First Choice Health®

Northwest Montana Schools' Health Consortium Plan

Plan Document
and
Summary Plan Description

Effective July 1, 2021

www.fchn.com

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

Table of Contents

Important Information about this Plan

This booklet serves as your Plan Document and Summary Plan Description for the self-funded health care plan offered by Northwest Montana Schools' Consortium Health Plan. The first section of the booklet describes your coverage and payment levels and how to use your benefits under the Northwest Montana Schools' Consortium Health Plan as of July 1, 2021. The second section contains information on eligibility and enrollment, terminating and continuing coverage, administration, claim and appeal procedures and other legally required material.

The Plan Sponsor and Plan Administrator (Northwest Montana Schools' Consortium) of this self-funded health care plan, delegate to First Choice Health (FCH – a division of First Choice Health, Inc.), a Third Party Administrator (TPA), to perform certain Plan services such as the authority to make decisions on benefit coverage, medical management, claim payment and certain other administrative services according to Northwest Montana Schools' Health Consortium's policies and procedures. However, the Plan Sponsor (as noted earlier) retains at all times the ultimate fiduciary authority, responsibility and control over Plan assets, management and administration.

The Northwest Montana Schools' Consortium Health Plan will be referred to within this document as the "Plan."

Please review this booklet carefully and share it with your family. If you have questions, contact the Plan's Benefits Department (Plan Administrator) or FCH. If you have questions about whether a provider is considered 'in-network,' contact the appropriate network listed 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. The Plan Sponsor 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 Northwest Montana Schools' Consortium.

Contacting First Choice Health

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

First Choice Health
Customer Service Department
PO Box 12659
Seattle, WA 98111-4659
Phone: (855) 378-6778
Fax: (888) 206-3092
Medical pre-authorization: (800) 808-0450
Mental health/chemical dependency pre-authorization: (800) 640-7682
www.fchn.com

Spanish (Español): Para obtener asistencia en Español, llame al (855)-378-6778.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (855)-378-6778.

Chinese (中文): 如果需要中文的帮助，请拨打这个号码(855)-378-6778.

FCH's Customer Service Department business hours are Monday through Friday, 8:00 AM to 6:00 PM Mountain Standard Time (MST). The office is closed on New Year's Day, Memorial Day, Independence Day (4th of July), Labor Day, Thanksgiving, and the day after Thanksgiving, Christmas Eve and Christmas Day. FCH offices close at 3:00 PM on the day before Thanksgiving and on December 23rd (or on the Friday before if the 23rd falls on a weekend). If the holiday falls on a Saturday, the office is closed on Friday; if the holiday falls on Sunday, the office is closed Monday (the holiday is recognized during the same calendar week in which the holiday falls).

You can access benefit information or your specific claim and enrollment status anytime at www.fchn.com or by calling FCH Customer Service's automated voice response system at (855) 378-6778.

How to Obtain Health Services

Your ID Card

Your ID card identifies you as a Plan participant and contains important information about your coverage and benefits. Please present your ID card each time you receive care. If you lose your ID card, you may order a new one either through contacting FCH Customer Service at (855)-378-6778, or logging into www.fchn.com. Under no circumstances should you give your ID card to another person for their use.

Choosing a Provider

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

Networks	State/Area	Phone	Websites
First Choice Health Network	Montana, Washington, Alaska, Oregon, Idaho, Wyoming, North and South Dakota	(800) 231-6935	www.fchn.com
First Health	All other states/areas not served by FCHN	(800) 226-5116	firsthealth.coventryhealthcare.com/
98point6	All States	N/A	www.98point6.com/myfch

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

Services Received outside of the U.S.

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

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

Medical Management

Pre-authorization Requirements

All inpatient admissions and certain outpatient services and procedures **require FCH pre-authorization**, as also noted in the *Summary of Medical Benefits* applicable to your chosen benefit plan. If pre-authorization is not obtained on the services noted below, your claim may be denied. 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:

- **Air Ambulance Transport** - non-urgent transport
- **Anesthesia for dental services**
- **Autism** (initial evaluation and treatment plan)
- **Chimeric Antigen Receptor (CAR) T-cell Therapy**
- **Clinical Trials** (any interventions provided under a clinical trial)
- **Dental Trauma Services** (follow-up services and anesthesia)
- **Durable Medical Equipment, medical supplies and prosthetics**
  - Bone Growth Simulators
  - Compression devices for home use
  - Cranial orthotic devices
  - Custom Fabricated Knee Braces
  - Custom, power operated, and manual wheelchairs and supplies
    - Standard, manual wheelchair rental for transition of care for up to 3 months does not require pre-authorization
  - Electrical stimulators- Spinal- external
  - Neuromuscular stimulators
  - Oscillatory devices and cough stimulating devices
  - Prosthetics
    - Myoelectric prosthetic components for the upper limb
    - Powered ankle-foot prosthesis, microprocessor-controlled ankle-foot prosthesis, and microprocessor-controlled knee prosthesis
  - Scooters
  - Speech Generating Devices
  - Tumor Treating Fields for Glioblastoma
- **Dialysis (all types)** (for chronic kidney disease)
- **Enteral Formula, Medical Food and Associated Services**
- **Facet joint injections, Medial Branch Blocks and Neurotomies (any location)**
- **Gastric band adjustments** (when gastric band placement was covered under a medical plan previously offered by this Plan)
- **Genetic testing**
  - Over $500
  - FIT-Fecal DNA

- **Home health care services** (Certain home infusion drugs may still require pre-authorization. See *Medical Injectables*.)
  - Home health visits (for wound therapy only)
  - Hospice
- **Hyperbaric oxygen therapy**
- **Imaging**
  - PET scans
- **Inpatient admissions**
  - Chemical dependency and mental health admissions
  - Partial Hospital Program admissions for chemical dependency or mental health
  - 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** (The following list may not be all-inclusive. Newly FDA-approved specialty drugs not included on the list below may also require pre-authorization. If you have questions, please call FCH at the number above.)
  - Abatacept (Orencia ®)
  - Ado-trastuzumab emtansine (Kadcyla™)
  - Aflibercept (Eylea®)
  - Agalsidase Beta (Fabrazyme®)
  - Alemtuzumab (Lemtrada®)
  - Alglucosidase alfa (Lumizyme®)
  - Atezolizumab (Tecentriq®)
  - Avelumab (Bavencio®)
  - Belimumab (Benlysta®)
  - Benralizumab (Faserna®)
  - Bevacizumab (Avastin®) and Biosimilar
  - Blood clotting factors - all
  - Bortezomib (Velcade®)
  - Botulinum toxin (all types and brands)
  - Brentuximab (Adcetris®)
  - Brolucizumab-dbll (Beovu®)
  - Cerliponase alfa (Brineura™)
  - Cetuximab (Erbitux®)
  - Crizanlizumab (Adakveo®)
  - C1 Esterase inhibitors
  - Daratumumab (Darzalex®)
  - Ecallantide (Kalbitor®)
  - Eculizumab (Soliris®)
  - Edaravone (MCI-186, Radicava, Radicut®)
  - Epoprostenol (Flolan®)
  - Eteplirsen (Exondys 51™)
  - Gemtuzumab ozogamicin (Mylotarg®)
  - Infliximab (Remicade®) and Biosimilar

- Inotuzumab Ozogamicin (Besponsa™)
- Intravenous immunoglobulin (IVIG) therapy (all types and brands)
- Ipilimumab (Yervoy®)
- Lutetium Lu 177 dotatate (Lutathera®)
- Mepolizumab (Nucala®)
- Natalizumab (Tysabri®
- Nivolumab (Opdivo®)
- Nusinersen (Spinraza™)
- Ocrelizumab (Ocrevus™)
- Omalizumab (Xolair®)
- Onasemnogene abeparvovec-xioi (Zolgensma®)
- Palivizumab (Synagis®)
- Pembrolizymab (Keytruda®)
- Pemetrexed (Alimta®)
- Pertuzumab (Perjeta®)
- Ranibizumab (Lucentis®)
- Ravulizumab-CWVZ (Ultomiris®)
- Rituximab (Rituxan®) and Biosimilar
- Romiplostim (Nplate®)
- Sipuleucel-T (Provenge®)
- Taglicerase alfa (Eleyso™)
- Tocilizumab (Actemra®)
- Trastuzamab (Herceptin®) and Biosimilar
- Ustekinumab (Stelara®)
- Vedolizumab (Entyvio™)
- Velaglucerase alfa (VPRIV®)
- Voretigene Neparvovec-Rzyl (Luxturna™)
- Ziv-aflibercept (Zaltrap®)

- **Medical Weight Loss Services** (non-surgical)
- **Oral Appliances for Sleep Apnea Therapy**
- **Organ and bone marrow transplants** (includes evaluation of, services for both recipient and donor, and travel and lodging expenses)
  - Notification only for evaluation
  - Pre-authorization for services for recipient and donor
  - Pre-authorization for travel and lodging
- **Peripheral Nerve Blocks**
- **Radiation Therapy**
  - Proton beam, neutron beam or helium ion radiation therapy
  - Stereotactic Body Radiation Therapy (SBRT)
  - Stereotactic radiosurgery (Gamma Knife, Cyber Knife)
- **Surgery**
  - BAHA-Bone Anchored Hearing Aid (surgical benefit applies)
  - Breast Surgeries - selected (Pre-authorization is not required for breast reconstruction and nipple/areola reconstruction following mastectomy for breast cancer.)
    - Implant removal,

        - Reduction Mammoplasty
    - Cochlear implants (surgical benefit applies)
    - Cosmetic or reconstructive surgery
    - Deep Brain Stimulation
    - Eyelid surgery (i.e. blepharoplasty)
    - Fetal/Intrauterine surgery
    - Implantable peripheral nerve and/or spinal cord stimulator placement (temporary and permanent) including electrodes and/or pulse generator/receiver
    - Orthognathic surgery
    - Ovarian, internal iliac and gonadal vein embolization, ablation and sclerotherapy
    - Rhinoplasty
    - Spinal surgery - selected
        - Artificial Intervertebral Disc
        - Cervical Fusions
        - Lumbar fusions
        - Minimally invasive, percutaneous & endoscopic spine surgery
        - Percutaneous vertebroplasty, kyphoplasty, sacroplasty and coccygeoplasty
    - Surgical interventions for sleep apnea
    - Vagus nerve stimulation
    - Varicose vein procedures
    - Ventricular assist devices and total heart replacement
- **Transcranial Magnetic Stimulation**
- **Travel benefit**

For any of these procedures, you are responsible for obtaining pre-authorization directly from FCH. You may have your provider contact FCH for you, but you are ultimately responsible. As noted above, if you neglect to obtain pre-authorization for services that require it, your claim may be denied. Payments of claims denied for lack of pre-authorization do **not** apply toward your Benefit Period deductible or out-of-pocket maximums.

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

Notification for Emergency Admissions

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

Concurrent Review and Discharge Coordination

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

Case Management

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

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

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

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

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

Maternity Management Program

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

Revised Medical Plan

Cost Sharing
Payment Provisions
Benefit Maximums
Benefit Summary

Cost Sharing
Revised Medical Plan

The Benefit Period begins on July 1st and ends on June 30th of the following year.

Annual Deductible, Out-of-Pocket Maximums and Coinsurance for the Revised Medical Plan

Plan	Deductible Individual/Family	Benefit Percentage (Plan pays)	Out-of-Pocket Maximum Individual/Family
Revised 1000-70-3000	$1,000 / $2,000	70%	$3,000 / $6,000

Annual Deductible, Out-of-Pocket Maximums and Coinsurance for the Revised Pharmacy Plan

Plan	Deductible Individual/Family	Out-of-Pocket Maximum Individual/Family
Revised 1000-70-3000	$100	$3,600 / $7,200

Payment Provisions
Revised Medical Plan

Highlights of the Revised Medical Plan Provisions

- The Plan pays the first $500 of eligible expenses related to accidental injuries when such expenses are incurred within ninety (90) days of the date of the accident.
- Your benefit coverage is greater, and your out-of-pocket costs less, when you choose a Network provider.
- Benefit payment for services received from Network providers are based on the Allowed Amounts agreed upon by those providers.
- Benefit payment for services received from non-network providers (except emergency services, see below) is based on an amount established by a prevailing fee schedule for the geographic area in which the claim was incurred. This includes flat dollar benefits and preventive benefits. If no such fee schedule exists, a percentage of the provider's billed charges will be paid. See *Allowed Amount* in *Plan Definitions*.
- Benefit payment for emergency services received from non-network providers is determined annually and is based on the greatest of the following amounts: 1) the median of the contracted amounts agreed upon by network providers; 2) the Usual, Customary and Reasonable (UCR) amount (see related definition); or 3) the Medicare amount. See *Allowed Amount* in *Plan Definitions*.
- Services received from a Recognized Provider (See Plan Definitions under Section II - Summary Plan Description) will be paid at the In-Network level. Benefits will be based on Usual, Customary and Reasonable data or a case negotiated rate. **You will be responsible for the difference (if any) between the Plan payment and the billed charges on Recognized Provider claims and this difference would not apply to your Out-of- Pocket (OOP) maximum as discussed below.**
- For services received from non-network providers, you are responsible to pay the difference between the Plan payment and the provider's actual charges.
- Claims are processed according to the diagnoses and services billed by the provider(s). Billing disputes regarding services received should be addressed with the rendering provider.

Annual Deductible

The annual deductible is the amount you (or your family) must pay each Benefit Period before the Plan will pay for covered services. Once the deductible is satisfied, coinsurance amounts as noted in the applicable *Benefit Summary* will be applied. Until then, the amount due a provider is your responsibility.

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

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

- Acupuncture
- Charges for first $500 in eligible expenses related to accidental injuries when such expenses are incurred within ninety (90) days of the date of the accident
- Charges of non-covered services and treatment
- Charges for services that are denied as not medically necessary
- Charges over the Allowed Amount for non-network services as determined by the Plan
- Charges that exceed any applicable benefit maximum
- Charges for claims denied for lack of pre-authorization
- Charges for services paid by the Plan at 100%, such as (but not limited to), Diabetic Education, etc.
- Chiropractic spinal manipulation
- Prescription drugs (note: separate deductible applies to preferred-brand and non-preferred brand drugs, please refer to *Pharmacy Plan - Benefit Summaries*)
- Preventive care services (network providers only)
- Professional/Physician office visits (for evaluation and management)
- Travel benefit

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the most you will need to pay in a Benefit Period. The following do **not** apply toward the annual out-of-pocket maximum:

- Acupuncture
- Charges of non-covered services and treatment
- Charges for services that are denied as not medically necessary
- Charges over the Allowed Amount for non-network services as determined by the Plan
- Charges that exceed any applicable benefit maximum
- Charges for claims denied for lack of pre-authorization
- Charges for services paid by the Plan at 100%
- Prescription drugs
- Travel benefit

Benefit Maximums
Revised Medical Plan

Your Benefit Period benefit maximums are noted in the tables that follow:

Summary of Benefit Maximums for the Revised Medical Plan

Benefit Period (or episodic) Maximums	
Accidental Injury Benefit (includes Dental Trauma)	$500 (per accident) within 90 days of accident
Acupuncture	25 visits/$25 per visit maximum (combined maximum with chiropractic spinal manipulation and massage therapy)
Chiropractic Spinal Manipulation – office visits/spinal manipulations	25 visits/$25 per visit maximum (combined maximum with acupuncture and massage therapy)
Chiropractic Spinal Manipulation – radiology (x-rays)	$100
Massage Therapy	25 visits/$25 per visit maximum (combined maximum with acupuncture and chiropractic spinal manipulation)
Diabetic Education (nutrition or otherwise)	5 visits
Home Health Care	180 visits (combined with Hospice visits)
Obesity Screening and Counseling	12 visits
Rehabilitation Therapy – Inpatient	60 days
Rehabilitation Therapy – Outpatient (Speech, Occupational, Physical Therapies and Cardiac Rehabilitation)	50 visits
Skilled Nursing Facility	60 days
Travel Benefit	$600 per Round Trip
Wigs	$500 per lifetime

Benefit Summary
Revised Medical Plan

Revised Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
Accidental Injury Benefit (includes Dental Trauma) Plan pays first $500 per plan year on accidental injuries each Benefit Period; care must be received within 90 days of accident.	N/A	N/A	100%	100%
Allergy Care	✓	✓	70%	70%
Alternative Care				
• **Acupuncture** 25 visits per Benefit Period combined with Chiropractic and Massage Therapy benefits, $25 per visit maximum.	N/A	N/A	100%	100%
• **Massage Therapy** 25 visits per Benefit Period combined with Acupuncture and Chiropractic benefits, $25 per visit maximum.	N/A	N/A	100%	100%
Ambulance Services FCH pre-authorization required for non-emergent air ambulance.	✓	✓	70%	70%
• **First Responder User Fees**	✓	✓	70%	70%
Anesthesia	✓	✓	70%	70%
Autism Spectrum Disorders (includes Applied Behavior Analysis (ABA Therapy)) Mental Health and Habilitative Services. FCH pre-authorization required for **initial evaluation and treatment plan for Autism**. Covered for children through age 18.				
• **Inpatient Care -** facility and professional	✓	✓	70%	70%
• **Outpatient -** facility and professional First 3 visits per Benefit Period.	N/A	N/A	100%	100%

Revised Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
• **Outpatient -** facility and professional 4th visit and after.	N/A	✓	100% after $35 copay	70%
Autologous Blood Donation/Blood Transfusion	✓	✓	70%	70%
Biofeedback Limited benefit, see *Biofeedback* for details.	✓	✓	70%	70%
Chemical Dependency FCH pre-authorization required for inpatient, residential and partial hospitalization.				
• **Inpatient Care -** facility and professional	✓	✓	70%	70%
• **Outpatient -** facility and professional First 3 visits per Benefit Period.	N/A	N/A	100%	100%
• **Outpatient -** facility and professional 4th visit and after.	N/A	✓	100% after $35 copay	70%
Chiropractic Spinal Manipulation				
• **Office Visits/Spinal Manipulations** 25 visits per Benefit Period combined with Acupuncture and Massage Therapy benefits; $25 per visit maximum.	N/A	N/A	100%	100%
• **Related Radiology/X-Rays** $100 per Benefit Period.	N/A	N/A	100%	100%
Clinical Trials	Covered as specifically outlined under Clinical Trials in the *Medical Benefits* section below.			
Dental Trauma FCH pre-authorization required for follow-up services and anesthesia.				
• **First $500 per Plan Year of Eligible Expenses** (applies to Accidental Injury Benefit)	N/A	N/A	100%	100%
• **Eligible Expenses Beyond First $500**				

Revised Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
– Office Visits	N/A	✓	100% after $35 copay	70%
– All other places of service	✓	✓	70%	70%
Diabetic Education (nutrition or otherwise) 5 visits per Benefit Period maximum.	N/A	N/A	100%	100%
Diagnostic Testing (lab and radiology services, non-routine, facility and professional services) FCH pre-authorization required for PET scans.				
• **Provided in the office**	N/A	✓ (OON only)	100%	70%
• **All other places of service**	✓	✓	70%	70%
Durable Medical Equipment/Supplies				
• **Breast Pumps**	✓ (OON only)	✓ (OON only)	100%	70%
• **Durable Medical Equipment**	✓	✓	70%	70%
• **Medical Supplies**	✓	✓	70%	70%
• **Oral Appliances** FCH pre-authorization required when related to Sleep Apnea.	✓	✓	70%	70%
• **Orthopedic Appliances/Braces**	✓	✓	70%	70%
• **Prosthetic Devices**	✓	✓	70%	70%
Emergency Care				
• **Emergency Department** (facility and professional services)	✓	✓	70%	70%
• **Urgent Care** (facility and professional services)	N/A	✓	100% after $35 copay	70%
Family Planning				
• **Female – Office Visits and Diagnostic Services**	✓ (OON only)	✓ (OON only)	100%	70%
• **Male – Office Visits and Diagnostic Services**	✓	✓	100%	70%
• **Contraceptive Devices, Implants, Injections**	✓ (OON only)	✓ (OON only)	100%	70%

Revised Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
• **Female - Contraceptive Diagnostic Testing**	✓ (OON only)	✓ (OON only)	100%	70%
• **Male - Contraceptive Diagnostic Testing**	✓	✓	100%	70%
• **Female – Sterilization**	✓ (OON only)	✓ (OON only)	100%	70%
• **Male - Sterilization**	✓	✓	100%	70%
Genetic Services FCH pre-authorization required for Genetic Testing if over $500.				
• **BRCA Testing**	✓ (OON only)	✓ (OON only)	100%	70%
• **FIT-Fecal DNA** FCH pre-authorization required. 1 per calendar year.	✓ (OON only)	✓ (OON only)	100%	70%
• **All other Genetic Testing/Counseling**	✓	✓	70%	70%
Habilitative Services (excluding autism-related services. See Autism benefit) Covered for children through age 18.	✓	✓	70%	70%
Hearing Exams (non-routine)	✓	✓	70%	70%
<u>Hearing Aids/Appliances are not covered.</u> However, Cochlear implants and Bone Anchored Hearing Aids (BAHA) are covered under the surgical benefit, not the Hearing Aids/Appliances benefit. Please see Hospital Outpatient Surgery and Services.				
Home Health Care (HHC) FCH pre-authorization required for wound therapy, enteral formula, medical food and associated services and home hospice.				
• **Home Health Care** 180 visits Benefit Period maximum, combined with Hospice Care.	✓	✓	70%	70%
• **Phototherapy** (home)	✓	✓	70%	70%
Hospice Care FCH pre-authorization required; 180 visits per Benefit Period maximum, combined with Home Health visits.	✓	✓	70%	70%

Revised Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
Hospital Inpatient Medical and Surgical Care FCH pre-authorization required.	✓	✓	70%	70%
Hospital Outpatient Surgery and Services FCH pre-authorization required for certain outpatient services; see *Pre-authorization Requirements* for details.	✓	✓	70%	70%
Infusion Therapy (includes infusion therapy provided in the home) FCH pre-authorization required for certain infusion therapy drugs, see *Pre-Authorizations Requirements.*	✓	✓	70%	70%
Maternity and Newborn Care				
• **Office Visits** (billed outside the global fee)	N/A	✓	100% after $35 copay	70%
• **All Other Maternity/Newborn Care**	✓	✓	70%	70%
Medical Weight Loss Program (non-surgical) FCH pre-authorization required and limited benefit; please see *Medical Benefits* section for more details.				
• **Office Visits** The first 4 office visits related to obesity will be covered as any other office visit. Once the maximum four obesity-related office visits have been exhausted, all obesity-related services will only be covered as part of the Medical Weight Loss Program benefits when pre-authorized by FCH.	N/A	✓	100% after $35 copay	70%
• **All other Services**	✓	✓	70%	70%
Mental Health Care FCH pre-authorization required for inpatient, residential and partial hospitalization.				
• **Inpatient Care -** facility and professional	✓	✓	70%	70%

Revised Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
• **Outpatient -** facility and professional First 3 visits per Benefit Period.	N/A	N/A	100%	100%
• **Outpatient -** facility and professional 4th visit and after.	N/A	✓	100% after $35 copay	70%
Nutritional Counseling (unrelated to diabetes)	N/A	✓	100% after $35 copay	70%
Nutritional and Dietary Formulas	✓	✓	70%	70%
Oral Surgery Limited benefit, see *Oral Surgery* for details**.**	✓	✓	70%	70%
Plastic and Reconstructive Services FCH pre-authorization required. Limited benefit, see *Plastic and Reconstructive Services* for details.	✓	✓	70%	70%
Podiatric Care See *Podiatric Care* for details on routine foot care.				
• **In Office** (includes services billed as part of the office visit)	N/A	✓	100% after $35 copay	70%
• **All Other Places of Service**	✓	✓	70%	70%
Preventive Care The preventive services payable by this Plan are designed to comply with Health Care Reform (HCR) regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control (CDC), including but not limited to those listed in the Plan. Periodic updates that may be made to these requirements will be incorporated into the Plan as required by law. The list of the types of payable preventive services is available at: www.healthcare.gov/preventive-care-adults/ www.healthcare.gov/preventive-care-children/ www.healthcare.gov/preventive-care-women/ Claims submitted outside the frequency limits noted herein will be paid under the major medical benefits (deductible and coinsurance will apply).				
Immunizations Immunizations for children and adults are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention. See Preventive Care for details. Shingles vaccine is covered beginning at age 50. Travel immunizations are covered.				
• **Immunizations** Immunizations done in the pharmacy will pay at 100% of billed.	✓ (OON only)	✓ (OON only)	100%	70%

Revised Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
Office Visits				
• **Well child exams -** children 0-36 months	✓ (OON only)	✓ (OON only)	100%	70%
• **Preventive Exams -** adults and children 3 and older	✓ (OON only)	✓ (OON only)	100%	70%
• **Nutritional Counseling** (counseling for a healthy diet) 3 visits per Benefit Period maximum. Subsequent visits are paid under the *Diabetic Education* or *Nutritional Counseling* medical benefits, as applicable.	✓ (OON only)	✓ (OON only)	100%	70%
• **Obesity Screening and Counseling** 12 visits per benefit period.	✓ (OON only)	✓ (OON only)	100%	70%
Screening Tests - children 0-36 months Screening tests are covered in accordance with the recommendations set forth by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See Preventive Care for more details.				
• **Hemoglobin/Hematocritic Blood Test**	✓ (OON only)	✓ (OON only)	100%	70%
• **Urinalysis**	✓ (OON only)	✓ (OON only)	100%	70%
• **Tuberculin Test**	✓ (OON only)	✓ (OON only)	100%	70%
• **All other Routine Lab/Radiology**	✓ (OON only)	✓ (OON only)	100%	70%
Screening Tests - adults and children 3 and older Screening tests are covered in accordance with the recommendations set forth by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See Preventive Care for more details.				

Revised Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
• **Colonoscopy** The first colonoscopy per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent colonoscopies in the same Plan year are covered under the medical benefits, regardless of diagnosis.	✓ (OON only)	✓ (OON only)	100%	70%
• **Virtual Colonoscopy** The first colonoscopy per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent colonoscopies in the same Plan year are covered under the medical benefits, regardless of diagnosis.	✓ (OON only)	✓ (OON only)	100%	70%
• **Sigmoidoscopy** The first sigmoidoscopy per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent sigmoidoscopies in the same Plan year are covered under the medical benefits, regardless of diagnosis.	✓ (OON only)	✓ (OON only)	100%	70%
• **Fecal Occult Blood Tests** The first fecal occult blood test per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent fecal occult blood tests in the same Plan year are covered under the medical benefits, regardless of diagnosis.	✓ (OON only)	✓ (OON only)	100%	70%
• **Mammograms** The first mammogram per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent mammograms in the same Plan year are covered under the medical benefits, regardless of diagnosis.	✓ (OON only)	✓ (OON only)	100%	70%
• **Pap Tests** (1 per Benefit Period)	✓ (OON only)	✓ (OON only)	100%	70%

Revised Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
• **All other Preventive Lab/Radiology**	✓ (OON only)	✓ (OON only)	100%	70%
Professional/Physician Services (office visits)				
• **Office Visit -** includes all services billed as part of the office visit.	N/A	✓	100% after $35 copay	70%
• **98point6** Telehealth visits	N/A	N/A	100%	N/A
Rehabilitation Therapy				
• **Inpatient** FCH pre-authorization required; 60 days per Benefit Period maximum.	✓	✓	70%	70%
• **Outpatient** (includes, physical, speech, occupational therapies and cardiac rehabilitation) 50 visits per Benefit Period; all therapies combined.	✓	✓	70%	70%
Skilled Nursing Facility FCH pre-authorization required; 60 days per Benefit Period maximum.	✓	✓	70%	70%
Tobacco Cessation Tobacco cessation medications are covered under the pharmacy benefits.	✓ (OON only)	✓ (OON only)	100%	70%
Transplants (Organ and Bone Marrow) FCH pre-authorization required.	✓	✓	70%	70%
Travel Benefit FCH pre-authorization required. For travel required to receive medically necessary care; $600 per round trip maximum. See Travel Benefit for details.	N/A	N/A	100%	100%
Wigs Covered when loss of hair is a result of chemotherapy, radiation therapy, burns or surgery. Maximum lifetime benefit of $500.	✓	✓	70%	70%

High Deductible Health Plan (HSA Compatible Plans)

Cost Sharing
Payment Provisions
Benefit Maximums
Benefit Summary

Cost Sharing
High Deductible Health Plan

The Benefit Period is a twelve-month period that begins on July 1st and ends on June 30th of the following year.

Annual Deductible, Out-of-Pocket Maximums and Coinsurance for the High Deductible Health Plan

Plan	Deductible Individual/Family	Benefit Percentage (Plan pays)	Out-of-Pocket Maximum Individual/Family
HDHP 3000-80-5000	$3,000 / $6,000	80%	$5,000 / $10,000
HDHP 4000-100-4000	$4,000 / $8,000	100%	$4,000 / $8,000
HDHP 6050-100-6050	$6,050 / $12,100	100%	$6,050 / $12,100

Note: These plans are "Embedded Deductible" Plans. See Annual Deductible on next page for an explanation.

Payment Provisions
High Deductible Health Plan

Highlights of the High Deductible Health Plan Payment Provisions

- Your benefit coverage is greater, and your out-of-pocket costs less, when you choose a Network provider.
- Benefit payment for services received from Network providers are based on the Allowed Amounts agreed upon by those providers.
- Benefit payment for services received from non-network providers (except emergency services, see below) is based on an amount established by a prevailing fee schedule for the geographic area in which the claim was incurred. This includes flat dollar benefits and preventive benefits. If no such fee schedule exists, a percentage of the provider's billed charges will be paid. See *Allowed Amount* in *Plan Definitions*.
- Benefit payment for emergency services received from non-network providers is based on the greatest of the following amounts: 1) the median of the contracted amounts agreed upon by network providers; 2) the Usual, Customary and Reasonable (UCR) amount (see related definition); or 3) the Medicare amount. See *Allowed Amount* in *Plan Definitions*.
- Services received from a Recognized Provider (See Plan Definitions under Section II - Summary Plan Description) will be paid at the In-Network level. Benefits will be based on Usual, Customary and Reasonable data or a case negotiated rate. **You will be responsible for the difference (if any) between the Plan payment and the billed charges on Recognized Provider claims and this difference would not apply to your Out-of- Pocket (OOP) maximum as discussed below.**
- For services received from non-network providers, you are responsible to pay the difference between the Plan payment and the provider's actual charges.
- Claims are processed according to the diagnoses and services billed by the provider(s). Billing disputes regarding services received should be addressed with the rendering provider.

Annual Deductible

The annual deductible is the amount you (or your family) must pay each Benefit Period before the Plan will pay for covered services. Once the deductible is satisfied, coinsurance amounts as noted in the applicable *Benefit Summary* will be applied. Until then, the amount due a provider is your responsibility.

Embedded Deductible

An Embedded Deductible is one in which each individual will meet no more than the individual maximum but the family will meet no more than the stated family maximum, regardless of family size. In this case, some individuals within the family may meet less than the individual maximum amount if the family maximum is met.

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 the Allowed Amount for non-network services as determined by the Plan
- Charges that exceed any applicable benefit maximum
- Charges for claims denied for lack of pre-authorization
- Preventive care (network providers only)
- Travel benefit

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the most you will need to pay in a Benefit Period. 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 the Allowed Amount for non-network services as determined by the Plan
- Charges that exceed any applicable benefit maximum
- Charges for claims denied for lack of pre-authorization
- Charges for services paid by the Plan at 100%
- Travel benefit

Benefit Maximums
High Deductible Health Plan

Your Benefit Period benefit maximums are noted in the tables that follow:

Summary of Benefit Maximums for the High Deductible Health Plan

Benefit Period (or episodic) Maximums	
Acupuncture	25 visits/$25 per visit maximum (combined maximum with chiropractic spinal manipulation and massage therapy)
Chiropractic Spinal Manipulation – office visits/spinal manipulations	25 visits/$25 per visit maximum (combined maximum with acupuncture and massage therapy)
Chiropractic Spinal Manipulation – radiology (x-rays)	$100
Massage Therapy	25 visits/$25 per visit maximum (combined maximum with acupuncture and chiropractic spinal manipulation)
Diabetic Education (nutrition or otherwise)	5 visits
Home Health Care	180 visits (combined with Hospice visits)
Obesity Screening and Counseling	12 visits
Rehabilitation Therapy – Inpatient	60 days
Rehabilitation Therapy – Outpatient (Speech, Occupational, Physical Therapies and Cardiac Rehabilitation)	50 visits
Skilled Nursing Facility	60 days
Travel Benefit	$600 per Round Trip
Wigs	$500 per lifetime

Refer to Pharmacy Plans Payment Provisions for Pharmacy Benefits.

Benefit Summary
High Deductible Health Plan

High Deductible Health Plan				
	Applies to Deductible	**Applies to OOP Max**	**HDHP 3000-80-5000**	**HDHP 6050-100-6050 4000-100-4000**
Allergy Care	✓	✓	80%	100%
Alternative Care				
• **Acupuncture** 25 visits per Benefit Period combined with Chiropractic and Massage Therapy benefits, $25 per visit maximum.	✓	✓	100%	100%
• **Massage Therapy** 25 visits per Benefit Period combined with Chiropractic and Acupuncture benefits, $25 per visit maximum.	✓	✓	100%	100%
Ambulance Services FCH pre-authorization required for non-emergent air ambulance.	✓	✓	80%	100%
• **First Responder User Fees**	✓	✓	80%	100%
Anesthesia	✓	✓	80%	100%
Autism Spectrum Disorders (includes Applied Behavior Analysis (ABA Therapy) Mental Health and Habilitative Services. FCH Pre-authorization required for **initial evaluation and treatment plan for Autism**. Covered for children through age 18.				
• **Inpatient Care** - facility and professional	✓	✓	80%	100%
• **Outpatient** - facility and professional	✓	✓	80%	100%
Autologous Blood Donation/Blood Transfusion	✓	✓	80%	100%
Biofeedback Limited benefit, see *Biofeedback* for details.	✓	✓	80%	100%
Chemical Dependency FCH pre-authorization required for inpatient, residential and partial hospitalization.	✓	✓	80%	100%

High Deductible Health Plan				
	Applies to Deductible	**Applies to OOP Max**	**HDHP 3000-80-5000**	**HDHP 6050-100-6050 4000-100-4000**
Chiropractic Spinal Manipulation				
• **Office Visits/Spinal Manipulations** 25 visits per Benefit Period combined with Acupuncture and Massage Therapy benefits; $25 per visit maximum.	✓	✓	100%	100%
• **Related Radiology/X-Rays** $100 per Benefit Period	✓	✓	80%	100%
Clinical Trials	Covered as specifically outlined under Clinical Trials in the *Medical Benefits* section below.			
Dental Trauma FCH pre-authorization required for follow-up services and anesthesia.	✓	✓	80%	100%
Diabetic Education (nutrition or otherwise) 5 visits per Benefit Period maximum.	✓	✓	100%	100%
Diagnostic Testing (lab and radiology services, non-routine, facility and professional services) FCH pre-authorization required for PET scans.	✓	✓	80%	100%
Durable Medical Equipment/Supplies				
• **Breast Pumps**				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓	✓	80%	100%
• **Durable Medical Equipment**	✓	✓	80%	100%
• **Medical Supplies**	✓	✓	80%	100%
• **Oral Appliances** FCH pre-authorization required when related to Sleep Apnea.	✓	✓	80%	100%
• **Orthopedic Appliances/Braces**	✓	✓	80%	100%
• **Prosthetic Devices**	✓	✓	80%	100%
Emergency Care				
• **Emergency Department** (facility and professional services)	✓	✓	80%	100%

High Deductible Health Plan				
	Applies to Deductible	**Applies to OOP Max**	**HDHP 3000-80-5000**	**HDHP 6050-100-6050 4000-100-4000**
• **Urgent Care** (facility and professional services)	✓	✓	80%	100%
Family Planning				
• **Female – Office Visits and Diagnostic Services**				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓	✓	80%	100%
• **Male – Office Visits and Diagnostic Services**				
– Network Providers	✓	✓	80%	100%
– Non-Network Providers	✓	✓	80%	100%
• **Contraceptive Devices, Implants, Injections**				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓	✓	80%	100%
• **Female - Contraceptive Diagnostic Testing**				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓	✓	80%	100%
• **Male – Contraceptive Diagnostic Testing**				
– Network Providers	✓	✓	80%	100%
– Non-Network Providers	✓	✓	80%	100%
• **Female - Sterilization**				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓	✓	80%	100%
• **Male – Sterilization**				
– Network Providers	✓	✓	80%	100%
– Non-Network Providers	✓	✓	80%	100%
Genetic Services FCH pre-authorization required for Genetic Testing if over $500.				
• **BRCA Testing**				
– Network Providers	N/A	N/A	80%	100%

High Deductible Health Plan				
	Applies to Deductible	**Applies to OOP Max**	**HDHP 3000-80-5000**	**HDHP 6050-100-6050 4000-100-4000**
– Non-Network Providers	✓ OON Only	✓ OON Only	80%	100%
• **FIT-Fecal DNA** FCH pre-authorization required. 1 per calendar year.	✓ OON Only	✓ OON Only	80%	100%
• **All other Genetic Testing/Counseling**	✓	✓	80%	100%
Habilitative Services (excluding autism-related services. See Autism benefit) Covered for children through age 18.	✓	✓	80%	100%
Hearing Exams (non-routine)	✓	✓	80%	100%
Hearing Aids/Appliances are not covered. However, Cochlear implants and Bone Anchored Hearing Aids (BAHA) are covered under the surgical benefit, not the Hearing Aids/Appliances benefit. Please see page 32 under Hospital Outpatient Surgery and Services.				
Home Health Care (HHC) FCH pre-authorization required for wound therapy, enteral formula, medical food and associated services and home hospice.	✓	✓	80%	100%
• **Home Health Care** 180 visits Benefit Period maximum (combined with Hospice Care)	✓	✓	80%	100%
• **Phototherapy** (home)	✓	✓	80%	100%
Hospice Care FCH pre-authorization required; 180 visits per Benefit Period maximum, combined with Home Health visits.	✓	✓	80%	100%
Hospital Inpatient Medical and Surgical Care FCH pre-authorization required.	✓	✓	80%	100%
Hospital Outpatient Surgery and Services FCH pre-authorization required for certain outpatient services; see *Pre-authorization Requirements* for details.	✓	✓	80%	100%

High Deductible Health Plan				
	Applies to Deductible	**Applies to OOP Max**	**HDHP 3000-80-5000**	**HDHP 6050-100-6050 4000-100-4000**
Infusion Therapy (includes infusion therapy provided in the home) FCH pre-authorization required for certain infusion therapy drugs, see *Pre-Authorizations Requirements.*	✓	✓	80%	100%
Maternity and Newborn Care	✓	✓	80%	100%
Medical Weight Loss Program (non-surgical) FCH pre-authorization required and limited benefit; please see *Medical Benefits* section for more details.	✓	✓	80%	100%
Mental Health Care FCH pre-authorization required for inpatient, residential and partial hospitalization.	✓	✓	80%	100%
Nutritional Counseling (unrelated to diabetes)	✓	✓	80%	100%
Nutritional and Dietary Formulas	✓	✓	80%	100%
Oral Surgery Limited benefit, see *Oral Surgery* for details.	✓	✓	80%	100%
Plastic and Reconstructive Services FCH pre-authorization required. Limited benefit, see *Plastic and Reconstructive Services* for details.	✓	✓	80%	100%
Podiatric Care See *Podiatric Care* for details on routine foot care.	✓	✓	80%	100%

Preventive Care

The preventive services payable by this Plan are designed to comply with Health Care Reform (HCR) regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control (CDC), including but not limited to those listed in the Plan. Periodic updates that may be made to these requirements will be incorporated into the Plan as required by law. The list of the types of payable preventive services is available at:

www.healthcare.gov/preventive-care-adults/
www.healthcare.gov/preventive-care-children/
www.healthcare.gov/preventive-care-women/

Claims submitted outside the frequency limits noted herein will be paid under the major medical benefits (deductible and coinsurance will apply)

High Deductible Health Plan				
	Applies to Deductible	**Applies to OOP Max**	**HDHP 3000-80-5000**	**HDHP 6050-100-6050 4000-100-4000**
Immunizations Immunizations for children and adults are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention. See Preventive Care for details. Shingles vaccine is covered beginning at age 50. Travel immunizations are covered.				
• **Network Providers**	N/A	N/A	100%	100%
• **Non-Network Providers** Immunizations done in the pharmacy will pay at 100% of billed.	✓ OON Only	✓ OON Only	80%	100%
Office Visits				
• **Well Child Exams** - children 0-36 months				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓ OON Only	✓ OON Only	80%	100%
• **Preventive Exams** - adults and children 3 and older				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓ OON Only	✓ OON Only	80%	100%
Nutritional Counseling (counseling for a healthy diet) 3 visits per Benefit Period maximum. Subsequent visits are paid under the *Diabetic Education* or *Nutritional Counseling* medical benefits, as applicable.				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓ OON Only	✓ OON Only	80%	100%
• **Obesity Screening and counseling** 12 visits per benefit period.				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓ OON Only	✓ OON Only	80%	100%
Screening Tests - children 0-36 months Screening tests are covered in accordance with the recommendations set forth by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See Preventive Care for more details.				

High Deductible Health Plan				
	Applies to Deductible	**Applies to OOP Max**	**HDHP 3000-80-5000**	**HDHP 6050-100-6050 4000-100-4000**
• **Hemoglobin/Hematocritic Blood test**				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓ OON Only	✓ OON Only	80%	100%
• **Urinalysis**				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓ OON Only	✓ OON Only	80%	100%
• **Tuberculin Test**				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓ OON Only	✓ OON Only	80%	100%
• **All other Routine Lab/Radiology**				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓ OON Only	✓ OON Only	80%	100%
Screening Tests - adults and children 3 years and older Screening tests are covered in accordance with the recommendations set forth by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See Preventive Care for more details.				
• **Colonoscopy** The first colonoscopy per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent colonoscopies in the same Plan year are covered under the medical benefits, regardless of diagnosis.				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓ OON Only	✓ OON Only	80%	100%

High Deductible Health Plan				
	Applies to Deductible	**Applies to OOP Max**	**HDHP 3000-80-5000**	**HDHP 6050-100-6050 4000-100-4000**
• **Virtual Colonoscopy** The first virtual colonoscopy per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent colonoscopies in the same Plan year are covered under the medical benefits, regardless of diagnosis.				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓ OON Only	✓ OON Only	80%	100%
• **Sigmoidoscopy** The first sigmoidoscopy per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent sigmoidoscopies in the same Plan year are covered under the medical benefits, regardless of diagnosis.				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓	✓	80%	100%
• **Fecal Occult Blood Tests** The first fecal occult blood test per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent fecal occult blood tests in the same Plan year are covered under the medical benefits, regardless of diagnosis.				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓ OON Only	✓ OON Only	80%	100%
• **Mammograms** The first mammogram per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent mammograms in the same Plan year are covered under the medical benefits, regardless of diagnosis.				

High Deductible Health Plan				
	Applies to Deductible	**Applies to OOP Max**	**HDHP 3000-80-5000**	**HDHP 6050-100-6050 4000-100-4000**
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓ OON Only	✓ OON Only	80%	100%
• **Pap Tests** (1 per Benefit Period)				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓ OON Only	✓ OON Only	80%	100%
• **All other Preventive Lab/Radiology**				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓ OON Only	✓ OON Only	80%	100%
Professional/Physician Services (office/hospital visits)	✓	✓	80%	100%
• **98point6** Telehealth visits	✓	✓	80%	100%
Rehabilitation Therapy				
• **Inpatient** FCH pre-authorization required; 60 days per Benefit Period maximum.	✓	✓	80%	100%
• **Outpatient** (includes physical, speech, occupational therapies and cardiac rehabilitation) 50 visits per Benefit Period; all therapies combined.	✓	✓	80%	100%
Skilled Nursing Facility FCH pre-authorization required; 60 days per Benefit Period maximum.	✓	✓	80%	100%
Tobacco Cessation Tobacco cessation medications are covered under the pharmacy benefits.				
– Network Providers	N/A	N/A	100%	100%
– Non-Network Providers	✓ OON Only	✓ OON Only	80%	100%
Transplants (Organ and Bone Marrow) FCH pre-authorization required.	✓	✓	80%	100%

High Deductible Health Plan				
	Applies to Deductible	**Applies to OOP Max**	**HDHP 3000-80-5000**	**HDHP 6050-100-6050 4000-100-4000**
Travel Benefit FCH pre-authorization required. For travel required to receive medically necessary care; $600 per round trip maximum. See *Travel Benefit* for details.	N/A	N/A	100%	100%
Wigs Covered when loss of hair is a result of chemotherapy, radiation therapy, burns or surgery. Maximum lifetime benefit of $500.	✓	✓	80%	100%

Comprehensive Major Medical Plan

Cost Sharing
Payment Provisions
Benefit Maximums
Benefit Summary

Cost Sharing
Comprehensive Medical Plan

The Benefit Period begins on July 1st and ends on June 30th of the following year.

Annual Deductible, Out-of-Pocket Maximums and Coinsurance for the Comprehensive Medical Plan

Plan	Deductible Individual/Family	Benefit Percentage (Plan pays)	Out-of-Pocket Maximum Individual/Family
Comprehensive 500-70-1500	$500 / $1,000	70%	$1,500 / $3,000
Comprehensive 1000-70-2000	$1,000 / $2,000	70%	$2,000 / $4,000
Comprehensive 2000-70-4000	$2,000 / $4,000	70%	$4,000 / $8,000
Comprehensive 3000-70-6000	$3,000 / $6,000	70%	$5,000 / $10,000

Annual Deductible, Out-of-Pocket Maximums and Coinsurance for the Comprehensive Pharmacy Plan

Plan	Deductible Individual/Family	Out-of-Pocket Maximum Individual/Family
Comprehensive 500-70-1500	$75	$5,100 / $10,200
Comprehensive 1000-70-2000	$75	$4,600 / $9,200
Comprehensive 2000-70-4000	$75	$2,600 / $5,500
Comprehensive 3000-70-6000	$75	$1,600 / $2,000

Payment Provisions
Comprehensive Medical Plan

Highlights of the Comprehensive Medical Plan Provisions

- The Plan pays the first $500 of eligible expenses related to accidental injuries when such expenses are incurred within ninety (90) days of the date of the accident.
- Your benefit coverage is greater, and your out-of-pocket costs less, when you choose a Network provider.
- Benefit payment for services received from Network providers are based on the Allowed Amounts agreed upon by those providers.
- Benefit payment for services received from non-network providers (except emergency services, see below) is based on an amount established by a prevailing fee schedule for the geographic area in which the claim was incurred. This includes flat dollar benefits and preventive benefits. If no such fee schedule exists, a percentage of the provider's billed charges will be paid. See *Allowed Amount* in *Plan Definitions*.
- Benefit payment for emergency services received from non-network providers is determined annually and is based on the greatest of the following amounts: 1) the median of the contracted amounts agreed upon by network providers; 2) the Usual, Customary and Reasonable (UCR) amount (see related definition); or 3) the Medicare amount. See *Allowed Amount* in *Plan Definitions*.
- Services received from a Recognized Provider (See Plan Definitions under Section II - Summary Plan Description) will be paid at the In-Network level. Benefits will be based on Usual, Customary and Reasonable data or a case negotiated rate. **You will be responsible for the difference (if any) between the Plan payment and the billed charges on Recognized Provider claims and this difference would not apply to your Out-of- Pocket (OOP) maximum as discussed below.**
- For services received from non-network providers, you are responsible to pay the difference between the Plan payment and the provider's actual charges.
- Claims are processed according to the diagnoses and services billed by the provider(s). Billing disputes regarding services received should be addressed with the rendering provider.

Annual Deductible

The annual deductible is the amount you (or your family) must pay each Benefit Period before the Plan will pay for covered services. Once the deductible is satisfied, coinsurance amounts as noted in the applicable *Benefit Summary* will be applied. Until then, the amount due a provider is your responsibility.

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

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

- Charges for first $500 in eligible expenses related to accidental injuries when such expenses are incurred within ninety (90) days of the date of the accident
- Charges of non-covered services and treatment
- Charges for services that are denied as not medically necessary
- Charges over the Allowed Amount for non-network services as determined by the Plan
- Charges that exceed any applicable benefit maximum
- Charges for claims denied for lack of pre-authorization
- Charges for services paid by the Plan at 100%, such as (but not limited to), Diabetic Education, etc.
- Prescription drugs (note: separate deductible applies to preferred-brand and non-preferred brand drugs, please refer to *Pharmacy Plan - Benefit Summaries*)
- Preventive care services (network providers only)
- Professional/Physician office visits (for evaluation and management)
- Travel benefit

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the most you will need to pay in a Benefit Period. 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 the Allowed Amount for non-network services as determined by the Plan
- Charges that exceed any applicable benefit maximum
- Charges for claims denied for lack of pre-authorization
- Charges for services paid by the Plan at 100%
- Prescription drugs
- Travel benefit

Benefit Maximums
Comprehensive Medical Plan

Your Benefit Period benefit maximums are noted in the tables that follow:

Summary of Benefit Maximums for the Comprehensive Medical Plan

Benefit Period (or episodic) Maximums	
Accidental Injury Benefit (includes Dental Trauma)	$500 (per accident) within 90 days of accident
Acupuncture	25 visits/$25 per visit maximum (combined maximum with chiropractic spinal manipulation and massage therapy)
Chiropractic Spinal Manipulation – office visits/spinal manipulations	25 visits/$25 per visit maximum (combined maximum with acupuncture and massage therapy)
Chiropractic Spinal Manipulation – radiology (x-rays)	$100
Diabetic Education (Nutrition or otherwise)	5 visits
Home Health Care	180 visits (combined with Hospice visits)
Massage Therapy	25 visits/$25 per visit maximum (combined maximum with acupuncture and chiropractic spinal manipulation)
Obesity Screening and Counseling	12 visits
Rehabilitation Therapy – Inpatient	60 days
Rehabilitation Therapy – Outpatient (Speech, Occupational, Physical Therapies and Cardiac Rehabilitation)	50 visits
Skilled Nursing Facility	60 days
Travel Benefit	$600 per Round Trip
Wigs	$500 per lifetime

Benefit Summary
Comprehensive Medical Plan

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
Accidental Injury Benefit (includes Dental Trauma) Plan pays first $500 on accidental injuries each Benefit Period; care must be received within 90 days of accident.	N/A	N/A	100%	100%
Allergy Care	✓	✓	70%	70%
Alternative Care				
• **Acupuncture** 25 visits per Benefit Period combined with Chiropractic and Massage Therapy benefits, $25 per visit maximum.	N/A	N/A	100%	100%
• **Massage Therapy** 25 visits per Benefit Period combined with Acupuncture and Chiropractic benefits, $25 per visit maximum.	N/A	N/A	100%	100%
Ambulance Services FCH pre-authorization required for non-emergent air ambulance.	✓	✓	70%	70%
• **First Responder User Fees**	✓	✓	70%	70%
Anesthesia	✓	✓	70%	70%
Autism Spectrum Disorders (includes Applied Behavior Analysis (ABA Therapy)) Mental Health and Habilitative Services. FCH Pre-authorization required for **initial evaluation and treatment plan for Autism**. Covered for children through age 18.				
• **Inpatient Care -** facility and professional	✓	✓	70%	70%
• **Outpatient -** facility and professional First 3 visits per Benefit Period.	N/A	N/A	100%	100%
• **Outpatient -** facility and professional 4th visit and after	N/A	✓	100% after $35 copay	70%

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
Autologous Blood Donation/Blood Transfusion	✓	✓	70%	70%
Biofeedback Limited benefit, see *Biofeedback* for details.	✓	✓	70%	70%
Chemical Dependency FCH pre-authorization required for inpatient, residential and partial hospitalization.				
• **Inpatient Care -** facility and professional	✓	✓	70%	70%
• **Outpatient Care** - facility and professional First 3 visits per Benefit Period.	N/A	N/A	100%	100%
• **Outpatient Care -** facility and professional 4th visit and after.	N/A	✓	100% after $35 copay	70%
Chiropractic Spinal Manipulation				
• **Office Visits/Spinal Manipulations** 25 visits per Benefit Period combined with Acupuncture and Massage Therapy benefits; $25 per visit maximum.	N/A	N/A	100%	100%
• **Related Radiology/X-Rays** $100 per Benefit Period.	✓	✓	70%	70%
Clinical Trials	Covered as specifically outlined under Clinical Trials in the *Medical Benefits* section below.			
Dental Trauma FCH pre-authorization required for follow-up services and anesthesia.				
• **First $500 per Plan Year of Eligible Expenses** (applies to Accidental Injury Benefit)	N/A	N/A	100%	100%
• **Eligible Expenses Beyond First $500**				
– Office Visits	N/A	✓	100% after $35 copay	70%
– All other places of service	✓	✓	70%	70%

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
Diabetic Education (nutrition or otherwise) 5 visits per Benefit Period maximum.	N/A	N/A	100%	100%
Diagnostic Testing (lab and radiology services, non-routine, facility and professional services) FCH pre-authorization required for PET scans.				
• **Non-routine, facility and professional services**	✓	✓	70%	70%
• **Professional in office**	N/A	✓ (OON only)	100%	70%
Durable Medical Equipment/Supplies				
• **Breast Pumps**	✓ (OON only)	✓ (OON only)	100%	70%
• **Durable Medical Equipment**	✓	✓	70%	70%
• **Medical Supplies**	✓	✓	70%	70%
• **Oral Appliances** FCH pre-authorization required when related to Sleep Apnea.	✓	✓	70%	70%
• **Orthopedic Appliances/Braces**	✓	✓	70%	70%
• **Prosthetic Devices**	✓	✓	70%	70%
Emergency Care				
• **Emergency Department** (facility and professional services)	✓	✓	70%	70%
• **Urgent Care** (facility and professional services)	N/A	✓	100% after $35 copay	70%
Family Planning				
• **Female – Office Visits and Diagnostic Services**	✓ (OON only)	✓ (OON only)	100%	70%
• **Male – Office Visits and Diagnostic Services**	✓	✓	100%	70%
• **Contraceptive Devices, Implants, Injections**	✓ (OON only)	✓ (OON only)	100%	70%
• **Female - Contraceptive Diagnostic Testing**	✓ (OON only)	✓ (OON only)	100%	70%

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
• **Male – Contraceptive Diagnostic Testing**	✓	✓	100%	70%
• **Female – Sterilization**	✓ (OON only)	✓ (OON only)	100%	70%
• **Male – Sterilization**	✓	✓	100%	70%
Genetic Services FCH pre-authorization required for Genetic Testing if over $500.				
• **BRCA Testing**	✓ (OON only)	✓ (OON only)	100%	70%
• **FIT-Fecal DNA** FCH pre-authorization required. 1 per calendar year.	✓ (OON only)	✓ (OON only)	100%	70%
• **All other Genetic Testing/Counseling**	✓	✓	70%	70%
Habilitative Services (excluding autism-related services. See Autism benefit) Covered for children through age 18.	✓	✓	70%	70%
Hearing Exams (non-routine)	✓	✓	70%	70%
Hearing Aids/Appliances are not covered. However, Cochlear implants and Bone Anchored Hearing Aids (BAHA) are covered under the surgical benefit, not the Hearing Aids/Appliances benefit. Please see page 46 under Hospital Outpatient Surgery and Services.				
Home Health Care (HHC) FCH pre-authorization required for wound therapy, enteral formula, medical food and associated services and home hospice.				
• **Home Health Care** 180 visits Benefit Period maximum, combined with Hospice Care.	✓	✓	70%	70%
• **Phototherapy** (home)	✓	✓	70%	70%
Hospice Care FCH pre-authorization required; 180 visits per Benefit Period maximum, combined with Home Health visits.	✓	✓	70%	70%
Hospital Inpatient Medical and Surgical Care FCH pre-authorization required.	✓	✓	70%	70%

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
Hospital Outpatient Surgery and Services FCH pre-authorization required for certain outpatient services; see *Pre-authorization Requirements* for details.	✓	✓	70%	70%
Infusion Therapy (Includes infusion therapy provided in the home) FCH pre-authorization required for certain infusion therapy drugs, see *Pre-Authorizations Requirements.*	✓	✓	70%	70%
Maternity and Newborn Care				
• **Office Visits**	N/A	✓	100% after $35 copay	70%
• **All Other Maternity/Newborn Care**	✓	✓	70%	70%
Medical Weight Loss Program (non-surgical) FCH pre-authorization required and limited benefit; please see *Medical Benefits* section for more details.				
• **Office Visits** The first 4 office visits related to obesity will be covered as any other office visit. Once the maximum four obesity-related office visits have been exhausted, all obesity-related services will only be covered as part of the Medical Weight Loss Program benefits when pre-authorized by FCH.	N/A	✓	100% after $35 copay	70%
• **All other place of service**	✓	✓	70%	70%
Mental Health Care FCH pre-authorization required for inpatient, residential and partial hospitalization.				
• **Inpatient care -** facility and professional	✓	✓	70%	70%
• **Outpatient -** facility and professional First 3 visits per Benefit Period.	N/A	N/A	100%	100%

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
• **Outpatient -** facility and professional 4th visit and after.	N/A	✓	100% after $35 copay	70%
Nutritional Counseling (unrelated to diabetes)	N/A	✓	100% after $35 copay	70%
Nutritional and Dietary Formulas	✓	✓	70%	70%
Oral Surgery Limited benefit, see *Oral Surgery* for details**.**	✓	✓	70%	70%
• **Office Visit**	N/A	✓	100% after $35 copay	70%
• **All Other Place of Service**	✓	✓	70%	70%
Plastic and Reconstructive Services FCH pre-authorization required. Limited benefit, see *Plastic and Reconstructive Services* for details.	✓	✓	70%	70%
Podiatric Care See *Podiatric Care* for details on routine foot care.				
• **In Office** (includes services billed as part of the office visit)	N/A	✓	100% after $35 copay	70%
• **All Other Places of Service**	✓	✓	70%	70%
Preventive Care The preventive services payable by this Plan are designed to comply with Health Care Reform (HCR) regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control (CDC), including but not limited to those listed in the Plan. Periodic updates that may be made to these requirements will be incorporated into the Plan as required by law. The list of the types of payable preventive services is available at: www.healthcare.gov/preventive-care-adults/ www.healthcare.gov/preventive-care-children/ www.healthcare.gov/preventive-care-women/ Claims submitted outside the frequency limits noted herein will be paid under the major medical benefits (deductible and coinsurance will apply).				
Immunizations Immunizations for children and adults are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention. See Preventive Care for details. Shingles vaccine is covered beginning at age 50.Travel immunizations are covered.				
• **Immunizations** Immunizations done in the pharmacy will pay at 100% of billed.	✓ (OON only)	✓ (OON only)	100%	70%

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
Office Visits				
• **Well Child Exams -** children 0-36 months	✓ (OON only)	✓ (OON only)	100%	70%
• **Preventive Exams -** adults and children 3 and older	✓ (OON only)	✓ (OON only)	100%	70%
Nutritional Counseling (counseling for a healthy diet) 3 visits per Benefit Period maximum. Subsequent visits are paid under the *Diabetic Education* or *Nutritional Counseling* medical benefits, as applicable.				
• **Nutritional Counseling**	✓ (OON only)	✓ (OON only)	100%	70%
Obesity Screening and Counseling 12 visits per benefit period.	✓ (OON only)	✓ (OON only)	100%	70%
Screening Tests - children 0-36 months Screening tests are covered in accordance with the recommendations set forth by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See Preventive Care for more details.				
• **Hemoglobin/Hematocritic Blood test**	✓ (OON only)	✓ (OON only)	100%	70%
• **Urinalysis**	✓ (OON only)	✓ (OON only)	100%	70%
• **Tuberculin Test**	✓ (OON only)	✓ (OON only)	100%	70%
• **All other Routine Lab/Radiology**	✓ (OON only)	✓ (OON only)	100%	70%
Screening Tests - adults and children 3 and older Screening tests are covered in accordance with the recommendations set forth by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See Preventive Care for more details.				
• **Colonoscopy** The first colonoscopy per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent colonoscopies in the same Plan year are covered under the medical benefits, regardless of diagnosis.	✓ (OON only)	✓ (OON only)	100%	70%

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
• **Virtual Colonoscopy** The first colonoscopy per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent colonoscopies in the same Plan year are covered under the medical benefits, regardless of diagnosis.	✓ (OON only)	✓ (OON only)	100%	70%
• **Sigmoidoscopy** The first sigmoidoscopy per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent sigmoidoscopies in the same Plan year are covered under the medical benefits, regardless of diagnosis.	✓ (OON only)	✓ (OON only)	100%	70%
• **Fecal Occult Blood Tests** The first fecal occult blood test per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent fecal occult blood tests in the same Plan year are covered under the medical benefits, regardless of diagnosis.	✓ (OON only)	✓ (OON only)	100%	70%
• **Mammograms** The first mammogram per Plan year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent mammograms in the same Plan year are covered under the medical benefits, regardless of diagnosis.	✓ (OON only)	✓ (OON only)	100%	70%
• **Pap Tests** (1 per Benefit Period)	✓ (OON only)	✓ (OON only)	100%	70%
All other Preventive Lab/Radiology	✓ (OON only)	✓ (OON only)	100%	70%
Professional/Physician Services (office visits)				

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
• **Office Visit-** includes all services billed as part of the office visit.	N/A	✓	100% after $35 copay	70%
• **98point6** Telehealth visits	N/A	N/A	100%	N/A
Rehabilitation Therapy				
• **Inpatient** FCH pre-authorization required; 60 days per Benefit Period maximum.	✓	✓	70%	70%
• **Outpatient** (includes physical, speech, occupational therapies and cardiac rehabilitation) 50 visits per Benefit Period; all therapies combined.	✓	✓	70%	70%
Skilled Nursing Facility FCH pre-authorization required; 60 days per Benefit Period maximum.	✓	✓	70%	70%
Tobacco Cessation Tobacco cessation medications are covered under the pharmacy benefits.	✓ (OON only)	✓ (OON only)	100%	70%
Transplants (Organ and Bone Marrow) FCH pre-authorization required.	✓	✓	70%	70%
Travel Benefit FCH pre-authorization required. For travel required to receive medically necessary care; $600 per round trip maximum. See Travel Benefit for details.	N/A	N/A	100%	100%
Wigs Covered when loss of hair is a result of chemotherapy, radiation therapy, burns or surgery. Maximum lifetime benefit of $500.	✓	✓	70%	70%

Section I:
Benefits

Medical Benefits -
Applies to All Plans

This section describes the benefits offered by the Plan and administered by FCH. The benefits described apply to all plans except where indicated. 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 Plan Benefits* and *Plan Limitations and Exclusions* for more details, along with *Plan Definitions* in Section II - 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.

Medical Expense Audit Bonus

The Plan offers an incentive to all plan participants to encourage examination and self-auditing of eligible medical bills to ensure the amounts billed by any provider accurately reflect the services and supplies received by the participant. The participant should review all medical charges and verify that each itemized service has been received and that the bill does not represent either an overcharge or a charge for services never received. Participation in this self-auditing procedure is strictly voluntary; however, it is to the advantage of the Plan as well as the participant to avoid unnecessary payment of health care costs.

In the event a self-audit results in a reduction of the amount paid by the Plan, fifty percent (50%) of the Plan savings will be paid directly to the participant as a bonus, provided the savings are accurately documented, and satisfactory evidence of a reduction in charges is submitted to the Plan Administrator (e.g. a copy of the incorrect bill and a copy of the corrected billing). The bonus shall only apply to charges which have been submitted to and paid by the Plan, and for which an erroneous charge was paid by the Plan. Erroneous charges corrected by the Plan during the claims adjudication process are not eligible for this bonus. Rewards are subject to the following:

- A minimum reward of $25 (on overcharge of $50)
- A maximum reward of $1,000 (on overcharge of $2,000 or more).

Accidental Injury Benefit

The Plan offers an accidental injury benefit, which pays 100% for accident related expenses, up to the maximum noted in the applicable benefit summary, prior to the deductible being met. Once the maximum is met, further charges will pay according to the appropriate medical benefit and applicable cost-sharing (deductible and coinsurance) will apply. In order for this benefit to be applied, the accidental injury must

be sustained after the participant's effective date and services and supplies must be ordered and furnished by a provider within a ninety (90) day period beginning with the date of the accident.

Acupuncture

Refer to *Alternative Care.*

Allergy Care

Benefits include allergy tests, injections, and serums, though serum is covered only when received and administered within the provider's office.

Alternative Care

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

Ambulance Services

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

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

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

Note: Emergent Air Ambulance Transport will be reviewed retrospectively.

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

Anesthesia

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

General Anesthesia for Dental Care

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

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

Autism Spectrum Disorder

Autism Spectrum Disorder (ASD) is characterized by varying degrees of difficulty in social interaction and verbal and nonverbal communication, and the presence of repetitive behavior and restricted interests. This means that no two individuals with an ASD diagnosis are the same with respect to how the disorder manifests. The different forms of autism are thought to overlap considerably. But the fact that there is wide variation in symptoms among children with autism led to the concept of autism spectrum disorder. The spectrum includes diagnosis such as Asperger's syndrome, pervasive developmental disorder, autistic disorder, Rett's syndrome and childhood disintegrative disorder.

Benefit Design:

The Autism Spectrum Disorder benefit will consist of the following components: Applied Behavioral Analysis (ABA); occupational, speech, and physical therapies; and behavioral health treatment.

Diagnosis:

The benefit will be "diagnosis-driven" meaning that coverage will be provided for the above-noted services for eligible members whose primary diagnosis is one of the following:

- Autistic Disorder
- Childhood Disintegrative Disorder
- Asperger's Disorder
- Rett's Disorder
- Pervasive Development Disorder Not Otherwise Specified

Applied Behavior Analysis (ABA)

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

ABA therapy programs incorporate behavior modification, training and education.

This benefit will cover the five components of ABA:

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

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

Covered Providers

For ABA:

ABA services are provided by a state certified behavior health facility that has ABA services overseen by a BCBA- BCBA-D or provided directly by them as independent practitioners. Qualified network

providers can be located using the FCH provider search at www.fchn.com, by selecting "other facilities" and then "Applied Behavior Analysis Facility."

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

Other services covered under this benefit may include:

- **Professional Treatment**– Occupational, speech and physical therapies will be covered under this benefit when billed with a diagnosis of an autism spectrum disorder. Any services rendered by these providers for the treatment of illness or injury not related to autism will apply to the standard habilitation or rehabilitation benefit.
- Behavioral Health Treatment – mental health and chemical dependency treatment, including psychotherapy and other psychiatric/psychological treatment services, will also be covered under this benefit when billed with a diagnosis of an autism spectrum disorder (subject to plan provisions and limitations).

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 ordered by your physician. Charges for autologous blood storage are not covered unless the blood is used during surgery.

Biofeedback

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

Chemical Dependency

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

Milieu Therapy (residential, therapeutic or experiential treatment) is covered on an inpatient bases provided certain conditions are met:

- Treatment is done on an inpatient basis for Chemical Dependency Rehabilitation
- Covered person is at least 12 years of age and through 19 years of age
- Milieu therapy treatment must be subsequent to an inpatient stay for chemical dependency
- Must have exhausted all other conservative treatment prior to milieu therapy

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

Chiropractic Spinal Manipulation

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

Clinical Trials

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

An approved clinical trial is:

- Pre-authorization for clinical trial participation has been granted.
- The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening

disease or condition. A "life-threatening condition" is a disease or condition likely to result in death unless the disease or condition is interrupted. The principal purpose of the trial intervention must be the therapeutic intent to potentially improve health outcomes.

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

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

Costs Covered:

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

Costs Not Covered:

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

- Interventions associated with treatment for conditions not covered by the Plan.

Dental Trauma

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

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

Diabetic Nutrition Education (nutrition or otherwise)

Diabetic education regarding nutrition and insulin management of diabetes is covered. The education must be performed by a licensed health care provider and may take place in classes through approved diabetic courses or as individual instruction.

Diagnostic Testing

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

Durable Medical Equipment (DME) and Supplies

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

Examples of DME include, but are not limited to:

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

This benefit also covers:

- **Breast Pumps**
- **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**: covered if needed in relation to a covered service under the Plan (for example, treatment of sleep apnea. FCH pre-authorization required when related to Sleep Apnea.).
- **Orthopedic appliances/Braces**: These include appliances used to support abnormal joints, limit pressure on a joint after injury to allow it to heal or correct abnormal curves in the spine.
- **Prosthetic devices**: Benefits include external prosthetic appliances that are used to replace all or part of a missing body part and are necessary for the alleviation or correction of illness, injury, or congenital defect.
- **Surgically implanted devices** may be covered under the appropriate surgical benefit and are not considered DME. Benefits for durable medical equipment are determined by the type of device and its intended use, and not by the entity that provides or bills for the device.

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

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

Family Planning

Voluntary sterilization procedures and FDA-approved birth control methods are covered for participants, spouse and/or domestic partner and covered dependents. Over-the-counter products are not covered except medications required under the Patient Protection and Affordable Care Act. Oral contraceptives are covered under the pharmacy benefit.

Termination of Pregnancy

Termination of pregnancy is covered only if carrying the fetus to full-term would seriously endanger the life of the mother. Voluntary termination of pregnancy for any other reason is not covered.

Genetic Services

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

Habilitative Services

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

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

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

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

Home Health Care

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

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

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

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

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

Hospice Care

FCH pre-authorization is required for inpatient hospice, home hospice and all respite care. Hospice care is covered when prescribed by your physician and s/he has determined that life expectancy is 12 months or less and a palliative, supportive care treatment approach has been chosen. *Note: patients are not required to discontinue treatment or "curative care" in order to access the hospice benefit.* This

benefit includes acute, respite, and home care to meet the physical, psychosocial, and special needs of a patient-family unit during the final stages of illness and dying. Hospice care is provided at a variety of levels to meet the individual needs of the patient-family unit. Levels offered are:

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

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

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

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

Hospital Inpatient Medical and Surgical Care

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

Hospital Outpatient Surgery and Services

Certain outpatient surgery/procedures **require FCH pre-authorization**; please see *Pre-authorization Requirements* for details. Covered outpatient care includes outpatient surgery, procedures and services, operating room and anesthesia, radiology, lab and pharmacy services furnished by and used while at a hospital or ambulatory surgical center.

Infusion Therapy

FCH pre-authorization required for certain infusion therapy drugs; please see *Pre-authorization Requirements* for details. This benefit covers the administration of medications using intravenous, subcutaneous, and epidural routes (into the bloodstream, under the skin, and into the membranes surrounding the spinal cord). Drug therapies commonly administered via infusion include, but are not

limited to, antibiotics, chemotherapy, pain management, parenteral nutrition, and immune globulin. Diagnoses commonly requiring infusion therapy include infections that are unresponsive to oral antibiotics; cancer and cancer-related pain; gastrointestinal diseases or disorders which prevent normal functioning of the GI system; congestive heart failure; immune disorders; and more. Nursing visits associated with infusion therapy are covered under the Home Health Care benefit, regardless of whether the patient is home bound.

Massage Therapy

Refer to *Alternative Care.*

Maternity and Newborn Care

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

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

Coverage for pregnancy and childbirth, for participants, spouse and/or domestic partner, and/or dependents, in a hospital or birthing center is provided on the same basis as any other medical condition, as are complications of pregnancy. Medically necessary screening(s) and diagnostic procedures during pregnancy for prenatal diagnosis of congenital disorders of the fetus are covered. The services of a licensed physician, an advanced registered nurse practitioner (ARNP) or a certified nurse midwife (CNM) are covered under this benefit. (Licensed midwives are not covered.)

Newborns of participants, spouses and/or domestic partners (not dependents) are considered automatically enrolled for benefits for the first thirty-one (31) days of life but the Plan must receive enrollment forms for coverage beyond that timeframe. Please see *Enrollment* section within Section II - Summary Plan Description for more details. Benefits are subject to the newborn child's own coinsurance and deductible requirements.

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

Newborns' and Mothers' Health Protection Act of 1996

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

Medical Weight Loss Program (Non-Surgical)

FCH Case Management is mandatory in order to receive this benefit. When you need additional support to lose weight and maintain your weight-loss this Plan covers non-surgical programs for the morbidly obese member. To enroll in a non-surgical, medically supervised outpatient program you must meet the following criteria:

- Have a Body Mass Index (BMI) of 30 or greater, **or,**
- A BMI between 27 and 29 with at least two co-morbid health conditions such as sleep apnea, medication-dependent diabetes, hypertension, coronary-artery disease, etc., **and**,
- The program selected must be medically supervised, **and**
- Pre-authorization for services is required

Your personal physician or an approved weight-loss program must submit medical record documentation to your FCH Case Manager for pre-authorization. FCH will review your care plan a minimum of every six months from date of approval by FCH. Continued coverage is dependent upon a one to two-pound weight-loss per week (24-48 pounds). Weight loss less than this will result in termination of benefits for medically supervised weight-loss.

A typical weight-loss program includes some or all of the following covered services as part of your care plan. These services include:

- Visits with licensed health care providers to support you in reaching your weight-loss goal
- Nutritional counseling
- FDA approved weight-loss medications prescribed for the management of weight-loss due to morbid obesity
- Office visits with your provider(s) and associated lab work ordered by the provider (The first four office visits per benefit period related to obesity will be covered as any other office visit. Once the maximum four obesity-related office visits have been exhausted, all obesity-related services will only be covered as part of the Medical Weight Loss Program benefits when pre-authorized by FCH.)

It is your responsibility to let FCH know when you reach your weight loss goal. Once you reach your weight-loss goal, your coverage for maintenance or follow-up programs will end, even if you gain some of the weight back after you met your goal weight. If you continue in the program after you met your weight goal, you may be financially responsible for costs of the program.

Mental Health Care

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

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

Family counseling and psychotherapeutic programs are covered only if related to the treatment of an approved clinical mental health diagnosis, specifically, those noted in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). (The only exception to this would be for coverage of autism spectrum disorders which may or may not be considered Axis I diagnoses per the DSM.)

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

Nutritional Counseling

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

Nutritional and Dietary Formula

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

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

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, but not replacement, of teeth damaged due to radiation therapy that occurred while under this Plan

Plastic and Reconstructive Services

Reconstructive/plastic procedures require FCH pre-authorization and are covered when performed to correct or repair abnormal structures of the body caused by congenital defects, trauma, infection, tumors,

disease, accidental injury or prior surgery (if the prior surgery would be covered under this Plan). Specific criteria follow:

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

Women's Health and Cancer Rights Act of 1998

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

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

Podiatric Care

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

Preventive Care

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

- Routine physicals
- Periodic examinations including the specific diagnostic testing/screening and laboratory services as recommended by the US Preventive Services Task Force and the Health Resources and Services Administration)
- Adult, child and adolescent immunizations as recommended by the Centers for Disease Control (CDC). Shingles vaccine is covered beginning at age 50.

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

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

www.healthcare.gov/preventive-care-adults/
www.healthcare.gov/preventive-care-children/
www.healthcare.gov/preventive-care-women/

Professional/Physician Services

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

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

98point6 Text Based Program

98point6 provides the following benefits:

- A Participant has access to an online interactive platform (including related iOS and Android applications) for continuity of care, including access to his or her diagnoses and treatment plans.
- A Participant may also use the platform to access non-urgent primary care via the 98point6 website or mobile application. The provider network is available at www.98point6.com.
  - Primary care services available through 98point6 include evaluation, diagnosis, and development of a treatment plan with respect to non-urgent primary care issues, including (as appropriate) referrals or orders for prescriptions or lab services.
  - Sessions with 98point6 providers can be done online or via two-way video or telephonic. Sessions are not time-limited.

Rehabilitation Therapy

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

- Services are to restore and significantly improve function that was previously present but lost due to acute injury or illness,
- Services are to restore and improve function for children with neurodevelopmental disabilities (not defined within the Autism Spectrum Disorder),
- 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 FCH pre-authorization and must be furnished and billed by a rehabilitative unit of a hospital or by another approved rehabilitation facility. When rehabilitation follows acute care in a continuous inpatient stay, this benefit starts on the day the care becomes primarily rehabilitative. Inpatient care includes all room and board, services provided and billed by the inpatient facility and therapies performed during the rehabilitative stay.

Outpatient Rehabilitation

Outpatient rehabilitation benefits are subject to the following provisions:

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

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

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

Skilled Nursing Facility

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

Transplants (Organ and Bone Marrow)

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

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

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

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

Email:
preauthorization@fchn.com

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

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

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

Recipient Services

Covered transplant recipient services include:

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

Donor Services

Donor expenses are covered if all criteria are met below:

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

Covered donor expenses include:

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

Travel Benefit

Travel expenses require FCH pre-authorization and the benefit is available along with associated pre-transplant evaluation, if travel is required to obtain medically necessary treatment not available within the state of Montana as determined by FCH. The cost of airfare (coach), train fare, bus fare or the IRS reimbursement automobile mileage rate will be covered (up to the maximum noted in the Benefit Summary) for the patient. Companion transportation charges are covered when the patient is 18 years old or younger. The Plan will not pay companion charges for a patient 19 years or older. In order to be reimbursed, completion of the Northwest Montana Schools' Consortium Travel Request Form (can be found on www.fchn.com) is required as well as submission of receipts for travel. Lodging and meals, rental car, parking, taxi and/or shuttle fare, etc. are not covered under this benefit.

Wigs or Artificial Hairpieces

Wigs are covered only when the covered person has experienced a loss of hair as a result of chemotherapy, radiation therapy, burns or surgery.

Medical Plan Exclusions and Limitations

Applies to all Plans

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:

- Acupuncture treatment unrelated to an illness or injury
- Adoption expenses or surrogate mother charges
- Autism Spectrum Disorder Benefit - the following are not covered:
  - Providers accompanying children or family members to health care appointments that are not part of the direct provision of ABA services
  - Services by more than one program manager for each child/family (program development, treatment planning, supervision)
  - Training of therapy assistants and family members (as distinct from supervision)
  - Parent training or classes, except for one-on-one or one-on-two direct training of the parents of one identified patient
  - Services provided in a home school, or public/private school environment that are part of a child's schooling as distinct from specific ABA treatment services (e.g. acting as the "Teacher's Aide," or helping a child with homework)
- Autism spectrum disorder treatments considered non-standard or experimental and investigational such as:
  - Auditory integration therapy
  - Augmentative communication devices
  - Chelation therapy
  - Cognitive behavioral therapy (a form of psychotherapy)
  - Cognitive rehabilitation
  - Craniosacral therapy
  - Dietary and nutritional interventions (e.g. elimination diets, gluten-free diets, casein-free diets, vitamins)
  - Facilitated communication
  - Holding therapy
  - Hyperbaric oxygen therapy
  - Immune globulin therapy
  - Music therapy
  - Psychotherapy
  - Secretin infusion
  - Vision therapy
- Autopsies

- Benefits relating to any condition, illness, or injury for which the participant receives compensation or reimbursement through another contractual arrangement or benefit, other than employer-based disability payments, such as surrogate pregnancy
- Charges for acupressure, homeopathy, herbal and vitamin supplements, holistic medical procedures or rolfing
- Charges for physician's fees for any treatment which is not rendered by or in the physical presence of a physician; includes charges for licensed health care provider's fees for any treatment not rendered by or in the physical presence of a licensed health care provider
- Charges in connection with any operation or treatment for temporomandibular joint dysfunction (TMJ) or any related diagnosis, or treatment of any nature, including but not limited to, realignment of the teeth or jaws, surgery for atrophy of the lower jaw, occlusion, maxillofacial surgery or retrognathia
- Chemical Dependency Rehabilitation treatments listed below:
  - Alcoholics Anonymous or other similar chemical dependency programs or support groups
  - Any care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior
  - Court-ordered or other assessments to determine the medical necessity of court-ordered treatments
  - Court-ordered treatments or treatments related to deferral of prosecution, deferral of sentencing or suspended sentencing or treatments ordered as a condition of retaining driving rights, when no medical necessity exists
  - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
  - Emergency patrol services
  - Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program
  - Information or referral services
  - Information schools
  - Long-term or custodial care
  - Non substance related disorders
  - Pain management, and stress reduction classes
  - Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs
  - Treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required
- Chiropractic spinal manipulation not related to an actual illness or injury
- Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational and custodial services are not covered
- Dental, oral surgery or orthodontic related services, such as (but not limited to) those listed below (unless accident related or otherwise specifically covered by the Plan):
  - Care of the teeth or dental structures
  - Charges in connection with any operation or treatment for temporomandibular joint dysfunction (TMJ) or any related diagnosis, or treatment of any nature, including but not limited to, realignment of the teeth or jaws, surgery for atrophy of the lower jaw, occlusion, maxillofacial surgery or retrognathia
  - Dental implants, except as covered under Dental Trauma
  - Procedures in preparation for dental implants, except as covered under the Dental Trauma benefits
  - Dental X-rays

  - Extractions of teeth, impacted or otherwise (except as covered under the Plan such as resulting from damage caused by radiation therapy treatment while under this Plan)
  - Tooth damage due to biting or chewing
  - Orthodontia
- Developmental delay treatment or services, except as covered by the Plan
- DME and medical supply charges listed below:
  - Biofeedback equipment
  - Equipment or supplies whose primary purpose is preventing illness or injury
  - Exercise equipment
  - Items not manufactured exclusively for the direct therapeutic treatment of an illness or injured patient
  - Items used outside the home primarily for sports/recreational activities Over-the-counter items (except medically necessary crutches, walkers, standard wheelchairs, diabetic supplies and ostomy supplies are covered)
  - Personal comfort items including but not limited to air conditioners, lumbar rolls, heating pads, diapers or personal hygiene items
  - Phototherapy devices related to seasonal affective disorder
  - Supportive equipment/environmental adaptive items including, but not limited to, hand rails, chair lifts, ramps, shower chairs, commodes, car lifts, elevators, and modifications made to the patient's home, place of work, or vehicle.
  - The following medical equipment/supplies: standard car seats or strollers, push chairs, air filtration/purifier systems or supplies, water purifiers, allergenic mattresses, orthopedic or other special chairs, pillows, bed wetting training equipment, corrective shoes, whirlpool baths, vaporizers, room humidifiers, hot tubs or other types of tubs, home UV or other light units (light boxes or specialized lamps or bulbs), home blood testing equipment and supplies (except diabetic equipment and supplies, and home anticoagulation meters)
  - Wigs or artificial hair pieces – unless the covered person has experienced a loss of hair as a result of chemotherapy, radiation therapy, burns or surgery.
- Elective Abortions/termination of pregnancy
- 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
- Home health care listed below:
  - Custodial care
  - Housekeeping or meal services
  - Maintenance care
  - Services by a participant or the patient's family or volunteers, or a person who resides in the home of the member
  - 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, or a person who resides in the home of the member
  - Services not specifically listed as covered hospice services under the Plan

  - Services provided in a convalescent nursing facility or nursing home
  - Supportive equipment such as handrails or ramps
  - Transportation
- Infertility services and studies, including diagnostic services 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)
  - Zygote intra-fallopian transplant (ZIFT)
- Lab and/or radiology services not ordered by a qualified health care provider
- Learning disabilities and related services, educational testing or associated training
- Medication therapy management
- Mental health care listed below:
  - Adventure-based and/or wilderness programs that focus primarily on education, socialization or delinquency
  - Court-ordered assessments
  - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
  - Family therapy, in the absence of an approved mental health diagnosis
  - Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program
  - Marriage and couples counseling
  - Nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories
  - Pain management, and stress reduction classes
  - Sensitivity training
  - Sexual dysfunction, gender dysphoria, personality disorders, and paraphilic disorders
  - Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs
- Non-covered services, or complications arising from non-covered services. Non-covered services include those services that would not have been covered by this Plan at the time the complication arose
- Non-duplication of payment/coordination of benefits to prevent double coverage, benefits under this Plan will not be paid for expenses that are reimbursed by other insurance companies, medical plan, or subscriber contracts
- Organ and Bone Marrow Transplant services listed below:
  - Animal-to-human transplants
  - Artificial or mechanical devices designed to permanently replace human organs
  - Complications arising from the donation procedure if the donor is not a Plan participant
  - Donor expenses for a Plan participant who donates an organ or bone marrow (however, complications from the donation are covered as any other illness to the extent they're not covered under the recipient's health Plan)
  - Organ transplants not specifically listed as covered transplants
  - Transplants considered experimental and investigational, as defined by the Plan
- Orthodontia for Temporomandibular Joint Dysfunction (TMJ)

- Personal, convenience or comfort services, supplies, house cleaning, house call home visits from a doctor, or items including but not limited to phones, TVs, guest services, deluxe or suite hospital room, air conditioners, diapers or hygiene items
- Plastic and reconstructive services such as those listed below:
  - Abdominoplasty/panniculectomy (unless medically necessary due to weight loss resulting from bariatric surgery)
  - 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
  - Hair transplant procedures
  - Gynecomastia surgery
- Podiatric services and supplies such as corrective shoes, orthotics (regardless of diagnosis of diabetes) or other supportive devices for the feet or routine foot care (except as covered by the Plan for diabetics), including but not limited to surgical procedures and treatment involving corns, calluses, hypertrophy, hyperplasia of the skin or subcutaneous tissues, the cutting or trimming of nails, fallen arches, flat feet, chronic foot strain or symptomatic complaints of the feet
- Professional services listed below:
  - Professional services provided by fax or email.
  - Follow up phone calls from provider for test results, referrals, prescription refills or reminders that occur within 7 days of an in-person office visit
  - Calls to nurse line or to obtain educational material are also not covered
- Private duty nursing
- Repair or replacement of items not used in accordance with manufacturer's instructions or recommendations
- Respite care, except as covered by the Plan
- Reversal of sterilization
- Routine hearing exams and hearing aids/appliances
- Services beyond the specified Plan Benefit Maximums
- Services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmy, and premature ejaculation
- Services provided by a spa or an athletic, health or fitness club/center, except covered medically necessary services provided within the scope of the provider's license
- Services provided in a school setting (such as early learning and K-12)
- Snoring treatment (surgical or other)
- Special diets, nutritional supplements, vitamins and minerals or other dietary formulas or supplements except as covered by the Plan
- Specialized intraocular lenses associated with cataract surgery that correct vision disorders, such as Multifocal and Toric intraocular lenses
- Treatment for sexual dysfunction, transsexualism (non-congenital transsexualism, gender dysphoria or sexual reassignment or change); related medications, implants, hormone therapy, surgery, medical or psychiatric treatment

- Tobacco and Smoking cessation programs (medication and aids are available through the pharmacy benefit)
- Transportation, except as covered by the Plan
- Vision Care such as eye refractions, the purchase or fitting of eyeglasses, contact lenses, hearing aids or such similar aid devices or charges for any surgical, medical or hospital services or supplies rendered in connection with radial keratotomy, LASIK or any other procedure designed to correct farsightedness, nearsightedness or astigmatism
- Vitamin B-12 injections except to treat Vitamin B-12 deficiency
- Weight management services such as those listed below:
  - Charges for commercial or franchise weight-loss programs such as Weight Watchers or Jenny Craig
  - Charges for nutritional foods
  - Surgery, including related services and supplies (except non-surgical medically supervised weight-loss programs as specifically outlined in this Plan) intended to result in weight reduction, regardless of diagnosis.
  - Replacement of a gastric band, regardless of whether the initial placement was covered under a medical plan previously offered by the Northwest Montana Schools' Consortium . (However, gastric band **adjustments** will be covered for members whose gastric band placement was covered under a medical plan previously offered by the Northwest Montana Schools' Consortium. Adjustments do not require pre-authorization if performed in the physician's office; **pre-authorization is required** if performed in an outpatient surgery setting.)
  - A second bariatric surgical procedure or revision of bariatric surgery, regardless of whether the initial procedure was covered under a medical plan previously offered by the Northwest Montana Schools' Consortium.
  - Complications related to any type of bariatric surgery, unless the surgery was covered under a medical plan previously offered by the Northwest Montana Schools' Consortium.
  - Treatment for weight gain, weight loss, or weight maintenance, except as covered by the Plan for the treatment of morbid obesity (as defined by the Plan)
- Wigs or artificial hairpieces – unless the covered person has experienced a loss of hair as a result of chemotherapy, radiation therapy, burns or surgery.

General Plan Exclusions and Limitations

Applies to all Plans

The following general exclusions and limitations apply to all benefit plans and benefit offerings (medical and pharmacy) under the Northwest Montana Schools' Consortium Health Plan:

- Any service received before the participant's effective date of coverage or after the coverage termination date
- Amounts over and above the Allowed Amount, 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)
- Bariatric surgery (except as covered by the Plan), prescription drugs for weight loss, gym memberships, prescription or non-prescription nutritional and/or food supplements including weight loss shakes, exercise programs and equipment, other surgical procedures primarily for reduction of adipose tissue, abdominoplasty and other cosmetic surgery/liposuction
- Care provided by phone, fax, e-mail, Internet or telemedicine, except as outlined under the *Professional Services* benefit
- Charges for failure to keep a scheduled visit, for the copying of medical records or for the completion of a claim or administrative forms
- Charges for non-medical expenses such as training, education, instructional or educational materials, even if they are performed, provided or prescribed by a Physician
- Charges for non-prescription contraceptive supplies or devices
- Charges for non-prescription vitamins or nutritional supplements
- Charges for services, treatment or supplies not considered legal in the United States
- Charges for treatment, services or supplies not actually rendered to or received and used by the participant
- Charges for treatments, services or supplies included as covered expenses under any other insurance plan or any plan of group benefits carried or sponsored by an employer, to the extent that the expenses have been paid by another applicable portion of this Plan or have been paid

by any other insurance or employee benefit plan and such payments have fully compensated the Covered Person for his or her damages

- Charges in connection with services and supplies which are in excess of the Allowed Amount (see Plan Definitions)
- Charges in connection with treatment, services or supplies provided for complications resulting from treatment, services or supplies excluded from the Plan
- Charges to the extent that the participant could have obtained payment, in whole or in part, if he/she had applied for coverage or obtained treatment under any federal, state or other governmental program (such as Medicare) or in a treatment facility operated by a government agency, except where required by law, such as for cases of medical emergencies or for coverage provided by Medicaid
- Claims for services that are a result of any injury or illness incurred by a participant while that participant is participating in the commission of a felony, unless the injury or illness is the result of domestic violence or a physical or mental health condition.
- Claims submitted more than one year after the date of service where timing of submission has caused the Plan prejudice
- Court ordered examinations or treatment of any kind, except when medically necessary
- Expenses incurred by persons other than the person receiving treatment
- Over-the-counter products (except as may be covered by the Plan)
- Procedures, regardless of medical necessity, outside the scope of the provider's license, registration or certification
- Replacement of lost or stolen items, such as but not limited to prescription drugs, prostheses or DME
- 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. However, this exclusion does not apply to charges for services and supplies as the result of an Illness or Injury which occurs in the course of employment if the Covered Person is not an independent contractor and is a corporate officer, sole proprietor, working partner of a partnership or working member of a member-managed limited liability company who is not required to have Workers' Compensation coverage and either the Covered Person or their employer has not elected to obtain Workers' Compensation coverage pursuant to the provisions of Title 39, Chapter 71, MCA
- 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, to the extent payments from such other sources have fully compensated the Covered Person for his or her damages
- 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 clergy
- Treatment furnished without charge or paid directly or indirectly by any government or for which a government prohibits payment of benefits
- Vocational rehabilitation, work hardening or training programs regardless of diagnosis or symptoms that may be present, or for non-medically necessary education

Dental Plan Benefits

Cost Sharing
Payment Provisions
Benefit Maximums
Dental Benefit Summary
Dental Exclusions

Please Note: Dental benefits available when offered by the participating school district and elected by the subscriber.

Payment 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.

Plan Year Dental Deductible

The annual Plan Year deductible is the amount you (or your family) must pay each Plan 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. The deductible is waived for all services considered Class I – Preventive and Diagnostic Dental Services.

Annual Deductible and Maximum:

Deductible and Maximums	
Deductible per Plan Year	
Individual	$50
Family (employee + dependents)	$150
Maximum Dental Benefits	
Per Participant or Dependent	$1,000 per Plan year
Orthodontia (dependent children under age 19)	$350 per Plan Year, up to $1,000 Lifetime Maximum

Participant Reimbursement Liability

You are always responsible for the following costs associated with your health care:

- Annual Deductible, if applicable
- Coinsurance, if applicable
- The difference between a provider's charge for a service and the Usual, Customary and Reasonable amount for that service (see UCR under *Dental Plan Definitions*)
- Any costs for care you receive after your benefit limits have been exhausted
- Any costs for non-covered services

Pre-Estimate

Pre-estimates are not mandatory. Although, getting a pre-estimate is recommended to help you budget for more expensive treatments like crowns and bridges. FCH recommends that you have your dentist submit a pre-estimate any time charges are expected to exceed $500.

Note: The pre-estimate is not a guarantee of payment. Benefits are payable if coverage is in effect on the date services are performed (subject to all Plan provisions) and the claim is submitted to the Plan within the timely filing period. If additional procedures are performed, the claim will be reviewed in its entirety.

Summary of Dental Benefits

Northwest Montana Schools' Consortium Dental Plan			
Dental Services	**Applies to Deductible**	**Applies to the Annual $1,000 Maximum**	**Plan Pays % of UCR**
Class I - Preventive and Diagnostic Dental Services			
• **Fluoride**			
– Topical Fluoride 1 per Plan year, under the age of 19.	N/A	✓	100%
– Fluoride Varnish 12 applications per Plan year under the age of 13.	N/A	✓	100%
• **Oral Evaluations** 2 per Plan year.	N/A	✓	100%
• **Prophylaxis** (cleaning) 2 per Plan year.	N/A	✓	100%
• **Space Maintainers** Covered for dependent children.	N/A	✓	100%
• **X-Ray**			
– Bitewings 2 sets per Plan year	N/A	✓	100%
– Full Mouth/Panoramic – X-ray – 1 Full Mouth or panoramic x-ray every 3 Plan years for adults	N/A	✓	100%
– Full Mouth/Panoramic – X-ray 1 Full Mouth or panoramic x-ray every 2 Plan years for children under the age of 18.	N/A	✓	100%
– All other X-rays	N/A	✓	100%
• **Emergency Palliative Treatment** (for pain)	N/A	✓	100%
Class II – Basic Dental Services			
• **Anesthesia** (General and conscious intravenous "IV")	✓	✓	80%
• **Antibiotic Drugs**	✓	✓	80%
• **Consultations**	✓	✓	80%
• **Extractions**	✓	✓	80%

Please Note: Dental benefits available when offered by the participating school district and elected by the subscriber.

Northwest Montana Schools' Consortium Dental Plan			
Dental Services	**Applies to Deductible**	**Applies to the Annual $1,000 Maximum**	**Plan Pays % of UCR**
• **Fillings/Restorations** (not including gold)	✓	✓	80%
• **Nitrous Oxide** (when combined with covered dental care)	✓	✓	80%
• **Oral Surgery**	✓	✓	80%
• **Periodontics**	✓	✓	80%
• **Prophylaxis for Periodontal Treatment**	✓	✓	80%
• **Sealants** Covered for children under the age of 16.	✓	✓	80%
Class III – Major Dental Services			
• **Bridges** (installation and repair)	✓	✓	50%
• **Crowns** (installation and repair) Includes post and core and core buildup including pins.	✓	✓	50%
• **Dentures and Partials**	✓	✓	50%
• **Endodontics** (root canal therapy)	✓	✓	50%
• **Gold Fillings/Restorations**	✓	✓	50%
• **Implants**	✓	✓	50%
• **Inlay/Onlay** Gold, porcelain or composite.	✓	✓	50%
• **Precision Attachments**	✓	✓	50%
• **Repair or Re-cementing** (bridges, crowns, inlays and onlays)	✓	✓	50%
• **Rebasing and Realigning Removable Dentures**	✓	✓	50%
• **Temporomandibular Joint** (TMJ)	Not Covered		
• **Occlusal Guard**	Not Covered		
Class IV - Orthodontia (dependent children 18 years of age and younger)			
• **Orthodontia** $350 per Plan Year, up to $1,000 Lifetime Maximum.	✓	N/A	50%

Please Note: Dental benefits available when offered by the participating school district and elected by the subscriber.

Dental Benefits

Dental Expenses

Dental expenses mean the charges for the dental services and supplies provided by your dental professional are based on usual, customary and reasonable (UCR) rates; the customary charges of all providers within a given geographical area for the same or similar services. The above table provides Plan coverage based on UCR rates.

Class I - Preventive and Diagnostic Dental Services

- Prophylaxis, limited to twice per Plan year.
- Oral evaluations of the mouth and teeth, limited to twice per Plan year.
- Fluoride treatments. Topical limited to once per Plan year. Varnish limited to 12 applications per Plan year for children 12 years of age and younger.
- Emergency services necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort or to prevent the imminent loss of teeth. Treatment limited to covered services offered by this Plan.
- Space maintainers designed to preserve the space between the teeth caused by premature loss of a primary tooth. Covered for dependent children only.
- The following dental x-rays:
  - One set of full mouth x-rays or one panorex x-ray every three Plan years for adults and every two Plan years for dependent children 18 years of age and younger.
  - Two sets of bitewing x-rays per Plan year.
  - Other x-rays. For example: periapical, occlusal view and extra-oral as necessary.

Class II Basic Dental Services

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

- Anesthesia (general and intravenous sedation)
- Antibiotic Drugs
- Application of sealants, on permanent posterior teeth, for a child 16 years of age and younger
- Consultations
- Extractions, simple or surgical extractions of one or more teeth
- Fillings (restorations) include the use of materials such as amalgam or composite resin (not gold) to restore teeth broken down by decay or injury. Charges for veneers, composite, plastic, silicate or similar restorations placed on or replacing any teeth other than the ten (10) upper and lower anterior teeth are considered optional services and not dentally necessary. Eligible Expenses will include only the charge for a corresponding amalgam restoration.
- Oral surgery:
  - Extractions: erupted tooth or exposed root, coronal remnants and surgical removal of erupted tooth/root tip
  - Impacted teeth: removal of tooth (soft tissue)

Please Note: Dental benefits available when offered by the participating school district and elected by the subscriber.

  - Surgical removal of impacted teeth: removal of tooth (partially bony) and removal of tooth (completely bony)
  - Odontogenic Cysts and Neoplasms: incision and drainage of abscess and removal of odontogenic cyst or tumor
  - Frenectomy: suture of soft tissue injury.
- Periodontal treatment, including periodontal surgery of diseased periodontal structures for periodontal and other diseases affecting such structure, full mouth debridement, periodontal maintenance, root planing, scaling and/or prophylaxis allowed.

Class III - Major Dental Services

Major dental expenses are charges for the following services and supplies:

- Bridges, the installation (and repair) of one or more artificial teeth attached by crowns to adjacent teeth (used to maintain space and function for missing teeth). If an existing appliance can be made serviceable, only the charges for improving the appliance will be eligible (not replacement costs).
- Crown installations (and repair and replacement) are covered only when teeth cannot be restored with other materials. Replacement of crowns is covered only if five (5) years have elapsed since last prior crown was furnished on any tooth.
- Denture installations and relining (full and partial) are covered.
- Endodontic treatment, including pulpotomy, pulp capping, apicoectomy, retrograde filling, and root canal therapy.
- Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
- Implants, which are artificial tooth roots used to support restorations that resemble a tooth or a group or teeth, are covered.
- Inlays/Onlays, the installation, repair or replacement of, are covered (gold/porcelain). Must be at least five (5) years since restoration was initially placed or last replaced, unless replacement is due to extraction of one or more teeth.

Class IV – Orthodontia

This benefit is available only for dependent children 18 years of age or younger for the following:

- Treatment for diagnosed malocclusion (excluding treatment for myofascial pain and temporomandibular joint dysfunction.)
- Initial placement of braces or appliances and ongoing treatment adjustment, removal and follow-up related to initial placement.

Dental Plan Exclusions and Limitations

These dental exclusions are in addition to the exclusions that apply to health coverage.

- Administrative fees, including but not limited to, telephone consultations, missed appointments, claim form completion, interest charges, legal services, obtaining and/or copying medical records, or provider travel and/or lodging expenses.
- Any condition for which the Veterans Administration or any of the armed services is responsible or to the extent benefits are provided or covered by any governmental agency, except as otherwise provided by law.
- Any instruction for diet, plaque control and oral hygiene.
- Biopsies or oral pathology, except as specifically provided for under Covered Dental Services
- Charges incurred for services rendered or started, or supplies furnished prior to the effective date of coverage under the Plan, or after coverage is terminated under the Plan, except as specifically provided for in the Plan provisions. This includes charges for dentures, crowns, inlays, onlays, bridgework or other appliances or services which were not ordered while the individual was a Covered Person. The date dentures, crowns, inlays, onlays, bridgework or other appliances are prepped is considered the date of service.
- Charges for extracoronal, equilibration and other periodontal splinting.
- Charges that 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 as defined by the Plan.
- Charges for services that, to any extent, are payable under the medical expense benefit of the Plan.
- Charges for services or supplies that are primarily for cosmetic purposes.
- Charges for services or supplies related to diagnosis or treatment of temporomandibular joint disorder or craniomandibular disorder (see Medical Benefits).
- Charges for services or supplies for injury or illness arising out of, or in the course of employment for wage or profit, or for which you are entitled to benefits under any workers' compensation or similar law.
- Charges for dental expenses for which benefits are payable under a liability plan, including but not limited to, an automobile policy or a homeowners' policy, to the extent payments from such other sources have fully compensated the Covered Person for his or her damages, if any
- Charges for services that are not included in the list of covered dental services.
- Complications from non-covered services.
- Duplicate set of dentures.
- Hypnosis, prescribed drugs, premedications or any euphoric drugs, and analgesia.
- Infection Control. Charges for infection control (OSHA) fees.
- Oral hygiene instruction.
- Orthognathic surgery.

- Replacement. Replacement of lost or stolen appliances.
- Veneers, except for the 12 anterior teeth
- Take-home fluoride solutions.
- Travel expenses.
- Treatment or services provided to correct any congenital defect or developmental malformation that does not interfere with function.
- Services and supplies provided for your personal comfort or convenience, or the convenience of any other person, including a provider.
- Services and supplies provided in connection with treatment or care that is not covered under the plan.
- Splinting, Crowns, fillings or appliances, including night guards and occlusal guards that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

Vision Plan Benefits

Vision Summary
Vision Benefits
Vision Exclusions

Please Note: Vision benefits available when offered by the participating school district and elected by the subscriber.

Vision Summary

Vision Benefits		
	Network Providers	**Non-Network Providers**
Vision Exam 1 exam per Plan year.		
• **Routine Eye Exam with Refraction** (includes dilation and contact lens exam and fitting)	100% up to $60	
• **Routine Eye Exam without Refraction** (included dilation and contact lens exam and fitting)	100% up to $49	
Hardware Member may choose either one set of frames and lenses or contact lenses, but not both during one Plan Year.		
• **Frames**	100% up to $85	
• **Lenses Per Lens** (standard plastic or glass lenses)	**Per Lens**	**Per Pair**
– Single Vision	100% up to $32	100% up to $64
– Bifocal	100% up to $41	100% up to $82
– Trifocal	100% up to $54	100% up to $108
– Lenticular	100% up to $77	100% up to $154
• **Contact Lenses**		
– Elective	One pair per plan year 100% up to $120	
– Disposable	100% up to $120	
– Medically Necessary	$165 per lens per plan year or $330 per pair per plan year	

Please Note: Vision benefits available when offered by the participating school district and elected by the subscriber.

Vision Benefits

Eye Exam

This benefit covers one routine vision exam per member each Plan year. Covered routine exam services include:

Routine Eye Exam with Refraction

- Examination of the outer and inner parts of the eye
- Glaucoma screening
- Refraction
- Binocular balance testing
- Routine tests of color vision, peripheral vision and intraocular pressure
- Case history and recommendations

A contact lens exam to ensure proper fit of your contacts, and evaluating your vision with the contacts, is also covered.

Routine Eye Exam without Refraction

- Examination of the outer and inner parts of the eye
- Glaucoma screening
- Binocular balance testing
- Routine tests of color vision, peripheral vision and intraocular pressure
- Case history and recommendations

A contact lens exam to ensure proper fit of your contacts, and evaluating your vision with the contacts, is also covered.

Hardware

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

- **Elective Contact Lenses** - Coverage is provided for elective contact lenses that are worn instead of glasses as a personal choice, versus a medical condition that prevents you from wearing glasses.
- **Frames and Spectacle Lenses** - Several lens options are available under the Plan.

Please Note: Vision benefits available when offered by the participating school district and elected by the subscriber.

Vision Exclusions

Vision Care, the following vision benefits are not covered:

- Hardware extras including, but not limited to, scratch resistant coating, tinting, etc.
- Non-prescription sunglasses or safety glasses
- Radial keratotomy, Lasik or any other refractive surgery, orthoptics, pleoptics, vision therapy, visual analysis therapy or training related to muscular imbalance of the eye; optometric therapy
- Services or supplies received principally for cosmetic purposes other than contact lenses selected in place of eyeglasses

Please Note: Vision benefits available when offered by the participating school district and elected by the subscriber.

Pharmacy Plans – Payment Provisions

Prescription drug benefits for Plan participants are administered by Express Scripts, a Pharmacy Benefit Manager not affiliated with FCH. The amounts for which you are responsible are outlined in Pharmacy Plans – Benefits Summaries on the next page.

Highlights of the Pharmacy Plans

- Prescription deductible and copay do not serve to satisfy the annual medical deductible and out of pocket maximum except under the HDHP/HSA plans.
- The Affordable Care Act expanded Prevention Coverage for Women's Health and Well-Being. All FDA approved contraceptive methods are covered at 100%. Over the counter contraceptive methods require a written prescription for coverage.
- Certain prescription drugs require step therapy, which means that the Plan will only pay for certain higher-cost drugs after you have tried, and failed to respond to, less costly alternatives.
- When a generic drug is available, but the pharmacy dispenses the brand-name medication for any reason, you will be responsible to pay the difference in price between the brand-name drug and the generic drug, plus the brand copayment/coinsurance. If your physician provides written notice to FCH that the brand-name medication is medically necessary, the Plan will consider waiving this requirement.
- If prescriptions are received at an Express Scripts Network pharmacy location and the member presents his/her ID card, the pharmacy will bill the Plan directly. The member need only pay the applicable copayment or coinsurance at the time and place of service.
- If prescriptions are received at a non-Express Scripts Network pharmacy, or if the member is unable to present his/her ID card at an Express Scripts Network pharmacy, the member will need to pay in full and be reimbursed by the Plan. However, the Plan will only reimburse the member the amount Express Scripts would have charged the Plan, minus any applicable copayment or coinsurance.
- The Revised Plan Pharmacy Benefits have a separate and distinct deductible from the medical plan deductible, and all prescriptions received apply to it, except for generic drugs.

Pharmacy Plans Structure

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:

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

You can access a copy of the most current Performance Drug List at ExpressScripts.com or by contacting our Member Services Department at 1-800-334-8134.

Pharmacy Plans – Benefit Summaries

Annual Deductible and Out-of-Pocket Maximums for the Revised Pharmacy Plan

Plan	Deductible Individual/Family	Out-of-Pocket Maximum Individual/Family
Revised 1000-70-3000	$100	$3,600 / $7,200

Revised Plan Pharmacy Benefits			
	Individual Deductible	**OOP Maximum**	**Copay/Coinsurance when received through Express Scripts Network Providers**
30-day supply - Retail Pharmacy			
• **Generic**	N/A	✓	$10
• **Preferred**	✓	✓	$20
• **Non-Preferred**	✓	✓	$40
• Preventive Medications (No charge with prescription)	N/A	N/A	100%
30-day supply - Specialty Pharmacy First prescription may be filled at a Network Retail pharmacy; subsequent refills must be filled through Accredo.			
• **Generic**	N/A	✓	$10
• **Preferred**	✓	✓	$20
• **Non-Preferred**	✓	✓	$40
90-day supply - Mail Order	Excludes Specialty Pharmacy		
• **Generic**	✓	✓	$20
• **Preferred**	✓	✓	$40
• **Non-Preferred**	✓	✓	$80

Annual Deductible and Out-of-Pocket Maximums for the High Deductible Pharmacy Plan

High Deductible Health Plan Pharmacy Benefits					
	Deductible	**OOP Maximum**	**Copay/Coinsurance when received through Express Scripts Network Providers**		
HDHP Pharmacy Benefits	Applicable HDHP Benefit Period deductible	Applicable HDHP Benefit Period OOP Maximum	HDHP 3000-80-5000 Plan	HDHP 6050-100-6050 Plan	HDHP 4000-100-4000 Plan
30-day supply - Retail Pharmacy					
• **Generic**	✓	✓	20%	0%	0%
• **Preferred**	✓	✓	20%	0%	0%
• **Non-Preferred**	✓	✓	20%	0%	0%
30-day supply - Specialty Pharmacy First prescription may be filled at a Network Retail pharmacy; subsequent refills must be filled through Accredo.					
• **Generic**	✓	✓	20%	0%	0%
• **Preferred**	✓	✓	20%	0%	0%
• **Non-Preferred**	✓	✓	20%	0%	0%
90-day supply - Mail Order					
• **Generic**	✓	✓	20%	0%	0%
• **Preferred**	✓	✓	20%	0%	0%
• **Non-Preferred**	✓	✓	20%	0%	0%
*The deductible noted here is the applicable Benefit Period deductible for whichever High Deductible Health Plan option the member is enrolled in. Pharmacy costs apply to the Medical deductible on these plans.					

Annual Deductible, Out-of-Pocket Maximums and Coinsurance for the Comprehensive Pharmacy Plan

Plan	Deductible Individual/Family	Out-of-Pocket Maximum Individual/Family
Comprehensive 500-70-1500	$75	$5,100 / $10,200
Comprehensive 1000-70-2000	$75	$4,600 / $9,200
Comprehensive 2000-70-4000	$75	$2,600 / $5,500
Comprehensive 3000-70-3000	$75	$1,600 / $3,200

Comprehensive Plan Pharmacy Benefits			
	Individual Deductible	**OOP Maximum**	**Copay/Coinsurance when received through Express Scripts Network Providers**
30-day supply - Retail Pharmacy			
• **Generic**	N/A	✓	$10
• **Preferred**	✓	✓	Greater of 30% or $20
• **Non-Preferred**	✓	✓	Greater of 40% or $40
30-day supply - Specialty Pharmacy First prescription may be filled at a Network Retail pharmacy; subsequent refills must be filled through Accredo Specialty Pharmacy.			
• **Generic**	N/A	✓	$10
• **Preferred**	N/A	✓	Greater of 30% or $20 (maximum copay of $500)
• **Non-Preferred**	N/A	✓	Greater of 40% or $40 (maximum copay of $500)
90-day supply - Mail Order	Excludes Specialty Pharmacy		
• **Generic**	N/A	✓	$20
• **Preferred**	✓	✓	Greater of 30% or $40
• **Non-Preferred**	✓	✓	Greater of 40% or $80

Pharmacy Plan - Filling a Prescription

Customer Service

Express Scripts, Inc., a separate entity from FCH, administers the pharmacy benefit programs. If you have questions, you may refer to www.Express-Scripts.com for additional information.

Filling a Prescription

30-Day Supply of Medication – Retail Pharmacy (excludes specialty)

- **30-Day Supply – Retail Pharmacy**. You may purchase up to a 30-day supply from an Express Scripts Retail Network pharmacy. To find out if your local pharmacy is part of Express Scripts' network, visit www.Express-Scripts.com or contact them directly at the appropriate number noted above.

90-Day Supply of Medication – Retail 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 medication through the 90-day retail program. The 90-day retail program is Express Scripts' retail-based program that allows you to obtain up to a 90-day supply of ongoing medication. To obtain a complete list of pharmacies participating in the Express Scripts national 90-day program, you may contact Express Scripts directly at (866) 707-1862; they are available 24 hours a day, 7 days a week. You can also find the information by linking to the Express Scripts website through www.express-scripts.com.

90-Day Supply of Medication – Mail Order

- Express Scripts Mail Order Service:

  You may obtain a 90-day supply of ongoing medications through Express Scripts' Mail Order program. Visit www.Express-Scripts.com for details. This site offers information about the benefits of ordering 90-day supplies of medication and provides guidance for downloading the necessary mail service order forms.
- Ridgeway Mail Order Pharmacy

  You may also obtain a 90-day supply of medication through Ridgeway Mail Order Pharmacy, which is located in Victor, Montana. Visit www.ridgewayrx.com for guidance on obtaining a 90-day supply of medication from Ridgeway. If you have questions about their mail service, please call (800) 630-3214.

Specialty Pharmacy - Limited to a 30-Day Supply

These medications are generic or non-generic drugs classified by the Plan and listed by Express Scripts as Specialty drugs and require special handling (for example, most injectable drugs other than insulin). Specialty drugs must be obtained from Accredo Specialty Pharmacy. Only your first prescription can be obtained at a Network Retail Pharmacy. All subsequent refills must be obtained through Accredo

Specialty Pharmacy. A list of specialty drugs may be obtained from Express Scripts or the Plan Administrator.

Step Therapy

Certain prescription drugs require step therapy, which means that the Plan will only pay for certain higher-cost drugs after you have tried, and failed to respond to, less costly alternatives. Contact Express Scripts for details and a list of drugs that require step therapy.

Quantity Limits

Supply is limited to 30 or 90 days for Member Submit and PBM Network Prescriptions or a 90-day supply for Mail-Order Prescriptions, except for the following:

Type of Medication	Quantity Limits
Migraine Therapy - All Strengths	**Amerge**: 9 tablets/30-day supply; 27/90-day supply
	Axert: 12 tablets/30-day supply; 36 tablets /90-day supply
	Frova: 9 tablets/30-day supply; 27/90-day supply
	Imitrex and Sumatriptan (generic): Injection: Syringes 8/30-day supply; 24/90-day supply
	Imitrex and Sumatriptan (generic): Nasal Spray 20mg: 12 units nasal sprays/30-day supply; 36 for a 90-day supply
	Imitrex and Sumatriptan (generic): Nasal Spray 5mg: 12 unit nasal sprays/30-day supply
	Imitrex and Sumatriptan (generic): tablets: 9 tablets/30-day supply; 27/90-day supply
	Imitrex and Sumatriptan (generic): Vials 10/30-day supply; 30/90-day supply
	Maxalt: 12 tablets/30-day supply; 36/90-day supply
	Replax: 12 tablets/30-day supply; 36/90-day supply
	Sumavel DosePro injectable: 12/30-day supply and 36/90-day supply
	Treximet: 9 tablets/30-day supply; 27/90-day supply
	Zomig/ZMT 2.5mg tablets: 12 tablets/30-day supply; 36/90-day supply
	Zomig/ZMT 5mg tablets: 12 tablets/30-day supply; 36/90-day supply
	Zomig Nasal Spray 5 mg:12 units/30 day supply and 36 units/90-day supply
Influenza Agents	**Relenza, Tamiflu**: two (2) treatments per 12-month period

Coordination of Benefits for Prescription Drugs

When primary coverage exists under another Plan for a Covered Person, expenses for prescription drugs may be eligible for secondary coverage under this Plan through Express Scripts (not applicable to members covered on the HDHP Plans). If a prescription drug is eligible for secondary coverage, this Plan will pay 100% of any deductible, copay, or coinsurance amount for which the Covered person would otherwise be responsible under their primary plan.

In order for your prescription drugs to be eligible for secondary coverage under this plan, you must follow these steps:

- Ensure that your primary coverage information has been submitted to this Plan.
- Submit your prescription drug receipt and explanation of benefits from the primary plan to Express Scripts, along with a reimbursement request form. The pharmacy must indicate either "generic" or "brand" on the prescription drug receipt.

Charges for prescription drugs are not eligible if the above conditions are not met.

Important note: Prescription drugs that are excluded by this Plan will not be eligible for coverage, regardless of whether this Plan is primary or secondary.

Pharmacy Plan Exclusions and Limitations

Prescription drugs or supplies in the following categories are specifically excluded:

- Cosmetic only indications, including but not limited to, photo-aged skin products (Renova); Hair Growth Agents (Propecia, Vaniqa); and injectable cosmetics (Botox cosmetic)
- Dermatology used in the treatment of acne and/or for cosmetic purposes (Retin A) for Covered Persons 26 years of age or older
- Depigmentation products used for skin conditions requiring a bleaching agent
- Fertility agents, oral, vaginal and injectable
- Impotence treatments
- Weight management**
- Allergen injectables
- Serums, toxoids and vaccines***
- Legend vitamins and legend fluoride products, except as specifically covered
- Over-the-counter equivalents and non-legend medications (OTC), except certain over-the-counter medications required by the Patient Protection and Affordable Care Act.
- Blood monitors and kits (glucose or ketone) *
- Durable Medical Equipment*
- Experimental or Investigational drugs
- Growth Hormones**
- Diabetic pumps and pump supplies*

*Eligible for coverage under the Medical Benefits, subject to all provisions and limitations of this Plan.

**Eligible for coverage subject to review for medical necessity.

***Flu shots and the Zostavax (shingles) vaccine covered at participating pharmacies

Section II:
Summary Plan Description

Eligibility and Enrollment

Eligible Classes of Employees

Employees of Northwest Montana Schools' Consortium participating schools who work 20 hours or more per week (subject to the provisions of applicable collective bargaining agreements) are considered employees eligible to enroll in the Plan.

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

- Leased or temporary employees,
- Employees on active military duty if that duty exceeds a period of 31 consecutive days (see *Other Continuation of Coverage* section)

Trustees of the Plan are also eligible to enroll in the Plan. An eligible Trustee is a person duly appointed and actively serving on the Board of Trustees of Northwest Montana Schools Health Consortium.

Retirees of Northwest Montana Schools' Consortium participating schools are also eligible under this Plan if the Retiree satisfies one of the following conditions:

- The retired person was an eligible covered employee under this Plan on the day immediately before the date of retirement and retired pursuant to the terms of the Montana Teachers Retirement or Public Employees Retirement laws and is eligible for coverage pursuant to the terms of 2-18-704, MCA, as amended from time to time;
- The retired person was an eligible Covered Employee under this Plan on the day immediately before the date of retirement, was not eligible for retirement under the terms of 2-18-704, MCA, but was eligible for retirement under the terms and conditions of the employment policies and practices of Northwest Montana Schools' Consortium participating schools (the person must have been employed by Northwest Montana Schools' Consortium participating school on the day immediately before retirement); or
- The retired person was an eligible covered Trustee under this Plan on the day immediately before the date the Trustee's term ended and has served two complete terms.

Waiting Period

Coverage for otherwise eligible employees becomes effective on the first of the month following the date of hire.

Enrollment Periods

Enrollment periods for eligible employees and dependents are:

- Within thirty (30) 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 30 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 30 days of the employee's initial eligibility period. Incomplete information will result in delayed eligibility, delayed access to benefits and non-payment of claims.

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

Open Enrollment

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

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 60 days after the marriage, 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, or a change from active to retired status
- 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
- Loss of other coverage ((see Involuntary Loss of Other Coverage below)

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

An enrollment is late, and a person considered a Late Enrollee, if s/he did not apply when first eligible (unless initial eligibility coincides with an Open Enrollment period).

Effective Date

Effective Date of Coverage for You, an Employee

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

Effective Date of Coverage for You, a Trustee

A Trustee's coverage under the Plan will become effective on the first day of the calendar month following the date the Trustee: 1) was appointed to the Board of Trustees of Northwest Montana Schools Health Consortium, and 2) the Plan is in receipt of the completed enrollment form with 30 days immediately following the official start date of the eligible employee. (Please see Eligibility Classes of employee section for definition of eligibility).

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 30 days (31 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 30 days of the date the dependent becomes eligible for coverage. If you do not notify us within 30 days, the dependent will be considered a late enrollee.

Special Rule

If an employee and spouse or domestic partner are each employees of Northwest Montana Schools' Consortium and are eligible for benefits, employees may not double cover each other as dependents.

Children whose parents are both Northwest Montana Schools' Consortium employees may enroll under only one parent.

If you are covered under a family member employed by Northwest Montana Schools' Consortium 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 as applicable.

Dependents

Dependent Eligibility

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

- Lawful spouse
- Domestic partner who meets the criteria for eligibility (see *Plan Definitions*)
- Your (or your Domestic Partner's) unmarried or married 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); or
- Your (or your Domestic Partner's) unmarried natural child, adopted child, child placed with you for legal adoption, stepchild, or other legally designated ward, age 26 or older, that a health care professional determines is not capable of self-sustaining employment due to a physical handicap or developmental disability.

A child who loses dependent status for coverage eligibility under this provision may be eligible for continuation of coverage under COBRA (See *COBRA* section).

Dependents do not include:

- A spouse who is legally separated or divorced;
- Any person who is on active duty, for more than 31 consecutive days, 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, spouse or domestic partner; or
- The newborn child, spouse or domestic partner 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 within 60 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 date of 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, that child will be covered by the Plan for the first thirty-one (31) days of life and premium will be waived for that time period. This automatic coverage is provided only when the newborn has no other coverage in effect during the first 31 days of life. If benefits are paid on a newborn under this provision and the newborn subsequently becomes enrolled in other coverage effective retroactively to any date during the first 31 days of life, the Plan will exercise the right to recover the excess payments from any persons(s), insurer(s) or other organizations, as the Plan deems appropriate. In order for benefits to continue after the first 31 days of life, the child must be enrolled according to the applicable Special Enrollment provisions of the Plan. This provision does not apply to grandchildren of the Subscriber or Spouse/Domestic Partner.

Adopted Children Acquired

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

If the enrollment form, with documentation to support legal guardianship, is received within 30 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 30 days of obtaining legal guardianship, dependent coverage becomes effective on the 1st of the month following request for enrollment. 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 30 days of the order, coverage becomes effective on the date of the order. If received after 30 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 (FCHN) providers within **Montana,** Washington, Idaho, Oregon, Alaska, Wyoming, North and South Dakota.

The First Choice Health PPO Network is available for network benefits to:

- Participants who live outside the FCHN 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 and proof of incapacity must be received within 30 days prior to the date the child reaches age 26. Additional proof of incapacity may be required from time to time.

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

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

A medical child support order:

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

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

- Employee's name and last known address

- Each alternate recipient's name and address (or state official/agency name and address if the order provides)
- Reasonable description of coverage the alternate recipient is entitled to receive
- Coverage effective date
- How long the child is entitled to coverage
- That the plan is subject to the order.
- If the medical child support order is a QMCSO:
- The Plan Administrator notifies you and the alternate recipient of the Plan's procedures and allows the alternate recipient to name a representative to receive copies of any QMCSO notices
- Alternate recipient coverage begins on the first of the month after the QMCSO is received
- If a dependent contribution is required, your specific authorization isn't needed to establish the payroll deduction, which would be retroactive to the alternate recipient's coverage effective date
- The Plan pays network providers directly for covered services; when an alternate recipient, custodial parent, legal guardian or employee pays a covered expense, the Plan reimburses the person who paid the expense.

If the medical child support order is not a QMCSO, the Plan Administrator notifies you and each alternate recipient of the specific 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 30 days of the order in order for coverage to become effective on the date of the order. If the enrollment information is received after 30 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

Termination of Participants' Coverage

For participants (employees, retirees or trustees) coverage ends at these events:

- On the last day of the month in which the participant's employment terminates
- On the last day of the month in which the participant ceases to be eligible for coverage
- The date the participant fails to make any required contribution for coverage
- The date the Plan is terminated
- On the last day of the month in which Northwest Montana Schools' Consortium no longer employs any employees, as defined by the Plan
- On the last day of the month in which the participant dies
- On the last day of the month in which the participant enters the armed forces of any country as a full-time member if active duty is to exceed 31 days
- On the last day of the month in which the Plan receives the Plan's Health Coverage Waiver Form for the participant
- The date 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 date the policy is materially breached
- The date the Plan Sponsor ceases to offer coverage in the group market under which this coverage is issued
- The date Northwest Montana Schools' Consortium discontinues Retiree or Trustee benefits
- On the last day of the month in which the Retiree or Trustee dies

Note: Employees whose regular employment coincides with the school year (regular work hours are reduced/eliminated in June and reinstated in late August or September) are considered covered through the summer break unless coverage is terminated at the employee's request in June. Employees may not terminate coverage retroactively.

Termination of Participating Dependents' Coverage

The Plan requires 30 days' written notice for dependent coverage termination.

For participating dependents (of employees, retirees or trustees), coverage ends at these events:

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

Related Details

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

Reinstatement of Coverage

An Employee whose coverage terminates in July as a result of a reduction in contribution to the Plan and who again becomes eligible for coverage under the Plan on September 1st immediately following the date of such termination of coverage will become eligible for reinstatement of coverage on the date of renewed eligibility. Coverage will be reinstated for the Employee and eligible Dependents on the date of renewed eligibility, September 1st, provided that application for such coverage is made on the Plan's enrollment form during the month of August immediately preceding the reinstatement date. Reinstatement of Coverage is subject to the following:

- Credit will be given for prior amounts applied toward the Deductible and Out-of-Pocket Maximum for the same Benefit Period during which renewed eligibility occurs.
- All prior accumulations toward annual maximums will apply if rehired within same year.
- Enrollment under this subsection will not be considered Late Enrollment.
- If renewed eligibility occurs under any circumstances other than as stated in this subsection, enrollment for coverage for the Employee and his/her Dependents will be treated as if initially hired for purposes of eligibility and coverage under this Plan.

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

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

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

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

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

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

Who Is a COBRA Qualified Beneficiary?

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

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

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

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 beginning on the date on which the covered person's absence begins (See also Military Leave under Other Continuation of Coverage section)
- If, while covered under COBRA, you (or a COBRA-eligible dependent) become disabled, you may be eligible for a coverage extension. The 18-month COBRA coverage period may be extended another 11 months for a total of 29 months COBRA coverage. To qualify for this disability extension, you must:
  - Meet the definition of disability under Title II or XVI of the Social Security Act at the time of the qualifying event or within the first 60 days of COBRA coverage
  - Provide the Plan Administrator with notice of the disability determination (from Social Security) on a date that is both within 60 days after the determination date and before the original 18-month coverage ends. If the disabled beneficiary is later determined by Social Security to no longer be disabled, the Plan Administrator must receive notice within 30 days of that determination date
- If another qualifying event occurs while receiving COBRA Continuation Coverage, the spouse, domestic partner and dependent children of the Employee can get additional months of COBRA Continuation Coverage, up to a maximum of 36 months. This extension is available to the spouse, Adult Dependent and dependent children if the former employee dies or becomes divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, you must notify FCH of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to FCH, One Union Square, 600 University Street, Suite 1400, Seattle WA 98101. Failure to provide notice within the time required will result in loss of eligibility for COBRA Continuation Coverage.**

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 30 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 however, if Medicare is obtained prior to COBRA election, COBRA coverage may not be discontinued, even if the other coverage continues after the COBRA election.
- If an extension from 18 to 29 months was granted due to a disability and the individual receives a final determination from the Social Security Administration stating the individual is no longer disabled, the individual must notify the plan administrator within 30 days after the date of that determination. Coverage ends on the last day of the month through which contribution payments have been received, so long as that date is within the first month that begins within 30 days after the final determination date, and after the initial 18-month COBRA coverage period

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

Contribution Payment Requirements

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

If you are eligible and receive a disability extension under Title II or XVI of the Social Security Act, your contribution will also be 102% of the full cost of coverage.

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

Failure to make payments within the designated time frame will result in automatic termination of coverage to the last day of the month for which a complete payment was made. Payments need to be sent directly to FCH, One Union Square, 600 University Street, Suite 1400, Seattle WA 98101. If you have COBRA related questions, you may call (877) 749-2032 to speak with a COBRA representative

Election Requirements

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

In the case of divorce, legal separation or the ineligibility of a dependent, 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 in any 12-month period 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 any 12-month period for the following reasons:

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

If you are granted an authorized leave of absence from work, you may choose to continue coverage under this group health plan during the approved leave time as long as you pay your required contribution. Since continuation of coverage under this provision is not extended automatically, please contact your Plan Administrator for more information. Any and all applicable monthly contributions must be paid 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 you lose coverage during your leave because you did not make the required contributions, you may enroll again within 30 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.

Temporary Layoff/ Leave of Absence

A Participant whose Active Service ceases as a result of a layoff or any school board approved leave of absence, including FMLA leave, may remain covered as an Employee in Active Service until the earliest of the following dates:

- The date the Participant fails to make any required contribution for coverage;
- The date the Participant otherwise cancels his/her coverage;
- A period of 12 weeks past the date the Employee's Active Service ends in the event the leave is FMLA leave;
- For a period of three months past the date the Employee's Active Service ends in the event of any temporary layoff or other school board leave; or
- The date the Participant no longer qualifies for FMLA leave.

Military Leave

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you take a military leave, for active duty or training, you may elect to 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 USERRA. While continued, coverage will be what was in force on the last day you worked as an active employee. However, if benefits decrease for others in the class, yours will also decrease.

If you return to active employment promptly after your military leave, in accordance with federal law, your medical and pharmacy, 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 that continues after you are discharged from active military service.

Montana Military Service Employment Rights Act (MMSERA)

To the extent required by MMSERA, the following provisions will apply:

"State Active Duty" means duty performed by a Montana National Guard member when a disaster is declared by the proper State authority and shall include the time period as certified by a licensed physician to recover from an illness or injury incurred while performing the state active duty.

1. In any case in which a participant has coverage under this Plan, and such participant is absent from employment with Employer by reason of State Active Duty, the Participant may elect to continue coverage under this Plan for himself or herself and his or her eligible Dependents as provided in this subsection. The maximum period of coverage under such an election shall be the period beginning on the thirty-first consecutive day of State Active Duty and ending on the day immediately before the day the Participant returns to a position of employment with the Employer, provided the Participant returns to employment in a timely manner, or ending on the day immediately after the day the Participant fails to return to a position of employment in a timely manner.

A. For purposes of this subsection, a timely manner means the following:

1) For State Active Duty of 30 days but not more than 180 days, the next regularly scheduled day of Active Service following 14 days after the termination of State Active Duty.
2) For State Active Duty of more than 180 days, the next regularly scheduled day of Active Service following 90 days after the termination of State Active Duty.

2. An eligible Participant who elects to continue Plan coverage under this Section may be required to pay not more than 102% of the full premium under the Plan associated with such coverage for the Employer's other Employees, except that in the case of a Participant who performs State Active Duty for less than 180 days, such person may not be required to pay more than the regular Employee share, if any, for such coverage.

In no event will this Plan cover any Illness or Injury determined by the Montana Department of Military Affairs to have been caused by or aggravated during, performance of State Active Duty.

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

Claim and Appeal Procedures

Claim

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

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

How to File a Claim for Plan Benefits

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

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

It is best to submit charges as soon as possible. However, charges for covered services submitted to FCH must be received within 12 months of the date the service or supply was rendered or received. Claims will not be considered for benefits if received after this timeframe where timing of submission has caused the Plan prejudice. (See your ID card for the FCH claim address.) Claim forms are available from your Plan Administrator (Northwest Montana Schools' Health Consortium).

Claim Types

- **Pre-service claim** means any claim for a Plan benefit for which the Plan requires approval before medical care is obtained.
- **Concurrent claim** means any claim reconsidered after initial approval for an ongoing course of treatment which results in a reduced or terminated benefit.
- **Post-service claim** means any claim for a Plan benefit that is not a pre-service claim and is a request for payment or reimbursement for covered services already received.

- **Urgent care claim** means a claim for medical care or treatment that, if normal pre-service standards are applied, would in the opinion of a physician with knowledge of the claimant's medical condition:
  - seriously jeopardize the claimant's life, health or ability to regain maximum function
  - subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested.

Claim Procedure

The Plan Sponsor (Northwest Montana Schools' Health Consortium) has final authority over appeals as the appropriate named fiduciary, however the Plan delegates to FCH, as it relates to benefits issues, the authority, responsibility and discretion to:

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

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

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

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

Adverse Benefit Determination

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

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

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

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

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

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

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

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

Appeal Procedure

FCH performs functions associated with the internal review of medical and pharmacy appeals for this Plan. Express Scripts performs functions associated with the internal review of pharmacy appeals. Northwest Montana Schools' Consortium has the final authority over appeals as the appropriate named fiduciary.

If a claim is denied in whole or in part, the Covered Person will receive written notice of the adverse benefit determination. A claim denial will be provided by the Plan showing:

1. The reason the claim was denied;
2. Reference(s) to the specific Plan provision(s) or rule(s) upon which the claims decision was based which resulted in the adverse benefit determination;
3. Any additional information needed to perfect the claim and why such information is needed; and
4. An explanation of the Covered Person's right to appeal the adverse benefit determination for a full and fair review.

If the Covered Person does not understand the reason for any adverse benefit determination, the Covered Person should contact First Choice Health (FCH), the third party administrator, for medical appeals, and Express Scripts for pharmacy appeals at the address or telephone number shown on the claim denial.

This Plan provides two internal levels of benefit determination review. The Covered Person must exercise both levels of review before bringing civil action.

Appeals or requests for review of adverse benefit determinations must be submitted to the Plan in writing, and supporting materials may be submitted via mail, the electronic claims submission process, facsimile (fax) or electronic mail (e-mail).

First Level of Benefits Determination Review of a Claim

To initiate the first level of benefit review on a Claim adverse benefit determination, the Covered Person must submit a written appeal or a request for review to the Plan within 180 days after the date of the initial adverse determination letter. The Covered Person should include any additional information supporting the appeal and forward this information to FCH or Express Scripts at the time of the appeal. Failure to appeal the adverse benefit determination within the 180-day period will render the determination final and any appeal received after the end of this 180-day period will not be considered

The first level of benefit determination review is done on behalf of the Plan Sponsor by FCH and/or other independent resources. FCH and/or other independent resources will research the information initially received and determine if the initial determination was appropriate based on the terms and conditions of the Plan and other relevant information.

Medical Appeals:

- For a standard pre-service or clinical claim, notice of the decision on the first level of review will be sent to the Covered Person within 30 days following the date of receipt of the written appeal by the Plan.
- For an urgent pre-service claim, notice of the decision on the first level of review will be sent to the Covered person within seventy-two (72 hours) following the date of receipt of the appeal by the Plan. In light of the expedited timeframes for decision on urgent care claims, an urgent care appeal may be submitted to FCH by telephone at (877) 749-2031 or by fax at (206) 268-2920. The claims should include at least the following information:
- The identity of the Claimant

- A specific medical condition or symptom:
- A specific treatment, service or product for which approval or payment is requested; and
- Any reasons why the appeal should be processed on a more expedited basis.
- Or, post-service non-clinical claim notice of decision on the first level of review will be sent to the Covered Person within 60 days following the date of receipt of the written appeal by the Plan.

If, based on this review, the initial adverse benefit determination remains the same, and the Covered Person does not agree with that benefit determination, the Covered Person may initiate the second level of benefit review. The Covered Person must request the second review in writing and send it to FCH not later than 60 days after receipt of FCH's decision from the first level of review. ***Failure to initiate the second level of benefit review within the 60-day time period will render the determination final, unless the appeal involves*** medical judgment. If the adverse benefit determination involves medical judgment, the member may request external review without completing the second level of internal appeal.

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

Pharmacy Appeals:

- Pharmacy appeals must be submitted in writing to:

  Express Scripts
  P.O. Box 631850
  Irving, TX 75063-0030
  Attn: Appeals

- For urgent appeals, contact:

  Express Scripts
  Phone: 1 (800) 753-2851
  Fax: 1 (888) 235-8551

Second Level of Benefit Determination Review of a Claim

If the member requests a second level of internal appeal, FCH will forward to the Plan Sponsor who will review the claim in question along with any additional information submitted by the Covered Person. The Plan Sponsor will conduct a full and fair review of the claim by individuals other than the original decision maker nor the decision maker's subordinate. The Plan Sponsor may consult with relevant health care professionals in making decisions about appeals that involve specialized medical judgment. Where the appeal involves issues of Medical Necessity or Experimental Treatment, the Plan Sponsor will consult with a health care professional with appropriate training. That health care professional will not be the medical professional consulted in the initial determination or his or her subordinate.

After a full and fair review of the Covered Person's appeal, the Plan will provide written or electronic notice of the final benefit determination, within a reasonable time, but no later than 30 days from the date the second level appeal is received by the Plan. Such notice will contain the same information as notices for the initial determination.

All claim determinations are based upon the terms contained in the Summary Plan Description on file with the Plan Administrator. The Covered Person may also request, free of charge, more detailed

information, names of any medical professionals consulted, and copies of relevant documents, as defined in and required by law, which were used by the Plan Administrator to adjudicate the claim.

Right to Request Independent External Review

After exhaustion of Level one (1) appeal rights stated above, a Covered Person may request a final external review by an independent external review organization (IRO) of an adverse claim determination benefit decision involving question of Medical Necessity, or other issue requiring medical expertise for resolution by filing a request for external review within 120 days after the date of receipt of a notice of the first Level adverse benefit determination.

The request for an IRO external review must be made in writing to FCH. If the request is eligible for an IRO review, FCH will forward the entire record of the appeal within 10 days to the IRO. The IRO will notify the Covered Person of its procedures to submit further information.

The IRO will provide written notice of the final external review decision to the Claimant and the FCH within forty-five (45) days after the IRO receives the request for external review. The notice will contain a general description of the reason for the request for external review and a discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision. To the extent the final external review decision reverses the FCH or the Plan's decision (as was reflected in the notice of adverse benefit determination), the FCH or the Plan shall follow the final external review decision of the IRO.

The decision of the IRO will be final and binding except that the Covered Person shall have an additional right to appeal the matter to a court with jurisdiction.

Before filing a lawsuit, the Claimant must exhaust all available levels of internal and external review as described in this section, unless an exception under applicable law applies. ***A legal action to obtain benefits must be commenced within one (1) year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable.***

Coordination of Benefits

Benefits Subject to the COB Provision

The purpose of this Coordination of Benefits (COB) provision is to ensure the total of claim benefits paid by this Plan and other plans with concurrent coverage does not exceed 100% of the Total Allowable Expenses (see *Plan Definitions*). This provision prevents a participant from receiving more in benefits than what s/he would otherwise be responsible to pay for services received.

The following formula is used in calculating this Plan's payment when COB applies:

- Allowed Amount (see *Plan Definitions*) minus (–) this Plan's patient responsibility of copays, coinsurance, deductibles and non-covered expense equals (=) FCH's net payment, **not to exceed the difference between the primary plan's payment and the Total Allowable Expenses.**

If the Plan pays benefits as primary when another plan is actually primary, the Plan will exercise the right to recover those paid amount(s). When a participant fails to use another group plan that is primary, this Plan, as secondary, will not assume liability for those charges.

All covered benefits provided under the Plan (with the exception of Pharmacy) are subject to this COB provision. Refer to *Coordination of Benefits for Prescription Drugs* within Section I – Benefits for information on COB rules for pharmacy benefits.

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 *Integrating Benefits with 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 *Integrating Benefits with Medicare*) then the order of benefits is reversed so that the plan covering the person as an employee, member, subscriber, policyholder or retiree is secondary to the plan covering the person as a dependent.

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

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

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

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

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

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

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

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

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

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

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

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

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

5. **Length of coverage**: If none of the preceding rules establish which plan pays first, the plan that has covered the person the longest is primary. To determine the length of time a person has been covered under a plan, two successive plans are treated as one if the covered person was eligible under the second plan within twenty-four hours after coverage under the first plan ended. The start of a new plan does not include:
   A. A change in the amount or scope of a plan's benefits;
   B. A change in the entity that pays, provides or administers the plan's benefits; or
   C. A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

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

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

Integrating Benefits with Medicare

For all purposes, this Plan will be primary to Medicare Part D.

1. **For Working Aged**
   A covered Employee who is 65 years of age or older may be covered under this Plan and be covered under Medicare, in which case this Plan will pay primary. A covered Employee, 65 years of age or older, may elect not to be covered under this Plan. If such election is made, this plan will not be secondary to Medicare, as coverage under this Plan will terminate.
   A covered Dependent spouse, 65 years of age or older, of a covered Employee may also be covered under this Plan and be covered under Medicare, in which case the Plan again will pay primary. A covered Dependent spouse, 65 years of age or older, may elect not to be covered under this Plan. If such election is made, this plan will not be secondary to Medicare, as coverage under this Plan will terminate.
   A covered Domestic Partner, 65 years of age or older, of a covered Employee may also be covered under this Plan and be covered under Medicare; however, Medicare will be primary.
2. **For Retired Persons**
   This Plan will coordinate benefits with Medicare according to the following rules whether or not the person is actually enrolled in Medicare and receiving Medicare benefits.
   Medicare is primary, and this Plan is secondary for the covered Retiree if he/she is eligible for Medicare Part A or Part B.
   Medicare is primary, and this Plan is secondary for a covered Retiree's dependent spouse who is eligible for Medicare Part A or Part B if both the covered Retiree and his/her covered spouse are eligible for Medicare Part A or Part B.
   Medicare is primary for the Retiree's covered dependent spouse when the Retiree is not eligible for Medicare Part A or Part B and the Retiree's spouse is eligible for Medicare Part A or Part B.

3. **For Covered Persons who are Disabled**
   The Plan is primary and Medicare will be secondary for the Participant or any covered Dependent (including a Domestic Partner) who is eligible for Medicare by reason of disability, if the Participant is actively employed by the Employer.
   The Plan is secondary and Medicare will be primary for the Participant or any covered Dependent (including a Domestic Partner) who is eligible for Medicare by reason of disability if the Participant is retired or otherwise not actively working for the Employer.
4. **For Persons with End Stage Renal Disease**
   Except as stated below*, for employees or retirees and their dependents (including a Domestic Partner), if Medicare eligibility is due solely to End Stage Renal Disease (ESRD), this Plan will be primary only during the first 30 months of Medicare coverage. Thereafter, this Plan will be secondary with respect to Medicare coverage, unless after the 30-month period described above:
   A. The Covered Person has no dialysis for a period of 12 consecutive months and then resumes dialysis, at which time the Plan will again become primary for a period of 30 months; or
   B. The Covered Person undergoes a kidney transplant, at which time the Plan will again become primary for a period of 30 months.

   *If a Covered Person is covered by Medicare as a result of disability, and Medicare is primary for that reason on the date the Covered Person becomes eligible for Medicare as a result of ESRD, Medicare will continue to be primary and the Plan will be secondary.

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.

Pre-authorization when this Plan is Secondary

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

Meaning of Plan for COB

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

- This Plan (the Plan with a capital "P")
- Group and non-group insurance contracts and subscriber contracts
- Uninsured arrangements of group or group-type coverage
- Group and non-group coverage through closed panel plans

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

"Plan" does not include:

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

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

Claim Determination Period

The claim determination period used when applying this COB provision is the Plan year: July 1 through the last day of June of the next year.

Right of Recovery

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

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

Facility of Payment

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

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

Right to Receive and Release Information

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

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

Third Party Recovery

By enrollment in the Plan, a Covered Person agrees to the provisions of this Section as a condition precedent to receiving benefits under this Plan. If the Covered Person fails to comply with the requirements of this Section, the Plan may reduce or deny benefits otherwise available under the Plan.

Defined Terms

"Recover," "Recovered," "Recovery" means all monies recovered by way of judgment, settlement, reimbursement, or otherwise, to compensate for any loss related to any injury, sickness, condition, and/or accident where a Third Party is or may be responsible. "Recovery" includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, wages and/or any other recovery of any form of damages or compensation whatsoever.

"Subrogation" means the Plan's right to exercise the Covered Person's rights to Recover or pursue Recovery from a Third Party who is liable to the Covered Person for expenses for which the Plan has paid or may agree to pay.

"Third Party" means any third party including but not limited to another person, any business entity, insurance policy, or any other policy or plan, including but not limited to uninsured or underinsured coverage, self-insured coverage, no-fault coverage, automobile coverage, premises liability (homeowners or business), and/or an umbrella policy.

Right to Recover Benefits Paid in Error

The Plan has the right to recover any benefits the Plan paid in error to the Covered Person, on behalf of a Covered Person or an assignee of a Covered Person to which the Covered Person is not entitled, for services which were not covered under the Plan, for benefits paid in excess of the Plan's allowable charge. The Plan may recover benefits paid in error from the Covered Person, the provider who received a payment from the Plan on the Covered Person's behalf, or from any person who may have benefited. The Plan may deduct the amount paid from the Covered Person's future benefits or from benefits of any family member even if the erroneous payment was not made on that Family Member's behalf.

Payment of benefits by the Plan for Participants' spouses, ex-spouses, or children, who are not eligible for coverage under this Plan, but for whom benefits were paid based upon inaccurate, erroneous, false information or omissions of information provided or omitted by the participant will be reimbursed to the Plan by the participant. The participant's failure to reimburse the Plan after demand is made may result in an interruption in or loss of benefits to the participant, and could be reported to the appropriate governmental authorities for investigation of criminal fraud and abuse.

The Plan may recover such amount by any appropriate method that the Plan Administrator, in its sole discretion, will determine. By receipt of benefits under this Plan, each Covered Person authorizes the deduction of any excess payment from such benefits or other present or future compensation payments.

The provisions of this subsection apply to any Licensed Health Care Provider who receives an assignment of benefits or payment of benefits under this Plan. If a Licensed Health Care Provider refuses to refund improperly paid claims, the Plan may refuse to recognize future assignments of benefits to that provider.

To the extent the Plan paid benefits on the Covered Person's behalf, the Covered Person agrees that, to the fullest extent permitted by law, the Plan has an equitable lien on any Recovery whether or not such

Recovery(s) is designated as payment for such expenses. This lien shall remain in effect until the Plan is repaid in full.

Right to Reimbursement

This provision applies when the Covered Person incurs medical or dental expenses due to an injury, sickness, condition, and/or accident that may be caused by the act or omission of a Third Party or where a Third Party may otherwise be responsible for payment.

If the Plan pays benefits for medical expenses on a Covered Person's behalf, and another party was actually responsible or liable for their medical expenses, the Plan has a right to be reimbursed by the Covered Person for the amounts the Plan paid, subject to the applicable laws and regulations, including the "Made Whole Doctrine."

Accordingly, if a Covered Person, or anyone on his or her behalf, settles, is reimbursed or recovers money from any person, corporation, entity or insurance carrier for liability, no-fault, uninsured, underinsured, or other insurance coverage, or funds for any accident, injury, condition or Illness for which benefits were provided by the Plan, the Covered Person agrees to hold the money received in trust for the benefit of the Plan. In accordance with the "Made Whole Doctrine," the Covered Person agrees to reimburse the Plan, in second priority, from any money recovered from a liable third party, for the amount of all money paid by the Plan to the Covered Person or on his or her behalf or that will be paid as a result of said accident, Injury, condition or Illness. The initial priority is for the member to be made whole for medical expense and attorney's fees.

Reimbursement to the Plan will be paid second after, the Covered Person is not paid for all of his or her claim for damages and regardless of whether the settlement, judgment or payment he or she receives is for or specifically designates the recovery, or a portion thereof, as including health care, medical, disability or other expenses or damages, including attorney's fees.

The Plan will not pay or be responsible for attorney fees and/or costs of recovery associated with a Covered Person pursuing a claim against a Third Party.

The Plan's right to Reimbursement is separate from and in addition to the Plan's right of Subrogation.

Right to Subrogation

This provision applies when the Covered Person incurs medical or dental expenses due to an injury, sickness, condition, and/or accident that may be caused by the act or omission of a Third Party or a Third Party may be responsible for payment. In such circumstances, the Covered Person may have a claim against a Third Party for payment of such expenses.

Subrogation is the right of the Plan to exercise the Covered Person's rights and remedies in order to recover from third parties who are legally responsible to the Covered Person for a loss paid by the Plan. This means the Plan can proceed through litigation or settlement in the name of the Covered Person, with or without his or her consent, to recover the money paid under the Plan. In other words, if another person or entity is, or may be, liable to pay for medical bills or expenses related to the Covered Person's accident, Injury, condition or Illness, which the Plan paid, then the Plan is entitled to recover, by legal action or otherwise, the money paid; in effect, the Plan has the right to "stand in the shoes" of the Covered Person for whom benefits were paid, and to take any action the Covered Person could have undertaken to recover the money paid.

The Plan acknowledges that the member must be "Made Whole" prior to the right of the Plan to recover medical expenses and attorney's fees it has incurred. The Covered Person agrees that the Plan is subrogated to any and all claims, causes of action or rights that the Covered Person may have now or in

the future against a Third Party who has or may have caused, contributed, aggravated, and/or be responsible for the Covered Person's injury, sickness, condition, and/or accident to the extent the Plan has paid benefits or has agreed to pay benefits, once all of the members' medical expenses, damages, and attorney's fees are recovered The Plan may assert this Right of Subrogation independently of the Covered Person. The Plan is not obligated to pursue this right independently or on behalf of the Covered Person, but may choose to exercise this right, in its sole discretion.

Provisions Applicable to Both the Right to Reimbursement and Right to Subrogation

The Covered Person automatically assigns to the Plan any and all rights he or she has or may have against any Third Party to the full extent of the Plan's equitable lien. The Covered Person agrees to:

a. Cooperate fully with the Plan and its agents, regarding the Plan's rights under this section;
b. Advise the Plan of any right or potential right to reimbursement and/or subrogation on the Plan's behalf;
c. Provide to the Plan in a timely manner any and all facts, documents, papers, information or other data reasonably related to the Covered Person's injury, sickness, condition, and/or accident, including any efforts by another individual to Recover on the Covered Person's behalf;
d. Execute all assignments, liens, or other documents that the Plan or its agents may request to protect the Plan's rights under this section;
e. Obtain the Plan's consent before releasing a Third Party from liability for payment of expenses related to the Covered Person's injury, sickness, condition, and/or accident;
f. Hold in trust that portion of any Recovery received by the Covered Person or on the Covered Person's behalf equal to the Plan's equitable lien until such time as the Plan is repaid in full;
g. Agree not to impair, impede or prejudice in any way, the rights of the Plan under this section; and
h. Do whatever else the Plan deems reasonably necessary to secure the Plan's rights under this section.

The Plan may take one or more of the following actions to enforce its rights under this section:

a.
b. The Plan may withhold payment of benefits if the Recovery received by or on behalf of a Covered Person has fully compensated the Covered Person for his or her damages;
c. The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Reimbursement against any Recovery received, or that will be received, by or on behalf of Covered Person, so long as the Covered Person is fully compensated for his or her damages;
d. The Plan may, to the extent of any benefits paid by the Plan, exercise its Right of Subrogation directly against a Third Party who is or may be responsible, so long as the Covered Person is fully compensated for his or her damages; or
e. The Plan may, to the extent of any benefits paid by the Plan, which have not otherwise been reimbursed to the Plan, offset any future benefits otherwise payable under the Plan to the Covered Person or on the Covered Person's behalf so long as the Covered Person is fully compensated for his or her damages.

The Plan Administrator is vested with full discretionary authority to interpret and apply the provisions of this section. In addition, the Plan Administrator is vested with the discretionary authority to waive or compromise any of the Plan's rights under this section. Any decision of the Plan Administrator made in good faith will be final and binding. The Plan Administrator is authorized to adopt such procedure as deemed necessary and appropriate to administrate the Plan's rights under this section and adhere to applicable law.

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 and security standards, contact the Plan Administrator for a copy of Northwest Montana Schools Health Consortium's HIPAA Privacy Notice.

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information (PHI) to the Plan Sponsor for Plan Administration Purposes

"Protected Health Information" (PHI) means individually identifiable health information, created or received by a health care provider, health plan, employer, or health care clearinghouse; and relates to the past, present, or future physical or mental health condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and is transmitted or maintained in any form or medium.

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as Required by Law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
4. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
5. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);

6. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
7. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
8. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);
9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
10. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    a. The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

       Northwest Montana Schools' Consortium Executive Director

    b. The access to and use of PHI by the individuals described in subsection (a) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

    c. In the event any of the individuals described in subsection (a) above do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non- compliance occurs. Appropriate sanctions shall be imposed so that they are commensurate with the severity of the violation.

       "Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage

The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Claims Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (MGUs) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards and any applicable Business Associate Agreement(s).

Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions

To enable the Plan Sponsor to receive and use Electronic PHI for Plan Administration Functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

- Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.
- Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate security measures to protect the Electronic PHI; and
- Report to the Plan any security incident of which it becomes aware.

Plan Administration

Benefits, Contributions and Funding

This Plan provides eligible employees and dependents with medical and pharmacy benefits. This Plan is an employer-sponsored self-funded group health plan with administration provided through the third party administrator (TPA), FCH.

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

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

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

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants, duties are incumbent upon the people who are responsible for the operation of this Plan. Specifically, the Plan fiduciaries, those 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.

Plan Administrator's Power of Authority

The Plan Administrator role for this Plan rests with Northwest Montana Schools' Consortium. The Plan Administrator is responsible for managing the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. Northwest Montana Schools' Consortium has the authority to amend the Plan, to determine its policies, to appoint and remove other services providers to the Plan, to fix their compensation (if any) and to exercise general administrative authority over the Plan. Northwest Montana Schools' Consortium has the authority and responsibility to review and make final decisions on all claims to benefits under the Plan.

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.

Plan Amendment/Modification

The Summary Plan Document contains all the terms of the Plan. They may be amended from time to time as authorized and adopted by Northwest Montana Schools Health Consortium. Written notification of any amendment, modifications, revocations or terminations will be given to Participants and Dependents within 120 days, except for reduction in benefits, for which notice will be provided within 60 days of the effective date of such change. Any such amendments will be binding on each Participant and Covered Person.

Assistance with Your Questions

If you have questions about your Plan, contact the Plan Administrator.

General Provisions

Examination

The Plan will have the right and opportunity to have the Covered Person examined whenever Injury or Illness is the basis of a claim hereunder when and so often as it may reasonably require during pendency of the claim hereunder. To the extent permitted under applicable law, the Plan will also have the right and opportunity to have an autopsy performed in case of death.

Legal Proceedings

No person shall bring an action at law or equity to recover on the Plan before the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the Plan. Any such action must be brought within three (3) years from the expiration of the time within which proof of loss is required by the Plan.

No Waiver or Estoppel

No term, condition or provision of this Plan will be waived, and there will be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver will be deemed a continuing waiver unless specifically stated therein, and each such waiver will operate only as to the specific term or condition waived and will not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

Verbal statements or representations of the Plan Administrator, its agents and Employees or Covered Persons will not create any right by contract, estoppel, unjust enrichment, waiver or other legal theory regarding any matter related to the Plan, or its administration, except as specifically stated in this subsection. No statement or representation of the Plan Administrator, its agents and Employees or Covered Persons will be binding upon the Plan or a Covered Person unless made in writing by a person with authority to issue such a statement. This subsection will not be construed in any manner to waive any claim, right or defense of the Plan or a Covered Person based upon fraud or intentional material misrepresentation of fact or law.

Free Choice of Physician

The Covered Person will have free choice of any legally qualified physician, licensed health care provider or surgeon and the physician-patient relationship will be maintained.

Workers' Compensation Not Affected

This Plan is not in lieu of, or supplemental to Workers' Compensation and does not affect any requirement for coverage by Workers' Compensation Insurance.

Conformity with Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of the applicable law. Only that provision which is contrary to applicable law will be amended to conform; all other parts of the Plan will remain in full force and effect.

Miscellaneous

Section titles are for convenience of reference only and are not to be considered in interpreting this Plan.

No failure to enforce any provision of this Plan will affect the right thereafter to enforce such provision, nor will such failure affect its right to enforce any other provision of the Plan.

Protection against Creditors

No benefit payment under this Plan will be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same will be void, except an assignment of payment to a provider of Covered Services. If the Plan Administrator finds that such an attempt has been made with respect to any payment due or which will become due to any Participant, the Plan Administrator, in its sole discretion, may terminate the interest of such Participant or former Participant in such payment. In such case, the Plan Administrator will apply the amount of such payment to, or for the benefit of, such Participant or covered Dependents or former Participant, as the Plan Administrator may determine. Any such application will be a complete discharge of all liability of the Plan with respect to such benefit payment.

Clerical Error

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

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

Summary Plan Description and General Information

Purpose:	The purpose of this Summary Plan Document is to set forth the provisions of the Plan that provide for the payment or reimbursement of all or a portion of Eligible Expenses. The terms of this Plan are legally enforceable and the Plan is maintained for the exclusive benefit of eligible Employees and their covered Dependents.
Plan Name:	Northwest Montana Schools' Consortium Health Plan
Plan Year:	July 1 through June 30
Plan Coverage Status:	This is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act.
Plan Number:	501
Plan Sponsor:	Northwest Montana Schools' Consortium
Plan Administrator's Employer Identification Number:	81-4546777
Plan Administrator:	Northwest Montana Schools' Consortium
Named Fiduciary:	Northwest Montana Schools' Consortium
Third Party Administrator:	First Choice Health, Inc. d/b/a First Choice Health 600 University Street, Suite 1400 Seattle WA 98101 (855)-378-6778 www.fchn.com
Agent for Service of Legal Process:	Northwest Montana Schools' Consortium PO Box 494 Somers, MT 59932
Summary Plan Description:	Each Participant covered under this Plan will have access through First Choice Health's member portal (www.fchn.com) to this Summary Plan Description (SPD) describing the benefits to which the Covered Persons are entitled, the required Plan procedures for eligibility and claiming benefits, the limitations and exclusions of the Plan and summarizing the provisions of the Plan. If requested by the member, a hardcopy document will be provided.

Plan Definitions

Accidental injury means an injury sustained as a result of an external force or forces that is/are sudden, direct and unforeseen and is/are exact as to time and place. A hernia of any kind will only be considered as an Illness.

Active Service means an employee is in service with Northwest Montana Schools Health Consortium on a day which is a regularly scheduled work day and the employee is performing all of the regular duties of his/her employment with Northwest Montana Schools Health Consortium on a regular basis, either at one of Northwest Montana Schools Health Consortium's business establishments or at some location to which Northwest Montana Schools Health Consortium's business requires him/her to travel.

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

Allowed amount means the maximum amount considered for payment by the Plan for a medically necessary covered service. This amount is equal to one of the following:

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

For services received from non-network providers, you are responsible to pay the difference between the Plan payment and the provider's actual charges.

ARRA refers to the American Recovery and Reinvestment Act, as amended.

Aural therapy is a service provided to both children and adults who have been diagnosed with hearing loss. Typically, aural therapy is an intervention that takes place following hearing aid fitting or cochlear implant hook-up. It involves working with the hearing-impaired individual providing the patient with strategies to better utilize his or her listening skills. Aural therapy involves training the brain to process and understand auditory information, teaching how to monitor speech through listening, and learning to develop listening skills in each ear separately and integrated. Usually provided by a speech therapist.

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

Benefit Period refers to a time period as shown in the Schedule of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the time period so established; or
2. The date the Plan terminates.

Birthing center means any freestanding licensed health facility, place, professional office or institution, that is not a hospital or in a hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to birthing centers in the jurisdiction where the facility is located. It must:

- Have facilities for obstetrical delivery and short-term recovery after delivery
- Provide care under the full-time supervision of a physician and either a registered nurse or a licensed nurse-midwife
- Have a written agreement with a hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

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

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

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

CHIP refers to the Children's Health Insurance Program Reauthorization Act of 2009.

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.

COBRA refers to sections 2201 through 2208 of the Public Health Service Act [42 U.S.C. 300bb-1 through 300bb-8] which contains provisions similar to Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Continuation of Coverage means continuation coverage provided under the provisions of the Public Health Service Act referenced herein under the definition of COBRA.

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

Covered Person means any Participant or dependent of a Participant meeting the eligibility requirements for coverage and properly enrolled for coverage as specified in the Plan.

Custodial Care means the type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person in the activities of daily living. Such activities include, but are not limited to bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication that can normally be self-administered.

Dependent means a person who is eligible for coverage according to the eligibility requirements noted within the Dependents section of this document.

Developmental Disabilities is an umbrella term that can include physical, cognitive and intellectual disability that are apparent during childhood.

Some developmental disabilities are largely physical issues, such as cerebral palsy or epilepsy. Some individuals may have a condition that includes a physical and intellectual disability, for example Down syndrome or fetal alcohol syndrome.

Intellectual disability encompasses the "cognitive" part of this definition, that is, a disability that is broadly related to thought processes. Because intellectual and other developmental disabilities often co-occur, intellectual disability professionals often work with people who have both types of disabilities

Domestic Partners are two individuals, who each meet all of the following criteria:

- Shares a permanent residence, and have resided with one another continuously for at least 12 consecutive months before filing an application for benefits and are expected to continue to reside with one another indefinitely; and,
- Has not signed a declaration or affidavit of domestic partnership with any other person and have not had another domestic partner within the 12 months prior to filing an application for benefits; and,
- Does not have any other domestic partner or spouse of the same or opposite sex; and,
- Is not currently married to anyone or legally separated from anyone else; and,
- Is not a blood relative any closer that would prohibit marriage between us in Montana; and,
- Was mentally competent to consent to contract when the partnership began; and,
- Is not acting under fraud or duress in accepting benefits; and,
- Is at least 18 years of age
- One partner qualifies as the tax dependent of the other under §(152) of the internal revenue code
- Is financially interdependent in at least three of the following ways (mark box and submit supporting documentation):
  - Having a joint mortgage, joint property tax identification, or joint tenancy on a residential lease;
  - Holding one or more credit or bank accounts jointly, such as a checking account in both names;
  - Having joint ownership of significant property, such as real estate or a vehicle;
  - Assuming joint liabilities;
  - Naming the partner as beneficiary on the employee's life insurance, under the employee's will, or employee's retirement annuities and being named by the partner as beneficiary on the partner's life insurance, under the partner's will, or partner's retirement annuities;
  - Each agreeing in writing to assume the financial responsibility for the welfare of the other; such as mutually granted powers of attorney

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.

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

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

Experimental and investigational procedures mean services determined to be either:

- Not in general use in the medical community,
- Not proven safe and effective or to show a demonstrable benefit for a particular illness or disease,
- Under continued scientific testing and research
- A significant risk to the health or safety of the patient, or,

Not proven to result in greater benefits for a particular illness or disease than other generally available services.

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

FMLA refers to the Family and Medical Leave Act, as amended.

Fiduciary means a person or entity who exercises discretionary authority or control over the management of the plan or its assets or has discretionary authority or responsibility in Plan administration. The fiduciary for this Plan is Northwest Montana Schools Health Consortium.

First Choice Health (FCH) is the Third Party Administrator for this Plan.

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

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

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

Legal Separation and/or Legally Separated shall mean an arrangement under the applicable state laws to remain married but maintain separate lives, pursuant to a valid court order.

Levels of Care related to *Mental Health* and *Chemical Dependency Conditions*:

- **Intensive Outpatient Programs** provide services for Mental Health or Chemical Dependency Conditions on an outpatient basis through planned, structured services available at least two hours per day and three days per week. Services include group, individual and when indicated family or multi-family group treatment. Medical monitoring, evaluation and adjunctive services are available. Treatment must follow a written plan of care.
- **Inpatient Psychiatric Hospitalization Programs** provide around-the-clock psychiatric and nursing interventions in secure, State-licensed psychiatric facilities for individuals diagnosed with a mental health disorder. These facilities operate under the supervision of a licensed and Board eligible/certified psychiatrist who evaluates the patient within 24 hours of admission. Subsequent face-to-face visits with a psychiatrist or psychiatric ARNP occur at least once every 24 hours along with daily medication management. Treatment must follow a written plan of care and include psychosocial and substance abuse evaluations. Individual, group, and/or family therapy occurs daily. The focus of the program is stabilization of client's psychiatric symptoms through the use of assessment, medication management, evidenced-based treatment strategies, group and individual therapy, behavior management, and active family engagement/therapy.

- **Partial Hospitalization Programs** provide multi-disciplinary care for Mental Health or Chemical Dependency Condition at least 6 hours a day, 5 days a week, and schedule at least three distinct services per day. Services include individual and group therapy, medication evaluation and management, family therapy, activity therapy, occupational therapy, and education training directed at treating the Condition. Services for Mental Health Conditions must include evaluation by a psychiatrist within 48 hours and weekly thereafter. All programs must include a substance abuse evaluation. Treatment must follow a written plan of care.
- **Mental Health Residential Treatment Program** provides around- the- clock behavioral health services that do not need the high level of physical security and psychiatric and nursing interventions that are available in an acute inpatient program. Care is medically monitored with on-site nursing and medical services. The focus of the program is an improvement of client's psychiatric symptoms through the use of assessment, evidenced-based treatment strategies, group and individual therapy, behavior management, medication management and active family engagement/therapy. Treatment must follow a written plan of care. The facility must be state licensed for residential treatment. Residential settings not meeting these criteria, such as group homes, halfway houses or adult/child foster homes, are not considered to be Mental Health Residential Treatment Programs.
- **Chemical Dependency Rehabilitation/Residential Programs** provide 24-hour rehabilitation treatment 7 days a week for Substance Related Conditions. Care is medically monitored, with 24-hour medical and/or nursing availability. Services include group, individual and when indicated family or multi-family group. The facility must offer sufficient availability of medical and nursing services to manage ancillary detoxification needs. Treatment must follow a written plan of care.

Late Enrollment/Late Enrollee means an eligible person who applies as a participant or dependent under this Plan other than during the initial enrollment period or a special enrollment period.

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

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

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

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

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

- Conditions related to Substance Related and Addictive Disorders (see Chemical Dependency definition)
- Relational, family, and lifestyle stressors absent a primary psychiatric diagnosis

Sexual dysfunctions, dysphoria, personality disorders, paraphilic disorders **Network provider** means a contracted FCHN provider in **Montana,** Washington, Idaho, Oregon, Alaska, Wyoming, North 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 **Montana,** Washington, Idaho, Oregon, Alaska, Wyoming, North 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 FCH 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. The Plan Administrator for this Plan is Northwest Montana Schools Health Consortium. 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
- Appoint and employ the individuals or entities to assist in Plan administration as necessary or advisable, including benefit consultants and legal counsel

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

Plan Year is the twelve (12) month period beginning July 1 and ending the last day of June of the next year.

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

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

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

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

Provider directory is the listing of the network providers, hospitals, and other facilities that have agreed to provide covered services to participants or dependents of Plans and who are contracted with First Choice Health PPO Network, Inc. (FCH) and First Health.

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)

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
- Non-contracted laboratories used by FCHN referring provider
- Ocular prosthetics (if covered by the Plan)
- Oral surgeons
- PKU formula
- Services of non-contracted providers when rendering care within a network facility, except a primary surgeon for a non-emergent admission

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.

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

- Pain in the musculature associated with the temporomandibular joint
- Internal derangement of the temporomandibular joint
- Arthritic problems with the temporomandibular joint
- An abnormal range of motion or limited motion of the temporomandibular joint.

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

Total Allowable Expenses mean, with respect to Coordination of Benefits, the following amounts:

1. If the primary plan is Medicare, the Medicare allowed amount;
2. If the primary plan is a PPO plan, the primary plan's allowed amount (PPO contract amount);
3. If the primary plan is non-PPO, this Plan's Allowed Amount.

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

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

Would seriously jeopardize the claimant's life, health or ability to regain maximum function

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

Usual, customary and reasonable (UCR) is the maximum amount that the Plan will consider for a covered health care service received from a non-network provider, that is consistent with and based upon what providers in a given particular geographic area charge for a same or similar medical procedure.

The Plan's UCR calculation is based upon the 25th percentile of the market rate for identical and similar services within a particular geographic area that has been obtained from a commercially-reasonable, independent, third-party source, which is updated semi-annually. If the third-party source does not have enough data to establish a UCR amount for a given medical procedure, the UCR will be calculated as a multiple of Medicare, specifically 400% of Medicare. If there is no value from the third-party source, and there is no Medicare allowed amount, and the service is deemed payable, the Plan will allow 50% of billed charges. Coinsurance, copayments, deductible, or non-covered services are applied against the UCR amount as patient responsibility. The provider can balance bill the member the difference between the Plan payment and provider's actual charges.