%	50%		90%		50%	
Nutritional Counseling – Visits 4 and beyond The first 3 Nutritional Counseling visits or Diabetic Nutrition Education visits per calendar year are considered preventive. This benefit applies when the first 3 visits per calendar year are exhausted.	✓	✓	90%	50%			80%	50%		90%	70%	50%	
Nutritional and Dietary Formulas													
• **PKU Formula**	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **All Others** Limited benefit, see *Nutritional and Dietary Formulas* for details.	✓	✓	90%	50%			80%	50%		90%	70%	50%	
Oral Surgery	✓	✓	90%	50%			80%	50%		90%	70%	50%	

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Reminder: The High Deductible PPO Plan is referred to within the table as "HDHP."

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
Plastic and Reconstructive Services FCH pre-authorization required. Limited benefit, see *Plastic and Reconstructive Services* for details.													
• **Facility Services**	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Professional Services**	✓	✓	90%	50%			80%	50%		90%	70%	50%	
Podiatric Care Routine foot care excluded (Not related to Diabetes or Peripheral Vascular Disease). See *Podiatric Care* for details on routine foot care.	✓	✓	90%	50%			80%	50%		90%	70%	50%	
Preventive Care Guidelines	**Important Notes: The following Preventive Care Guidelines are meant to be a reference guide for recommended preventive care timelines and services. These guidelines are not meant to be benefit limitations** (except nutritional counseling, which does apply to the stated limits)**.**												
Preventive Care Visits													
• **Adult Periodic Preventive Visit** (19 and over) 1 visit per Plan year.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Pelvic Exam** 1 visit per Plan year for women age 18 and/or sexually active.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%

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Reminder: The High Deductible PPO Plan is referred to within the table as "HDHP."

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
• **Well Baby Care** (through 36th month) 11 visit maximum.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Well Child Care** (3 to 18 years) 1 visit per Plan year.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Nutritional Counseling Visits - First 3 visits per Plan year** Visits 4 and beyond are paid under the applicable medical benefits (subject to deductible and coinsurance.)	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Obesity Screening and Counseling** 12 counseling visits per calendar year.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
Preventive Screening Procedures	Screening tests are covered in accordance with the recommendations set forth by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See *Preventive Care* for more details.												

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
• **Abdominal Aortic Aneurysm Ultrasound Screening** One (1) test per lifetime for current or prior male tobacco users between ages 65 – 75.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Colonoscopy** The first colonoscopy per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent colonoscopies in the same calendar year are covered under the medical benefits, regardless of diagnosis.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Hearing Screening** 1 visit per Plan year.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
• **Mammogram** The first mammogram per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent mammograms in the same calendar year are covered under the medical benefits, regardless of diagnosis.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Obesity Prevention Counseling** For women aged 40-60 years who are normal weight or overweight.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Sigmoidoscopy** The first sigmoidoscopy per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent sigmoidoscopies in the same calendar year are covered under the medical benefits, regardless of diagnosis.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
• **Periodic Bone Density Screening** 1 test every other Plan year, women age 65, or, age 60 for those with increased risk for osteoporotic fractures.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
Preventive Laboratory Screenings													
• **Chemistry Panel** (CHEM) 1 per Plan year.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Cholesterol/Lipid** 1 every 5 Plan years.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Completed Blood Count** (CBC) 1 per Plan year.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
• **Fecal Occult Blood Tests** The first fecal occult blood test per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent fecal occult blood tests in the same calendar year are covered under the medical benefits, regardless of diagnosis.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **FIT-Fecal DNA** 1 per Calendar year	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **HIV Screening** As needed.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Lead Level Tests** 1 test for children, age 2 or under.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Pap tests/Pelvic Exam** 1 per Plan year for women 18 and/or sexually active.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
• **Periodic Blood Glucose Testing** 1 per Plan year.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Prostate Cancer Screening (PSA)** 1 per Plan year, for men, beginning age 50 years.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Sexually Transmitted Disease Screening** 1 per Plan year	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
• **Urinalysis (UA)** 1 per Plan year.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
• **Immunizations** Immunizations for children and adults are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention. (Travel immunizations are covered.) Covered immunizations done at a pharmacy are covered at the In Network benefit level at billed charges.	✓ (OON Only)	✓ (OON Only)	100%			50%	100%		50%	100%			50%
Professional/Physician Services (office visits, certain telemedicine visits and office surgeries)	*Virtual care visits are covered like any other professional service subject to deductible and coinsurance based on the network status of the provider.*												
• **Office Visits** (Primary Care Provider)	✓ (N/A for MyConnected Care Plan)	✓	$20 copay	50%			$20 copay	50%		90%	70%		50%
• **Office Visits** (Specialist)	✓	✓	$35 copay	50%			$35 copay	50%		90%	70%		50%

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
Rehabilitation Therapy	** MyConnected Care Plan "Network" Benefits apply to Tier 1 Out-of-Pocket. No deductible.*												
• **Inpatient *** FCH pre-authorization required; 30-day maximum per Plan year. Spinal cord injuries have a maximum of 45 days.													
– Facility Services	✓ *	✓ *	90%		50%		80%	50%		90%	70%	50%	
– Professional Services	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Outpatient** (includes physical, speech and occupational therapies) 45 visit maximum per Plan year; all therapies combined.													
– Facility Services	✓	✓	90%	50%			80%	50%		90%	70%	50%	
– Professional Services	✓	✓	90%	50%			80%	50%		90%	70%	50%	
• **Cardiac Rehab** Services count toward 45 visit outpatient rehabilitation maximum.													
– Facility Services	✓	✓	90%	50%			80%	50%		90%	70%	50%	
– Professional Services	✓	✓	90%	50%			80%	50%		90%	70%	50%	

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	Tier 2	Tier 3	Tier 4	Tier 1	Tier 2	Tier 3	Tier 1	Tier 2	Tier 3	Tier 4
Skilled Nursing Facility * 90 days per calendar year. Maintenance and custodial care are not covered. FCH pre-authorization required. ** MyConnected Care Plan "Network" Benefits apply to Tier 1 Out-of-Pocket. No deductible.*	✓ *	✓ *	90%		50%		80%	50%		90%		50%	
Temporomandibular Joint Syndrome (TMJ) FCH pre-authorization required for inpatient care.	✓	✓	90%	50%			80%	50%		90%	70%	50%	
Tobacco Cessation Must complete course of treatment to obtain reimbursement.	✓	✓	90%	50%			80%	50%		90%	70%	50%	
Transgender/Gender Affirming Services FCH pre-authorization required for surgery. Limited benefit, see *Transgender/Gender Affirming Services* for details.	Payment is based on Place of Service and Provider type												
Transplants (Organ and Bone Marrow) FCH pre-authorization required. Subject to benefit waiting period of 6 months.	Payment is based on Place of Service and Provider type. Case Management for Transplants provided by FCH. **Covered only at qualified Centers of Excellence.** See *Transplants (Organ and Bone Marrow)* for details. ** MyConnected Care Plan "Network" Benefits apply to Tier 1 Out-of-Pocket. No deductible.*												

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	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
Vision (routine eye exams and hardware)	Vision routine care is not covered in the First Choice Health administered medical plans. Routine vision care is available to individuals who enroll in the separate standalone VSP vision benefit option.												
Weight Management	UWMC Weight Loss and Metabolic Surgery for bariatric surgery and weight management will be processed under Tier 1 for the MyConnected Care and HDHP Plans. Bariatric surgery and weight management is not covered on the Standard PPO Plan. All other services billed in relation to bariatric surgery from UWMC are subject to deductible and coinsurance based on the applicable medical benefit and network status of the provider.												
• **Non-Surgical Weight Management** The first 12 Obesity Screening and Counseling visits per calendar year for members with an obesity diagnosis are considered preventive. This benefit applies for visits 13 through 20.													
– Obesity Screening and Counseling (visits 13-20)	✓	✓	$35 copay	Not covered			Not covered			$35 copay	Not covered		
• **Surgical Weight Management (Bariatric Surgery)** FCH pre-authorization required. Care Management through PSW required. $50,000 Lifetime Maximum													
– Facility Services	✓ (N/A for MyConnected Care and PPO Plan)	✓	90%	Not covered			Not covered			90%	Not covered		
– Professional Services	✓ (N/A for MyConnected Care and PPO Plan)	✓	90%	Not covered			Not covered			90%	Not covered		

	Applies to Deductible	Applies to OOP Max	MyConnected Care Plan				Standard PPO Plan			High Deductible PPO Plan			
			Tier 1	**Tier 2**	**Tier 3**	**Tier 4**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 1**	**Tier 2**	**Tier 3**	**Tier 4**
– Anesthesia	✓ (N/A for MyConnected Care and PPO Plan)	✓	90%	90% when services performed at a MCC facility			Not covered			90%	90% when services performed at a MCC facility		
Wigs Limit 1 per calendar year	✓	✓	90%	50%			80%	50%		90%	70%	50%	

Medical Benefits

FCH administers the benefits described in this section for MultiCare Plan participants. All benefits are subject to plan exclusions and limits. Coinsurance and deductibles apply as previously noted above. See *Payment Provisions*, *Summary of Medical Benefits* and *Medical Limitations and Exclusions* for more details, along with definitions in the Group Health Summary Plan Description.

Coverage is provided only when all these conditions are met:

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

Allergy Care

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

Ambulance Services

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

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

Air ambulance transport services require pre-authorization for non-urgent transport and non-emergent ground or air ambulance transport to a MultiCare Health facility.

Note: Emergent Air Ambulance Transport will be reviewed retrospectively.

Transportation for personal or convenience reasons is not a covered benefit and is excluded.

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 when administered within a hospital or ASC in conjunction with dental care provided to a participant who meets the criteria for medical necessity as defined in the most current FCH medical policy for dental anesthesia services.

Applied Behavior Analysis (ABA)

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

ABA therapy programs incorporate behavior modification, training and education.

This benefit will cover the five components of ABA:

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

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

Covered Providers

For ABA:

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

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

Board Certified Assistant Behavior Analysts and others who implement behavior analytic interventions.

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

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.

Chemical Dependency

All inpatient admissions, residential, and partial hospitalizations **require FCH pre-authorization** by calling (800) 640-7682. The plan covers services provided to of 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. Non-manipulation services provided by a chiropractor are not included in this benefit and are covered based on the service billed. For example, an office visit will be billed as a professional visit under the professional benefit. Maintenance therapy is not covered.

Clinical Trials

An exception to the plan's exclusion of experimental or investigational treatments or services may be made for members participating in an approved clinical trial when this participation has been pre-authorized.

An approved clinical trial is defined as follows:

- Pre-authorization for clinical trial participation has been granted as described below.
- The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening disease or condition. A "life-threatening condition" is a disease or condition likely to result in death unless the disease or condition is interrupted. The principal purpose of the trial intervention must be the therapeutic intent to potentially improve health outcomes.
- The clinical trial intervention must be intended for a condition covered by the health plan.
- The approved clinical trial must be classed as one of the following:
  - A federally funded or federally approved trial.
  - A clinical trial conducted under a U.S. Food and Drug Administration (FDA) investigational new drug application.
  - A drug trial that is exempt from the requirement of an FDA investigational new drug application.
- The clinical trial must be conducted under a written research protocol approved by an appropriate Institutional Review Board (IRB). This protocol must demonstrate that the trial is in compliance with Federal regulations relating to the protection of human subjects.
- The clinical trial must provide a thorough informed consent document to the participating member, and this document must be signed by the member.
- All applicable plan limitations for coverage of out-of-network care along with all applicable plan requirements for precertification, and registration, 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, and 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 is required by FCH. Treatment must begin within 30 days of the date of injury and be completed within 24 months from the date of occurrence. Any services received after you become disenrolled from this Plan 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.

See *Anesthesia* for information regarding anesthesia benefits for dental services.

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:

- **Breastfeeding Supplies & Equipment:** 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 and breastfeeding supplies are also covered. 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
- **Orthopedic appliances/braces:** These include appliances used to support abnormal joints, limit pressure on a joint after injury to allow it to heal or correct abnormal curves in the spine.
- **Prosthetic devices:** Benefits include external prosthetic appliances that are used to replace all or part of a missing body part and are necessary for the alleviation or correction of illness, injury, or congenital defect.

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

Emergency 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 two (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. Oral, patch, and ring contraceptives are covered under the prescription drug benefit.

Termination of Pregnancy

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

Foot Orthotics

An orthotic is a device involving the ankle-foot or knee-ankle-foot used to support, align, prevent or correct deformities, or to improve the function of movable parts of the body. Items obtained under this benefit shall be limited to the standard and/or most cost-effective model of such orthotic. Repairs or replacement costs will only be covered if the orthotic was used by the member in the manner and for the purpose for which the orthotic was intended and damage was incurred due to normal wear and tear of the orthotic.

Genetic Services

FCH pre-authorization is required for genetic testing. Benefits include genetic testing, counseling, interventions, and therapy.

Habilitative Services

Benefits are provided for habilitative services when medically necessary and 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/Appliances

Routine hearing exams to detect/prevent auditory deterioration are covered for employees and their dependents.

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

Note: *Cochlear implants and Bone Anchored Hearing Aids (BAHA) are not considered hearing aids/appliances and are covered under the surgical benefit, and not under the Hearing Aids/ Appliances benefit.*

Home Health Care

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

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

- Nursing services (RN, LPN);
- Licensed or registered physical, occupational, respiratory 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;
- Nutritional guidance; or,
- Registered dietician

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

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

Hospice Care

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

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

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

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

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 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.

Out-of-network inpatient admissions limited to 10 admissions per calendar year. This applies to all out-of-network inpatient admissions combined, including all out-of-network inpatient hospital, residential treatment center, inpatient chemical dependency, chemical dependency residential

treatment center, skilled nursing facility, inpatient rehabilitation and any other type of inpatient service.

Hospital Outpatient Surgery and Services

Certain outpatient surgery/procedures **require FCH pre-authorization**; refer to the list on page 4 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

All claims related to evaluation and diagnosis of infertility will be covered. Examples of covered items include endometrial biopsy, hysterosalpingography, reproductive screening services, sperm count, and other laboratory and radiology diagnostic testing even if performed after the diagnosis of infertility has been made. A pre-authorization must be obtained from FCH if care is provided inpatient. Treatments and procedures that induce pregnancy are not covered. Examples include in vitro fertilization and gamete intra-fallopian transplant (GIFT).

Infusion Therapy

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

Maternity and Newborn Care

Coverage for pregnancy and childbirth, for employees or their spouse/domestic partner (not dependents), in a hospital, birthing center, or home, is provided on the same basis as any other medical condition, as are complications of pregnancy. Medically necessary prenatal diagnosis of congenital disorders of the fetus by means of screening and diagnostic procedures during pregnancy is covered. The services of a licensed physician (M.D. or D.O.), a Physician's Assistant (P.A.), an advanced registered nurse practitioner (A.R.N.P.), a licensed midwife, or a certified nurse midwife (CNM) are covered under this benefit.

See the *Medical Management* section, specifically the subsections: *Pre-authorization Requirements and Notification for Emergency Admissions* for details.

Coverage for Newborns

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.

If the subscriber or subscriber's spouse is not eligible for the maternity benefits under this Plan, the professional services and hospital services benefits of this Plan will be provided for routine care for her newborn child while hospitalized for the first 72 hours following birth.

Note: Refer to the companion document MultiCare Health System Flexible Benefit Program SPD to details on eligibility and enrollment and to understand the plan's special enrollment limited period of time for adding a newborn to your coverage.

Medication Therapy Management

This benefit covers pharmacist consultations received for a covered medical condition. Benefits for pharmacist consultations are limited to MultiCare pharmacists. Benefits are provided at 100% of billed charges. Calendar deductibles, coinsurance and copays are waived for these services when billed as preventive.

Mental Health Care

All inpatient admissions, residential, 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 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, 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*.

Nutritional and Dietary Formulas

Coverage for dietary formulas and nutritional supplements are covered when medically necessary as defined in the most current FCH medical policy.

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

Oral Surgery

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

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

Plastic and Reconstructive Services

Reconstructive/plastic procedures **require FCH pre-authorization**. Specific criteria follow:

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

Women's Health and Cancer Rights Act of 1998

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

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

Podiatric Care

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

Preventive Care

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

- Routine physicals;
- Periodic examinations including the specific diagnostic testing/screening and laboratory services noted in the Summary of Benefits (the frequency of these examinations is determined by the age, gender, health status and medical needs of the participant);
- Adult, child and adolescent immunizations as recommended by the Centers for Disease (CDC). For more information visit the following website: www.healthcare.gov

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

Professional/Physician Services

These services refer to any professional, physician, provider or facility practicing medicine or providing health care within their lawful scope of practice as defined by the state from which their license was bestowed. This benefit applies to in-person, face to face office visits, e-visits and telemedicine consultation, and the following Telehealth visits: Virtual urgent care visits via a secure portal are covered when initiated by the member. Scheduling and medical record documentation of these visits follows the same standard as in-person visits. Health professionals must meet the licensure requirements of the state where they are located and be licensed or legally permitted to practice in the state where the patient is located.

Women's healthcare providers include any generally recognized medical specialty of licensed practitioners who provide women's healthcare services within their lawful scope of practice. They include, but are not limited to:

- An allopathic physician (M.D.) or osteopathic physician (D.O.) who is a family or general practitioner, internist, obstetrician or gynecologist;
- A licensed physician assistant;
- An advanced registered nurse practitioner (A.R.N.P.) who specializes in women's health, family practice or midwifery; or,
- A certified nurse midwife (CNM) or licensed midwife.

Rehabilitation Therapy

Coverage is provided for inpatient and outpatient physical therapy, speech therapy, occupational therapy and cardiac therapy for disabling conditions. Examples of such therapies include, but are not limited to, physical therapy, speech therapy, and occupational therapy.

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

Inpatient Rehabilitation

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

Outpatient Rehabilitation

Outpatient rehabilitation benefits are subject to the following provisions:

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

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 nor custodial care is covered.

Temporomandibular Joint Syndrome (TMJ)

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

- Oral appliances for the treatment of TMJ;
- 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; and,
- Not primarily for cosmetic purposes.

Tobacco Cessation

Coverage is provided for the services of a physician, psychologist or other smoking cessation providers/programs. To find a program call the Washington State Tobacco Quit Line at (877) 270-STOP or your county health district, or check with your local FCHN preferred provider hospital.

No benefits will be provided under this benefit for inpatient services; vitamins, minerals and other supplements; acupuncture, hypnotherapy, book or tapes, or over-the-counter drugs to ease nicotine withdrawal. However, prescription drugs to ease nicotine withdrawal *are* covered under your Pharmacy benefit.

For reimbursement of smoking cessation programs, send receipt and claim form to FCH Claims Department, PO Box 12659, Seattle, WA 98111-4659.

Transgender/Gender Affirming Services

FCH pre-authorization required for inpatient admissions and gender affirming surgery. These services are intended to provide treatment for patients with gender dysphoria when they meet the criteria for medical necessity as defined in the most current FCH medical policy. This assistance may include primary care, gynecologic and urologic care, reproductive options, mental health services (e.g., assessment, counseling, psychotherapy, psychotropic medication management), and hormonal and gender affirming surgical treatments. Transportation and lodging are not covered. FDA approved medications for support and treatment of transgender related services are covered through the Pharmacy Benefit.

Transplants (Organ and Bone Marrow)

FCH pre-authorization is required for transplant service. Case Management services for Organ and Bone Marrow Transplants are provided by First Choice Health. Transplants will **only be covered when performed at a qualified Centers of Excellence (COE).** There is a **6-month waiting period** for this benefit, meaning, services are not available to you until the first day of your seventh month of continuous coverage under this Plan. Services directly related to organ transplants must be coordinated by your participating provider. If a transplant is not successful (defined as the need for a retransplantation within 18 months of the original transplant), only one re-transplant will be covered. **Proposed transplants will not be covered if considered experimental or investigational for the participant's condition.**

FCH pre-authorization approval for transplants is based on these criteria:

- Your provider submits a written recommendation and supporting documentation.
- The requested procedure will be performed at a qualified Center of Excellence per the Commercial United Pediatric or Adult Centers of Excellence List based on the date by which your provider submitted a written request for pre-authorization to First Choice Health.

    - Adult Centers of Excellence: https://cmcnetworkmanagementtool.uhc.com/clarity-fhcp/standardNetworkMap.do?isInternal=&product=TRS&population=ADULT&designation=COE&clientId=&fhcpClientName=&lobCode=COMM
    - Pediatric Centers of Excellence: https://cmcnetworkmanagementtool.uhc.com/clarity-fhcp/standardNetworkMap.do?isInternal=&product=TRS&population=PED&designation=COE&clientId=&fhcpClientName=&lobCode=COMM
- 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 not considered an organ transplant and are covered under the medical-surgical benefits, and not under the transplant benefit.

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

Email:
preauthorization@fchn.com

Written:
FCH Medical Management
P.O. Box 12659
Seattle, WA 98111

Alternatively, Fax:
(833) 227-4256

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 (these are covered under the Prescription Drugs Benefit however, claims for such drugs will be applied to and are subject to the Transplants Benefit maximum of this Plan).
- 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 enrolled in this Plan. However, complications arising from the donation would be covered as any other illness to the extent that they are not covered under the recipient's health plan.

Travel & Lodging expenses

The benefit provides reimbursement for eligible expenses up to $3,000 per episode.

This travel benefit is available for approved transplants and associated pre-transplant evaluations that are not available within the local commutable area defined as 75 miles outside of the patient's home address.

Travel Allowances

Travel allowance is paid for the eligible patient and costs of one (1) travel companion for an adult patient or up to two (2) travel companions for a pediatric patient (under age 18). Travel allowance is paid for travel between the patient's home and the provider/facility for round trip air (coach class only), train, shuttle and bus transportation costs.

Personal auto travel will be reimbursed mileage based upon the published IRS standard rate for business vehicle usage at the date the claim is incurred in addition to parking and tolls. Payment rate information is available at www.irs.gov.

Lodging Per Diem

Lodging expenses are paid for at a per diem rate of up to $50 per day for the patient, or up to $100 per day for the patient and travel companion(s). One travel companion is allowed for patients 18 and older, and up to two travel companions are allowed for patients under 18.

Covered Services

- Airline tickets (economy or coach)
- Taxi and Uber/Lyft fees
- Rental car and fuel
- Fuel in a personal vehicle -OR- IRS medical mileage allowance
- Train, bus, subway
- Parking, tolls

- Lodging — IRS allowed amount of $50/diem or $100/diem if traveling with a companion (or two companions for a child under 18)

Excluded Services

Examples of lodging items that are not covered (not an all-inclusive list)

- Groceries, meals, beverages
- Alcoholic beverages
- Clothing and dry cleaning
- Cleaning supplies
- Over-the-counter dressings, medical supplies, and personal care items
- Entertainment (cable television, books, magazines, newspapers, movie rentals)
- Phone calls, roaming cell phone charges and calls
- Cards, stationery, stamps, flowers
- Deposits and tips
- Vehicle maintenance
- Other expenses not included under the covered items indicated as covered above

Taxable Expenses

The employee is solely responsible for taxes associated with expenditures that fall outside of the IRS regulations.

Weight Management

FCH pre-authorization is required by calling 1-800-808-0450. Benefits are provided for the surgical treatment of obesity, subject to the benefit eligibility and medical criteria, and other provisions described in this benefit. In order to be eligible for benefits, services must be received from either MCC or UWMC Weight Loss and Metabolic Surgery.

Benefit Eligibility Criteria

Benefits for surgical treatment of obesity are available only for MultiCare Health System Plan participant dependents age 18 or older.

Medical Criteria

Benefits for primary surgical obesity treatment and repair-revision surgical procedures are provided only for eligible participants and eligible adult dependents who meet medical necessity criteria per the most current First Choice Health Bariatric Surgery Policy (FCH.MP.13.05 Bariatric Surgery).

Physicians of Southwest Washington provides Care Management services for MultiCare employees. Members are required to contact PSW Care Management via phone call prior to surgery approval with the purpose to ensure members have awareness of the free care management services available to them following the surgery. PSW will notify the member's

provider office that the member is aware of the care management services after speaking with the member regarding those free services.

Benefits

Non-surgical (visits 13-20) and surgical benefits are only available on the MyConnected Care Plan and the HDHP Plan. This is not a covered benefit for Standard PPO Plan participants. When enrollment and medical criteria have been met, benefits for surgical treatment of obesity will be provided for the services listed below. These services are subject to your copayments and coinsurance amounts as listed in the *summary of benefits* and must be rendered within the MCC provider network or at UWMC Weight Loss and Metabolic Surgery.

- Surgical services, including anesthesia
- Hospital services
- Medical necessary services provided before and after the surgery, including nutritional therapy, diagnostic services and rehabilitation services
- Benefits for treatment of complications of obesity surgery are provided on the same basis as any other medical care.
    - Treatment of complications of obesity surgery are covered for the Standard PPO plan if the initial surgery was performed at MultiCare and paid for under a prior MultiCare benefit plan.

Surgical Services Include:

- Gastric Bypass (open or laparoscopic)
- Adjustable gastric band surgery
- Sleeve gastrectomy
- Duodenal Switch
- Gastric band adjustments (unlimited)
- Treatment of complications and surgical revisions

This benefit does not cover:

- Diet programs that are not supervised by a physician (e.g. Weight Watchers, Jenny Craig, Nutrisystem).
- Mental health or psychiatric treatment, except as covered under the “Mental Health Care” benefit (covered if pre-authorized as part of bariatric surgery program).
- Gym or health club fees or equipment.

  Note: Weight management non-surgical (visits 13-20) **and** surgical benefits are not a covered benefit under the Standard PPO Plan.
- Complications resulting from bariatric surgery performed internationally.
- Complications arising from bariatric surgery performed at non-ASMBS centers after 2010 will not be covered. Prior to 2010, complications arising from bariatric surgery will be covered if performed domestically, but not for bariatric surgery performed internationally.

Wigs

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

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.

- Abdominoplasty/panniculectomy
- Abortion (termination of pregnancy) for female dependent children, regardless of complications
- Adoption expenses
- Amounts over and above UCR, as defined by the Plan
- Amounts for which the covered person has no obligation to pay
- Any condition resulting from declared or undeclared acts of terrorism, war, military service, participation in a riot or civil disobedience
- Any service not medically necessary for the diagnosis, treatment or prevention of injury or illness, even if it is not specifically listed as an exclusion (except for specific services offered through the Preventive Care benefit)
- Any service received before the participant's effective date of coverage or after the coverage termination date
- Aromatherapy
- Athletic training, body-building, fitness training or related expenses
- Autopsies
- Bariatric surgery (except for specific services offered through the weight management benefit applicable to MCC and HDHP plans), prescription drugs for weight loss, gym memberships, prescription or non-prescription nutritional and/or food supplements including weight loss shakes, exercise programs and equipment, and other surgical procedures primarily for reduction of adipose tissue. This exclusion does not apply to preventive care items or services required under the ACA.
- Benefits relating to any condition, illness, or injury for which the participant receives compensation or reimbursement through another contractual arrangement or benefit, other than employer-based disability payments, such as surrogate pregnancy.
- Biofeedback
- Botanical or herbal medicines, as well as other over-the-counter medications, except as required under ACA
- Chaperoning services for healthcare appointments or healthcare related services
- 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 Veteran's 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

- Charges for failure to keep a scheduled visit, for the copying of medical records or for the completion of a claim or administrative forms
- Charges for textbooks, cookbooks, or any charges for documentation related to any classes taken as part of a Plan benefit, including but not limited to, diabetic education and/or tobacco cessation
- 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
  - Biofeedback, pain management and/or stress reduction classes
  - Court-ordered or other assessments to determine the medical necessity of court-ordered treatments
  - Court-ordered treatments or treatments related to deferral of prosecution, deferral of sentencing or suspended sentencing or treatments ordered as a condition of retaining driving rights, when no medical necessity exists
  - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
  - Emergency patrol services
  - Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program
  - Information or referral services
  - Information schools
  - Long-term or custodial care
  - Non-substance related disorders
  - Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs
- 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
- Cognitive therapy
- Corrective shoes
- Court ordered examinations or treatment of any kind, except when medically necessary
- Custodial care
- 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 X-rays
  - Extractions of teeth, impacted or otherwise (except as covered under the Plan)
  - Orthodontia
  - Procedures in preparation for dental implants, except as covered under the Dental Trauma benefits

  - Services to correct malposition of teeth
- Dental extractions, wisdom or otherwise, except as specifically covered under the Plan
- Dental services including but not limited to associated anesthesia or facility charges, except as covered by the Plan
- Dental implants or procedures in preparation for dental implants, except as covered by the Plan under the Dental Trauma benefits.
- DME and medical supply charges listed below:
  - Biofeedback equipment
  - Breastfeeding supplies including, but not limited to, nursing pads, nipple shields, nipple cream, and nursing bras.
  - Equipment or supplies whose primary purpose is preventing illness or injury
  - Exercise equipment
  - Items not manufactured exclusively for the direct therapeutic treatment of an illness or injured patient
  - Items used outside the home primarily for sports/recreational activities
  - Oral appliances except to treat obstructive sleep apnea (covered under the TMJ benefit)
  - Over-the-counter items (except medically necessary crutches, walkers, standard wheelchairs, diabetic supplies and ostomy supplies are covered)
  - Personal comfort items including but not limited to air conditioners, lumbar rolls, heating pads, diapers or personal hygiene items
  - Phototherapy devices related to seasonal affective disorder
  - Supportive equipment/environmental adaptive items including, but not limited to, hand rails, chair lifts, ramps, shower chairs, commodes, car lifts, elevators, and modifications made to the patient's home, place of work, or vehicle.
  - The following medical equipment/supplies: standard car seats or strollers, push chairs, air filtration/purifier systems or supplies, water purifiers, allergenic mattresses, orthopedic or other special chairs, pillows, bed wetting training equipment, corrective shoes, whirlpool baths, vaporizers, room humidifiers, hot tubs or other types of tubs, home UV or other light units (light boxes or specialized lamps or bulbs), home blood testing equipment and supplies (except diabetic equipment and supplies, and home anticoagulation meters)
  - Wigs, except as covered by Plan due to chemotherapy, radiation therapy or surgery
- Duplication of ongoing program management services
- Experimental or investigational services
- Eyeglasses or contact lenses.
- FDA-approved drugs, medications or other items for non-FDA 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
- Fensolvi
- Fertility Preservation, regardless of diagnosis, including both sperm and egg preservation
- First Responder User Fees
- Growth hormone treatment
- Hair analysis
- Home health care listed below:
  - Custodial care
  - Financial or legal counseling services

  - Housekeeping or meal services
  - Maintenance care
  - Private duty/hourly nursing charges
  - Services by a participant or the patient's family or volunteers
  - Services not specifically listed as covered home health services under the plan
  - Supportive equipment such as handrails or ramps
  - 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
  - Bereavement or spiritual counseling
  - 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.
- Implants including but not limited to penile implant prostheses, except as covered by the plan
- 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)
- Injuries sustained while practicing for or competing in a professional or semiprofessional athletics contest. Semiprofessional athletics contest is defined as an athletic activity for gain or pay that requires an unusually high level of skill and a substantial time commitment from the participants, who are nevertheless not engaged in the activity as a full-time occupation
- Injuries while under the influence of a controlled substance and/or alcohol
- Lab and/or radiology services not ordered by a qualified health care provider
- Laser Assisted Uvuloplasty (LAUP), Laser Assisted Uvulopalatoplasty (LAUPP) or somnoplasty
- Learning disabilities and related services, educational testing or associated training
- Liposuction or other procedures for removal of adipose tissue
- Medication therapy management provided at Tier 2 or 3
- Mental health care listed below:
  - Adventure-based and/or wilderness programs that focus primarily on education, socialization or delinquency
  - Biofeedback, pain management, and stress reduction classes
  - Court-ordered assessments
  - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite

  - Family therapy, in the absence of an approved mental health diagnosis, specifically, those noted in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM)
  - Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program
  - Marriage and couples counseling
  - Nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories
  - Sensitivity training
  - Sexual dysfunctions, personality disorders, and paraphilic disorders
  - 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. This exclusion does not apply to services under the weight management benefit.
- 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)
- Obesity treatment or weight management programs are excluded, except for the weight management program at MultiCare. This exclusion does not apply to obesity-related services required under the Patient Protection and Affordable Care Act (PPACA) as part of the Preventive Care benefits.
- Occupational injuries or diseases
- Oral surgery services listed below:
  - care of the teeth or dental structures
  - dental implants
  - extractions of teeth, impacted or otherwise (except as necessary due to damage caused by radiation therapy treatment while under this Plan)
  - services to correct malposition of the teeth
- Orthodontic treatment, appliances or services; dentures or related services
- Over-the-counter products, except as covered by the plan
- Parental group training classes
- Pegfilgrastim injection for subcutaneous use; single-dose prefilled syringe (Neulasta) or on-body injector (Neulasta OnPro)
- 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
- 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.
- Physician services or professional services provided by fax, or e-mail are not covered. Follow- up phone calls from a provider after an in office visit within 7 days for test rests, referrals, prescriptions renewals, or reminders are not covered. Calls to nurse line or to obtain educational material are also not covered

- Phototherapy devices related to seasonal affective disorder
- Plastic and reconstructive services listed below:
  - 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
  - Dermabrasion, chemical peels or skin procedures to improve appearance or to remove scars or tattoos; or
  - Breast implant removal when inserted for cosmetic purposes
- Preservation of tissue or cells, unless related to a covered illness or disease established while under this Plan
- Preventive care or screening that exceeds the benefit limits or is otherwise not covered by the plan
- Procedures, regardless of medical necessity, outside the scope of the provider's license, registration or certification
- Professional services listed below:
  - Professional services provided by fax or email.
  - Follow up phone calls from provider for test results, referrals, prescription refills or reminders that occur within 7 days of an in-person office visit
  - Calls to nurse line or to obtain educational material are also not covered
- Provider continuing education or training services
- Radial keratotomy, Lasik or any other refractive surgery, orthoptics, pleoptics, visual analysis therapy or training related to muscular imbalance of the eye; optometric therapy
- Repair or replacement of items not used in accordance with manufacturer's instructions or recommendations
- Replacement of lost or stolen items, such as but not limited to prescription drugs, prostheses or DME
- Respite care, except as covered by the plan
- Reversal of sterilization
- Routine foot care, except as covered by the plan for members with peripheral vascular disease and diabetes
- Services beyond the specified Plan Benefit Maximums
- Services for any condition, illness or injury that arises from or during the course of work for wages or profit that is covered by state insurance workers' compensation and federal act or similar law
- Services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation
- Services or supplies payable under a contract or insurance for uninsured or underinsured (UIM) coverage, motor vehicle, motor vehicle no-fault, or personal injury protection (PIP) coverage, commercial premises or homeowner's medical premise coverage or other similar type of contract or insurance
- Services or supplies received without charge from a medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar group
- Services or supplies required by an employer as a condition of employment

- Services or supplies that are prohibited by law
- Services provided by a family member (spouse, parent or child)
- Services provided by a spa, health club or fitness center, except covered medically necessary services provided within the scope of the provider's license
- Services provided by clergy
- Services provided in a school setting (such as early learning and K-12)
- Smoking and Tobacco cessation programs except as covered by the Plan
- 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 lenses
- Tooth damage due to biting or chewing
- Transplant services listed below (organ and bone marrow):
  - Animal-to-human transplants
  - Artificial or mechanical devices designed to replace human organs
  - Complications arising from the donation procedure if the donor is not a plan participant
  - Donor expenses for a plan participant who donates an organ or bone marrow (however, complications from the donation are covered as any other illness to the extent they're not covered under the recipient's health plan)
  - Donor procurement services and costs incurred outside the United States unless approved by the Plan
  - Expenses incurred when government funding of any kind is provided
  - Services in a facility not approved by the Plan
  - Transplants considered experimental and investigational, as defined by the Plan
- Transportation for personal or convenience reasons is not a covered benefit and is excluded
- Treatment furnished without charge or paid directly or indirectly by any government or for which a government prohibits payment of benefits
- Tutoring, homework assistance and/or educational assistance services
- Viscosupplementation
- Vision, the following vision benefits are not covered:
  - Routine eye exams
  - Vision hardware including frames, lenses, contact lenses, and contact lens fitting fee (Frames, lenses, and contact lenses needed to treat a medical condition, or needed as a result of a medical condition are covered under the *Durable Medical Equipment* benefit)
  - Non-prescription or cosmetic contact lenses
  - Non-prescription sunglasses or safety glasses
  - Radial keratotomy, Lasik or any other refractive surgery, orthoptics, pleoptics, visual analysis therapy or training related to muscular imbalance of the eye; optometric therapy
  - Services or supplies received principally for cosmetic purposes
- 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 (except as covered by the Plan), prescription drugs for weight loss, gym membership (might be available outside of medical benefits), prescription or non-prescription nutritional and/or food supplements including weight loss shakes, exercise programs and equipment, and other surgical procedures primarily for reduction of adipose tissue

Summary of Pharmacy Benefits

Members enrolled in the High Deductible PPO Plan are subject to meeting the out-of-pocket deductible prior to receiving drugs identified with an asterisk (*) below. Please note: Under section 223(c)(2) of the Internal Revenue Code (IRC), High Deductible PPO Plan members may not receive benefits outside the expanded preventive coverage until the deductible is satisfied. Neither MultiCare or Ventegra can guarantee this list includes all medications subject to IRC guidance.

Members enrolled in the High Deductible PPO Plan will not be authorized to utilize manufacturer assistance coupons when paying for their medications. The use of such programs may disqualify an individual from making contributions to a Health Savings Account (HSA). Enrollment in patient coupon support programs, such as the Benefit Preservation Program, is not available for High Deductible PPO Plan enrollees. It is advisable for members to carefully evaluate alternative plan options to ensure they align with their healthcare needs for 2024.

<table>
<tr><th rowspan="3"></th><th colspan="2">Applies to Deductible</th><th colspan="2">Applies to OOP Max</th><th colspan="4">Network Providers Member Coinsurance</th></tr>
<tr><th rowspan="2">MyConnected Care Plan* and Standard PPO Plan*</th><th rowspan="2">HDHP**</th><th rowspan="2">MyConnected Care Plan* and Standard PPO Plan* (Separate Rx OOP)</th><th rowspan="2">HDHP** Med OOP</th><th colspan="2">MyConnected Care Plan* and Standard PPO Plan*</th><th colspan="2">HDHP**</th></tr>
<tr><th>MHS Pharmacy</th><th>Ventegra, Inc. Retail Pharmacy</th><th>MHS Pharmacy</th><th>Ventegra, Inc. Retail Pharmacy</th></tr>
<tr><td>Pharmacy – administered by Ventegra, Inc.</td><td colspan="8"><u>Standard PPO Plan</u>
Annual Pharmacy OOP of $1,500/individual; $3,000/family.
<u>MyConnected Care Plan</u>
Annual Pharmacy OOP of $1,500/individual; $3,000/family.
<u>HDHP Plan</u>
Pharmacy applies to Medical OOP of $3,500/individual; $6,850/family after the member deductible is satisfied (preventive medications are exempt from the deductible).</td></tr>
<tr><td>Retail (up to a 34-day supply)</td><td colspan="8">Available at MultiCare pharmacies and Ventegra, Inc. Network pharmacies; examples noted on next page. This benefit available to all members.
Refill of maintenance medications are required at a preferred pharmacy based on state of residence. Refer to the Maintenance Medication List. Visit fchn.com/multicare under the Pharmacy section.</td></tr>
</table>

	Applies to Deductible		Applies to OOP Max		Network Providers Member Coinsurance			
	MyConnected Care Plan* and Standard PPO Plan*	HDHP**	MyConnected Care Plan* and Standard PPO Plan* (Separate Rx OOP)	HDHP** Med OOP	MyConnected Care Plan* and Standard PPO Plan*		HDHP**	
					MHS Pharmacy	Ventegra, Inc. Retail Pharmacy	MHS Pharmacy	Ventegra, Inc. Retail Pharmacy
	- Members residing in Washington and Idaho will be required to refill maintenance medications at MultiCare Health System pharmacies. - Members residing outside of Washington and Idaho will be required to refill maintenance medications at Costco Mail Order Pharmacy.							
• **Tier 0 – Formulary**	N/A	N/A	N/A	N/A	Covered at 100% ($0 copay)	Limited ACA list, $0 copay	Covered at 100% ($0 copay)	Limited ACA list, $0 copay
• **Tier 1 – Formulary**	N/A	✓	✓	✓	20% ($10 minimum)	40% ($20 minimum)	20% ($10 minimum)	40% ($20 minimum)
• **Tier 2 – Formulary**	N/A	✓	✓	✓	20% ($25 minimum)	40% ($50 minimum)	10%	30%
• **Tier 3 – Formulary**	N/A	✓	✓	✓	20% ($40 minimum)	40% ($80 minimum)	10%	30%
• **Tier 4 – Formulary**	N/A	✓	✓	✓	20%	Not Covered	10%	Not Covered
Mail Order (91 day supply) - through MultiCare	**91-day supplies received through MultiCare pharmacies. This benefit available to all members. Costco Mail Order is available to members residing outside of Washington and Idaho.**							
• **Tier 0 – Formulary**	N/A	N/A	N/A	N/A	Covered at 100% ($0 copay)	Limited ACA list, $0 copay	Covered at 100% ($0 copay)	Limited ACA list, $0 copay

	Applies to Deductible		Applies to OOP Max		Network Providers Member Coinsurance			
	MyConnected Care Plan* and Standard PPO Plan*	HDHP**	MyConnected Care Plan* and Standard PPO Plan* (Separate Rx OOP)	HDHP** Med OOP	MyConnected Care Plan* and Standard PPO Plan*		HDHP**	
					MHS Pharmacy	Ventegra, Inc. Retail Pharmacy	MHS Pharmacy	Ventegra, Inc. Retail Pharmacy
• **Tier 1 – Formulary**	N/A	✓	✓	✓	20% ($20 minimum)	N/A	20% ($20 minimum)	N/A
• **Tier 2 – Formulary**	N/A	✓	✓	✓	20% ($50 minimum)	N/A	10%	N/A
• **Tier 3 – Formulary**	N/A	✓	✓	✓	20% ($80 minimum)	N/A	10%	N/A
• **Tier 4 – Formulary**	Specialty Medications are limited to a 30-day supply at MultiCare Pharmacies							

*The cost sharing values provided in the plan design are True Out of Pocket amounts. To minimize the impact of the high cost of specialty drugs, members are able to enroll in the Benefits Preservation Program, which limits member out of pocket costs and helps support the use of patient assistance programs. Any amounts paid by patient assistance programs and copay coupon programs will not apply to final patient out of pocket costs and will not be accumulated towards member maximum out of pocket values. Participation in available copay coupon programs or other forms of patient assistance programs are required when available and member is deemed eligible by the program and is supported by the Benefits Preservation Program. Members needing assistance for determining eligibility and navigating such programs should call the Benefits Preservation Program at 877-393-0009. Members who opt out of the Benefits Preservation Program will be subject to standard benefit design cost share parameters, with the value of coupons not counting towards member Maximum Out of Pocket values as defined by the plan.

**If a member participates in a high deductible health plan option and uses a patient assistance program or copay coupon program to offset the member's responsibility for the cost of a prescription medication prior to satisfying the annual deductible, the member may be ineligible to contribute to a Health Savings Account (HSA).

The Ventegra, Inc. Drug Formulary:

Tier 0 – Formulary: Preventive Medications

Tier 1 – Formulary: Generic Medications

Tier 2 – Formulary: Preferred Brands and High-Cost Generics

Tier 3 – Formulary: Non-Preferred Brands

Tier 4* – Formulary: Specialty Medications

In addition to the applicable cost share, 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. Benefits are not available through out-of-network pharmacies.

See *Filling a Prescription* for details on where and how to obtain your prescription drugs whether through a retail pharmacy or mail order. Specialty medications are limited to dispensing only a 30-day supply at a MultiCare Pharmacy.

(Standard PPO Plan and MCC Plan only) If a member is using a manufacturer copay coupon, copays may be adjusted to the maximum allowed by the manufacturer coupon. Only true out-of-pocket amounts will be applied to the maximum out-of-pocket. Copays paid by manufacturer coupons will not be applied to member maximum out-of-pocket.

Refill of maintenance medications are required at a preferred pharmacy based on state of residence. Refer to the Maintenance Medication List. Visit fchn.com/multicare under the Pharmacy section.

- Members residing in Washington and Idaho will be required to refill maintenance medications at MultiCare Health System pharmacies.
- Members residing outside of Washington and Idaho will be required to refill maintenance medications at Costco Mail Order Pharmacy.

Pharmacy Benefits

Providers must verify coverage of medications with the pharmacy benefit administrator prior to submitting claims through the medical plan.

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

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

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, know that five tiers exist within the pharmacy structure:

- **Tier 0 – Formulary** – Preventive Medications
- **Tier 1 – Formulary** – Generic Medications
- **Tier 2 – Formulary** – Preferred Brands and High-Cost Generics
- **Tier 3 – Formulary** – Non-Preferred Brands
- **Tier 4 – Formulary –** Specialty Medications

If a brand name drug is prescribed by your provider because s/he feels it is medically necessary, or selected by you, when a generic formulary equivalent drug is available, you will be responsible for paying the difference in price between the brand name drug and the generic, plus the applicable coinsurance. This difference in price does not apply to the annual deductible and out-of-pocket maximum applicable to the plan in which you are enrolled. The difference will continue to apply even after you meet your annual out-of-pocket maximum.

If a member is using a manufacturer copay coupon, copays may be increased to the maximum allowed by the manufacturer coupon. Copays paid by manufacturer coupons will not be applied to member maximum out-of-pocket. This benefit does not apply to the High Deductible PPO Plan.

Preventive Drug Pharmacy Benefit

The Plan offers members zero-dollar coverage on a limited list of preventive medications needed to manage conditions such as hypertension, high cholesterol, diabetes, asthma or osteoporosis. This benefit includes only generic or formulary brand drugs for which no generic equivalent is available. This means that, like other preventive benefits, members may receive coverage for these drugs before meeting their deductible. These medications must be filled at a MHS pharmacy.

Growth Hormone

Growth hormones are covered as a Specialty Drug (30-day supply), when pre-authorized by Ventegra, Inc.

Pre-Authorization and Step Therapy

Certain medications may require pre-authorization. You or your provider should contact Ventegra, Inc. at (833) 393-0445 for information on which medications require pre-authorization.

For certain conditions, the Pharmacy benefit requires participants to take part in "step therapy" prior to approving brand name medications. Step therapy means a generic (or preferred alternative) must first be tried, and determined by your provider to be a failure, prior to receiving approval for filling brand name medication prescriptions. Examples of conditions that may require step-therapy include, but are not limited to:

- Depression
- Digestive Aids
- Ophthalmics

Any compounded medication with total cost exceeding $400 requires prior authorization to determine its clinical appropriateness in order for it to be covered.

Filling a Prescription

Maintenance Medications

The plan requires members to refill maintenance medications at a preferred pharmacy based on your state of residence. For a list of maintenance medications, please visit fchn.com/MultiCare under the pharmacy section.

- MultiCare Employee Health Plan members residing in Washington and Idaho will be required to refill maintenance medications at MultiCare Health System pharmacies.
- MultiCare Employee Health Plan members residing outside of Washington and Idaho will be required to refill maintenance medications at the Costco Mail Order Pharmacy.

MultiCare Pharmacy

If you reside in Washington or Idaho and you need assistance in refilling a maintenance medication a MultiCare System Pharmacy, contact:

1. MultiCare Covington Clinic Pharmacy at (253) 372-7220 to have your prescriptions mailed to you.
2. Spokane residents can also call Rockwood Clinic Pharmacy at (509) 530-5450.

If you reside outside of Washington and Idaho, maintenance medications are required to be refilled at Costco Mail Order Pharmacy. You can contact Costco Mail Order Pharmacy at (800) 607-6861 or visit www.costco.com/home-delivery.

MultiCare has outpatient pharmacies to offer convenient access and serve the needs of patients. MultiCare's pharmacies can dispense retail amounts (up to a 34-day supply) as well as a 91-day supply of maintenance medications.

Visit www.multicare.org/pharmacy-employees/ for more information about how to use MultiCare pharmacies, and the sites' hours of operation.

Retail Network Pharmacy

Beyond MultiCare's pharmacies, Ventegra, Inc. has a retail pharmacy network. With the retail pharmacy program, you may receive up to a 34-day supply of medication. Refer to the website or contact customer service for a complete list of participating pharmacies.

Following are details for filling a prescription through the retail network pharmacy or mail order. Contact Ventegra, Inc. for any questions on filling a prescription. If you need assistance in determining if your local, independent pharmacy is part of the Ventegra, Inc. network of retail pharmacies, you may call Ventegra, Inc. directly at (833) 393-0445.

Mail Order

MultiCare Prescription Delivery

Skip the trip to the pharmacy. Get medications delivered right to your door.

- Mail order deliver is free and arrives through the United States Postal Service or authorized carrier like UPS or FedEx within one to three days
- Same-day or next-day home delivery via courier costs $10 and is available within 40 miles of any MultiCare pharmacy, found at www.multicare.org/find-a-location
  - Home courier delivery orders received before the cutoff time are eligible for same-day delivery
  - Orders received after that time can be delivered the next business day
- Live outside of Washington or Idaho?
  - MultiCare Employee Health Plan members residing outside of WA and ID can use prescription delivery services via Costco Mail Order Pharmacy
  - Visit the Costco mail order page at www.costco.com/home-delivery or call (800) 607-6861

Visit MultiCare's prescription delivery and employee prescription benefits pages at www.multicare.org or call the MHS pharmacy directly to learn more. To view a list of MHS pharmacies, visit the pharmacy location finder at www.multicare.org/find-a-location

Prescription Transfer

Switch to MultiCare Pharmacy Services from another pharmacy easily by completing the form located here: www.multicare.org/services-and-departments/pharmacy/prescription-transfer/ or call the MHS pharmacy directly.

- Answer a few simple questions, then we'll start moving your medications over
- Most of the detail you need for this form is located on your prescription bottle
- If you live outside of WA or ID, reference the Costco mail order page at www.costco.com/home-delivery or call (800) 607-6861

For additional information, visit the pharmacy services page at www.multicare.org/services-and-departments/pharmacy/.

Specialty Medications

Required to be filled at a MHS Pharmacy location. Due to significant cost savings to both the Plan and participants, certain specialty medications must be filled at a MHS Pharmacy location.

If a drug is limited distribution, and/or MHS Pharmacy is not able to provide it to the member, then it is allowed through Costco Specialty at a cost savings for the member.

Contact Ventegra, Inc. at (833) 393-0445 for a complete list of Specialty medications.

Exclusions specific to Pharmacy exist; see "Pharmacy Exclusions and Limitations" for details.

Pharmacy Exclusions and Limitations

The following items are not covered under the pharmacy benefit:

- Anti-obesity drugs (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 dispensed from a non-participating pharmacy unless dispensed resulting from an emergent condition or as a first-time fill
- 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
- Any prescription for which an over-the-counter equivalent exists.
- Botanicals and herbal medicines
- Charges for the administration or injection of any drug except for pharmacy-administered vaccines, biological sera, blood or blood plasma
- Diabetic supplies not considered either a therapeutic devices or appliances, for example, alcohol swabs and blood calibration solutions
- Infertility medications (e.g. Clomid, Metrodin, Pergonal, Profasi)
- 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
- Legend fluoride products, except as required by the Patient Protection and Affordable Care Act
- Legend homeopathic drugs
- Legend vitamins except prenatal agents and therapeutic agents used for specific deficiencies and conditions (for example, Rocaltrol, Calcitriol, Niacin, Potaba)
- Lost, stolen, spilled or replacement prescriptions
- Minoxidil (Rogaine) or any other medications used for cosmetic purposes and/or 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, except certain medications required by the Patient Protection and Affordable Care Act
- Prescription medications which may be obtained without charge under local, state or federal programs
- Prescription medications for the treatment of a non-covered condition
- Prescription medications to treat sexual dysfunction
- Prescription medications not approved by the FDA for any use/indication in the U.S.
- Prescription medications purchased outside the U.S. that are not legal in the U.S.
- Prescription medications dispensed or administered during an inpatient stay at an institution which dispenses drugs or medicines
- Products used for cosmetic purposes

- Therapeutic devices or appliances, including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, unless covered as diabetic supplies

Claim and Appeal Procedures

Claim

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

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

How to File a Claim for Plan Benefits

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

- Provider name
- Provider tax ID information
- Specific dates of service
- Diagnosis codes (ICD-10 codes) or description of the symptoms or a diagnosis
- Specific procedure codes (CPT codes) or description of the medical service or procedure.
- Specific 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 for medical claims and submitted to Ventegra for prescription claims) must be received within 12 months from the date the service or supply was rendered or received. 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 (MultiCare).

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 or Direct Member Reimbursement (DMR)** 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 (MultiCare) 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 or 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 and Ventegra Notice of Incorrectly Filed Claim – Notice to Claimant**	**FCH and Ventegra 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:

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

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

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

Appeal Procedure

FCH performs functions associated with the internal review of medical appeals for this Plan. MultiCare has final authority over appeals as the appropriate named fiduciary. Pharmacy Appeals are handled by Ventegra, Inc.

If your medical 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 medical claim for medical necessity or experimental or investigational care or treatment.

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

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

Medical Appeals:
First Choice Health
Attn: Appeals Coordinator
P.O. Box 12659
Seattle, WA 98111
Fax: (206) 268-2920

Pharmacy Appeals:
Ventegra, Inc.
Attn. Appeals Department
10400 W. Overland Rd, Box #353
Boise, ID 83709
Fax # (855) 336-6612
Phone # (833) 393-0445

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 else you lose the 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 five (5) business days.

FCH's designated Appeals Coordinator will prepare your documents and any applicable documentation from the Summary Plan Description for the review and discussion of the FCH Appeals Committee or Medical Director (the individual who made the original adverse benefit determination will not be involved in the internal appeal process). The committee or Medical Director will review the information and make a recommendation to the Plan Fiduciary to either uphold or overturn the original adverse benefit determination, and such recommendation will be sent to MultiCare for a final decision. 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. 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. Ventegra, Inc. will notify you within 45 days in writing of the decision to either uphold the original denial or overturn your pharmacy appeal. 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.**

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.

Your request to FCH for external review must be received within 125 calendar days of receipt of the final internal adverse benefit determination. Your request to Ventegra, Inc. must be received within 180 days from the date of your Notice of Denial of Prescription Drug Coverage.

Within five (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 of its decision within one business day thereafter. This notice will include:

- 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 the both the original denial and the internal review, as well as any additional documentation you submit) to an Independent Review Organization (IRO) within six (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 MultiCare. 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.**

Ventegra, Inc. will allow any additional information to be submitted to the IRO that you wish to be considered in reviewing your pharmacy appeal.

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.

Note: This Plan does not coordinate benefits with prescription drug card programs

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 policyholders determines the order of benefits.

4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the plans covering the child pay in the following order:
   a. The plan covering the custodial parent
   b. The plan covering 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 policyholders will determine the order of benefits.

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

   This rule does not apply if Rule 1 can determine the order of benefits.
4. **COBRA or State Continuation Coverage:** If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to state or other federal law is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member, subscriber or retiree is the primary plan and the plan covering that same person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

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

   This rule does not apply if Rule 1 can determine the order of benefits.
5. **Length of coverage**: If none of the preceding rules establish which plan pays first, the plan that has covered the person the longest is primary. To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended. The start of a new plan does not include:

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

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

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

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

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

What if I'm Covered by Medicare?

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

If your Medicare entitlement is due to:

- **Age**:

  If you are covered under this Plan as an active employee or a dependent of an active employee (excluding Domestic Partners) and you become entitled to Medicare because of reaching age 65, this Plan will be primary.

  If you are covered under this Plan as a 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. 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 that are excluded by your primary plan but payable under this Plan are subject to medical review by First Choice Health.

Meaning of Plan for COB

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

- This MultiCare 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, January 1 through December 31.

Right of Recovery

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

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

Facility of Payment

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

This Plan will not make any additional payment on any claim with a date of service that is more than 365 days prior to the date on which the Plan receives 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.

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 MultiCare.

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

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

Who Is a COBRA Qualified Beneficiary?

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

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

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

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

Domestic Partners are not eligible for COBRA coverage under federal law; however, MultiCare offers a similar extension of coverage for up to 18 months. 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:

- The Plan no longer provides group health coverage to any employees;
- The COBRA coverage premium is not paid within 31 days of the due date (the initial grace period is 45 days after the first COBRA election);
- The qualified beneficiary becomes covered under another group health plan with no applicable pre-existing condition exclusion or limit;
- The qualified beneficiary enrolls in Medicare; or,

- If an extension from 18 to 29 months was granted due to a disability and the individual receives a final determination from the Social Security Administration stating the individual is no longer disabled, the individual must notify the plan administrator within 30 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 30 days after the final determination date, and after the initial 18-month COBRA coverage period.

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 be 150% of the full cost of coverage.

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

Failure to make payments within the designated time frame will result in automatic termination of coverage to the last day of the month for which a complete payment was made. Payments need to be sent directly to FCH, P.O. Box 12659, Seattle, WA 98111. 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. The Plan is not obligated to offer COBRA benefits to beneficiaries if this notification is not received within the 61 days.

What Coverage Must Be Offered When Electing COBRA?

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

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

- **Open enrollment** – qualified beneficiaries must be notified of any benefit or carrier changes at open enrollment and be given the opportunity to change coverage just like active employees. Qualified beneficiaries have the same rights as active employees during open enrollment to add or drop family members, change coverages and change carriers, if available. However, if a qualified beneficiary adds a family member during open enrollment who was not previously covered, that added family member does not become a qualified beneficiary
- **Modification of coverage** – if an employer modifies coverage for similarly situated active employees; the coverage for qualified beneficiaries must be modified similarly. Some examples of modifications include benefit enhancements, elimination of coverage and changes in carriers.

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.

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. Generally, this amount is equal to the following:

- The contracted amount agreed to by Network Providers
- For services subject to the No Surprises Act (which includes 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 ambulance services), the Allowed Amount is the Recognized Amount (see related definition)
- For services received from out-of-network providers who are not subject to the No Surprises Act, the Allowed Amount is the Usual, Customary and Reasonable (UCR) rate (see related definition). For these services, 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
- Have a written agreement with a hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

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

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

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

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

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

Covered Expense is any service or supply covered by the Plan as outlined in the *Medical Benefits* section and not specifically noted in the *Plan Exclusions and Limitations* section.

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

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

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

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

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

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

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

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

Incurred means the date on which a service or supply is furnished or provided.

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
- 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, personality disorders, paraphilic disorders.

Network Health Care Facility or Participating Health Care Facility means a facility contracted with any network offered under the Plan that renders services within the service area of that network as described under *How to Obtain Health Services*.

Network Provider or Participating Provider means a provider contracted with any network offered under the Plan who renders services within the service area of that network as described under *How to Obtain Health Services*.

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 or facility who is not a Network Provider or Network Health Care Facility.

Participant means any eligible employee or other eligible individual enrolled in the Plan, also referred to as covered member.

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

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

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

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

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.

Primary Care Provider (PCP) providers with the following specialties may commonly be considered PCPs as defined by the MultiCare Connected Care Network:

- Family Practice
- Family Practice with OB
- Internal Medicine
- General Practice
- Pediatrics
- Nurse Practitioner - Family Practice
- Nurse Practitioner - Pediatrics
- Nurse Practitioner - Adult
- Nurse Practitioner - Women's Health
- Nurse Practitioner - Geriatric Medicine
- Geriatric Medicine
- Obstetrics & Gynecology
- Gynecology
- Naturopathic Physicians
- Physician Assistants - designated at PCP

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

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

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

Qualifying Payment Amount is generally a plan's median contracted rate on January 31, 2019 for the same or similar item or service, increased for inflation.

Recognized Amount means:

- For emergency services and certain non-emergency services provided within certain Network Health Care Facilities, the Recognized Amount is:
  - An amount determined by an All-Payer Model Agreement,
  - If no All Payer Model Agreement exists, then the Recognized Amount is the amount determined by specified state law,
  - If no All Payer Model Agreement or specified state law exists, the Recognized Amount is the lesser of 1) the amount billed by the provider or facility, or 2) the Qualifying Payment Amount for the item or service.
- For Air Ambulance Services, the Recognized Amount is the lesser of:
  - The amount billed by the provider of air ambulance services, or
  - The Qualifying Payment Amount for the item or service.

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:

- Air Ambulance services
- Emergency services
- Services of non-contracted providers when rendering care within an in-network facility, except a primary surgeon for a non-emergent admission. Examples include:
  - Anesthesiologists services
  - Assistant surgeon services
  - Hospitalist services
  - Intensivist services
  - Laboratory services
  - Neonatology services
  - Pathology services
  - Radiology services

If you receive any of the services listed above, then those out-of-network providers cannot balance bill you, unless you are provided with written notice and give written consent to waive your protections against balance billing.

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

- Ambulance services

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

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

Skilled nursing facility means a qualified facility that has the staff and equipment to provide skilled nursing care as well as other related services.

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

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

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

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

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

- Pain in the musculature associated with the temporomandibular joint
- Internal derangement of the temporomandibular joint
- Arthritic problems with the temporomandibular joint

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

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

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

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

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

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

The Plan's UCR calculation is based upon the 25th percentile of the market rate for identical and similar services within a particular geographic area that has been obtained from a commercially-reasonable, independent third-party source, which is updated semi-annually. If the third party source does not have enough data to establish a UCR amount for a given medical procedure, the UCR will be calculated as a multiple of Medicare, specifically 300% 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 45% 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.