First Choice Health

Medical, Vision and Pharmacy Benefits Summary Plan Description

PPO Plan

Effective January 1, 2025

www.fchn.com

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

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Table of Contents

Important Information about this Plan

This booklet serves as your Plan Document and Summary Plan Description. The first section of the booklet describes your coverage and payment levels under the Public Hospital District No. 4, King County dba Snoqualmie Valley Health Plan as of January 1, 2025, and how to use your benefits. The second section contains information on eligibility and enrollment, terminating and continuing coverage, administration, claim and appeal procedures and other legally required material.

Public Hospital District No. 4, King County dba Snoqualmie Valley Health, the employer, Plan Sponsor and Plan Administrator of this self-funded Plan, delegates to First Choice Health (FCH - a division of First Choice Health Network, Inc.), a Third Party Administrator (TPA), to perform certain Plan services. Public Hospital District No. 4, King County dba Snoqualmie Valley Health has delegated fiduciary responsibility for appeal decisions related to medical claims to First Choice Health (FCH) but otherwise retains at all times the ultimate fiduciary authority, responsibility and control over Plan assets, management and administration, including appeals related to eligibility status, change in status, special enrollment, termination and continuation of coverage, and qualified medical child support orders.

The Public Hospital District No. 4, King County dba Snoqualmie Valley Health Plan (hereafter referred to as Snoqualmie Valley Health or the "Plan") will be referred to within this document as the Plan. Under the Plan, you receive the higher network level of benefits when you see a network provider. If you receive care from an out-of-network provider, you will receive the lower, out-of-network level of benefits.

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

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

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

This document is a summary description of the overall Snoqualmie Valley Health medical, pharmacy and vision benefits, here after referred to as the Plan. No oral interpretations can change this Plan. This booklet, combined with the Medical, Vision and Pharmacy Benefit Plan Document booklet, and the applicable provider directories, comprise the Plan document and summary plan description for Snoqualmie Valley Health. These materials do not create a contract of employment or any rights to continued employment with Snoqualmie Valley Health.

Contacting First Choice Health

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

First Choice Health
Customer Service Department
PO Box 12659
Seattle, WA 98111-4659
(833) 316-0913
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 (833) 316-0913.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (833) 316-0913.

Chinese（中文）：**如果需要中文的帮助**，请拨打这个号码 (833) 316-0913.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (833) 316-0913.

FCH's Customer Service Department business hours are Monday through Friday, 8:00 AM to 5:00 PM Pacific Standard Time (PST). The office is closed on New Year's Day, Memorial Day, Independence Day (4th of July), Labor Day, Thanksgiving, and the day after Thanksgiving, Christmas Eve and Christmas Day.

You can access benefit information or your specific claim and enrollment status anytime at www.fchn.com or by calling FCH Customer Service's automated voice response system at (833) 316-0913.

How to Obtain Health Services

Your ID Card

Your ID card identifies you as a Plan participant and contains important information about your coverage and benefits. Please present your ID card each time you receive care. If you lose your ID card, you may order a new one either through contacting FCH Customer Service at (833) 316-0913, or logging into www.fchn.com. Under no circumstances should you give your ID card to another person for their use.

Choosing a Provider

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

Networks	State/Area	Phone	Website
Tier 1 Snoqualmie Valley Health Providers	Snoqualmie Valley Health Providers	(833) 316-0913	www.fchn.com/ProviderSearch
Tier 2 Eastside Health Network Providers	Evergreen and Overlake Hospital Providers	(833) 316-0913	www.fchn.com/ProviderSearch
Tier 3 First Choice Health (FCH)	Washington, Alaska, Oregon, Idaho, Montana, Wyoming, Nebraska, Iowa, North Dakota, South Dakota	(800) 231-6935	www.fchn.com/ProviderSearch
Tier 3 First Health Network Providers	All states/areas not served by FCHN	(800) 226-5116	www.myfirsthealth.com/
Tier 4 Out-of-Network	Any provider not participating in the above networks.		

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

Continuity of Care

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

course of treatment for pregnancy from the provider; or (5) determined to be terminally ill and receiving treatment for such illness from the provider or facility. This requirement does not apply to for-cause terminations of a provider.

Services Received Outside of the U.S.

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

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

Medical Management

Pre-authorization 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:

- **Air Ambulance Transport** - non-urgent transport
- **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
  - 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**
- **Gene, Immune, and CAR T-Cell Therapy**
- **Genetic Testing over $1,000**
- **Hyperbaric Oxygen Therapy**
- **Imaging**
  - PET scans
- **Inpatient Admissions**
- **Medical Injectables, Chemotherapy and Other Drugs over $7,000/annually** (Newly FDA-approved medications may also require pre-authorization.)
  - 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
- **Nerve Ablations (any location)**
- **Organ and Bone Marrow Transplants**
- **Radiation Therapy**

  - Proton beam, neutron beam or helium radiation therapy
  - Stereotactic body radiation therapy (SBRT)
  - Stereotactic radiosurgery (Gamma Knife, Cyber Knife)
- **Select Bioengineered Skin/Amniotic and Soft Tissue Products**
- **Select Peripheral Nerve Blocks**
- **Surgery**
  - BAHA-bone anchored hearing aid (surgical benefit applies)
  - Blepharoplasty
  - 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
  - HIPEC/Cytoreductive 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
- **Transcranial Magnetic Stimulation**

As noted above, if you neglect to obtain pre-authorization for services which require it, your claim may be denied. Payments of claims denied due to lack of pre-authorization do **not** apply toward your calendar year deductible or out-of-pocket maximums. Your provider may submit an advance request to FCH Medical Management for benefit or medical necessity determinations. **Experimental and investigational services are not covered.** If a service could be considered experimental and investigational for a given condition, we recommend a benefit determination in advance.

Notification for Emergency Admissions

Admissions directly from the emergency room 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.

Case Management

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

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

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

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

Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis. The final decision on the course of treatment rests with patients and their providers.

Maternity Management Program

Expecting a baby? The Plan offers a Maternity Management Program that provides prenatal education to help mothers carry their babies to term. To enroll, or if you want additional information, call (800) 808-0450.

Payment Provisions – PPO Plan

Tier	Network
Tier 1	Snoqualmie Valley Health
Tier 2	Eastside Health Network
Tier 3	First Choice Health and First Health Providers
Tier 4	Out-of-Network Providers

Highlights of Plan Provisions

- Your benefit coverage is highest, and your out-of-pocket costs are less, when you receive services from Snoqualmie Valley Health and providers (Tier 1 Network).
- You will receive the second-highest benefit coverage if you receive services within the Eastside Health Network (Tier 2 Network).
- You will receive the third-highest benefit coverage if you receive services within the First Choice Health Network, or the First Health Network if travelling outside FCHN service area (Tier 3 Network).
- Your benefit coverage will be lowest if you receive services from an Out-of-Network provider (Tier 4 Out-of-Network).
- Benefit payment is based on the Allowed Amounts agreed upon by Network providers.
- 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* under Summary Plan Description) will be paid at the In-Network level. An Allowed Amount will be obtained through Usual, Customary and Reasonable data or a negotiated rate. If neither is available or appropriate, billed charges may be used as the Plan payment. You will be responsible for the difference (if any) between the Allowed Amount and the billed charges on Recognized Provider claims and this difference would not apply to your Out-of-Pocket (OOP) maximum as discussed below.
- For services received from out-of-network providers (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*) 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*).
- 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

The annual deductible is the amount you (or your family) must pay each Plan year before the Plan will pay for covered services (payment for non-covered services will not be applied to the deductible). Once the deductible is satisfied, coinsurance amounts as noted in the *Summary of Medical Benefits* will be applied. Until then, the amount due to a provider is your responsibility. The Tier 1, Tier 2, and Tier 3 annual deductibles are inclusive of each other. Tier 4 is exclusive of the first three tiers.

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

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

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

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

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the most you will need to pay in a Plan year for covered services. This Plan offers an Embedded Family Out-of-Pocket (OOP) Maximum, which means once each individual within a family meets the individual maximum, s/he will not be assessed

further co-insurances. Also, the family will meet no more than the stated family maximum regardless of family size. Pharmacy services apply to the out-of-pocket maximum for the applicable tiers.

The Tier 1, Tier 2, and Tier 3 annual out-of-pocket maximums are inclusive of each other. Tier 4 is exclusive of the first three tiers.

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

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

Benefit Maximums

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

Annual Deductible and Out-of-Pocket Maximums

Deductible and Out-of-Pocket Maximums	**Tier 1** **Snoqualmie Valley Health**	**Tier 2** **Eastside Health Network**	**Tier 3** **First Choice Health and First Health Providers**	**Tier 4** **Out-of-Network Providers**
Annual Medical Deductible (per calendar year)				
Individual	$1,500	$1,500	$3,000	$6,000
Family	$3,000	$3,000	$6,000	$12,000
Annual Medical and Pharmacy Out-of-Pocket Maximum (per calendar year)				
Individual	$4,000	$4,000	$6,900	$12,000
Family	$8,000	$8,000	$13,800	$24,000

Summary of Benefit Maximums

Calendar Year Maximums	
Alternative Care • Acupuncture	20 visit maximum
Chiropractic Spinal Manipulation	20 visit maximum
Rehabilitation Therapy • Outpatient (includes physical, speech, occupational and massage therapies)	25 visit maximum
Skilled Nursing Facility	120 days maximum
Transportation and Lodging	$1,500 maximum

Summary of Medical Benefits

PPO Plan						
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Snoqualmie Valley Health**	**Tier 2 Eastside Health Network**	**Tier 3 First Choice Health and First Health Providers**	**Tier 4 Out-of-Network Providers**
Allergy Care						
• **Testing**						
– Primary Care Physician	✓ (Tier 4 only)	✓	100%	$25 copay, then 100%	$35 copay, then 100%	60%
– Specialist	✓ (Tier 4 only)	✓	100%	$35 copay, then 100%	$45 copay, then 100%	60%
• **Injections**	✓	✓	90%	85%	80%	60%
Alternative Care						
• **Acupuncture** 20 visit maximum per calendar year (Benefit maximum does not apply to a Chemical Dependency diagnosis.)	✓ (Tier 4 only)	✓	100%	$35 copay, then 100%	$45 copay, then 100%	60%
• **Massage Therapy**	See *Rehabilitation Therapy*					
Ambulance Services FCH pre-authorization required for non-emergent air ambulance.	✓	✓	90%	85%	80%	60%
• **First Responder User Fees**	Not Covered					
Anesthesia FCH pre-authorization required for anesthesia for dental services.	✓	✓	90%	85%	80%	80% if provided at a network facility 60% if provided at an out-of-network facility

PPO Plan						
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Snoqualmie Valley Health**	**Tier 2 Eastside Health Network**	**Tier 3 First Choice Health and First Health Providers**	**Tier 4 Out-of-Network Providers**
Applied Behavior Analysis (ABA) Therapy FCH pre-authorization required for inpatient services.	✓	✓	90%	85%	80%	60%
Autologous Blood Donation/Blood Transfusion	✓	✓	90%	85%	80%	80%
Bariatric Services and Surgery	Not Covered					
Biofeedback	✓	✓	90%	85%	80%	60%
Chemical Dependency FCH pre-authorization required for inpatient, residential and partial hospitalization.						
• **Inpatient** (facility)	✓	✓	90%	85%	80%	60%
• **Inpatient** (professional)	✓	✓	90%	85%	80%	60%
• **Outpatient** (facility and professional)	✓ (Tier 4 only)	✓	100%	$25 copay, then 100%	$35 copay, then 100%	60%
Chiropractic Spinal Manipulation 20 visit maximum per calendar year	✓	✓	90%	85%	80%	60%
Clinical Trials	Covered based on place of service and as specifically outlined under *Clinical Trials*.					
Dental Trauma FCH pre-authorization required for follow-up services, inpatient and anesthesia.						
• **Office Visits**						
– Primary Care Physician	✓ (Tier 4 only)	✓	100%	$25 copay, then 100%	$35 copay, then 100%	60%

PPO Plan						
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Snoqualmie Valley Health**	**Tier 2 Eastside Health Network**	**Tier 3 First Choice Health and First Health Providers**	**Tier 4 Out-of-Network Providers**
– Specialist	✓ (Tier 4 only)	✓	100%	$35 copay, then 100%	$45 copay, then 100%	60%
• **All Other Places of Service**	✓	✓	90%	85%	80%	60%
Diabetic Education and Diabetic Nutrition Education The first 3 Diabetic Nutrition Education per calendar year are considered preventive. This benefit applies after the first 3 visits per calendar year are exhausted.						
– Primary Care Physician	✓ (Tier 4 only)	✓	100%	$25 copay, then 100%	$35 copay, then 100%	60%
– Specialist	✓ (Tier 4 only)	✓	100%	$35 copay, then 100%	$45 copay, then 100%	60%
Diagnostic Services – non-routine (facility and professional) FCH pre-authorization required for PET scans.						
• **Hospital Inpatient** (professional)	✓	✓	90%	85%	80%	60%
• **Hospital Outpatient** (facility)	✓	✓	90%	85%	80%	60%
• **Hospital Outpatient** (professional)	✓	✓	90%	85%	80%	60%

PPO Plan						
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Snoqualmie Valley Health**	**Tier 2 Eastside Health Network**	**Tier 3 First Choice Health and First Health Providers**	**Tier 4 Out-of-Network Providers**
• **Independent Facility** Diagnostic Testing provided by an independent diagnostic testing provider, group, facility or office. Billed separately from the provider of care.	✓	✓	90%	85%	80%	60%
• **In Office**	✓	✓	90%	85%	80%	60%
Dialysis	Covered based on place of service.					
Durable Medical Equipment and Supplies						
• **Breastfeeding Supplies and Equipment**	✓ (Tier 4 only)	✓ (Tier 4 only)	100%	100%	100%	60%
• **Durable Medical Equipment**	✓	✓	90%	85%	80%	60%
• **Medical Supplies**	✓	✓	90%	85%	80%	60%
• **Oral Appliances**	✓	✓	90%	85%	80%	60%
• **Orthopedic Appliances/Braces**	✓	✓	90%	85%	80%	60%
• **Prosthetic Devices**	✓	✓	90%	85%	80%	60%
• **Wigs**	✓	✓	90%	85%	80%	60%
Emergency Care						
• **Emergency Department** (facility) (copay waived if admitted)	N/A	✓	$150 copay, then 90%	$150 copay, then 90%	$150 copay, then 90%	$150 copay, then 90%
• **Emergency Department** (professional)	N/A	✓	90%	90%	90%	90%
• **Urgent Care**	✓ (Tier 4 only)	✓	$50 copay, then 100%	$50 copay, then 100%	$65 copay, then 100%	60%

PPO Plan						
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Snoqualmie Valley Health**	**Tier 2 Eastside Health Network**	**Tier 3 First Choice Health and First Health Providers**	**Tier 4 Out-of-Network Providers**
Family Planning						
• **Contraceptive Office Visits**	✓ (Tier 4 only)	✓ (Tier 4 only)	100%	100%	100%	60%
• **Devices, Implants and Injections**	✓ (Tier 4 only)	✓ (Tier 4 only)	100%	100%	100%	60%
• **Contraceptive Diagnostic Testing**	✓ (Tier 4 only)	✓ (Tier 4 only)	100%	100%	100%	60%
• **Sterilizations**	✓ (Tier 4 only)	✓ (Tier 4 only)	100%	100%	100%	60%
• **Termination of Pregnancy** covered for all female participants FCH pre-authorization required for inpatient services.						
– Facility and Professional Services	✓	✓	90%	85%	80%	60%
– Primary Care Physician	✓ (Tier 4 only)	✓	100%	$25 copay, then 100%	$35 copay, then 100%	60%
– Specialist	✓ (Tier 4 only)	✓	100%	$35 copay, then 100%	$45 copay, then 100%	60%
Foot Orthotics (for the treatment of diabetes only)	✓	✓	90%	85%	80%	60%
Gender Affirming Services FCH pre-authorization required for inpatient admission and surgery.	Covered based on place of service.					

PPO Plan						
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Snoqualmie Valley Health**	**Tier 2 Eastside Health Network**	**Tier 3 First Choice Health and First Health Providers**	**Tier 4 Out-of-Network Providers**
Genetic Services FCH pre-authorization required for genetic testing over $1,000.						
• **BRCA Testing**	✓ (Tier 4 only)	✓ (Tier 4 only)	100%	100%	100%	60%
• **All Other Genetic Testing**	✓	✓	90%	85%	80%	60%
• **Genetic Counseling**						
– Office Visit - Primary Care Physician	✓ (Tier 4 only)	✓	100%	$25 copay, then 100%	$35 copay, then 100%	60%
– Office Visit - Specialist	✓ (Tier 4 only)	✓	100%	$35 copay, then 100%	$45 copay, then 100%	60%
– All Other Places of Services	✓	✓	90%	85%	80%	60%
Habilitative Services FCH pre-authorization required for inpatient services.						
• **Inpatient** (facility)	✓	✓	90%	85%	80%	60%
• **Inpatient** (professional)	✓	✓	90%	85%	80%	60%
• **Outpatient** (facility and professional)	✓ (Tier 4 only)	✓	100%	$35 copay, then 100%	$45 copay, then 100%	60%
Hearing						
• **Routine Hearing Exams**	✓	✓	90%	85%	80%	60%
• **Medically Necessary Hearing Exams**	✓	✓	90%	85%	80%	60%
• **Hearing Aids/Appliances**	Not Covered					

PPO Plan						
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Snoqualmie Valley Health**	**Tier 2 Eastside Health Network**	**Tier 3 First Choice Health and First Health Providers**	**Tier 4 Out-of-Network Providers**
Home Health Care FCH pre-authorization required for enteral formula, medical food, and associated services.						
• **Home Health Care**	✓	✓	90%	85%	80%	60%
• **Phototherapy** (home)	✓	✓	90%	85%	80%	60%
Hospice FCH pre-authorization required for inpatient hospice and inpatient respite care.						
• **Hospice Care**	✓	✓	90%	85%	80%	60%
• **Respite Care**	✓	✓	90%	85%	80%	60%
Hospital Inpatient Surgery and Services FCH pre-authorization required.						
• **Inpatient Facility Services**	✓	✓	90%	85%	80%	60%
• **Inpatient Doctor Visits/ Consultations**	✓	✓	90%	85%	80%	60%
• **Inpatient Professional Services** (surgeon)	✓	✓	90%	85%	80%	60%
• **Inpatient Professional Services** (assistant surgeon)	✓	✓	90%	85%	80%	80% if provided at a network facility 60% if provided at an out-of-network facility

PPO Plan						
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Snoqualmie Valley Health**	**Tier 2 Eastside Health Network**	**Tier 3 First Choice Health and First Health Providers**	**Tier 4 Out-of-Network Providers**
Hospital Outpatient Surgery and Services FCH pre-authorization required for certain outpatient services; see *Pre-Authorization Requirements* for details.						
• **Outpatient Facility Services**	✓	✓	90%	85%	80%	60%
• **Ambulatory Surgery Center** (ASC)	✓	✓	90%	85%	80%	60%
• **Outpatient Professional Services** (surgeon)	✓	✓	90%	85%	80%	60%
• **Outpatient Professional Services** (assistant surgeon)	✓	✓	90%	85%	80%	80% if provided at a network facility 60% if provided at an out-of-network facility
Infertility Diagnostic Services Limited benefit; see *Infertility Diagnostic Services* for details.	✓	✓	90%	85%	80%	60%
Infusion Therapy (includes infusion therapy provided in the home) FCH pre-authorization required for certain infusion therapy drugs; see *Pre-Authorization Requirements* for details.	✓	✓	90%	85%	80%	60%
Maternity and Newborn Care (Covered for all female participants)						

PPO Plan						
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Snoqualmie Valley Health**	**Tier 2 Eastside Health Network**	**Tier 3 First Choice Health and First Health Providers**	**Tier 4 Out-of-Network Providers**
• **Maternity Care**	✓	✓	90%	85%	80%	60%
• **Newborn Care**	✓	✓	90%	85%	80%	60%
Mental Health Care FCH pre-authorization required for inpatient, residential and partial hospitalization.						
• **Inpatient** (facility)	✓	✓	90%	85%	80%	60%
• **Inpatient** (professional)	✓	✓	90%	85%	80%	60%
• **Partial Day Treatment (PDT)**	✓	✓	90%	85%	80%	60%
• **Outpatient** (facility and professional)	✓ (Tier 4 only)	✓	100%	$25 copay, then 100%	$35 copay, then 100%	60%
Nutritional Counseling	✓ (Tier 4 only)	✓ (Tier 4 only)	100%	100%	100%	60%
Nutritional and Dietary Formulas FCH pre-authorization required.	✓	✓	90%	85%	80%	60%
Oral Surgery	✓	✓	90%	85%	80%	60%
Pharmacy	Administered by CVS Caremark					
• **Retail** (30-day supply)						
– Generic	N/A	✓	$15 copay			$15 copay then 60%
– Preferred/ Formulary Brand	N/A	✓	$45 copay			$45 copay then 60%
– Non-Preferred/ Non-Formulary Brand	N/A	✓	$70 copay			$70 copay then 60%
• **Mail order or Choice90** (90-day supply)						
– Generic	N/A	✓	$30 copay			Not Covered

PPO Plan						
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Snoqualmie Valley Health**	**Tier 2 Eastside Health Network**	**Tier 3 First Choice Health and First Health Providers**	**Tier 4 Out-of-Network Providers**
– Preferred/ Formulary Brand	N/A	✓	$90 copay			Not Covered
– Non-Preferred/ Non-Formulary Brand	N/A	✓	$140 copay			Not Covered
• **Specialty Drugs** (limited to 30-day supply)	N/A	✓	70%, member pays up to $150			Not Covered
Plastic and Reconstructive Services FCH pre-authorization required. Limited benefit; see *Plastic and Reconstructive Services* for details.						
• **Inpatient** (facility)	✓	✓	90%	85%	80%	60%
• **Inpatient** (professional)	✓	✓	90%	85%	80%	60%
• **Outpatient** (facility)	✓	✓	90%	85%	80%	60%
• **Outpatient** (professional)	✓	✓	90%	85%	80%	60%
Podiatric Care See *Podiatric Care* for details on routine foot care.	✓	✓	90%	85%	80%	60%
Preventive Care						

PPO Plan						
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Snoqualmie Valley Health**	**Tier 2 Eastside Health Network**	**Tier 3 First Choice Health and First Health Providers**	**Tier 4 Out-of-Network Providers**
• **Immunizations** Immunizations for children and adults are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention. See *Preventive Care* for details. Covered Immunizations provided at a pharmacy are covered at the In-Network benefit level based on billed charges. Travel immunizations are not covered.	✓ (Tier 4 Only)	✓ (Tier 4 Only)	100%	100%	100%	60%
• **Periodic Exams** (adult and child)	✓ (Tier 4 Only)	✓ (Tier 4 Only)	100%	100%	100%	60%
• **Nutritional Counseling** 3 visits per calendar year.	✓ (Tier 4 Only)	✓ (Tier 4 Only)	100%	100%	100%	60%
• **Obesity Screening and Counseling** 12 visits per calendar year. For members with an obesity diagnosis.	✓ (Tier 4 Only)	✓ (Tier 4 Only)	100%	100%	100%	60%
• **Obesity Prevention Counseling** For women aged 40-60 years who are normal weight or overweight.	✓ (Tier 4 Only)	✓ (Tier 4 Only)	100%	100%	100%	60%

PPO Plan						
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Snoqualmie Valley Health**	**Tier 2 Eastside Health Network**	**Tier 3 First Choice Health and First Health Providers**	**Tier 4 Out-of-Network Providers**
Screening Tests Screening tests are covered in accordance with the recommendations set forth by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See *Preventive Care* for more details.						
• **Bone Density Screening**	✓ (Tier 4 Only)	✓ (Tier 4 Only)	100%	100%	100%	60%
• **Colonoscopy** (beginning at age 45 – or younger, if at increased risk) The first colonoscopy per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent colonoscopies in the same calendar year are covered under the medical benefits, regardless of diagnosis.	✓ (Tier 4 Only)	✓ (Tier 4 Only)	100%	100%	100%	60%
• **Fecal Occult Blood Test** The first fecal occult blood test per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent fecal occult blood tests in the same calendar year are covered under the medical benefits, regardless of diagnosis.	✓ (Tier 4 Only)	✓ (Tier 4 Only)	100%	100%	100%	60%

PPO Plan						
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Snoqualmie Valley Health**	**Tier 2 Eastside Health Network**	**Tier 3 First Choice Health and First Health Providers**	**Tier 4 Out-of-Network Providers**
• **FIT-Fecal DNA** 1 per calendar year.	✓ (Tier 4 Only)	✓ (Tier 4 Only)	100%	100%	100%	60%
• **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.	✓ (Tier 4 Only)	✓ (Tier 4 Only)	100%	100%	100%	60%
• **Pap Test**	✓ (Tier 4 Only)	✓ (Tier 4 Only)	100%	100%	100%	60%
• **Prostate Cancer Screening (PSA)**	✓ (Tier 4 Only)	✓ (Tier 4 Only)	100%	100%	100%	60%
• **Sigmoidoscopy** The first sigmoidoscopy per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent sigmoidoscopies in the same calendar year are covered under the medical benefits, regardless of diagnosis.	✓ (Tier 4 Only)	✓ (Tier 4 Only)	100%	100%	100%	60%
• **All Other Screening Tests**	✓ (Tier 4 Only)	✓ (Tier 4 Only)	100%	100%	100%	60%

PPO Plan						
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Snoqualmie Valley Health**	**Tier 2 Eastside Health Network**	**Tier 3 First Choice Health and First Health Providers**	**Tier 4 Out-of-Network Providers**
Professional/Physician Services – office visits, certain telehealth visits and office surgeries.						
• **Office Visit**						
– Primary Care Physician	✓ (Tier 4 only)	✓	100%	$25 copay, then 100%	$35 copay, then 100%	60%
– Specialist	✓ (Tier 4 only)	✓	100%	$35 copay, then 100%	$45 copay, then 100%	60%
• **Office Visit Related Services**	✓	✓	90%	85%	80%	60%
Rehabilitation Therapy FCH pre-authorization required for inpatient services.						
• **Inpatient** (facility)	✓	✓	90%	85%	80%	60%
• **Inpatient** (professional)	✓	✓	90%	85%	80%	60%
• **Outpatient** – includes physical, speech, massage, and occupational therapies (facility) 25 visits per calendar year combined with outpatient professional.	✓ (Tier 4 only)	✓	100%	$25 copay, then 100%	$35 copay, then 100%	60%
• **Outpatient** – includes physical, speech, massage, and occupational therapies (professional) 25 visits per calendar year combined with outpatient facility	✓ (Tier 4 only)	✓	100%	$25 copay, then 100%	$35 copay, then 100%	60%

PPO Plan						
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Snoqualmie Valley Health**	**Tier 2 Eastside Health Network**	**Tier 3 First Choice Health and First Health Providers**	**Tier 4 Out-of-Network Providers**
• **Cardiac and pulmonary rehabilitation**	✓ (Tier 4 only)	✓	100%	$25 copay, then 100%	$35 copay, then 100%	60%
Skilled Nursing Facility 120 days per calendar year. FCH pre-authorization required.	✓	✓	90%	85%	80%	60%
Temporomandibular Joint (TMJ) Disorder FCH pre-authorization required if inpatient or surgery.						
• **Specialist Office Visit**	✓ (Tier 4 only)	✓	100%	$35 copay, then 100%	$45 copay, then 100%	60%
• **All Other Services**	✓	✓	90%	85%	80%	60%
Tobacco Cessation	✓ (Tier 4 Only)	✓ (Tier 4 Only)	100%	100%	100%	60%
Transplants – organ and bone marrow FCH pre-authorization required.						
• **Recipient/Donor Services** (facility and professional)	✓	✓	90%	85%	80%	60%
• **Recipient/Donor Services** (office visits)						
– Primary Care Physician	✓ (Tier 4 only)	✓	100%	$25 copay, then 100%	$35 copay, then 100%	60%
– Specialist	✓ (Tier 4 only)	✓	100%	$35 copay, then 100%	$45 copay, then 100%	60%

PPO Plan						
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Snoqualmie Valley Health**	**Tier 2 Eastside Health Network**	**Tier 3 First Choice Health and First Health Providers**	**Tier 4 Out-of-Network Providers**
Transportation and Lodging $1,500 maximum per calendar year.	✓	✓	100%			
Vision – routine eye exams and hardware	Administered through VSP					

Medical Benefits

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

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

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

Acupuncture

Refer to the *Alternative Care* Benefit.

Allergy Care

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

Alternative Care

Benefits include services of an acupuncturist to treat a covered illness or injury. Maintenance therapy is not covered.

Ambulance Services

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

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

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

Note: Emergent Air Ambulance Transport will be reviewed retrospectively.

Transportation for personal or convenience reasons is not covered.

Anesthesia

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

General Anesthesia for Dental Care

Coverage is provided for general anesthesia and associated facility charges in conjunction with dental care provided to a participant 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 FCHN 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.

Biofeedback

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

Blood Transfusions/Donation

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

Chemical Dependency

All inpatient admissions, residential, and partial hospital programs **require FCH pre-authorization** by calling (800) 640-7682. The plan covers services provided to individuals requiring chemical dependency treatment for abuse of substances (e.g. alcohol or other drugs). Care must be medically necessary and provided at the least restrictive level.

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

Chiropractic Spinal Manipulation

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

Clinical Trials

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

An approved clinical trial is:

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

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

Costs Covered:

- Routine Patient Costs defined as follows-

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

Costs Not Covered:

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

Dental Trauma

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

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

Diabetic Education and Diabetic Nutrition Education

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

Diagnostic Services

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

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

Emergency Services and Urgent Care

The Plan covers emergency department visits (including pre-stabilization, post-stabilization, certain ancillary services) and urgent care visits to evaluate an Emergency Medical Condition at in-network and out-of-network facilities.

Emergency (or emergent) means the sudden and acute onset of a symptom(s), including severe pain, that would lead a person, acting reasonably, to believe a health condition exists that requires immediate medical attention and that failure to provide medical attention would result in

serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

Examples of **emergent** conditions include severe pain, difficulty breathing, deep cuts or severe bleeding, poisoning, drug overdose, broken bones, unconsciousness, stab or gunshot wounds, automobile accidents, and pain or bleeding during pregnancy. Examples of **urgent** conditions include cuts and lacerations, diarrhea, allergic reactions, sprains, urinary tract infections and vomiting.

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

Family Planning

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

Termination of Pregnancy

Voluntary termination of pregnancy is covered for all female plan participants.

Foot Orthotics

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

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. Coverage 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.

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

Genetic Services

FCH pre-authorization is required for genetic testing over $1,000. Benefits include genetic testing, counseling, interventions, and therapy.

Habilitative Services

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

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

Covered services include speech, occupational, physical and aural therapy services.

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

Hearing Exams, Aids/Appliances

Hearing aids and appliances are not covered.

Please 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 or speech therapist (or an assistant working under the supervision of one of these providers)
- Home health aide working directly under the supervision of one of the above providers
- Licensed as a social worker - masters prepared
- Registered dietician

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

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

Hospice Care

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

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

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

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

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

Hospital Inpatient Surgery and Services

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

Hospital Outpatient Surgery and Services

Certain outpatient surgery/procedures **require FCH pre-authorization**; please see *Pre-Authorization Requirements* for details. Covered outpatient care includes outpatient surgery,

procedures and services, operating room and anesthesia, radiology, lab and pharmacy services furnished by and used while at a hospital or ambulatory surgical center.

Infertility Diagnostic Services

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

Infusion Therapy

FCH pre-authorization is required for certain infusion therapy drugs; please see *Pre-Authorization Requirements* for details. This benefit covers 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 the Home Health Care benefit, regardless of whether the patient is home bound.

Massage Therapy

Refer to the *Rehabilitation Therapy* Benefit.

Maternity and Newborn Care

The Plan offers a Maternity Management Program that provides prenatal education to help mothers carry their babies to term. To enroll, or if you want additional information, call (800) 808-0450.

Coverage for pregnancy and childbirth, for employees or his/her spouse or female dependent children, in a hospital, birthing center, or home birth is provided on the same basis as any other medical condition, as are complications of pregnancy. Medically necessary screening(s) and diagnostic procedures during pregnancy for prenatal diagnosis of congenital disorders of the fetus are covered. The services of a licensed physician, an advanced registered nurse practitioner (ARNP), a licensed midwife, or a certified nurse midwife (CNM) are covered under this benefit.

Coverage for newborns is provided automatically for the first 31 days following birth when no other coverage is in effect during the first 31 days of life. In order for coverage to continue beyond the first 31 days, the child must be enrolled as a dependent under this Plan (see Eligibility and Enrollment for details). Benefits are subject to the newborn child's own coinsurance and deductible requirements.

Newborn care includes inpatient hospital services and professional care (including circumcision) performed during the initial period of hospitalization immediately following birth. Any services performed after the baby is discharged from this level of care are covered under the benefit

applicable to the services billed, and are not considered newborn care. Circumcisions are covered up to 28 days following birth. Circumcisions performed after 28 days must be medically necessary as determined by FCH.

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

Mental Health Care

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

Care must be medically necessary and provided at the least restrictive level of care. Facilities offering inpatient level of care must have a medical model with physician and/or nursing staff 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, psychological testing and psychotherapeutic programs are covered only if related to the treatment of an approved clinical mental health diagnosis, specifically, those noted in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

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

Nutritional Counseling

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

Nutritional and Dietary Formulas

Coverage for nutritional and dietary formulas is provided when medically necessary as defined in the most current FCH medical policy.

Oral Surgery

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

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

Pharmacy

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 CVS Caremark, a separate provider not affiliated with FCH. Covered medications must meet these requirements:

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

You may order up to a 30-day supply from a retail network pharmacy. Alternatively, you may order up to a 90-day supply through CVS Caremark's mail order service, or through the retail pharmacy. If you or a family member regularly take medication for chronic, long-term conditions, you may receive up to a 90-day supply of these maintenance medications through CVS Caremark. If you use the mail order service, you pay the 90-day copay even if your prescription is written for less than a 90-day supply. See "Filling a Prescription" below for more detailed information on how and where you can obtain your prescription drugs.

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

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

This difference in price does not apply toward your annual deductible or out-of-pocket maximum. Your out-of-pocket expense will never exceed the cost of the drug. This provision does not apply to drugs that are considered preventive under PPACA.

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

Filling a Prescription

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

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

Retail Network Pharmacy

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

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

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

Mail Order Service

If you, or a covered family member, regularly take medication for chronic, long-term conditions such as diabetes, arthritis, high blood pressure, heart conditions, etc., you have two options for obtaining a 90-day supply of ongoing medications. The prescription will be delivered directly to your home.

1. **Mail Order** You may obtain a 90-day supply of medication through a mail order program with CVS Caremark
    a. Ask your doctor to send your prescription to CVS Caremark electronically
    b. Download the order form at www.caremark.com. Complete the form, mail it to CVS Caremark with your paper prescription, and include your payment information. Attach a voided check if you wish to pay from your checking account. Your information will be kept on file for future orders.
    c. Call CVS Caremark toll-free at: (866) 818-6911. With a simple phone call, their friendly pharmacy staff will transfer your prescription to CVS Caremark.

Out-of-Network Pharmacy

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

Specialty Pharmacy Program

This program supports patients with complex health conditions who are taking self-injectable medications or other medications with strict compliance requirements or special storage needs. To receive these drugs, you now must purchase them through CVS Caremark Direct Specialty Pharmacy. You may receive your medications via delivery to your home, workplace, physician's office, or any other designated location. For additional information, please contact CVS Caremark at (866) 818-6911. Note: Refer to the Medical benefits for coverage of drugs not classified as self-administered. FCH prior authorization may be required for drugs covered under the medical benefit.

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 or diabetes.

Preventive Care

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

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

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

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

Professional/Physician Services

This benefit applies to in-person, face-to-face office visits, and Telemedicine. Telemedicine includes videoconferences, scheduled telephone visits and electronic visits (e-Visits). 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.

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

Rehabilitation Therapy

Coverage for disabling conditions is provided through inpatient and outpatient rehabilitation therapy. Examples of such therapies include, but are not limited to, physical therapy, speech therapy, massage 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, and
- Services must be billed by a hospital, physician, 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 care nor custodial care are covered.)

Temporomandibular Joint Syndrome (TMJ)

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

Tobacco Cessation

Coverage is provided for tobacco cessation programs.

Transplants, Organ and Bone Marrow

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

- A written recommendation with supporting documentation received from your provider,
- The procedure is performed at a facility, and by a provider, approved by FCH, and
- Upon evaluation, you are accepted into the approved facility's transplant program and comply with all program requirements.

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

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

Email:
preauthorization@fchn.com

Written:
FCH Medical Management
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
- Anti-rejection drugs

Donor Services

Donor expenses are covered if all criteria are met below:

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

Covered donor expenses include:

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

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

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

Travel & Lodging

FCH review and approval is required for travel and lodging benefits. The travel benefit provides reimbursement for eligible expenses up to $1,500 per calendar year maximum.

This travel benefit is available for any covered benefit provided by the Plan that is not available within the local commutable area defined as 75 miles outside of the patient's home address. Medical services must be deemed medically necessary.

This benefit is not available for any medical services that are not covered under the Plan.

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.

Vision Care

This benefit covers medically necessary vision exams.

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
- Adoption expenses
- Amounts for which the covered person has no obligation to pay
- Amounts over and above UCR, as defined by the Plan
- Any charges by a facility owned or operated by the United States or any state or local government unless the participant is legally obligated to pay (excluding: (i) covered expenses rendered by a medical facility owned or operated by the United States Veteran's Administration when the services are provided to a participant for a non-service related illness or injury, and (ii) covered expenses rendered by a United States military medical facility to participants who are not on active military duty)
- Any condition resulting from participation in declared or undeclared acts of terrorism, war, military service, participation in a riot or civil disobedience
- Any service not medically necessary for the diagnosis, treatment or prevention of injury or illness, even if it is not specifically listed as an exclusion (except for specific services offered through the Preventive Care benefit)
- Any service received before the participant's effective date of coverage or after the coverage termination date
- Aromatherapy
- Athletic training, body-building, fitness training or related expenses
- Autopsies
- Bariatric surgery, 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. 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.
- Botanical or herbal medicines, as well as other over-the-counter medications, except as required under ACA
- Care provided by phone, fax, e-mail, Internet or telemedicine, except as outlined under the *Professional Services* benefit
- Chaperoning services for healthcare appointments or healthcare related services
- Charges for failure to keep a scheduled visit, for the copying of medical records or for the completion of a claim or administrative forms

- Chemical Dependency treatments listed below:
  - Alcoholics Anonymous or other similar chemical dependency programs or support groups
  - Care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior
  - Court-ordered or other assessments to determine the medical necessity of court-ordered treatments
  - Court-ordered treatments or treatments related to deferral of prosecution, deferral of sentencing or suspended sentencing or treatments ordered as a condition of retaining driving rights, when no medical necessity exists
  - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
  - Emergency patrol services
  - Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program
  - Information or referral services
  - Information schools
  - Long-term or custodial care
  - Non substance related disorders
  - Pain management and/or stress reduction classes
  - Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs
- 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
- Court ordered examinations or treatment of any kind, except when medically necessary
- Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational and custodial services are not covered
- Dental, oral surgery or orthodontic related services, such as (but not limited to) those listed below (unless accident related or otherwise specifically covered by the Plan):
  - Care of the teeth or dental structures
  - Tooth damage due to biting or chewing
  - Dental 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
- 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

  - 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)
- Duplication of ongoing program management services
- Experimental, investigational, or unproven services
- FDA-approved drugs, medications or other items for non- approved indications, except when an FDA-approved drug has been proven clinically effective to treat such indication and is supported in peer-reviewed scientific medical literature
- Fertility Preservation, regardless of diagnosis, including both sperm and egg preservation
- First responder user fees
- Hearing Aids/Appliances
- Home health care listed below:
  - Custodial care
  - Housekeeping or meal services
  - Maintenance care
  - Shift or hourly care services
- Hospice care listed below:
  - Custodial care or maintenance care, except palliative care to the terminally ill patient subject to the stated limits
  - Financial or legal counseling services
  - Housekeeping or meal services
  - Services by a participant or the patient's family or volunteers
  - Services not specifically listed as covered hospice services under the Plan
  - Supportive equipment such as handrails or ramps
  - Transportation
- Immunizations for travel
- Infertility services or treatments to achieve pregnancy (regardless of the cause) including but not limited to:
  - Artificial insemination
  - In vitro fertilization (IVF)
  - Gamete intra-fallopian transplant (GIFT)
- 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
- Learning disabilities and related services, educational testing or associated training

- Medication therapy management
- Mental health care listed below:
  - Adventure-based and/or wilderness programs that focus primarily on education, socialization or delinquency
  - Court-ordered assessments
  - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
  - Marriage and couples counseling
  - 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
  - Nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories
  - Pain management, and stress reduction classes
  - Sensitivity training
  - Sexual dysfunctions
  - 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
- Orthodontia for Temporomandibular Joint Dysfunction (TMJ)
- Orthodontic treatment, appliances or services; dentures or related services
- Over-the-counter products, except as covered by the Plan
- Parental group training classes
- Personal, convenience or comfort services, supplies, or items including but not limited to phones, TVs, guest services, deluxe or suite hospital room, air conditioners, diapers or hygiene items
- Pharmacy services listed below:
  - Anorectics (any drug used for the purpose of weight loss)
  - Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order
  - Blood, blood serum, and blood plasma
  - Charges for the administration or injection of any drug, except as covered by the Plan I.e. Influenza, Shingles and other CDC recommended vaccines provided at the pharmacy under the Pharmacy benefit
  - Diagnostic tests
  - Drugs labeled "Caution: Limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual
  - Drugs used for cosmetic purposes, including but not limited to drugs such as Botox, Minoxidil (Rogaine), Tretinoin (Retin A, covered through age 25)
  - FDA Approved High Dollar Non-Essential Drugs: New drug formulations and derivatives of similar agents already marketed, or combinations of agents that provide no additional clinical benefit to the currently available medications.
  - High dollar kits and non-FDA approved patches
  - Fluoride, except as required under the Patient Protection and Affordable Care Act

  - Impotency drugs, including but not limited to Viagra
  - Infertility medications
  - Infused drugs or drugs otherwise classified as not self-administered unless specifically identified as covered elsewhere in the Plan Document i.e. vaccinations provided at a Pharmacy
  - Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed medical facility, rest home, sanitarium, extended care facility, convalescent medical facility, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals
  - Non-legend drugs (except insulin, over-the-counter oral contraceptives, and certain over-the-counter medications required under the Patient Protection and Affordable Care Act).
  - Non-systemic contraceptives and implants, such as diaphragms, IUDs, or cervical caps which would be covered through the medical benefits
  - Nutritional supplements
  - Out-of-network Mail Order and Specialty Drugs
  - Prescriptions which an eligible individual is entitled to receive without charge from any Workers' Compensation laws
  - Renova
  - Replacement of lost or stolen medications/items
  - Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, except those listed above
  - Vitamins, singly or in combination, except prenatal and federal legend vitamins to treat covered medical conditions, or as required by the Patient Protection and Affordable Care Act (PPACA)
- Physical examinations, reports or related services for the purpose of obtaining or maintaining employment, insurance, or licenses or permits of any kind, school admission, school sports clearances, immigration, foreign travel, medical research, camps, or government licensure, or other reasons not related to medical needs
- Plastic and reconstructive services listed below:
  - Complications resulting from non-covered services
  - Cosmetic services, supplies or surgery to repair, modify or reshape a functioning body structure for improvement of the patient's appearance or self-esteem (except for gender affirming surgery);
  - Dermabrasion, chemical peels or skin procedures to improve appearance or to remove scars or tattoos
- Procedures, regardless of medical necessity, outside the scope of the provider's license, registration or certification
- Professional services listed below:
  - Professional services provided by fax or email.
  - Follow up phone calls from provider for test results, referrals, prescription refills or reminders that occur within 7 days of an in-person office visit
  - Calls to nurse line or to obtain educational material are also not covered
- Provider continuing education or training services
- 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 or 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)
- Snoring treatment (surgical or other)
- Special diets, nutritional supplements, vitamins and minerals or other dietary formulas or supplements except as covered by the Plan
- Specialized intraocular lenses associated with cataract surgery that correct vision disorders, such as Multifocal and Toric intraocular lenses
- 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 permanently replace human organs
  - Complications arising from the donation procedure if the donor is not a Plan participant
  - Donor expenses for a Plan participant who donates an organ or bone marrow, however, complications arising from the donation would be covered as any other illness to the extent they are not covered under the recipient's health plan.
  - Transplants considered experimental and investigational, as defined by the Plan
- 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
- Vision Care, 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 sunglasses or safety glasses
  - Radial keratotomy, Lasik or any other refractive surgery, orthoptics, pleoptics, vision therapy, visual analysis therapy or training related to muscular imbalance of the eye; optometric therapy
  - Services or supplies received principally for cosmetic purposes other than contact lenses selected in place of eyeglasses
- Vitamin B-12 injections except to treat Vitamin B-12 deficiency
- Vocational rehabilitation, work hardening or training programs regardless of diagnosis or symptoms that may be present, or for non-medically necessary education
- Weight management programs

Eligibility and Enrollment

Eligible Classes of Employees

All active, full-time Snoqualmie Valley Health employees are eligible to enroll in the Plan. Full-time employees work a minimum of 20 hours per week.

Examples of employees who are considered non-eligible are those classified on Snoqualmie Valley Health's books or records as:

- Agency and Contracted Staff,
- Leased or temporary employees, or
- One that is enrolled as a dependent on another Snoqualmie Valley Health employee's plan.

Enrollment Periods

Enrollment periods for eligible employees and dependents are:

- Within 60 days of initial eligibility, or
- During any open enrollment.

If a completed enrollment application is not received by the Plan Administrator within the 60 days of the employee's initial eligibility period, the employee and their dependents cannot enroll until the next group open enrollment period.

How to Enroll

To enroll, contact the Plan Administrator for an enrollment form and instructions. It is very important that the enrollment information is complete and accurate and returned to the Plan Administrator within the 60 days of the employee's initial eligibility period. Incomplete information will result in delayed eligibility, delayed access to benefits and non-payment of claims.

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

Open Enrollment

Open enrollment is a defined period when you, if an eligible employee, are allowed to enroll or make changes to your health care benefit coverage. Open enrollment occurs once each Plan year. Under no circumstances will you be able to change the medical plan outside of open enrollment.

Special Enrollment Periods

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

Change in Status

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

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

A change in status includes:

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

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

Involuntary Loss of Other Coverage

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

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

The Plan Administrator must receive a completed enrollment form within 60 days of the date your prior coverage ended. Coverage under this Plan will become effective on the first of the month following loss of coverage.

Late Enrollment

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

Effective Date

Effective Date of Coverage for You

The employee's coverage will become effective on the date the employee is eligible for benefits as long as the employee has satisfied: 1) the eligibility requirements noted under *Eligible Classes of Employees*, and 2) the Plan is in receipt of the completed enrollment form.

Effective Date of Coverage for Your Dependents

If you have one or more eligible dependents on the date that you become covered under this Plan and you elect to enroll them, they will be covered on the date your coverage becomes effective. Only dependents for which you have submitted an enrollment form and paid any required contributions will be covered. Your dependent will be considered a late enrollee if we do not receive the enrollment form and contribution payment within 60 days of the date he or she is eligible for coverage. **Late enrollments are not accepted.**

Deferred Effective Date of Your Coverage or an Increase in Coverage

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

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

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

Any dependents added after your effective date of coverage will be covered on the date they become eligible. You must submit an enrollment form to us for any such dependent and pay any required contributions. The Plan Administrator must receive the form within 60 days of the date the dependent becomes eligible for coverage. If you do not notify us within 60 days, the dependent will be considered a late enrollee. **Late enrollments are not accepted.**

Special Rule

If an employee and spouse or domestic partner are each employees of Snoqualmie Valley Health and are eligible for benefits, employees may not double cover each other as dependents.

Children whose parents are both Snoqualmie Valley Health employees may enroll under only one parent.

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

Dependents

Dependent Eligibility

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

- Lawful spouse
- Domestic Partner (same or opposite sex) who meets the criteria for eligibility (with a signed affidavit regarding eligibility of the Domestic Partner); see section *Plan Definitions*;
- Your (or your domestic partner's) Natural child, adopted child, child placed with you for legal adoption, stepchild, or other legally designated ward up to age 26; or,
- Natural child, adopted child, child placed with you for legal adoption, stepchild, or other legally designated ward that a health care professional determines is not capable of self-sustaining employment due to a physical or developmental disability. Proof of such incapacity must be furnished to the Plan Administrator within 31 days prior to the date the child reaches age 26. Thereafter, employees are required to resubmit proof of continued disability once per year.

A child who loses dependent status for coverage eligibility under this provision may be eligible for continuation of coverage under COBRA (*see COBRA section*). You are responsible for paying the contribution for your dependent's group health plan benefits.

Dependents do not include:

- A spouse who is legally separated or divorced unless coverage is required by court order or decree;
- A spouse, Domestic Partner or child eligible for employee coverage under the Plan;
- You or your spouse's natural child for whom you have given up rights through legal adoption;
- A parent of an employee, spouse or Domestic Partner; or
- The newborn child, spouse or Domestic Partner of an enrolled dependent child.

Special Rules for Domestic Partners

Domestic Partners who qualify for coverage under the terms and conditions of this Plan may only enroll during the open enrollment period. Federal law does not recognize domestic partners; therefore, domestic partners are not eligible for continuation of coverage under COBRA. However, although not required, Snoqualmie Valley Health will offer a COBRA-like continuation of coverage to domestic partners and their dependent children, under the same conditions as that offered to an eligible spouse/dependent child under COBRA.

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

Dependents Acquired Through Marriage/Domestic Partnership

If you acquire a new dependent through marriage or domestic partnership, the Plan Administrator must receive the completed enrollment application and a copy of the marriage certificate/affidavit of domestic partnership within 60 days after the marriage/start of the domestic partnership for coverage to be effective, or your new dependent will not be able to enroll until the next open enrollment.

Coverage for your new dependent will become effective on the first of the month following the date of lawful marriage, or the date the domestic partnership is established.

Dependent Children

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

Children whose parents are both Snoqualmie Valley Health employees may enroll under only one (1) parent (see *Special Rule*).

Natural Newborn Children

If you acquire a new dependent through birth, the Plan Administrator must receive the enrollment form within 60 days after the date of birth. This provision does not apply to grandchildren of the Subscriber or Spouse/Domestic Partner. Coverage is provided for the newborn child for up to 31 days following birth when the Subscriber or Spouse/Domestic Partner is eligible for the maternity benefits provided by the Plan. This automatic coverage is provided only when the newborn has no other coverage in effect during the first 31 days of life. If benefits are paid on a newborn under this provision and the newborn subsequently becomes enrolled in other coverage effective retroactively to any date during the first 31 days of life, 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. Benefits will be provided after day 31 only if the newborn is enrolled within 60 days after the date of birth. If the newborn is timely enrolled, coverage becomes effective on the date of birth.

Adopted Children Acquired.

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

If the enrollment form, with documentation to support legal guardianship, is received within 60 days of placement, coverage becomes effective on the date of placement. The Plan Administrator may request added information.

Children Acquired Through Legal Guardianship

If the enrollment form, with documentation to support legal guardianship, is received within 60 days of obtaining legal guardianship, dependent coverage becomes effective on the date of the order. The Plan Administrator may request added information.

Children Covered Under Qualified Medical Child Support Orders

If the enrollment form, with notification of the medical child support order (from you, the custodial parent or a state agency administering Medicaid) is received within 60 days of the order, coverage becomes effective on the date of the order. If received after 60 days, coverage becomes effective on the first of the month after the Plan Administrator has the enrollment information. (See *Qualified Medical Child Support Orders* for more information.)

Dependent Children Out of Area

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

The First Health Network is available for network benefits to:

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

A full description of the provider networks is under *How to Obtain Health Services*.

Continued Eligibility for a Child who is Disabled

Coverage may be extended beyond age 26 if the child is:

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

Contact the Plan Administrator for details and enrollment forms. For continued eligibility of a child who is disabled, the enrollment form must be received within 31 days of the date the child reaches age 26. Thereafter, employees are required to resubmit proof of continued disability once per year.

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

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

The participant must also submit the following:

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

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

Qualified Medical Child Support Orders

Snoqualmie Valley Health will provide medical coverage to certain children (called alternate recipients) if directed by a Qualified Medical Child Support Order (QMCSO), including benefits for adopted children. The participant, the child's custodial parent, or a state agency administering Medicaid may submit notification.

A medical child support order:

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

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

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

If the medical child support order is a QMCSO:

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

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

The enrollment form with the notification of the medical child support order needs to be received within 60 days of the order in order for coverage to become effective on the date of the order. If

the enrollment information is received after 60 days of the order, coverage will become effective on the first of the month following the date we receive the enrollment information for coverage.

Termination of Coverage

For participating employees, coverage ends at these events:

- Non-payment of a contribution that is your responsibility
- You no longer meet eligibility requirements for coverage (see *Eligibility and Enrollment*); coverage ends the last day of the month after the date you are no longer in a class of eligible or active employees
- The employee or any participant performs an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of this plan
- The plan is materially breached
- The Plan Sponsor ceases to offer coverage in the group market under which this coverage is issued.

For participating dependents, coverage ends at these events:

- The date the participant's coverage ends for any reason
- The last day for which any required Plan contributions are paid
- The last day of the month in which the participant dies
- The participating employee and spouse legally divorce (the Plan Administrator must receive a copy of the decree); or a Domestic Partnership is dissolved or terminated
- The last day of the month in which the dependent child reaches age 26, unless disabled (see *Continued Eligibility for a Child who is Disabled*)

Related Details

- Coverage is automatically extended through the last day of the month of the termination, provided the applicable contribution for the coverage period has been paid.
- If your share of the Plan contribution is paid on a pre-tax basis through a §125 Cafeteria Plan, enrollment into this Plan is a 1-year commitment. You can opt out of the Plan mid-year only as permitted under §125 regulations. Refer to your §125 Cafeteria Plan Summary Plan Description for details.
- If your share of the Plan contribution is paid on an after-tax basis (i.e., not through a §125 Cafeteria Plan), you may cancel coverage at any time during the Plan year. Coverage ends the last day of the month in which the Plan Administrator receives written notice of termination.
- The Plan requires 31 days' written notice for dependent coverage termination.

A terminated employee who is rehired will be treated as a new hire for benefit purposes and be required to satisfy all eligibility and enrollment requirements.

If you or your dependents lose coverage under this Plan, you may be eligible to continue coverage. For more information, read the COBRA section or ask your Plan Administrator.

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

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

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

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

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

Who Is a COBRA Qualified Beneficiary?

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

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

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

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

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

Qualifying Events and Continuation Periods

Qualifying events and continuation periods are explained below:

- If employment terminates (voluntary or involuntary), you and your covered dependents may continue coverage under this Plan for up to 18 months unless the cause is gross misconduct
- If your work hours are reduced, resulting in loss of group coverage, you and your covered dependents may continue coverage under this Plan for up to 18 months
- If you and your spouse legally divorce or are legally separated, your spouse and covered dependent children may continue coverage under this Plan for up to 36 months
- When your covered dependent child no longer meets the Plan's definition of dependent child, the child may continue coverage under this Plan for up to 36 months
- When you become Medicare eligible, your Medicare-ineligible covered dependents may continue coverage under this Plan for up to 36 months
- If you die your spouse or covered dependents may continue coverage under this Plan for up to 36 months
- If you enter into uniformed service, you may elect to continue Plan coverage for up to 24 months (See also 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 of 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

- If an extension from 18 to 29 months was granted due to a disability and the individual receives a final determination from the Social Security Administration stating the individual is no longer disabled, the individual must notify the plan administrator within 31 days after the date of that determination. Coverage ends on the last day of the month through which contribution payments have been received, so long as that date is within the first month that begins within 31 days after the final determination date, and after the initial 18-month COBRA coverage period

Please note: Once COBRA coverage ends, it cannot be reinstated.

Contribution Payment Requirements

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

If you are eligible and receive a disability extension under Title II or XVI of the Social Security Act, your contribution will also be 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 COBRA Management Services. If you have COBRA related questions, you may call (866) 517-7580 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, the employee or qualified beneficiary is responsible for notifying the Plan Administrator within 61 days of the divorce, legal separation or ineligibility of a dependent. The Plan is not obligated to offer COBRA benefits to beneficiaries if this notification is not received within the 61 days.

What Coverage Must Be Offered When Electing COBRA?

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

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

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

Other Continuation of Coverage

Leaves of Absence

Family Medical Leave Act of 1993 (FMLA) Leaves

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

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

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

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

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

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

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

Military Leave

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

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

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

All Leave of Absences

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

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

Claim and Appeal Procedures

Claim

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

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

How to File a Claim for Plan Benefits

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

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

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

Claim Types

- **Pre-service claim** means any claim for a Plan benefit for which the Plan requires approval before medical care is obtained.
- **Concurrent claim** means any claim reconsidered after initial approval for an ongoing course of treatment which results in a reduced or terminated benefit.

- **Post-service claim** means any claim for a Plan benefit that is not a pre-service claim and is a request for payment or reimbursement for covered services already received.
- **Urgent care claim** means a claim for medical care or treatment that, if normal pre-service standards are applied, would in the opinion of a physician with knowledge of the claimant's medical condition:
  - Seriously jeopardize the claimant's life, health or ability to regain maximum function
  - Subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested.

Claim Procedure

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

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

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

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

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

Adverse Benefit Determination

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

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

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

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

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

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

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

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

Appeal Procedure

FCH performs functions associated with the internal review of medical and pharmacy appeals for this Plan. First Choice Health (FCH) has final authority over appeals as the appropriate named fiduciary. Pharmacy Appeals are handled by CVS Caremark.

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

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

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

Medical Appeals:

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

Pharmacy Appeals:

Caremark, Inc.
Attn: Appeals Department
P.O. Box 52084
Phoenix, AZ 85072-2084

Fax: (866) 443-1172

Internal Appeal Process

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

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

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

will be made as soon as possible, but not later than 72 hours after receipt of a request for internal review if a delay would jeopardize the member's or their dependent's health.

External Review

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.

You are entitled to 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. Denials that do not involve rescission or medical judgment (i.e., denials that involve only contractual or legal interpretation without any use of medical judgment) are not eligible for external review. You must first submit an internal appeal and receive a final internal adverse benefit determination before you may request external review. Your request for external review must be received within 125 calendar days of receipt of the final internal adverse benefit determination.

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 if its decision within one business day thereafter. This notice will include the following:

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

If eligible for external review, FCH will forward your appeal (including all information and documentation considered in both the original denial and the internal review, as well as any additional documentation you submit) to an Independent Review Organization (IRO) within 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 Snoqualmie Valley Health. 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's or their dependent's health.**

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

You have a right to file a civil action for benefits after you exhaust these claim procedures; the civil action must be filed within 180 days from your receipt of the Plan's final determination regarding your claim.

Independent Dispute Resolution

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

Coordination of Benefits

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

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

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 to the rules under *What if I'm Covered by Medicare?*), then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is secondary to the plan covering the person as a dependent.

2. Child covered under more than one plan:

   A. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

      1) The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or
      2) If both parents have the same birthday, the plan that has covered the parent longest is the Primary Plan.

   B. For a dependent child whose parents are divorced or separated or are not living together, whether or not they have ever been married:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What if I'm Covered by Medicare?

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

If your Medicare entitlement is due to:

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

- **Disability:** If you are covered under this Plan as an active employee or dependent of an active employee (including Domestic Partners) and become entitled to Medicare due to disability, this Plan will be primary. Once you or your dependent is declared disabled by Social Security, the individual who is disabled should apply for coverage under Medicare Parts A and B. If you are covered under this Plan as [Domestic Partner or a] COBRA qualified beneficiary and are also entitled to Medicare based on disability, Medicare is primary.
- **End Stage Renal Disease (ESRD)**: If you become entitled to Medicare on the basis of ESRD, this Plan will pay primary during the initial coordination period (refer to the Medicare Secondary Payer Manual at www.cms.gov/manuals/downloads/msp105c02.pdf for more information regarding the initial coordination period). After this initial coordination period, this Plan will pay secondary to Medicare. This is true even if you are covered under this Plan as a Domestic Partner or COBRA qualified beneficiary.

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

Pre-authorization when this Plan is Secondary

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

Meaning of Plan for COB

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

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

insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.

- The medical care components of long-term care contracts, such as skilled nursing care
- The medical benefits coverage in automobile “no fault” and traditional automobile “fault” type contracts
- Medicare or other governmental benefits, as permitted by law.

“Plan” does not include:

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

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

Claim Determination Period

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

Right of Recovery

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

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

Facility of Payment

When another plan makes payments that should have been made under this Plan and in accordance with this provision, the Plan may, at its sole discretion, elect to reimburse to the other plan the amount necessary to satisfy the intent of this COB provision. Any amount paid

under this subsection will be considered benefits paid under this agreement, and the Plan will be fully discharged from liability under this agreement to the extent of those payments.

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

Right to Receive and Release Information

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

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

Subrogation, Reimbursement and Right of Recovery

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

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

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

Assignment of Rights (Subrogation)

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

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

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

you or your covered dependent (including your minor dependent) has not received the full damages claimed, unless the Plan agrees in writing to a reduction.

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

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

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

Equitable Lien and Other Equitable Remedies

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

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

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

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

Obligation to Assist in the Plan's Reimbursement Activities

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

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

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

Health Insurance Portability and Accountability Act of 1996

Privacy Rights

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

Disclosures to the Plan Sponsor

The Plan may disclose your health information to Public Hospital District NO.04, King County dba Snoqualmie Valley Health, the Plan Sponsor of the Plan, to carry out plan administration functions performed by the Plan Sponsor on behalf of the Plan. The plan documents have been amended in accordance with federal law to permit this use and disclosure.

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

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

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

Plan Benefit Information

Benefits, Contributions and Funding

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

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

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

The Plan will provide benefits in accordance with the requirements of all applicable laws, including but not limited to, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Newborns' and Mothers' Health Protection Act of 1996, the Women's Health and Cancer Rights Act of 1998, the Mental Health Parity and Addiction Equity Act of 2008, Genetic Information Nondiscrimination Act (GINA) of 2008, and the Patient Protection and Affordable Care Act of 2010 (PPACA).

Plan Administrator's Power of Authority

The Plan Administrator role for this Plan rests with Snoqualmie Valley Health's Human Resources Department. The Plan Administrator is responsible for:

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

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

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

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

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

Discretionary Authority

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

Collective Bargaining Agreements

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

Clerical Error

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

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

Your Rights and Protections Against Surprise Medical Bills

What is Balance Billing (sometimes called surprise billing)?

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

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

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

You Are Protected from Balance Billing for:

Emergency Services

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

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

Out-of-Network Providers

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

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

You are never required to give up your protections from balance billing. You also are not required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing is not allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If the medical service at issue was performed in a state with an All-Payer Model Agreement with Centers for Medicare & Medicaid Services (CMS), such as Maryland, you may call that applicable state Department of Insurance for more information about your rights under applicable state law.

Maryland:

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

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

Summary Plan Description and General Information

Plan Name:	Public Hospital District No. 04, King County dba Snoqualmie Valley Health
Plan Year:	January 1 through December 31
Plan Coverage Status	This is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (ACA).
Funding Medium:	Claims are paid directly out of the general assets of the Company. Employee contributions are placed in the general assets of the company and accounted for separately in the accounting records of the Company. Employee contributions shall only be used to pay medical or dental claims.
Source of Contributions:	The company bears the entire cost of this benefit Plan, minus the participants' contribution.
Name, address and telephone number of Plan Sponsor, Administrator:	Public Hospital District No. 04, King County dba Snoqualmie Valley Health 9801 Frontier Avenue S.E. Snoqualmie, WA 98065
Agent for Service of Legal Process:	Patrick Ritter, CFO Public Hospital District No. 04, King County dba Snoqualmie Valley Health 9801 Frontier Avenue S.E. Snoqualmie, WA 98065
Named Fiduciary for medical claims and appeals:	First Choice Health Network, Inc. 400 Westlake Ave. N., Suite 1500 Seattle, WA 98109/ (206) 292-8255
Named Fiduciary for all other matters:	Public Hospital District No. 04, King County dba Snoqualmie Valley Health 9801 Frontier Avenue S.E. Snoqualmie, WA 98065
Plan Sponsor's Employer Identification Number:	91-0908129
Third Party Administrator:	First Choice Health Network, Inc. d/b/a First Choice Health 400 Westlake Ave. N., Suite 1500 Seattle, WA 98109 (800) 430-3818/Local (206) 268-2360 www.fchn.com
Plan Description:	The written Plan Description consists of this entire document plus benefit summary booklets and provider directories.

Plan Definitions

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

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

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

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

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

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

Fiduciary means a person who exercises discretionary authority or control over the management of 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 FCH 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.

Made Whole Doctrine is an equitable defense to the subrogation or reimbursement rights of a subrogated Plan or other party, requiring that before subrogation and/or reimbursement will be allowed, the Covered Person must be made whole for all of its damages.

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.

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.

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) includes the following provider types:

- 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 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 who: 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) FCH does not offer agreements to his/her category of providers, or 2) agreements are offered but covered participant choice is not provided. Examples of both types are outlined below:

- Ambulance services

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

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

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

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 includes: 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 seven (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 80th percentile for facility and professional services, and the 50th percentile for ASC services 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 180% of Medicare. If there is no value from the third-party source, and there is no Medicare allowed amount, and the service is deemed payable, the Plan will allow 50% of billed charges. Coinsurance, copayments, deductible, or non-covered services are applied against UCR amount as patient responsibility. The provider can balance bill the member the difference between the Plan payment and provider's actual charges.