First Choice Health™

Healthy Employees. Healthy Companies.™

Central Washington Comprehensive Mental Health Employee Health Care Plan

Effective February 1, 2013

www.myFirstChoice.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.

v.01.13

Table Of Contents

Important Information about this Plan 1

- Grandfathering 2

Contacting First Choice Health Administrators 3

Section I - Benefits

How to Obtain Health Services 4

- Your ID Card 4
- Choosing a Provider 4

Medical Management 5

- Pre-authorization Requirements 5
- Notification for Emergency Admissions 7
- Concurrent Review and Discharge Coordination 7
- Case Management 7

Payment Provisions 8

- Highlights of Plan Provisions 8
- Summary of Annual Deductible and Out-of-Pocket Maximums: 8
- Annual Deductible 9
- Annual Out-of-Pocket Maximum 9
- Benefit Maximums 10

Summary of Medical Benefits 11

Medical Plan Benefits 16

- Allergy Care 16
- Ambulance Services 16
- Anesthesia 16
- Autologous Blood Donation/Blood Transfusions 17
- Chemical Dependency 17
- Dental Trauma 17
- Diabetic Instruction and Counseling 18
- Durable Medical Equipment (DME) 18
- Emergency and Urgent Care 19
- Family Planning 19
- Foot Orthotics 19
- Hearing 20
- Home Health Care 20

- Hospice Care ... 20
- Hospital Inpatient Medical and Surgical Care ... 21
- Hospital Outpatient Surgery and Services ... 21
- Infusion Therapy ... 21
- Lab and Radiology Services ... 21
- Maternity and Newborn Care ... 22
- Mental Health Care ... 22
- Neurodevelopmental Therapy ... 23
- Nutritional and Dietary Formulas ... 23
- Oral Surgery ... 23
- Orthognathic Surgery ... 24
- Pharmacy ... 24
- Plastic and Reconstructive Services ... 26
- Podiatric Care ... 26
- Preventive Care ... 27
- Professional/Physician Services ... 27
- Rehabilitation Therapy ... 27
- Skilled Nursing Facility ... 28
- Transplants (Organ and Bone Marrow) ... 28
- Vision Care ... 30

Plan Exclusions and Limitations ... 31

Dental Benefit Plan Provisions ... 38

- Calendar Year Dental Deductible ... 38

Summary of Dental Benefits ... 39

Dental Benefits ... 41

- Dental Expenses ... 41
- Class I - Preventive and Diagnostic Dental Services ... 41
- Class II - Basic Dental Services ... 41
- Class III - Major Dental Services ... 42
- Class IV - Orthodontia ... 42

Dental Limitations and Exclusions ... 43

Section II - Summary Plan Description

Eligibility and Enrollment ... 45

- Eligible Classes of Employees ... 45
- Waiting Period ... 45
- Enrollment Periods ... 45
- How to Enroll ... 45

- Open Enrollment ... 46
- Special Enrollment Periods ... 46
- Late Enrollment ... 47
- Effective Date ... 47
- Special Rule ... 48
- Waiver of Group Health Plan Benefits ... 48

Pre-Existing Condition Exclusion Limitation ... 49

- Pre-Existing Condition ... 49
- Pre-Existing Condition Exclusion ... 49

Dependents ... 50

- Dependents Acquired Through Marriage ... 50
- Dependent Children ... 51
- Dependent Children Out of Area ... 51
- Continued Eligibility for a Disabled Child ... 52
- Qualified Medical Child Support Orders ... 53

Termination of Coverage ... 54

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) ... 56

- Who Is a COBRA Qualified Beneficiary? ... 56
- Qualifying Events and Continuation Periods ... 57
- When COBRA Coverage Ends ... 57
- Contribution Payment Requirements ... 58
- Election Requirements ... 58
- What Coverage Must Be Offered When Electing COBRA? ... 58

Other Continuation of Coverage ... 60

- Leaves of Absence ... 60

Claim and Appeal Procedures ... 62

- Claim ... 62
- How to File a Claim for Plan Benefits ... 62
- Claim Types ... 62
- Claim Procedure ... 63
- Adverse Benefit Determination ... 63
- Appeal Procedure ... 64

Coordination of Benefits ... 67

- Pre-authorization when this Plan is Secondary ... 70

Subrogation ... 73

- Liable Third Parties and Insurers ... 73
- Uninsured/Underinsured Motorist Coverage ... 74
- Venue ... 74
- Subrogation Forms ... 74

Health Insurance Portability and Accountability Act of 1996 75

- Privacy Rights 75

Plan Benefit Information 76

- Benefits, Contributions and Funding 76
- Plan Administrator's Power of Authority 76
- Discretionary Authority 77
- Collective Bargaining Agreements 77
- Clerical Error 77

Statement of ERISA Rights 78

- Prudent Actions by Plan Fiduciaries 78
- Enforce Your Rights 78
- Continue Group Health Coverage/Certificate of Creditable Coverage 79
- Assistance with Your Questions 79

Summary Plan Description and General Information 80

Plan Definitions...81

Important Information about this Plan

This booklet serves as your Plan Document and Summary Plan Description for the Central Washington Comprehensive Mental Health Employee Health Care Plan as of February 1, 2013. The first section of the booklet describes your coverage and payment levels under the plan(s) offered. The second section contains information on eligibility and enrollment, terminating and continuing coverage, administration, claim and appeal procedures and other legally required material applicable to each benefit plan.

Central Washington Comprehensive Mental Health (CWCMH), the employer, Plan Sponsor and Plan Administrator of this self-funded Plan, delegates to First Choice Health Administrators (FCHA – a division of First Choice Health Network, Inc.), a Third Party Administrator (TPA), to perform certain Plan services. CWCMH delegates to FCHA the authority to make decisions on benefit coverage, medical management, claim payment and certain other administrative services according to CWCMH's policies and procedures. However, CWCMH retains at all times the ultimate fiduciary authority, responsibility and control over Plan assets, management and administration.

The CWCMH 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 a non-network provider, you will receive the lower network level of benefits except in certain instances as outlined in the summary of benefits.

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

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

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

These materials do not create a contract of employment or any rights to continued employment with CWCMH.

Grandfathering

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

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

Contacting First Choice Health Administrators

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

First Choice Health Administrators
Customer Service Department
PO Box 12659
Seattle, WA 98111-4659
(866) 551-6788
Local: (206) 268-2360
Fax: (888) 206-3092
Medical pre-authorization: (800) 808-0450
Mental health/chemical dependency pre-authorization: (800) 640-7682
TTY: (866) 876-5924
www.myFirstChoice.fchn.com

Spanish (Español): Para obtener asistencia en Español, llame al (866) 551-6788.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (866) 551-6788.

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

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

FCHA'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. FCHA offices close at 3:00 PM on the day before Thanksgiving and on December 23rd (or on the Friday before if the 23rd falls on a weekend). If the holiday falls on a Saturday, the office is closed on Friday; if the holiday falls on Sunday, the office is closed Monday (the holiday is recognized during the same calendar week in which the holiday falls).

You can access benefit information or your specific claim and enrollment status anytime at www.myFirstChoice.fchn.com or by calling FCHA Customer Service's automated voice response system at (866) 551-6788.

How to Obtain Health Services

Your ID Card

Your ID card identifies you as a Plan participant and contains important information about your coverage and benefits. Please present your ID card each time you receive care. If you lose your ID card, you may order a new one either through contacting FCHA Customer Service at (866) 551-6788, or logging into www.myFirstChoice.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	Websites
First Choice Health PPO Network	Washington, Alaska, Oregon, Idaho, Montana, Wyoming, Utah, Colorado, North Dakota, South Dakota	(800) 231-6935	www.fchn.com
First Health	All states/areas not served by FCHN, as well as Wyoming, Utah, Colorado, North Dakota, South Dakota.	(800) 226-5116	firsthealth.coventryhealthcare.com/

Note: For providers in Wyoming, Utah, Colorado, North Dakota and South Dakota who are contracted under both the First Choice Health PPO Network and the First Health Network, this Plan will pay according to the First Choice Health PPO Network contract.

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

Services Received Outside the U.S.

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

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

Medical Management

Pre-authorization Requirements

All inpatient admissions and certain outpatient services and procedures **require FCHA pre-authorization**, as also noted in the *Summary of Medical Benefits.* If pre-authorization is not obtained on the services noted below a $500 penalty will be assessed. For any of these procedures, you are responsible for obtaining pre-authorization directly from FCHA. You may have your provider contact FCHA for you, but you are ultimately responsible. Call (800) 808-0450 for pre-authorization on medical services or (800) 640-7682 for mental health or chemical dependency services. Pre-authorization is required for:

- **Ambulance** (except in life-threatening circumstances)
  - Air transport
  - Inter-facility transport
- **Clinical trials** (any treatment provided under a clinical trial)
- **Dental trauma services** (follow-up services)
- **Durable medical equipment, medical supplies and prosthetics**
  - When purchase exceeds $2,000; or
  - When rental exceeds $500 per month
- **Experimental, investigational or unproven services**
- **Genetic Testing**
  - Over $500
- **Hemodialysis** (for chronic kidney disease)
- **Home health care services**
  - Home health visits
  - Home infusion therapy (enteral and IV)
  - Hospice
- **Hyperbaric therapy**
- **Imaging**
  - PET scans
- **Inpatient admissions**
  - Chemical dependency and mental health admissions (including residential)
  - Inpatient hospice
  - Inpatient rehabilitation admissions
  - Long- term acute care facility
  - Medical/surgical admissions (excluding routine maternity deliveries)
  - Skilled nursing admissions

- **Medical injectables and other drugs**
  - Abatacept
  - Alpha-1 proteinase inhibitor
  - Blood clotting factors
  - Botulinum toxin (all types and brands)
  - Cytarbine Liposme
  - Epoprostenol
  - Imiglucerase
  - Infliximab
  - Intravenous immunoglobulin (IVIG) therapy
  - Ixabepilone
  - Palivizumab (Synagis)
  - Ranibizumab
  - Rituximab
  - Sipuleucel-T (Provenge)
  - Ustekinumab
- **Organ and bone marrow transplants** (includes evaluation of, services for both recipient and donor, and travel and lodging expenses)
- **Radiation Therapy**
  - Intensity-Modulated Radiation Therapy
  - Proton Beam Radiation Therapy
  - Stereotactic radiosurgery (Gamma Knife, Cyberknife)
- **Reconstructive procedures -** All procedures that may be considered cosmetic, including but not limited to:
  - Eyelid surgery (i.e. blepharoplasty)
  - Removal of breast implants
  - Rhinoplasty
- **Spinal injections that require conscious sedation** (any location)
- **Surgery**
  - Cochlear Implants (surgical benefit applies)
  - Lumbar fusions
  - Orthognathic surgery
  - Surgical interventions for sleep apnea
  - Varicose vein procedure

As previously noted, if you neglect to obtain pre-authorization for services which require it, a $500 penalty will be assessed. Such penalties will **not** apply toward your calendar year deductible or out-of-pocket maximums.

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

Notification for Emergency Admissions

Admissions directly from the emergency room do not require pre-authorization. However, notification is required within 2 business days after the admission, or as soon as possible. You, or your provider, may call FCHA 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 medical condition may require long-term, perhaps lifetime care involving extensive services in a facility or at home. With case management, a nurse monitors these patients and explores coordinated and/or alternative types of appropriate care. The case manager consults with the patient, family, and attending physician to develop a 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
- Addressing alternative care options
- Assisting in obtaining any necessary equipment and services
- Providing guidance and information on available resources

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

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

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

Payment Provisions

Highlights of Plan Provisions

- In general, your benefit coverage is greater, and your out-of-pocket costs less, when you choose a Network provider.
- If the closest network provider in the specialty you are seeking is more than 20 miles from your home zip code, you may see a non-network provider if there is one closer to you, and the Plan will reimburse those services at the network level. In order for your claim to be paid at the network level, you must submit an appeal according to the procedures listed under *Claim and Appeal Procedures*.
- If you are travelling and experience a medical Emergency (see *Plan Definitions*) and a network provider is not available, you may see any provider and the Plan will reimburse those services at the network level. In order for your claim to be paid at the network level, you must submit an appeal according to the procedures listed under *Claim and Appeal Procedures*.
- Services provided at Yakima Regional Medical Center and Toppenish Community Hospital are not covered, with the exception of the following services: inpatient and outpatient cardiac care, inpatient rehabilitative care, and emergency treatment, which are paid at the network level (generally 80%). Services provided by Medical Center Lab are not covered, except tissue exams, which are paid at the network level (generally 80%).
- Benefit payment is based on the Allowed Amounts agreed upon by Network providers.
- Services received from a Recognized Provider (See *Plan Definitions* in *Section II – Summary Plan Description*) will be paid at the Network level (80%). 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 Allowed Amount. 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. Common examples include:
  - Ambulance services
  - Anesthesiologists
  - Assistant surgeon
  - Non-contracted laboratories used by FCHN referring provider

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

Calendar Year Annual Deductible	Network/Non-Network
Employee only	$450
Family	$1,350
Calendar Year Annual Out-of-Pocket Maximum	**Network/Non-Network**
Employee only	$2,000
Family	$5,000

Annual Deductible

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

This Plan offers a Traditional Family Deductible which means each individual within a family will meet no more than the individual maximum, but the family will meet no more than the stated family maximum regardless of family size.

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

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

- Charges of non-covered services and treatment
- Charges for services that are denied as not medically necessary
- Charges over Usual, Customary and Reasonable (UCR) for non-network services as determined by FCHA
- Charges that exceed any applicable benefit maximum
- First 2 preventive visits per calendar year
- Penalties assessed due to lack of pre-authorization
- Routine eye exams and hardware
- Routine hearing exams
- Prescription drugs
- Copayments

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the most you will need to pay in a calendar year. This Plan offers a Traditional Family Out-of-Pocket (OOP) Maximum which means once each individual within a family meets the individual maximum; s/he will not be assessed further coinsurances. Also, the family will meet no more than the stated family maximum regardless of family size. The network and non-network calendar year out-of-pocket amounts are inclusive of each other. The following do **not** apply toward the annual out-of-pocket maximum:

- Charges of non-covered services and treatment
- Charges for services that are denied as not medically necessary
- Charges over Usual, Customary and Reasonable (UCR) for non-network services as determined by FCHA
- Charges that exceed any applicable benefit maximum

- Charges for claims denied for lack of pre-authorization
- Copayments
- Deductible
- Penalties assessed due to lack of pre-authorization
- Prescription drugs

Benefit Maximums

Your lifetime and calendar year benefit maximums are noted in the following table:

Summary of Benefit Maximums

Lifetime Maximums Benefits	
Organ Transplants – Recipient	
• **Travel/Lodging**	$5,000 (per transplant episode)
Calendar Year Maximums	
Individual Aggregate	$2,000,000
Hearing Exams, Aids/Appliances (Combined)	$1,250
Rehabilitation and Physical Therapy (Inpatient care)	30 days
Skilled Nursing Facility	30 days
Vision Care	
• **Routine Vision Care**	1 routine eye exam
• **Lenses, Frames, Contacts**	$200 every 2 calendar years ($300 if exam was performed and hardware received from Costco)

Summary of Medical Benefits

	Network Providers	Non-Network Providers
Allergy Care (testing, serum, injections)	80%	60%
Ambulance Services FCHA pre-authorization required for non-emergent air ambulance and inter-facility transport.	80%	80%
Anesthesia	80%	60%
Autologous Blood Donation/Blood Transfusions	80%	80%
Chemical Dependency FCHA pre-authorization required for inpatient, residential and partial hospitalization.	80%	60%
Dental Trauma FCHA pre-authorization required for follow-up services.	80%	80%
Diabetic Instruction and Counseling	80%	60%
Durable Medical Equipment FCHA pre-authorization required if purchases exceed $2,000 or $500 per monthly rental.		
• **Durable Medical Equipment**	80%	60%
• **Medical Supplies**	80%	60%
• **Oral Appliances** For treatment of obstructive sleep apnea only	80%	80%
• **Orthopedic Appliances**	80%	60%
• **Prosthetic Devices**	80%	60%
Emergency Care		
• **Emergency Room** (facility services) Copay is waived if admitted.	80% after $200 copay	60% after $200 copay
• **Emergency Room** (professional services)	80%	60%
• **Urgent Care** (facility and professional services)	80%	60%
Family Planning	80%	60%
Foot Orthotics	80%	60%

Services provided at Yakima Regional Medical Center, Toppenish Community Hospital are not covered, with the exception of inpatient and outpatient cardiac care, inpatient rehabilitative care and emergency treatment which will be paid at the Network level, generally 80%. Services provided by Medical Center Lab are not covered, with the exception of tissue exams which will be paid at the Network level.

	Network Providers	Non-Network Providers
Genetic Services FCHA pre-authorization required for genetic testing over $500.	80%	60%
Hearing (exams, aids, appliances)		
• **Routine Hearing Exams** 1 exam per calendar year	100%	100%
• **Medical Hearing Exams and Hearing Aids/ Appliances** $1,250 per calendar year	50%	50%
Home Health Care (HHC) FCHA pre-authorization required	80%	60%
Hospice Care FCHA pre-authorization required	80%	60%
Hospital Inpatient Medical and Surgical Care FCHA pre-authorization required.		
• **Facility Services**	80% after $200 copay per day up to $400 maximum	60% after $200 copay per day up to $400 maximum
• **Inpatient Professional Services** (doctor, surgeon, assistant surgeon, radiologist, pathologist)	80%	60%
Hospital Outpatient Surgery and Services FCHA pre-authorization required for certain outpatient services; see *Pre-authorization Requirements* for details.		
• **Surgical Facility Services**	80%	60%
• **Ambulatory Surgery Center** (ASC)	80%	60%
• **Outpatient Professional Services** (doctor, surgeon, assistant surgeon, radiologist, pathologist)	80%	60%
Infusion Therapy (Separate from Home Health Care)	80%	60%

Services provided at Yakima Regional Medical Center, Toppenish Community Hospital are not covered, with the exception of inpatient and outpatient cardiac care, inpatient rehabilitative care and emergency treatment which will be paid at the Network level, generally 80%. Services provided by Medical Center Lab are not covered, with the exception of tissue exams which will be paid at the Network level.

	Network Providers	Non-Network Providers
Lab and Radiology Services (non-routine, facility and professional services) FCHA pre-authorization required for PET Scans.		
• **Hospital Inpatient / Outpatient**	80%	60%
• **Lab and X-ray Facility** Lab or radiology services provided by an independent lab or radiology provider, group, facility or office, but billed separately from the provider of care	80%	60%
• **Doctor's Office** Office based lab or radiology service provided as part of the office visit, and billed as part of the office visit	80%	60%
Maternity and Newborn Care		
• **Inpatient Facility Services**	80% after $200 copay per day up to $400 maximum	60% after $200 copay per day up to $400 maximum
• **Professional Services**	80%	60%
Mental Health Care FCHA pre-authorization required for inpatient, residential and partial hospitalization.	80%	60%
Neurodevelopmental Therapy (through age 6)	80%	60%
Nutritional and Dietary Formulas	80%	60%
Oral Surgery	80%	80%
Orthognathic Surgery	80%	80%
Pharmacy		
• **Retail** (30 day supply)	• Generic: $10 • Preferred: $30 • Non-preferred: $55	
• **Mail Order/Online Pharmacy** (90 day supply)	• Generic: $20 • Preferred: $65 • Non-preferred: $130	
• **Specialty Pharmacy** (through Costco Specialty Pharmacy)	80% with a maximum copayment of $200	

Services provided at Yakima Regional Medical Center, Toppenish Community Hospital are not covered, with the exception of inpatient and outpatient cardiac care, inpatient rehabilitative care and emergency treatment which will be paid at the Network level, generally 80%. Services provided by Medical Center Lab are not covered, with the exception of tissue exams which will be paid at the Network level.

	Network Providers	Non-Network Providers
• **Proton Pump Inhibitors (PPIs) Step Therapy**	Prilosec OTC or Omeprazole is required before use of a non-formulary PPI will be considered.	
Plastic and Reconstructive Services FCHA pre-authorization required. Limited benefit; see *Plastic and Reconstructive Services* for details.	80%	60%
Podiatric Care See *Podiatric Care* for details on Routine Foot Care.	80%	60%
Preventive Care The first two preventive visits per calendar year are paid at 100%. A visit may include: preventive exam, immunizations or routine screening tests (such as colonoscopy/sigmoidoscopy, mammogram, pap test, etc).		
Well Baby and Child Care (children age 0 – 19)		
• **First 2 visits per calendar year**	100%	100%
• **Services received after the first two visits**	80%	60%
Adult Preventive Care (Adults age 20+)		
• **First 2 visits per calendar year**	100%	100%
• **Services received after the first two visits**	80%	60%
Screening Tests		
• **Colonoscopy** (1 every 10 years beginning at age 50 or younger if at increased risk)	80% (100% if included in first 2 visits)	60% (100% if included in first 2 visits)
• **Mammograms** Age 35-39 = 1 baseline test Age 40-49 = 1 every 2 calendar years Age 50+ = 1 per calendar year	80% (100% if included in first 2 visits)	60% (100% if included in first 2 visits)
• **Sigmoidoscopy** (1 every 5 years beginning at age 50 or younger if at increased risk)	80% (100% if included in first 2 visits)	60% (100% if included in first 2 visits)
• **Pap tests, pelvic exams** (for women 18 and/or sexually active, once per calendar year)	80% (100% if included in first 2 visits)	60% (100% if included in first 2 visits)
• **Other screenings** (lab/x-rays, as medically necessary)	80% (100% if included in first 2 visits)	60% (100% if included in first 2 visits)

Services provided at Yakima Regional Medical Center, Toppenish Community Hospital are not covered, with the exception of inpatient and outpatient cardiac care, inpatient rehabilitative care and emergency treatment which will be paid at the Network level, generally 80%. Services provided by Medical Center Lab are not covered, with the exception of tissue exams which will be paid at the Network level.

	Network Providers	Non-Network Providers
Professional/Physician Services (office visits)	80%	60%
Rehabilitation Therapy		
• **Inpatient** FCHA pre-authorization required; 30 days per calendar year	80%	60%
• **Outpatient** (includes physical, speech, and occupational therapies)	80%	60%
Skilled Nursing Facility FCHA pre-authorization required; 30 days calendar year	80%	60%
Transplants (Organ and Bone Marrow) FCHA pre-authorization required; 12-month waiting period applies.		
• **Recipient**	80%	80%
• **Donor**	80%	Not covered
• **Travel and Lodging**	80%	80%
Vision Care		
• **Eye Exam** 1 per calendar year	80%	Costco: 100% Other providers: 80%
• **Hardware** (lenses, frames, contacts, and extras, received at a Costco location - if the exam is through Costco) $300 benefit maximum every 2 calendar years	n/a	100%
• **Hardware** (lenses, frames, contacts, and extras, received through all other providers) $200 benefit maximum every 2 calendar years	100%	100%

Services provided at Yakima Regional Medical Center, Toppenish Community Hospital are not covered, with the exception of inpatient and outpatient cardiac care, inpatient rehabilitative care and emergency treatment which will be paid at the Network level, generally 80%. Services provided by Medical Center Lab are not covered, with the exception of tissue exams which will be paid at the Network level.

Medical Plan Benefits

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

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

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

Allergy Care

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

Ambulance Services

In an emergency, the plan covers licensed ground ambulance transportation to the nearest hospital where emergency can be rendered if **both** of the following conditions apply:

- Other forms of transportation would likely endanger the participant's health, and
- The transportation is not for personal or convenience reasons.

Air and inter-facility transport ambulance services are covered, but require pre-authorization, except in life-threatening circumstances.

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 in conjunction with dental care provided to a participant if such participant is:

- Six years of age or younger,
- Is physically developmentally disabled, or
- Is an individual with a medical condition which his/her physician determines will place the person at undue risk if the procedure is performed in a dental office. The covered participant's physician must approve the procedure.

Autologous Blood Donation/Blood Transfusions

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

Chemical Dependency

All inpatient admissions **require FCHA pre-authorization** by calling (800) 640-7682. Emergency admissions require **notification** as described in the *Medical Management* section. The Plan covers treatment of individuals requiring chemical dependency rehabilitation for abuse of substances such as alcohol or DEA-controlled oral, intravenous or inhaled medications and materials. Care must be medically necessary and provided at the least restrictive level of care. A clear treatment plan containing measurable progress toward a rehabilitative goal(s), including but not limited to movement to a less restrictive setting (if applicable), or other medically necessary goal(s) as determined by your provider and FCHA's medical management.

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

Dental Trauma

Not intended as dental coverage, this benefit coverage is provided for repair or replacement of sound natural teeth, and repair of the jaw bone or supporting tissues, due to accidental injury. After the initial examination by your dentist, a pre-authorization for further services is required by FCHA. All services related to the repair must begin within 30 days of the date of the injury and be completed within 90 days. Any services received after 90 days have elapsed, or after you become disenrolled from this Plan regardless of whether 3 months have elapsed or not, are not covered.

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.

Please see *Anesthesia* for information regarding anesthesia benefits for dental services.

Diabetic Instruction and Counseling

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

Durable Medical Equipment (DME)

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

Examples of DME include, but are not limited to:

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

This benefit also covers:

- **Diabetic monitoring equipment,** such as the initial cost of an insulin pump and blood glucose monitor (including supplies related to such equipment). Diabetic supplies such as insulin, syringes, needles, lancets, etc, are covered under the pharmacy benefit.
- **Medical supplies** needed for the treatment or care of an appropriate covered condition, including but not limited to compression garments, mastectomy supplies and ostomy supplies. Supplies available over-the-counter are excluded.
- **Oral Appliances** specific to the treatment of Sleep Apnea**.**
- **Orthopedic appliances:** 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.

Durable medical equipment or supplies provided as part of home health care, hospice care, or by a hospital would be paid under those benefits. Prosthetic devices requiring surgical implantation would be covered under the appropriate surgical benefit.

Emergency and Urgent Care

The Plan covers emergency room and urgent care visits in network and non-network facilities.

Emergency (or emergent) means the sudden and acute onset of a symptom(s), including severe pain, that would lead a person, acting reasonably, to believe a health condition exists that requires immediate medical attention and that failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

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

In the case of an emergency, home or away, seek the most immediate care available. To receive the network level of benefits, you must obtain all follow-up care from network providers. If you require non-network follow-up services, you must obtain a pre-authorization from FCHA in order to receive the highest benefit level.

Family Planning

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

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

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

Termination of pregnancy is not covered (unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest).

Foot Orthotics

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

Genetic Services

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

Hearing

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

Home Health Care

FCHA pre-authorization is required for Home Health benefits. Home health care is covered when prescribed by your physician. The patient must be homebound and require skilled care services (as defined by the Plan). Benefits are limited to intermittent visits by a licensed home health care agency and home infusion services.

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

- Nursing services (RN, LPN)
- Licensed or registered physical, occupational or speech therapist
- Home health aide working directly under the supervision of one of the above providers
- Medical Social Worker (MSW)

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 FCHA 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 FCHA.

Hospice Care

FCHA pre-authorization is required for Hospice benefits. Hospice care is covered when prescribed by your physician and s/he has determined that life expectancy is 6 months or less and a palliative, supportive care treatment approach has been chosen. This benefit includes acute, respite, and home care to meet the physical, psychosocial, and special needs of a patient-family unit during the final stages of illness and dying. Hospice care is provided at a variety of levels to meet the individual needs of the patient-family unit. Levels offered are:

- **Intermittent in-home visits** are provided on an as needed basis by the hospice team, which includes health care professionals, support staff, and a twenty-four (24) hour a day “on-call” registered nurse. This level of care does not cover room and board while a member resides in a skilled nursing facility, adult family home, or assisted living facility.
- **Inpatient Hospice care** is needed when care cannot be managed where the patient resides. The care will be provided at an inpatient facility until the patient’s condition stabilizes. Coverage for room and board is covered at this level.
- **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 for up to 5 days.

- **Inpatient respite care** is available to provide the patient's caregiver a rest of up to 5 days at one period of time. This acknowledges that caring for a dying person can be difficult. Care for the patient is provided at an inpatient facility and includes room and board costs.

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

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

Any charges for hospice care that qualify under this benefit, and under any other benefit of this plan, will be covered under the most appropriate benefit as determined by FCHA.

Hospital Inpatient Medical and Surgical Care

Hospital inpatient and facility charges for medically necessary care are covered. **FCHA 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 FCHA pre-authorization;** please see *Pre-authorization Requirements* for details. Covered outpatient care includes outpatient surgery, procedures and services, operating room and anesthesia, radiology, lab and pharmacy services furnished by and used while at a hospital or ambulatory surgical center.

Infusion Therapy

FCHA pre-authorization is required if performed in the home or a free-standing infusion suite. Infusion therapy is the administration of medications using intravenous, subcutaneous, and epidural routes (into the bloodstream, under the skin, and into the membranes surrounding the spinal cord). Drug therapies commonly administered via infusion include, but are not limited to, antibiotics, chemotherapy, pain management, parenteral nutrition, and immune globulin. Diagnoses commonly requiring infusion therapy include infections that are unresponsive to oral antibiotics; cancer and cancer-related pain; gastrointestinal diseases or disorders which prevent normal functioning of the GI system; congestive heart failure; immune disorders; and more.

Lab and Radiology Services

The plan covers lab and radiology services for diagnostic purposes when medically necessary and ordered by a qualified provider.

Maternity and Newborn Care

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

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

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

Coverage for newborns is provided when s/he is enrolled as a dependent under this Plan (see *Enrollment section* within *Section II - Summary Plan Description* for details). Benefits are subject to the newborn child's own coinsurance and deductible requirements.

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

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 **require FCHA pre-authorization** by calling (800) 640-7682. Emergency admissions require notification as described in the *Medical Management* section. The Plan covers treatment of mental health or psychiatric conditions.

Care must be medically necessary and provided at the least restrictive level of care. A clear treatment plan containing measurable progress toward a rehabilitative goal(s), including but not limited to movement to a less restrictive setting (if applicable), or other medically necessary goal(s) as determined by your provider and FCHA's medical management.

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

Family and couples counseling, psychological testing and psychotherapeutic programs are covered only if related to the treatment of a clinical mental health diagnosis, specifically, those noted as Axis I diagnoses per the Diagnostic and Statistical Manual of Mental Disorders (DSM).

Neurodevelopmental Therapy

Neurodevelopmental therapy services are covered to restore and improve function in children with neurodevelopmental disabilities age 6 and younger only. Children age 7 years and older are not covered. Benefits include:

- Neurological and psychological testing, evaluations and assessments
- Ongoing maintenance in cases where serious significant deterioration would result without ongoing treatment
- Outpatient physical, occupational and speech therapy

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

Nutritional and Dietary Formulas

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

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

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

Oral Surgery

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

- The reduction or manipulation of fractures of facial bones
- Excision of lesions, cysts, and tumors of the mandible, mouth, lip or tongue
- Incision of accessory sinuses, mouth salivary glands or ducts

- Extraction of teeth damaged due to radiation therapy that occurred while under this Plan

Please see *Anesthesia* for information regarding anesthesia benefits for dental services.

Orthognathic Surgery

Orthognathic surgery is surgery to correct conditions of the jaw and face related to structure and growth. Bones can be cut and re-aligned, held in place with either screws or plates and screws. This Plan will cover it only when related to birth defects, such as cleft palate or facial injuries.

Pharmacy

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

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

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

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

Step Therapy

A PPI (Proton Pump Inhibitor) step therapy program has been implemented. Covered Persons (as of January 1, 2009) currently using a PPI, no change will occur. Covered Persons that have the 2nd step in their history will be grandfathered to the current PPI benefit.

Covered Persons that need to use a PPI and have not previously received a prescription will need to start with a 1st step PPI, Prilosec OTC or Omeprazole prior to utilizing the prescription PPI product to receive coverage. If it is later determined that the Prilosec OTC or Omeprazole is not appropriate treatment, then 2nd step therapy can be prescribed and will be covered.

This program generally requires utilization of an effective first-line agent before other alternative therapies may be covered. The aim of the program is to control costs and minimize risks. For more information, call (800) 797-9791.

In addition to copays 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.

OptumRx Retail Pharmacy

You may receive a 30-day supply of your prescription at an OptumRx pharmacy. OptumRx has an extensive nationwide network of retail pharmacies. You may call them directly at (800) 797-9791, or visit their website at www.optumrx.com to determine if your local pharmacy is in their network.

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

Costco Mail Order/Online Pharmacy

If you, or a covered family member, regularly take medication for chronic, long-term conditions such as diabetes, arthritis, high blood pressure, heart conditions, etc., you may obtain a 90-day supply of ongoing medications through Costco. Please contact OptumRx at (800) 797-9791, or visit their website at www.optumrx.com to learn more about how to obtain a 90-day supply.

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

If you have questions on how to get started using the Costco Mail Order/Online Pharmacy please visit http://pharmacy.costco.com or contact the pharmacy at (800) 607-6861; Monday-Friday 5am – 7pm (PST) and Saturday 9:30 – 2pm (PST).

Specialty Pharmacy Program

Costco Specialty Services is the exclusive provider for your specialty medications as part of your prescription drug plan. What this means for you is that you and your loved ones will receive the personalized care and expertise of Costco Specialty Services' dedicated pharmacists, which is essential to successful therapy. This is because Costco Specialty Services goes beyond traditional retail pharmacy, helping you get the most from your specialty medication therapy.

Because specialty medications can be more difficult to manage, Costco Specialty Services offers the following patient support services at no charge:

- Personalized support to help you achieve the best results from your prescribed therapy
- Convenient delivery to your home or prescriber's office

- Easy access to a Care Team who can answer medication questions, provide educational materials about your condition, help you manage any potential medication side effects, and provide confidential support—all with one toll-free phone call
- Assistance with your specialty medication refills

If you have any questions, or to begin to take advantage of these complimentary patient support services, please call Costco Specialty Services toll free at (866) 218-5445.

Plastic and Reconstructive Services

Reconstructive/plastic procedures (including reconstructive breast surgery as outlined below by the Women's Health and Cancer Rights Act of 1998) **require FCHA pre-authorization** and are covered when performed to correct or repair abnormal structures of the body caused by congenital defects, trauma, infection, tumors, disease, accidental injury or prior surgery (if the prior surgery would be covered under this Plan). Specific criteria follow:

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

Women's Health and Cancer Rights Act of 1998

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

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

Podiatric Care

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

Preventive Care

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

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

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

For more information on recommended immunization schedules visit the CDC's website at: www.cdc.gov/vaccines/.

Professional/Physician Services

This benefit applies to in-person or Telemedicine visits only – not charges for care provided by phone, fax, e-mail or Internet.

Rehabilitation Therapy

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

- Services are to restore and significantly improve function that was previously present but lost due to acute injury or illness,
- Services are not for palliative, recreational, relaxation or maintenance therapy, and
- Loss of function was not the result of a work-related injury.

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

Inpatient Rehabilitation

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

Outpatient Rehabilitation

Outpatient rehabilitation benefits are subject to the following provisions:

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

Coverage for outpatient rehabilitative services is limited to those services that are reasonably expected to result in significant self-sustaining functional improvement (not dependent on maintenance therapy) within 90 days of initiation. Speech therapy is covered only when required as a result of brain or nerve damage secondary to an accident, disease or stroke.

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

Skilled Nursing Facility

Inpatient skilled nursing facility care **requires FCHA 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.)

Transplants (Organ and Bone Marrow)

FCHA pre-authorization is required for transplant service; and, there is a **12 month waiting period** for this benefit. Services directly related to organ transplants must be coordinated by your participating provider. **There are no non-network benefits for donor services related to organ transplants. Proposed transplants will not be covered if considered experimental or investigational for the participant's condition.** FCHA pre-authorization approval for transplants is based on these criteria:

- A written recommendation with supporting documentation received from your provider
- The request for the transplant is based on medical necessity
- The requested procedure and associated protocol is not considered experimental or investigational treatment for your condition
- The procedure is performed at a facility, and by a provider, approved by FCHA
- Upon evaluation you are accepted into the approved facility's transplant program and comply with all program requirements

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

Have your provider send a written request, prior to evaluation, to FCHA Medical Management at 600 University St., Suite 1400, Seattle WA 98101.

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:

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

Covered donor expenses include:

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

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

Travel expenses

Travel and lodging expenses **require FCHA pre-authorization** and are available for either the recipient or his/her family or the donor for medically necessary services related to an approved transplant. Travel and lodging benefits are paid up to a maximum of $5,000 per transplant episode. The maximum applies to all associated transportation, lodging and meal expenses incurred by the transplant recipient and companion(s).

Vision Care

Eye Exam

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

Hardware

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

Hardware Extras

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

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

Plan Exclusions and Limitations

Covered services are limited to the diagnosis, therapeutic care or treatment, and prevention of disease, sickness or injury as described in this document. In addition to limits and exclusions stated elsewhere in this document, coverage is specifically excluded for each of the following items and any related services and charges:

- Abortion (termination of pregnancy) unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest. Complications of a non-covered abortion are covered.
- Acupuncture
- Adoption or surrogacy expenses
- Amounts over and above UCR, as defined by the Plan.
- Amounts for which the covered person has no obligation to pay.
- Any charges by a facility owned or operated by the United States or any state or local government unless the participant is legally obligated to pay (excluding: (i) covered expenses rendered by a medical facility owned or operated by the United States Veteran's Administration when the services are provided to a participant for a non-service related illness or injury, and (ii) covered expenses rendered by a United States military medical facility to participants who are not on active military duty).
- Any condition resulting from declared or undeclared acts of terrorism, war, military service, participation in a riot or civil disobedience.
- Any service not medically necessary for the diagnosis, treatment or prevention of injury or illness, even if it is not specifically listed as an exclusion (except for specific services offered through the Preventive Care benefit).
- Any service received before the participant's effective date of coverage or after the coverage termination date.
- Aromatherapy
- Athletic training, body-building, fitness training or related expenses.
- Autopsies
- Bariatric surgery, or any other surgical or non-surgical treatment, programs or supplies intended to result in weight reduction, regardless of diagnosis.
- Biofeedback
- Bone Anchored Hearing Aid (BAHA) devices
- Botanical or herbal medicines, as well as other over-the-counter medications.
- Breast reduction
- Care, treatment, supplies received outside of the U.S. if travel is for the sole purpose of obtaining medical services.
- Care provided by phone, fax, e-mail or Internet, except Telemedicine (see *Plan Definitions*)

- Charges for failure to keep a scheduled visit, for the copying of medical records or for the completion of a claim or administrative forms.
- Chemical Dependency treatments listed below:
  - Alcoholics Anonymous or other similar chemical dependency programs or support groups.
  - Biofeedback, pain management and/or stress reduction classes.
  - Care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior.
  - Chemical dependency benefits not specifically listed.
  - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite.
  - Emergency patrol services
  - Information or referral services
  - Information schools
  - Long-term or custodial care
  - Treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required.
- Chiropractic Care
- Court ordered examinations, assessments, or treatment of any kind.
- Dental, oral surgery or orthodontic related services, such as (but not limited to) those listed below (unless accident related or otherwise specifically covered by the Plan):
  - Care of the teeth or dental structures
  - Tooth damage due to biting or chewing
  - Dental implants, except as covered by the Plan under the Dental Trauma benefits
  - Dental X-rays
  - Extractions of teeth, impacted or otherwise (except as covered under the Plan).
  - Orthodontia
  - Services to correct malposition of teeth
- Developmental delay treatment or services, except as covered by the Plan
- DME and medical supply charges listed below:
  - Biofeedback equipment
  - Breast pumps
  - Electronic and/or keyboard communication devices
  - Equipment or supplies whose primary purpose is preventing illness or injury
  - Exercise equipment
  - Items not manufactured exclusively for the direct therapeutic treatment of an illness or injured patient
  - Items primarily for comfort, convenience, sports/recreational activities or use outside the home
  - Oral appliances except to treat obstructive sleep apnea
  - Over-the-counter items (except medically necessary crutches, walkers, standard wheelchairs, diabetic supplies and ostomy supplies are covered)

- Personal comfort items including but not limited to air conditioners, lumbar rolls, heating pads, diapers or personal hygiene items
- Phototherapy devices related to seasonal affective disorder
- Supportive equipment/environmental adaptive items including, but not limited to, hand rails, chair lifts, ramps, shower chairs, commodes, car lifts, elevators, and modifications made to the patient's home, place of work, or vehicle.
- The following medical equipment/supplies: regular or special 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, home blood testing equipment and supplies (except diabetic equipment and supplies, and home anticoagulation meters)
- Wigs

- Experimental or investigational services
- FDA-approved drugs, medications or other items for non-approved indications, except when an FDA-approved drug has been proven clinically effective to treat such indication and is supported in peer-reviewed scientific medical literature.
- Hair loss care, treatment or prescriptions.
- Home births
- Home health care listed below:
  - Custodial care
  - Housekeeping or meal services
  - Maintenance care
  - Shift or hourly care services
- Hospice care listed below:
  - Custodial care or maintenance care, except palliative care to the terminally ill patient subject to the stated limits.
  - Financial or legal counseling services.
  - Housekeeping or meal services.
  - Services by a participant or the patient's family or volunteers.
  - Services not specifically listed as covered hospice services under the Plan.
  - Supportive equipment such as handrails or ramps.
  - Transportation
- Immunizations for work
- Injuries or illnesses resulting, directly or indirectly, from an illegal act. "Illegal Act" shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence if imprisonment could be imposed. It is not necessary that criminal charges be filed, or if filed, that a conviction result, or that a sentence of imprisonment be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the injury or illness resulted from an act of domestic violence or a medical (physical or mental) condition.

- Infertility services of any kind, and treatments to achieve pregnancy (regardless of the cause) including but not limited to:
    - Artificial insemination
    - In vitro fertilization (IVF)
    - Gamete intra-fallopian transplant (GIFT)
- Learning disabilities and related services, educational testing or associated training
- Massage therapy (unless performed by a physical therapist as part of a rehabilitative care).
- Mental health care listed below:
    - Adventure-based and/or wilderness programs that focus primarily on education, socialization or delinquency.
    - Biofeedback, pain management, and stress reduction classes.
    - Court-ordered assessments
    - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite.
    - Developmental delay disorders
    - Family therapy, in the absence of a mental health diagnosis.
    - Marriage and couples counseling
    - Nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories.
    - Sensitivity training
    - Sexual dysfunction
    - Sexual and gender identity disorders (DSM codes 302.0 – 302.9).
- Naturopathic services
- Non-compliance, specifically, all charges in connection with treatments or medications where the patient either is in non-compliance with or is discharged from a hospital or skilled nursing facility against medical advice.
- Non-covered services, or complications arising from non-covered services. *Complications from a non-covered abortion and complications of pregnancy for a dependent daughter are covered.*
- Nutritional counseling
- Orthodontic treatment, appliances or services; dentures or related services.
- Over-the-counter products, except as covered by the Plan.
- Personal, convenience or comfort services, supplies, or items including but not limited to phones, TVs, guest services, deluxe or suite hospital room, air conditioners, diapers or hygiene items.
- Pharmacy services listed below:
    - Accutane over age 25
    - Retin A over age 39
    - Allergens/allergy injections
    - Contraceptive services and supplies listed below:

    - Devices such as IUDs, diaphragms
    - Injections such as depo-provera
    - Vaginal ring (nuvaring)
    - Emergency contraception such as Plan B and Preven
  - Cosmetic drugs
  - Fluoride preparations
  - Impotency drugs such as Viagra, Cialis, Levitra, Edex, Caverject
  - Miscellaneous injectable (retail)
  - Miscellaneous medical supplies
  - Over-the-counter (OTC) products such as Claritin OTC, Loratidine OTC, Prilosec OTC
  - Tobacco cessation products
  - Weight loss drugs/products
  - Vitamins, in multiple or singular combinations and/or pediatric vitamins.
- Physical examinations, reports or related services for the purpose of obtaining or maintaining employment, insurance, or licenses or permits of any kind, school admission, school sports clearances, immigration, foreign travel, medical research, camps, or government licensure, or other reasons not related to medical needs.
- Plastic and reconstructive services such as those listed below:
  - Abdominoplasty/panniculectomy
  - Complications resulting from non-covered services.
  - Cosmetic services, supplies or surgery to repair, modify or reshape a functioning body structure for improvement of the patient's appearance or self-esteem.
  - Dermabrasion, chemical peels or skin procedures to improve appearance or to remove scars or tattoos.
  - Gynecomastia surgery
- Pregnancy care or treatment for a dependent daughter, except complications resulting from such a pregnancy.
- Preservation of tissue or cells.
- Private duty nursing.
- Procedures, regardless of medical necessity, outside the scope of the provider's license, registration or certification.
- Repair or replacement of items not used in accordance with manufacturer's instructions or recommendations.
- Replacement of lost or stolen items, such as but not limited to prescription drugs, prostheses or DME.
- Respite care, except as covered by the Plan.
- Reversal of sterilization.
- Routine foot care, except as covered by the Plan for diabetics.
- 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 payable under a contract or insurance for uninsured or underinsured (UIM) coverage, motor vehicle, motor vehicle no-fault, or personal injury protection (PIP) coverage, commercial premises or homeowner's medical premise coverage or other similar type of contract or insurance.
- Services or supplies received without charge from a medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar group.
- Services or supplies required by an employer as a condition of employment.
- Services provided by a family member (spouse, parent or child).
- Services provided by, or that could be provided by, a spa, health club or fitness center.
- Services provided by clergy.
- Sex change operations or treatment for transsexualism (non-congenital transsexualism, gender dysphoria or sexual reassignment or change); related medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- Sexual dysfunction treatment.
- Smoking and Tobacco cessation programs except as covered by the Plan.
- Snoring treatment (surgical or other).
- Special diets, nutritional supplements, vitamins and minerals or other dietary formulas or supplements except as covered by the Plan.
- Transplant services listed below (organ and bone marrow):
  - Animal-to-human transplants
  - Artificial or mechanical devices designed to replace human organs.
  - Complications arising from the donation procedure if the donor is not a Plan participant.
  - Donor expenses for a Plan participant who donates an organ or bone marrow (however, complications from the donation are covered as any other illness to the extent they're not covered under the recipient's health Plan).
  - Organ transplants not specifically listed as covered transplants.
  - Transplants considered experimental and investigational, as defined by the Plan.
- Treatment of Temporomandibular Joint Dysfunction Syndrome (TMJ).
- Termination of pregnancy for dependent child (unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest).
- Transportation, except as covered by the Plan.
- Treatment furnished without charge or paid directly or indirectly by any government or for which a government prohibits payment of benefits, except for complications.
- Vision Care, the following vision benefits are not covered:
  - Non-prescription sunglasses or safety glasses.
  - Radial keratotomy, Lasik or any other refractive surgery, orthoptics, pleoptics, visual 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.

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

Dental Benefit Plan Provisions

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

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

Calendar Year Dental Deductible

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

Annual Deductible and Maximum:

Deductible and Maximums	
Deductible per Calendar Year	
Per Participant or Dependent	$50
Family	$100
Maximum Dental Benefits per Calendar Year (applies per calendar year to all services)	
Per Participant or Dependent	$1,500
Maximum Orthodontia Benefit (per Lifetime Per Dependent - child under age 19 only)	$1,250

Summary of Dental Benefits

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

Class II - Basic Dental Services			
Service	Applies to Deductible	Children 0-19	Adults 19+
• **Anesthesia** (e.g., Novocaine) If dental procedure requires general anesthesia within hospital setting coverage is provided under the Medical Plan, see *Anesthesia* in Medical, Vision, Pharmacy, and Dental Benefit Summary.	✓	80%	
• **Endodontics**	✓	80%	
• **Extractions**	✓	80%	
◦ Simple extraction	✓	80%	

◦ Surgical extraction	✓	80%	
• **Fillings** Composite resin or amalgam (not gold)	✓	80%	
• **Occlusal guard** (adult/child)	✓	80%	
• **Oral surgery**	✓	80%	
• **Periodontics**	✓	80%	
• **Repair or recementing of Bridge, Crown, Inlay/Onlay or Dentures**	✓	80%	
• **X-rays** (other than as noted in Class I section, such as periapical, occlusal, etc., as necessary)	✓	80%	
• **Other Class II Services**	✓	80%	
Class III - Major Dental Services			
Service	**Applies to Deductible**	**Children 0-19**	**Adults 19+**
• **Bridges** (installation)	✓	50%	
• **Crown** (installation)	✓	50%	
• **Dentures** (installation)	✓	50%	
• **Implants**	✓	50%	
• **Inlays/Onlays**	✓	50%	
• **Other Class III services**	✓	50%	
Class IV - Orthodontia			
Service	**Applies to Deductible**	**Children 0-19**	**Adults 19+**
• **Orthodontia** For children through age 19 only; $1,250 lifetime maximum	✓	50%	Not Covered

Dental Benefits

Dental Expenses

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

Class I - Preventive and Diagnostic Dental Services

Preventive and diagnostic dental expenses mean charges for the following services and supplies:

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

Class II - Basic Dental Services

Basic dental expenses mean charges for the following services and supplies:

- Anesthesia, such as novocaine. If dental procedure requires general anesthesia within hospital setting coverage is provided under the medical plan, see *Anesthesia* in *Medical, Vision and Pharmacy Benefit Summary* booklet.
- Endodontic treatment, including pulpotomy, pulp capping, apicoectomy, retrograde filling, and root canal therapy.
- Extractions, simple or surgical extractions of one or more teeth are covered.
- Fillings include the use of materials such as amalgam or composite resin to restore teeth broken down by decay or injury. Gold fillings are not covered.
- Occlusal Guard: a removable appliance designed to minimize the effects of bruxism, or teeth grinding.

- Oral surgery, for surgical treatment or procedures needed in and about the mouth and jaw.
- Periodontal services required for treatment of disease of the gums and supportive structures of the teeth, such as root planing or subgingival curettage.
- Repair or recementing of bridge, crown, inlay/onlay, or dentures or bridgework.
- X-rays other than those noted in Class I section, for example periapical or occlusal, as necessary.

Class III - Major Dental Services

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

- Bridges, the installation of one or more artificial teeth attached by crowns to adjacent teeth. It is used to maintain space and function for missing teeth.
- Crowns and Crown Build Ups: installation of a crown (also known as ‘cap’) made of porcelain and/or metal used to cover a decayed or damaged tooth.
- Dentures, installation of dentures.
- Implants, artificial (prosthetic) tooth replacements for tooth loss.
- Inlays/Onlays: a gold, porcelain or composite custom-made filling cemented into the tooth.

Class IV - Orthodontia

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

Dental Limitations and Exclusions

No dental benefit will be paid for the following charges:

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

- Treatment or services provided to correct any congenital defect or developmental malformation which does not interfere with function.
- Treatment of Temporomandibular Joint Dysfunction Syndrome (TMJ).
- Vertical dimension procedures (crowns, dentures, splinting, etc.) for the restoration or alteration of occlusions, except as covered under the medical or orthodontia benefits of this Plan.

Eligibility and Enrollment

Eligible Classes of Employees

All active, full-time CWCMH employees working at least 30 hours per week are eligible to enroll in the Plan after completing the Waiting Period.

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

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

Waiting Period

The waiting period is the time between the first day of employment and the first day of coverage under the Plan. The waiting period is counted in the pre-existing conditions exclusion time.

Enrollment Periods

Enrollment periods for eligible employees and dependents are:

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

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

How to Enroll

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

Discovery of false or misrepresented information will result in the complete nullification of coverage and you will be held financially responsible for any benefits paid. Examples of false or misrepresented information are failing to provide requested information, providing incorrect

or incomplete information, enrolling an ineligible dependent, and failing to comply with the Plan's requirements for eligibility. It is your responsibility to notify the Plan Administrator of all dependent eligibility changes.

Open Enrollment

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

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

Special Enrollment Periods

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

Change in Status

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

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

A change in status includes:

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

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

Involuntary Loss of Other Coverage

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

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

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

Late Enrollment

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

Effective Date

Effective Date of Coverage for You

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

Effective Date of Coverage for Your Dependents

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

Deferred Effective Date of Your Coverage or an Increase in Coverage

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

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

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

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

Special Rule

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

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

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

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

Waiver of Group Health Plan Benefits

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

Pre-Existing Condition Exclusion Limitation

Pre-Existing Condition

A pre-existing condition, whether physical or mental, and regardless of the cause of the condition, is a condition for which medical advice, diagnosis, care, or treatment has been recommended or received within the six (6) month period ending on the date of hire (which is defined as your enrollment date per HIPAA). In order to be taken into account, the medical advice, diagnosis, care or treatment must have been recommended or received from an individual licensed or similarly authorized to provide such services under State law and who operates within the scope of practice authorized by the State law.

Pre-Existing Condition Exclusion

The exclusion period for pre-existing conditions commences on the first day of the waiting period (date of hire) and will be no longer than twelve (12) months, less any creditable coverage (see definition of "Certificate of Creditable Coverage" in the Summary Plan Document, Plan Definitions). You have the right to demonstrate any creditable coverage and the exclusion period will be reduced by that creditable coverage period unless it occurred before a significant break in coverage of no less than 63 days (per HIPAA). Please discuss with your Plan Administrator (Human Resources) for further clarification.

Important notes:

- ***The pre-existing conditions exclusion does not apply to: dependent children under age 19 (including adopted children), pregnancy related issues or genetic information.***
- ***If a claim is paid that was related to a pre-existing condition, the payment will not constitute a waiver of this exclusion for that claim or any subsequent claim if it is later determined that the condition was pre-existing.***
- ***Pre-authorization received from FCHA does not constitute Plan liability for any pre-existing condition charges during the pre-existing waiting period.***

Dependents

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

- Legally married spouse (a "spouse" will mean a person of the opposite sex; "legally married" means a legal union between one man and one woman as husband and wife);
- Natural child, adopted child, child placed with you for legal adoption, stepchild, or other legally designated ward up to age 26 (the limiting dependent child age), except if s/he is eligible for his or her own employer-sponsored coverage; or,
- Natural child, adopted child, child placed with you for legal adoption, stepchild, dependent child of or other legally designated ward that a health care professional determines is not capable of self-sustaining employment due to a physical handicap or developmental disability (see *Continued Eligibility for a Disabled Child*).

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

Dependents Acquired Through Marriage

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

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

Dependent Children

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

Natural Newborn Children

If you acquire a new dependent through birth, the Plan Administrator must receive the enrollment form within 60 days from the date of birth. In order for coverage to exist for a newborn, the child must be enrolled within this timeframe. Coverage for the facility nursery charges will be in effect until discharge from this level of care under the enrolled mother's coverage. There is no coverage for physician services or other facility levels of care other than nursery until the newborn is enrolled. If enrolled, coverage becomes effective on the date of birth.

Adopted Children Acquired

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

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

Children Acquired Through Legal Guardianship

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

Children Covered Under Qualified Medical Child Support Orders

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

Dependent Children Out of Area

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

First Health Network is available for network benefits to:

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

(A full description of the provider networks can be found under *How to Obtain Health Services*.)

Continued Eligibility for a Disabled Child

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

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

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

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

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

The participant must also submit the following:

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

A disabled child will continue to be eligible for coverage until the employee participant fails to submit proof of dependence due to disability or physical handicap, 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

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

A medical child support order:

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

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

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

If the medical child support order is a QMCSO:

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

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

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

Termination of Coverage

For participating employees, coverage ends at these events:

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

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

For participating dependents, coverage ends at these events:

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

Related details follow:

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

- A terminated employee who is rehired will be treated as a new hire for benefit purposes and be required to satisfy all eligibility and enrollment requirements. However, if the employee is returning to work directly from COBRA coverage s/he does not have to satisfy any employment waiting period or pre-existing conditions exclusion limitation provision.

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

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

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

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

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

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

Who Is a COBRA Qualified Beneficiary?

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

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

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

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

Qualifying Events and Continuation Periods

Qualifying events and continuation periods are explained below:

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

When COBRA Coverage Ends

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

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

- If an extension from 18 to 29 months was granted due to a disability and the individual receives a final determination from the Social Security Administration stating the individual is no longer disabled the individual must notify the plan administrator within 31 days after the date of that determination. Coverage ends on the last day of the 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 be 150% of the full cost of coverage.

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

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

Election Requirements

At the time of a qualifying event, such as termination of employment or reduction in hours, the qualified beneficiary must be notified of the right to continue coverage within 14 days of FCHA 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 servicemember, 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 servicemember).

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

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

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

Military Leave

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

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

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

All 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.

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 have a signed form 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.

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, write your name, participant ID number and group number on the bill and send a copy to the claim address on your ID card. (Your group number can also be found on your ID card.) Any bill you submit must contain:

- Provider name
- Provider tax ID information
- Specific dates of service
- Diagnosis codes (ICD-9 codes) or description of the symptoms or a diagnosis
- Specific procedure codes (CPT codes) or description of the medical service or procedure.
- Specific procedure codes (CDT codes) or description of the dental service or procedure.

It is best to submit charges as soon as possible. However, charges for covered services submitted to FCHA must be received within 12 months from the date the service or supply was rendered or received. Claims will not be considered for benefits if received after this timeframe. (See your ID card for the FCHA claim address.) Claim forms are available from your Plan Administrator.

Claim Types

- **Pre-service claim** means any claim for a Plan benefit for which the Plan requires approval before medical care is obtained.
- **Concurrent claim** means any claim reconsidered after initial approval for an ongoing course of treatment which results in a reduced or terminated benefit.
- **Post-service claim** means any claim for a Plan benefit that is not a pre-service claim and is a request for payment or reimbursement for covered services already received.
- **Urgent care claim** means a claim for medical care or treatment that, if normal pre-service standards are applied:
  - Would seriously jeopardize the claimant's life, health or ability to regain maximum function

- In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested.

Claim Procedure

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

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

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

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

Adverse Benefit Determination

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

The different claim types listed in the preceding subsection have specific times for approval, payment, request for information or denial, as shown below:

Time Table for Adverse Benefit Determinations for Claim Procedures			
Type of Review	**FCHA Notice of Incorrectly Filed Claim – Notice to Claimant**	**FCHA Notice of Incomplete Claim – Notice to Claimant**	**Initial Benefit Determination by FCHA**
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

Time Table for Adverse Benefit Determinations for Claim Procedures			
Type of Review	**FCHA Notice of Incorrectly Filed Claim – Notice to Claimant**	**FCHA Notice of Incomplete Claim – Notice to Claimant**	**Initial Benefit Determination by FCHA**
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 adverse benefit determination notice that includes:

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

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

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

Appeal Procedure

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

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

1. You, or your authorized representative, must file your appeal within 180 days of the date you receive the adverse benefit determination or else you lose the right of appeal.
2. You may submit written comments or questions, documents, records and other information including the reason you feel your claim should not have been denied.

3. On request, you may obtain reasonable access to and copies of all documents, records and information relevant to your claim for benefits, free of charge.
4. You may request the name of the health care expert who reviewed your claim for medical necessity or experimental or investigational care or treatment.
5. You must exhaust these claim procedures before filing a civil action for benefits under ERISA §502(a)(1)(b); the civil action must be filed within 180 days from your receipt of the Plan's final determination regarding your claim.

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

Time Table for Processing and Notification of Appeal Procedures	
Type of Review	**Appeal (Benefit Determination on Review and Notification to Claimant)**
Pre-Service Claim	Reasonable period = 30 days No extension from claimant
Concurrent Claim	Before treatment ends or is reduced
Post-Service Claim	Reasonable period = 60 days No extension from claimant
Urgent Care Claim	72 hours No extension from claimant

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

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

If the decision is to uphold the denial of your claim, you will receive a written notice of adverse benefit determination containing:

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

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

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

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

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

Medical Appeals:

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

Pharmacy Appeals:

OptumRx
3515 Harbor Blvd
Costa Mesa, CA 92626
Phone: 1-888-403-3398
Fax: 1-877-239-4565

Coordination of Benefits

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

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

Calculation of Benefit Payments

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

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

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

Example 1

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

Example 2

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

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

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

How Do I Know Which Plan is my Primary Plan?

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

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

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

2. **Child covered under more than one plan:**

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

      1) The plan of the parent whose birthday falls earlier in the calendar year is the Primary Plan; or

      2) If both parents have the same birthday, the plan that has covered the parent longest is the Primary Plan.

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

      1) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage, that plan is primary. If the parent with responsibility has no health care coverage for the dependent child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This does not apply to any plan year during which benefits are paid or provided before the plan has actual knowledge of the court decree provision.

      2) If a court decree states one parent is to assume primary financial responsibility for the dependent child but does not mention responsibility for health care expenses, the plan of the parent assuming financial responsibility is primary

      3) If a court decree states that both parents are responsible for the child's health care expenses or health care coverage, or that the parents have joint custody without mentioning financial responsibility or responsibility for health care expenses, the birthday rule of the policy holders determines the order of benefits.

4) If there is no court decree allocating responsibility for the child's health care expenses or health care coverage, the plans covering the child pay in the following order:

   a. The plan covering the custodial parent

   b. The plan covering the custodial parent's spouse

   c. The plan covering the non-custodial parent

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What if I'm Covered by Medicare?

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

If your Medicare entitlement is due to:

- **Age:** If you are covered under this Plan as an active employee or a dependent of an active employee and you become entitled to Medicare because of reaching age 65, this Plan will be primary. If you are covered under this Plan as a COBRA qualified beneficiary and are also entitled to Medicare based on age, Medicare is primary
- **Disability:** If you are covered under this Plan as an active employee or dependent of an active employee and become entitled to Medicare due to disability, this Plan will be primary. Once you or your dependent is declared disabled by Social Security, the disabled individual should apply for coverage under Medicare Parts A and B. If you are covered under this Plan as a COBRA qualified beneficiary and are also entitled to Medicare based on disability, Medicare is primary
- **End Stage Renal Disease (ESRD)**: If you become entitled to Medicare on the basis of ESRD, this Plan will pay primary during the initial coordination period (refer to the Medicare Secondary Payer Manual at www.cms.gov/manuals/downloads/msp105c02.pdf for more information regarding the initial coordination period). After this initial coordination period, this Plan will pay secondary to Medicare. This is true even if you are covered under this Plan as a COBRA qualified beneficiary.

Important note: this Plan will not pay benefits for dialysis services normally allowed under Medicare Part B when, by law, Medicare Part B would be primary and you are eligible for, but not enrolled in, Medicare Part B coverage.

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

Pre-authorization when this Plan is Secondary

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

Meaning of Plan for COB

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

- This Plan (the Plan with a capital "P")
- Group and non-group insurance contracts and subscriber contracts
- Uninsured arrangements of group or group-type coverage
- Group and non-group coverage through closed panel plans
- Group-type contracts ("group-type contract" means a contract that is not available to the general public and is obtained and maintained only because of membership in or a connection with a particular organization or group, including blanket coverage. It does not include an individually underwritten and issued guaranteed renewable policy even if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.
- The medical care components of long-term care contracts, such as skilled nursing care
- The medical benefits coverage in automobile "no fault" and traditional automobile "fault" type contracts
- Medicare or other governmental benefits, as permitted by law

"Plan" does not include:

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

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

Claim Determination Period

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

Right of Recovery

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

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

Facility of Payment

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

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

Right to Receive and Release Information

The Plan Administrator and FCHA 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 FCHA 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 FCHA.

Subrogation

Liable Third Parties and Insurers

If the Plan makes payments on your behalf for injury or illness another party is liable for, or injury or illness covered by uninsured/underinsured motorists (UIM) or personal injury protection (PIP) insurance, the Plan is entitled to be repaid for those payments out of any recovery from that liable party. (The liable party is also known as a third party because it is a party other than you or the Plan, including your UIM and PIP carriers because they stand for a third party and because the Plan excludes coverage for such benefits.) *Subrogation* means the Plan can collect directly from third parties, to the extent the Plan has paid for illness or injury caused by the third party, to recover those expenses.

To the fullest extent permitted by law, the Plan is entitled to the proceeds of any settlements or judgments that result in the recovery from a first or third party, up to the amount of benefit paid by the Plan for the condition. In recovering those amounts, the Plan Administrator (Benefits Department), Plan Sponsor (CWCMH) and/or FCHA may either hire their own attorney or be represented by your attorney. If the Plan chooses to be represented by your attorney, the Plan will pay, on a contingent basis, a reasonable portion of the attorney's fees necessary for asserting right of recovery in the case. This portion will not exceed 20% of the amount the Plan seeks to recover. The Plan will not pay for any legal costs incurred by or for you, and you won't be required to pay any portion of the costs incurred by or for the Plan.

Before accepting any settlement on your claim against a third party, you must notify FCHA's Subrogation Department in writing of any terms or conditions offered in a settlement, and you must notify the third party of the Plan's interest in the settlement (established by this provision). You must also cooperate with the Plan in recovering amounts paid on your behalf. If you retain an attorney or other agent to represent you in the matter, you must require your attorney or agent to reimburse the Plan directly from the settlement or recovery proceeds. Notify the FCHA Subrogation Department at PO Box 12659, Seattle WA 98111-4659 ((800) 395-0212, local: (206) 268-2360, fax: (888) 206-3092).

To the maximum permitted by law, the Plan is subrogated to your rights against any third party responsible for the condition, meaning the Plan has the right to:

- Sue the third party in your name
- Have a security interest in and a lien on any recovery to the extent of the benefit amount paid by the Plan and for its expenses in obtaining a recovery
- Recover benefits directly from the third party.

However claims, recoveries, etc. are classified or characterized by the parties, the courts or any other entity will not affect your responsibilities described above or the Plan's entitlement to first dollar recovery, regardless of whether you are made whole.

Uninsured/Underinsured Motorist Coverage

If the Plan pays for services also covered by uninsured/underinsured motorist coverage, despite the exclusion above, the Plan has the right to be reimbursed for benefits provided from any proceeds of that UIM or PIP coverage.

Venue

All suits or legal proceedings (including arbitration proceedings) brought against the Plan by a participant or anyone claiming any right under this contract, and all suits or legal proceedings brought by the Plan against a participant or other party, will be filed within the appropriate statutory period of limitation. In all suits or legal proceedings brought by the Plan or brought against the Plan, venue may lie, at the Plan's option, in King County, state of Washington.

Subrogation Forms

The participant will be required to complete a Subrogation Questionnaire, a Subrogation Agreement form and Authorization for Release of Information when details of the injury or condition do not clearly indicate if there is third party liability. Claims are denied 30 days after the forms have been mailed if they are not both completed and returned in their entirety, and until the Incident Response Questionnaire and Subrogation Agreement forms are completed and returned.

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 CWCMH HIPAA Privacy Notice.

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), FCHA. The benefits will be funded in part by the Plan Sponsor's general assets and contributions made by Plan participants. The Plan will determine, and periodically communicate, your share of the cost for benefits under each component benefit plan, and may change that determination at any time.

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

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

Plan Administrator's Power of Authority

The Plan Administrator role for this Plan rests with CWCMH'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 FCHA. In the case of a Plan participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

Statement of ERISA Rights

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

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

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor,

or you may file suit in a federal court. The court will decide who should pay court costs and fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Continue Group Health Coverage/Certificate of Creditable Coverage

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

You are entitled to a reduction or elimination in coverage exclusion periods for pre-existing conditions under your health plan if you have creditable coverage from another plan. You should receive a certificate of creditable coverage, free of charge, from the Plan when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months after your enrollment date in your new coverage.

Assistance with Your Questions

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

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

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

Summary Plan Description and General Information

Plan Name:	Central Washington Comprehensive Mental Health Employee Health Care Plan
Calendar Year:	January 1 through December 31
Type of Plan:	Group health plan (a type of welfare benefit plan subject to ERISA provisions)
Plan Number:	501
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.
Plan Sponsor's Employer Identification Number:	91-1043304
Name, Address & Telephone Number of Plan Sponsor/ Plan Administrator	Central Washington Comprehensive Mental Health 402 S. 4th Ave/PO Box 959 Yakima, WA 98907 (509) 575-4084
Named Fiduciary:	Central Washington Comprehensive Mental Health 402 S. 4th Ave/PO Box 959 Yakima, WA 98907 (509) 575-4084
Agent for Service of Legal Process:	Central Washington Comprehensive Mental Health 402 S. 4th Ave/PO Box 959 Yakima, WA 98907 (509) 575-4084
Third Party Administrator:	First Choice Health Network, Inc. d.b.a. First Choice Health Administrators 600 University Street, Suite 1400 Seattle, WA 98101 (800) 430-3818/Local (206) 268-2360 www.myFirstChoice.fchn.com
Plan Description:	The written Plan Description required by ERISA §402 consists of this entire document plus benefit summary booklets and provider directories.

Plan Definitions

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

Allowed amount means the maximum amount paid by the Plan for a medically necessary covered service. Generally, this is a contracted amount agreed to by FCHN participating providers (known as the First Choice Health Network). The allowed amount paid by the Plan for services from non-network providers and for out-of-area providers is based on usual, customary and reasonable (UCR) rates.

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

Category 1

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

Category 2

1. The trial is to treat a condition too rare to qualify for approval under Category 1
2. The available clinical or preclinical data provide a reasonable expectation that the trial treatment will be at least as effective as non-investigational therapy
3. There is no therapy that is clearly superior to the trial treatment, and,
4. Criteria 2 and 3 as noted in Category 1

Authorized representative means an individual acting on behalf of the participant or beneficiary claimant in obtaining or appealing a benefit claim. The authorized representative must have a signed form (specified by the Plan) by the claimant except for urgent care benefits or appeals. Once an authorized representative is selected, all information and notifications should be directed to that representative until the claimant states otherwise.

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.

Certificate of creditable coverage means a certificate issued by a group health plan that describes a person's prior period(s) of creditable health care coverage as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

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 on Axis I of 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)

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

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

Developmental disability means a condition that meets all of the following:

- Is defined as mental retardation, cerebral palsy, epilepsy, autism or other neurological or other condition
- Originates before the individual reaches age 18
- Is expected to continue indefinitely
- Results in a substantial handicap.

Emergency means the emergent and acute onset of a symptom or symptoms, including severe pain, that would lead a prudent 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.

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

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

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, excepting Approved Clinical Trials (see related definition)
- 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.

First Choice Health Administrators (FCHA) 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 FCHA and defines the service area.

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

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

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

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

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

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

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

Mental Health Condition means a mental disorder listed on Axis I of 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 Mental Health Conditions or are covered under other benefits offered by this Plan (subject to all terms, limitations and exclusions):

- Conditions related to Substance Disorders (see Chemical Dependency definition)
- Developmental Delays/Learning Disorders (see Neurodevelopmental Therapy benefit)
- Relational or behavioral issues (specifically those claims submitted with DSM V code as a primary diagnosis)
- Sexual and gender identity disorders (specifically DSM codes 302.0-302.9)

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

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

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

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

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.

Calendar Year means the twelve (12) month period beginning January 1 and ending December 31 of the same year.

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

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

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

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

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

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

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

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

Telemedicine means the use of medical information exchanged from one site to another via both synchronous and asynchronous electronic communications.

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

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

- Pain in the musculature associated with the temporomandibular joint;
- Internal derangement of the temporomandibular joint;
- Arthritic problems with the temporomandibular joint;
- 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. FCHA 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 allowed amount paid by FCHA for services received from non-network providers. This amount is determined at FCHN's discretion based on various, yet consistently applied, criteria such as the state in which the provider practices and geographic cost data obtained from an independent entity.