



City of Kirkland

Request for Proposal

2021 Medical Plan Third Party Administrator RFP

Job # 24-20-HR

Issue Date: April 13, 2020

Due Date: June 1, 2020–5:00 p.m. (Pacific Time)

REQUEST FOR PROPOSALS

Notice is hereby given that proposals will be received by the City of Kirkland, Washington, for:

2021 Medical Plan Third Party Administrator RFP

File with Greg Piland, Purchasing Agent, Finance & Administration Department, 123 - 5th Ave, Kirkland WA, 98033

Proposals received later than **5:00 p.m. June 1, 2020 will not** be considered.

A copy of this Request for Proposal (RFP) may be obtained from City's web site at <http://www.kirklandwa.gov/>. Click on the Business tab at the top of the page and then click on the Request for Proposals link found under "Doing Business with the City".

The City of Kirkland reserves the right to reject any and all proposals, and to waive irregularities and informalities in the submittal and evaluation process. This RFP does not obligate the City to pay any costs incurred by respondents in the preparation and submission of a proposal. Furthermore, the RFP does not obligate the City to accept or contract for any expressed or implied services.

A Service Provider response that indicates that any of the requested information in this RFP will only be provided if and when the Service Provider is selected as the apparently successful Service Provider is not acceptable, and, at the City's sole discretion, may disqualify the proposal from consideration.

The City of Kirkland assures that no person shall, on the grounds of race, color, national origin, or sex be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity. The City of Kirkland further assures that every effort will be made to ensure non-discrimination in all of its programs and activities, whether those programs are federally funded or not.

In addition to nondiscrimination compliance requirements, the Service Provider(s) ultimately awarded a contract shall comply with federal, state and local laws, statutes and ordinances relative to the execution of the work. This requirement includes, but is not limited to, protection of public and employee safety and health; environmental protection; waste reduction and recycling; the protection of natural resources; permits; fees; taxes; and similar subjects.

Dated this 13th day of April 2020

Greg Piland
Purchasing Agent
425-587-3123

Background Information

The City of Kirkland, Washington is located in the Seattle metropolitan area, on the eastern shore of Lake Washington and approximately 10 miles east of downtown Seattle. It has a population of over 88,000 and is the twelfth largest city in the State of Washington and the sixth largest city in King County, Washington.

Since its incorporation in 1905, Kirkland has grown in geographic size and now occupies 18 square miles. The city employs over 600 regular employees. Kirkland operates under a Council-Manager form of government. The City Council is the policy-making branch of Kirkland's government and consists of seven members elected at large to staggered, four-year terms. The Mayor is elected from within the Council. The City Council is supported by several advisory boards and commissions and the City Manager. The City Manager is appointed by the City Council and serves as the professional administrator of the organization, coordinating its day-to-day activities.

The City of Kirkland is seeking the professional assistance of qualified third-party administrators to provide a self-insured, high deductible health plan. We currently have 530 individuals who are eligible for the plan, with 392 currently enrolled on the high deductible plan.

Purpose of Request

The primary purpose of this Request for Proposal (RFP) is to identify a third-party administrator (TPA) that will provide access to a robust provider health network and have the ability to process health insurance claims for the City of Kirkland's high deductible health plan (HDHP). This high deductible health plan is offered alongside a Kaiser Permanente HMO plan as an offering to all eligible employees at the City of Kirkland (excluding firefighters). The TPA would need to accept the City of Kirkland's near site VERA medical clinic for employee and dependents health services. Additional details about the City's current medical plan can be found as Attachment C.

Scope of Services and Desired Qualifications

The scope of services provided by the identified TPA will not only include broad access to care and proactive claims services but also the services outlined in this RFP. The TPA shall provide expertise and resources in:

1. Data analysis to assist the City in cost efficiency opportunities; and
2. Plan management flexibility, real-time data, and proactive services.

The City is seeking a single TPA, who can provide all of the services outlined in this RFP. The TPA will perform all services as requested that are usual and customary for an administrator regarding the on-going development, administration, and valuation of the City's health plan. These services include, but may not be limited to, the following:

1. Identify opportunities for the health plan that result in improved employee health and productivity, improved health care quality and optimal financial control;
2. Assist in program performance measures that demonstrate whether these outcomes have been met;
3. Project cost savings that might be achieved from these programs over time; and
4. Provide timely information on current, pending, or proposed changes in federal and state laws, which may affect the City's benefit plans or participants.

Budget and Length of Contract

The initial length of the contract is three (3) years with satisfactory performance with a start date of January 1, 2021. At the sole discretion of the City, this contract may be extended for up to one, two (2) year term.

Terms and Conditions

The City reserves the right to terminate this solicitation process at any time without prior notice and makes no representation that any contract will be awarded to any proposer as a result of this RFP. The City expressly reserves the right to postpone opening responses to this solicitation for its own convenience, and/or to waive any informality or irregularity in the responses received.

The City reserves the right to request clarification of information submitted, and to request additional information from any entity submitting a proposal. The City may also elect to meet in person with any entity that has submitted a proposal to discuss the proposal in more detail.

Any proposal may be withdrawn up until the date and time set forth for submittal of the proposals. Any proposal not timely withdrawn shall constitute an irrevocable offer to perform the services provided for in the proposal, which offer is valid for a period of 120 days, or until another proposal has been accepted by the City and that other vendor begins providing service under contract, whichever occurs first.

The City reserves the right to award any contract to the next most qualified agency, if the successful agency does not execute a contract within 30 days of being notified of selection.

The contract resulting from acceptance of a proposal by the City shall be in a form supplied or approved by the City and shall reflect the specifications in this RFP. A copy of the City's standard Professional Services Agreement is available for review (see attachment B).

The City reserves the right to reject any proposed agreement or contract that does not conform to the specifications contained in this RFP and which is not approved by the City Attorney's office.

The City shall not be responsible for any costs incurred by the agency in preparing, submitting or presenting its response to the RFP.

Any material submitted by a proposer shall become the property of the City. Materials submitted after a contract is signed will be subject to the ownership provision of the executed contract.

The selected proposer will be required to obtain a City business license.

The firm and all applicable personnel must be legally qualified in the State of Washington (i.e. be appropriately licensed or certified) to practice the work proposed to be performed.

Proposers responding to this RFP must follow the procedures and requirements stated in the RFP document. Adherence to the procedures and requirements of this RFP will ensure a fair and objective analysis of your proposal. Failure to comply with or complete any part of this RFP may result in rejection of your proposal.

Evaluation Process and Selection of Proposals

Proposer's will follow the Proposal Questionnaire included as Attachment A in preparing their proposal.

Responsive proposers for this RFP will be evaluated and scored according to the non-exclusive criteria set forth below. Other factors not listed here may be considered as the selection process develops.

This evaluation and scoring process will guide the City's decision but will not control the City's decision. The RFP process is inherently subjective and qualitative, and the City will consider scoring results and all other submission materials, presentations, and interviews when making the final decision. The City has complete discretion in selecting a proposer who, in judgement of the City, best meets the City's needs.

Each proposal has a total possible score of 100 points with the points assigned as follows:

	Proposal Evaluation Criteria	Points
Approach to Scope of Work	Ability to convey a clear understanding of the scope of services and the City’s health plan goals/objectives. Proven administration management process, including subrogation.	25
Account Team	Experience, qualifications and expertise of team assigned to the City. Local presence, experience in Puget Sound healthcare market and local references.	20
Cost	Pricing of services.	20
Functional Expertise	Expertise in comprehensive management of high deductible health plans with numerous carve out and a la carte programs. Provide an extensive network that covers the providers members of the City have accessed. Experience in working with governmental agencies in health plan administration.	25
Technology Capabilities	Ability to provide online services to members as well as utilization data information for claims analytics.	10
	Total Evaluation	100

Oral interviews will be conducted with the top-ranked Proposers. Interviews will have a value of 40 points. Final award would then be based on the sum total of the written evaluations and oral interview points.

Submission Instructions

Proposals must be received by no later than **5:00 pm PDT on Friday, June 1, 2020.** We encourage that proposals be submitted by email. Emailed proposals should include “Proposal-Job 24-20-HR in the subject line and be addressed to: purchasing@kirklandwa.gov. (Emailed proposals must be in PDF format and cannot exceed 20MB).

As an alternate to email, proposals can be mailed or delivered to:

City of Kirkland
 Attn: Greg Piland – 24-20-HR
 123 5th Avenue
 Kirkland, WA 98033

If submitting a paper proposal, the supplier’s name and address must be clearly indicated on the envelope. The original, plus four (4) copies of all proposals in printed form must be submitted in a sealed envelope or box with the following words clearly marked on the outside of the envelope:

Proposal - 24-20-HR
 Title - Medical TPA Proposal Questionnaire Response

Proposals should be prepared simply and economically, providing a straightforward, concise description of provider capabilities to satisfy the requirements of the request. Special bindings, colored displays, promotional materials, etc. are not required or desired. Emphasis should be on completeness and clarity of content. Use recycled paper for responses and any printed or photocopied material created pursuant to a contract with the City whenever practicable. Use both sides of the paper for any submittal to the City whenever practicable.

The City is not liable for any cost incurred by the Proposer prior to issuing the contract. This RFP is primarily designed to identify the most qualified TPA. A contract with fixed pricing and schedule may be negotiated with the Proposer, whose proposal would be most advantageous to the City in the opinion of the City's Human Resources and Finance Department.

News release pertaining to this RFP, the services, or the project to which it relates, shall not be made without prior approval by, and then only in coordination with, the City.

Submittal Deadlines

April 13, 2020	Release RFP
April 24, 2020	Proponent questions due
May 1, 2020	Answers to RFP questions posted on website
June 1, 2020	Proposals Due by 5:00 PM PDT
June 8, 2020	Notify proposers of interviews
Week of June 15, 2020	Interviews
July 1, 2020	Notify selected proponent
August 15, 2020	Contract negotiation/preparation/signature
January 1, 2021	Required date services commence

Proposals (including all accompanying materials) will become the property of the City and will be held in confidence to the extent permitted by law. After award of contract or rejection of all proposals, the proposals will be public records subject to disclosure under the applicable Washington statute. By electing to participate in this RFP process, the Proposer agrees not to make a public records request for any documents or information submitted by any applicant for this Proposal or related in any way to this RFP, and to the extent allowed by law, waives its right to make such a request until contract execution is complete.

Questions

Upon release of this RFP, all Vendor communications concerning the RFP should be directed to the City's RFP Coordinator listed below via email. Unauthorized contact regarding this RFP with any other City employees may result in disqualification. Any oral communications will be considered unofficial and non-binding on the City. Service Providers should rely only on written statements issued by the RFP Coordinator. The City's RFP Coordinator for this project is:

Name: Angela Southworth
Address: City of Kirkland, Human Resources
123 5th Avenue, Kirkland, Washington 98033
E-mail: asouthworth@kirklandwa.gov

Cooperative Purchasing

Chapter 39.34 RCW allows cooperative purchasing between public agencies in the State of Washington. Public agencies which have filed an Intergovernmental Cooperative Purchasing Agreement with the City may purchase from City contracts, provided that the consultant agrees to participate. The City does not accept any responsibility for contracts issued by other public agencies, however.

Public Disclosure

Once submitted to the City, proposals shall become the property of the City, and all proposals shall be deemed a public record as defined in "The Public Records Act," chapter 42 section 56 of the RCW. Any proposal containing language which copyrights the proposal, declares the entire proposal to be confidential, declares that the document is the exclusive property of the proposer, or is any way contrary to state public disclosure laws or this RFP, could be removed from consideration. The City will not accept the liability of determining what the proposer considers proprietary or not. Therefore, any information in the proposal that the proposer claims as proprietary and exempt from disclosure under the provisions of RCW 42.56.270 must be clearly designated as described in the "Proprietary Material Submitted" section above. It must also include the exemption(s) from disclosure upon which the proposer is making the claim, and the page it is found on must be identified. With the exception of lists of prospective proposers, the City will not disclose RFP proposals until a bid selection is made. At that time, all information about the competitive procurement will be available with the exception of: proprietary/confidential portion(s) of the proposal(s), until the proposer has an adequate opportunity to seek a court order preventing disclosure. The City will consider a proposer's request for exemption from disclosure; however, the City will make a decision predicated upon RCW 42.56.



SECTION 1: COMPANY PROFILE

1. Please describe your organization's history, size (by number of employees serviced) and target market.
2. What is your average size group?
3. Please provide the contact information for the individual authorized to answer questions regarding your response to the RFP.

SECTION 2: MEDICAL PLAN ADMINISTRATION/CLAIMS PROCESSING/CUSTOMER SERVICE

1. Describe your account management system, including the list of people that would be assigned to the City of Kirkland account management team (include bios and experience for each team member).
2. What service guarantees would you include in your contract with the City of Kirkland?
3. How do you audit claims for overpayments/ underpayments?
4. Describe your medical management process:
 - a. How are individuals identified as candidates for care management?
 - b. What programs do you offer?
 - c. How do you ensure that members receive the care they need at the most efficient setting?
5. Will you allow the City of Kirkland to conduct on-site claims audits either personally or through a third party consultant? Will you absorb the cost of assisting the auditors? Describe what information you will release to auditors.
6. Do you provide virtual or on-line doctor calls?
 - a. If yes, what services are offered?
 - b. Do you contract with an outside vendor?
 - c. How many of your members are using this service?
 - d. What is the cost?
 - e. Do you provide utilization reports?
7. Do you subcontract any part of your proposed services? Please provide details.
8. Which office will provide account services?

9. Do you accept 834 file feeds for eligibility?
 - a. How long is the 834 testing phase to get a file prepared?
 - b. Upon receiving the 834 file, how long does it take for ID cards to be generated?
 - c. Please provide a sample calendar identifying key dates to ensure 834 eligibility is received and loaded properly in your system.
10. Do you prepare SPD's / SBC's? Is there a fee for the preparation? Is there a fee for printing?
11. In the event of termination, will you provide all services performed prior to termination during a 12-month runout period? What are the costs to process runout claims?
12. Do you offer any vendor transition cost incentives? Please provide details

SECTION 3: SUBROGATION

1. When do you review your subrogation process with the plan sponsor?
2. Do you use a third party for subrogation? If so, who and what is their background?
3. If there is a subrogation case, when would you inform the plan sponsor?
4. What are the stages of your subrogation process?
5. How do you determine the recovery strategy?
6. If litigation is contemplated, what is your role in that process?
7. What is your fee, if financial recovery is needed on behalf of the plan sponsor?
8. For your non-ERISA clients, what have been your success rate in recovering payment?

SECTION 4: PRESCRIPTION BENEFIT MANAGER QUESTIONS

1. Who does your organization sub-contract with for PBM services? List your preferred PBM Partners.
2. What cost containment programs/ Step Therapy plans do you offer? Please describe in detail.
3. Describe your rebate program.
 - a. How are rebates calculated?
 - b. How often are rebate payments made to the client?
 - c. Will you disclose and pass through 100% of all revenues received from pharmaceutical manufactures or rebate aggregators?
4. Describe the development of your current formulary.
5. How do you influence physicians to reduce inappropriate prescribing?
6. Please describe your cost containment strategy and program for specialty meds?
 - a. What type of savings are associated with this program?
7. How will you help manage costs for high dollar drugs?
8. How do you identify and monitor high cost claimants?

9. What is the name & location of your mail order facility?
 - a. Do you have ownership in the PBM?
10. Do you retain any spread between payments made to network pharmacies and what the client is ultimately charged?
 - a. Is it possible to have this aspect of the program removed? If yes, is there a cost impact to administration fees or other aspects of the plan to recoup lost revenues?
11. Do you have any other fees or revenue sources built into the pharmacy program?
12. Is the City of Kirkland required to use your contracted PBM or do you allow Rx carve-outs? Can they integrate pharmacy services with another vendor? If another PBM is allowed, is there a coordination fee or an impact to administration costs for using a different PBM?

SECTION 5: PROVIDER NETWORK

1. Which provider network(s) do you use?
2. Does your TPA support medical travel programs managed by independent third party vendors specializing in medical travel? Do you have your own medical travel program? Can you support medical travel incentives (reduced out of pocket costs etc.)?
3. Included in the RFP packet is a list of the providers City of Kirkland members accessed over the last year. How many of these providers are in your provider network?
4. Describe how you contract with providers? What criteria needs to be met for a provider to be part of your network?
5. How would you communicate to the City of Kirkland when providers are terminated? How much lead time would the City of Kirkland receive?
6. How much notice do providers need to give before they terminate their contract?
7. In the upcoming year, do you anticipate any significant changes to your provider network?
8. Do you offer Medicare like Rates (MLR) for ESRD claims? Please explain your program.
 - a. Do you assume any liability in the event a provider challenges these discounts?
9. Do you utilize a transplant network?
10. Do you utilize a Centers of Excellence network?
11. Would you be willing to pay for a network discount analysis if awarded the business? Potentially up to \$10,000.

SECTION 6: ONLINE SERVICES

1. Will employees have access to a price modeler to determine the cost of care? Will the modeler take into consideration ACTUAL claims costs or does your tool estimate the cost of care? Will the modeler take into consideration the employee's deductibles/ co-insurance/ copays, etc. when modeling out the cost of care? Please provide details.
2. Alliant utilizes the Deerwalk platform for in depth claims data analytics. Does your TPA support Deerwalk? Can you provide funding for the use of this program?

SECTION 7: DIRECT CONTRACTING / BUNDLED PRICING

1. Describe your TPA's ability to support an independent third-party vendor that specializes in direct contract bundled pricing in which treatments and procedures are paid for in advance, and member costs are waived?
2. Does your TPA have the ability to provide Reference Based Pricing for out of network claims? If yes, is your Reference Based Pricing done internally, or do you partner with an independent third-party vendor for that service?
3. Describe your experience and philosophy regarding non-network discount pricing strategies outside of the traditional network discount system.

SECTION 8: FEE

1. Please provide the below information outlining the cost of the services your firm is offering.
 - a. Administration Fee
 - b. Network Access Fee
 - c. Stop Loss Coordination Fee
 - d. Out of Network Claims Management Fee (if applicable)
 - e. Reporting (if applicable)
 - f. Prescription Drug (if applicable)
 - g. Case Management/ Medical Management
 - h. Subrogation
 - i. Other (list out service and fee)

SECTION 9: REFERENCES

1. Please provide 3 references of current clients with contact information. The references should be for public agencies with a minimum of 500 employees.
2. Please provide 2 references of former clients with contact information. The references should be for public agencies with over 500 employees.
3. Please provide a list of all Washington state municipalities or public employers you service.



Professional Services Agreement
Medical TPA Proposal

Attachment B

The City of Kirkland, Washington, a municipal corporation ("City") and _____,
whose address is _____ ("Consultant"), agree and contract as follows:

I. SERVICES BY CONSULTANT

- A. The Consultant agrees to perform the services described in Attachment _____ to this Agreement, which attachment is incorporated herein by reference.
- B. All services and duties shall be conducted and performed diligently, completely and in accordance with professional standards of conduct and performance.

II. COMPENSATION

- A. The total compensation to be paid to Consultant for these services shall not exceed \$_____, as detailed in Attachment _____.
- B. Payment to Consultant by the City in accordance with the payment ceiling specified above shall be the total compensation for all services performed under this Agreement and supporting documents hereto as well as all subcontractors' fees and expenses, supervision, labor, supplies, materials, equipment or the use thereof, reimbursable expenses, and other necessary incidentals.
- C. The Consultant shall be paid monthly on the basis of invoices submitted. Invoicing will be on the basis of percentage complete or on the basis of time, whichever is applicable in accordance with the terms of this Agreement.
- D. The City shall have the right to withhold payment to Consultant for any services not completed in a satisfactory manner until such time as Consultant modifies such services to the satisfaction of the City.
- E. Unless otherwise specified in this Agreement, any payment shall be considered timely if a warrant is mailed or is available within 45 days of the date of actual receipt by the City of an invoice conforming in all respects to the terms of this Agreement.

III. TERMINATION OF AGREEMENT

The City or the Consultant may terminate this Agreement at any time, with or without cause, by giving ten (10) days' notice to the other in writing. In the event of termination, all finished or unfinished reports, or other material prepared by the Consultant pursuant to this Agreement, shall be provided to the City. In the event the City terminates prior to completion without cause, consultant may complete such analyses and records as may be necessary to place its files in order. Consultant shall be entitled to receive just and equitable compensation for any satisfactory services completed on the project prior to the date of termination, not to exceed the payment ceiling set forth above.

IV. OWNERSHIP OF WORK PRODUCT

- A. Ownership of the originals of any reports, data, studies, surveys, charts, maps, drawings, specifications, figures, photographs, memoranda, and any other documents which are developed, compiled or produced as a result of this Agreement, whether or not completed, shall be vested in the City. Any reuse of these materials by the City for projects or purposes other than those which fall within the scope of this Agreement or the project to which it relates, without written concurrence by the Consultant will be at the sole risk of the City.

- B. The City acknowledges the Consultant's plans and specifications as instruments of professional service. Nevertheless, the plans and specifications prepared under this Agreement shall become the property of the City upon completion of the services. The City agrees to hold harmless and indemnify consultant against all claims made against Consultant for damage or injury, including defense costs, arising out of any reuse of such plans and specifications by any third party without the written authorization of the Consultant.

- C. Methodology, materials, software, logic, and systems developed under this Agreement are the property of the Consultant and the City, and may be used as either the consultant or the City sees fit, including the right to revise or publish the same without limitation.

V. GENERAL ADMINISTRATION AND MANAGEMENT

The _____ for the City of Kirkland shall review and approve the Consultant's invoices to the City under this Agreement, shall have primary responsibility for overseeing and approving services to be performed by the

Consultant, and shall coordinate all communications with the Consultant from the City.

VI. COMPLETION DATE

The estimated completion date for the Consultant's performance of the services specified in Section I is _____.

Consultant will diligently proceed with the services contracted for, but consultant shall not be held responsible for delays occasioned by factors beyond its control which could not reasonably have been foreseen at the time of the execution of this Agreement. If such a delay arises, Consultant shall forthwith notify the City.

VII. SUCCESSORS AND ASSIGNS

The Consultant shall not assign, transfer, convey, pledge, or otherwise dispose of this Agreement or any part of this Agreement without prior written consent of the City.

VIII. NONDISCRIMINATION

Consultant shall, in employment made possible or resulting from this Agreement, ensure that there shall be no unlawful discrimination against any employee or applicant for employment in violation of RCW 49.60.180, as currently written or hereafter amended, or other applicable law prohibiting discrimination, unless based upon a bona fide occupational qualification as provided in RCW 49.60.180 or as otherwise permitted by other applicable law. Further, no person shall be denied or subjected to discrimination in receipt of the benefit of any services or activities made possible by or resulting from this Agreement in violation of RCW 49.60.215 or other applicable law prohibiting discrimination.

IX. HOLD HARMLESS/INDEMNIFICATION

To the greatest extent allowed by law the Consultant shall defend, indemnify and hold the City, its officers, officials, employees and volunteers harmless from any and all claims, injuries, damages, losses or suits including attorney fees, arising out of or resulting from its negligence or breach of any of its obligations in performance of this Agreement.

In the event of liability for damages arising out of bodily injury to persons or damages to property caused by or resulting from the concurrent negligence of the Consultant and the City, its officers, officials, employees, and volunteers, the Consultant's liability

hereunder shall be only to the extent of the Consultant's negligence. It is further specifically and expressly understood that the indemnification provided herein constitutes the Consultant's waiver of immunity under Industrial Insurance, Title 51 RCW, solely for the purposes of this indemnification. This waiver has been mutually negotiated by the parties. The provisions of this section shall survive the expiration or termination of this Agreement.

X. LIABILITY INSURANCE COVERAGE

The Consultant shall procure and maintain for the duration of the Agreement, insurance against claims for injuries to persons or damage to property which may arise from or in connection with the performance of the work hereunder by the Consultant, its agents, representatives, or employees. A failure to obtain and maintain such insurance or to file required certificates and endorsements shall be a material breach of this Agreement.

Consultant's maintenance of insurance as required by the agreement shall not be construed to limit the liability of the Consultant to the coverage provided by such insurance, or otherwise limit the City's recourse to any remedy available at law or in equity.

A. Minimum Scope of Insurance

Consultant shall obtain insurance of the types described below:

1. Automobile Liability insurance covering all owned, non-owned, hired and leased vehicles. Coverage shall be as least as broad as Insurance Services Office (ISO) form CA 00 01 or a substitute form providing equivalent liability coverage. If necessary, the policy shall be endorsed to provide contractual liability coverage.
2. Commercial General Liability insurance shall be as least as broad as ISO occurrence form CG 00 01 and shall cover liability arising from premises, operations, stop-gap independent contractors and personal injury and advertising injury. The City shall be named as an additional insured under the Consultant's Commercial General Liability insurance policy with respect to the work performed for the City using an additional insured endorsement at least as broad as ISO CG 20 26.
3. Workers' Compensation coverage as required by the Industrial Insurance laws of the State of Washington.
4. Professional Liability insurance appropriate to the Consultant's profession.

B. Minimum Amounts of Insurance

Consultant shall maintain the following insurance limits:

1. Automobile Liability insurance with a minimum combined single limit for bodily injury and property damage of \$1,000,000 per accident.
2. Commercial General Liability insurance shall be written with limits no less than \$1,000,000 each occurrence, \$2,000,000 general aggregate.
3. Professional Liability insurance shall be written with limits no less than \$1,000,000 per claim and \$1,000,000 policy aggregate limit.

C. Other Insurance Provisions

The insurance policies are to contain, or be endorsed to contain, the following provisions for Automobile Liability and Commercial General Liability insurance:

1. The Consultant's insurance coverage shall be primary insurance as respects the City. Any insurance, self-insurance, or self-insured pool coverage maintained by the City shall be excess of the Consultant's insurance and shall not contribute with it.
2. The Consultant shall provide the City and all Additional Insureds for this services with written notice of any policy cancellation, within two business days of their receipt of such notice.

D. Acceptability of Insurers

Insurance is to be placed with insurers with a current A.M. Best rating of not less than A:VII.

E. Verification of Coverage

Consultant shall furnish the City with original certificates and a copy of the amendatory endorsements, including but not necessarily limited to the additional insured endorsement, evidencing the insurance requirements of the Consultant before commencement of the services.

F. Failure to Maintain Insurance

Failure on the part of the Consultant to maintain the insurance as required shall constitute a material breach of contract, upon which the City may, after giving five business days' notice to the Consultant to correct the breach, immediately terminate the contract or, at its discretion, procure or renew such insurance and pay any and all premiums in connection therewith, with any sums so expended to be repaid to the City on demand, or at the sole discretion of the City, offset against funds due the Consultant from the City.

G. City Full Availability of Consultant Limits

If the Consultant maintains higher insurance limits than the minimums shown above, the City shall be insured for the full available limits of Commercial General and Excess or Umbrella liability maintained by the Consultant,

irrespective of whether such limits maintained by the Consultant are greater than those required by this contract or whether any certificate of insurance furnished to the City evidences limits of liability lower than those maintained by the Consultant.

XI. COMPLIANCE WITH LAWS/BUSINESS LICENSE

The Consultant shall comply with all applicable State, Federal, and City laws, ordinances, regulations, and codes. Consultant must obtain a City of Kirkland business license or otherwise comply with Kirkland Municipal Code Chapter 7.02.

XII. FUTURE SUPPORT

The City makes no commitment and assumes no obligations for the support of Consultant activities except as set forth in this Agreement.

XIII. INDEPENDENT CONTRACTOR

Consultant is and shall be at all times during the term of this Agreement an independent contractor and not an employee of the City. Consultant agrees that he or she is solely responsible for the payment of taxes applicable to the services performed under this Agreement and agrees to comply with all federal, state, and local laws regarding the reporting of taxes, maintenance of insurance and records, and all other requirements and obligations imposed on him or her as a result of his or her status as an independent contractor. Consultant is responsible for providing the office space and clerical support necessary for the performance of services under this Agreement. The City shall not be responsible for withholding or otherwise deducting federal income tax or social security or for contributing to the state industrial insurance or unemployment compensation programs or otherwise assuming the duties of an employer with respect to the Consultant or any employee of Consultant.

XIV. EXTENT OF AGREEMENT/MODIFICATION

This Agreement, together with all attachments and addenda, represents the final and completely integrated Agreement between the parties regarding its subject matter and supersedes all prior negotiations, representations, or agreements, either written or oral. This Agreement may be amended only by written instrument properly signed by both parties.

XV. ADDITIONAL WORK

The City may desire to have the Consultant perform work or render services in connection with the project other than provided for by the express intent of this Agreement. Any such work or services shall be considered as additional work, supplemental to this

Agreement. This Agreement may be amended only by written instrument properly signed by both parties.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement on the dates written below:

CONSULTANT:

CITY OF KIRKLAND:

By: _____

By: _____

Tracey Dunlap, Deputy City Manager

Date: _____

Date: _____



Medical

	HDHP Plan	
	In-network	Out-of-network
Annual deductible	\$1,500/individual (offset by HRA contribution) \$3,000/family (offset by HRA contribution)	
Annual out-of-pocket maximum	\$2,500/individual \$5,000/family	
Preventive care	Plan pays 100% (see contract for limitations)	Plan pays 60% after deductible (see contract for limitations)
Primary office visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Specialist office visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Virtual office visit	Plan pays 80% after deductible	Plan pays 60% after deductible
Chiropractic care	Plan pays 80% after deductible	Plan pays 60% after deductible
	(up to 20 visits per year)	
Diagnostic lab and X-ray	Plan pays 80% after deductible	Plan pays 60% after deductible
Urgent care	Plan pays 80% after deductible	Plan pays 60% after deductible
Emergency room	Plan pays 80% after deductible	
Hospitalization	Plan pays 80% after deductible	Plan pays 60% after deductible
Outpatient surgery	Plan pays 80% after deductible	Plan pays 60% after deductible

Prescription Drugs

	HDHP Plan	
	In-network	Out-of-network
Generic	\$4 copay then plan pays 100%	Not covered
Preferred Brand	\$15 copay then plan pays 100%	Not covered
Non-preferred Brand	\$35 copay then plan pays 100%	Not covered
Supply limit	34 days	Not applicable
MAIL ORDER		
Generic	\$8 copay then plan pays 100%	Not covered
Preferred Brand	\$30 copay then plan pays 100%	Not covered
Non-preferred Brand	\$70 copay then plan pays 100%	Not covered
Number of days' supply	90 days	Not applicable

VERA Whole Health

The City of Kirkland has partnered with Vera Whole Health to establish an Employee Health Center. The Employee Health Center is available to employees and their eligible dependents who are enrolled in one of the City of Kirkland health plans.

The health professionals at the clinic provide top of the line care that includes both coaching and education. Schedule appointments for a variety of preventive and basic services as well as wellness and nutritional counseling.

Preventive care	Primary care	Acute care
<ul style="list-style-type: none"> • Annual Whole Health Evaluation • Includes biometric screening, provider visit, health survey and health coaching • Physical Exams • Blood pressure screening • Immunizations and routine injections 	<ul style="list-style-type: none"> • Episodic sick care • Chronic disease and prescription management • Coordination of specialty and acute care • On-site labs 	<ul style="list-style-type: none"> • Suturing/basic wound care • Rashes • Colds/upper respiratory infections • Acute pediatrics (ages 3 and up)

Asserta

If you are enrolled on the HDHP plan, planning an upcoming surgery or procedure and looking to save money, Asserta Health can help. Asserta Health is a concierge surgery service that helps you understand your benefits and facilitates the surgeon selection process to connect you with high-value, high-quality providers.

Why Asserta?

Asserta will help you navigate complex procedures and save money at the same time while connecting you with a high value provider who consistently delivers quality outcomes at an affordable price. Asserta can assist with procedures such as joint replacements, orthopedic procedures (excluding spinal procedures) and other high cost general surgeries. Best of all, members who participate in the Asserta Health program will be provided with up to a **\$1,500 incentive** in their HRA VEBA!

How it works

1. Asserta will gather information regarding your procedure
2. Asserta will work with the provider and insurance company to negotiate a cash price that is less than your medical plan's cost
3. Once all parties have agreed upon a negotiated rate, Asserta will help schedule the procedure, ensure any required pre-certification is completed and prepare to pay the full cash price when you receive care



High Deductible Plan

Medical and Pharmacy Benefits Plan Document

Effective January 1, 2020

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.....	1
Contacting First Choice Health Administrators	2
How to Obtain Health Services	3
• Your ID Card	3
• Choosing a Provider.....	3
• Services Received Outside of the U.S.....	3
Medical Management.....	4
• Pre-authorization Requirements	4
• Notification for Emergency Admissions	7
• Concurrent Review and Discharge Coordination.....	7
• Case Management.....	7
• Maternity Management Program	9
Payment Provisions High Deductible Plan	10
• Highlights of Plan Provisions	10
• Annual Deductible	10
• Annual Out-of-Pocket Maximum	11
• Benefit Maximums.....	11
• Summary of Benefit Maximums	12
Summary of Medical Benefits High Deductible Plan.....	13
Medical Benefits.....	25
• Acupuncture	25
• Allergy Care	25
• Alternative Care	25
• Ambulance Services	25
• Anesthesia	26
• Applied Behavior Analysis (ABA).....	26
• Blood Transfusions/Donation.....	27
• Biofeedback	27
• Chemical Dependency.....	27
• Chiropractic Spinal Manipulation	28
• Clinical Trials.....	28
• Dental Trauma	29

• Diabetic Nutrition Education.....	30
• Diagnostic Testing.....	30
• Durable Medical Equipment (DME) and Supplies	30
• Emergency and Urgent Care	31
• Family Planning.....	31
• First Responder User Fee.....	31
• Foot Orthotics.....	31
• Genetic Services	31
• Habilitative Services	32
• Hearing Exams.....	32
• Home Health Care	32
• Hospice Care	33
• Hospital Inpatient Medical and Surgical Care	33
• Hospital Outpatient Surgery and Services	33
• Infertility Diagnostic Services	34
• Infusion Therapy	34
• Massage Therapy	34
• Maternity and Newborn Care	34
• Mental Health Care	35
• Nutritional Counseling	35
• Nutritional and Dietary Formulas	36
• Oral Surgery	36
• Pharmacy	36
• Filling a Prescription	37
• Plastic and Reconstructive Services	38
• Podiatric Care	39
• Preventive Care	39
• Professional/Physician Services	39
• Rehabilitation Therapy	39
• Skilled Nursing Facility	40
• Transgender Program	40
• Transplants, Organ and Bone Marrow.....	41
Plan Exclusions and Limitations.....	43
Eligibility and Enrollment.....	50
• Eligible Classes of Employees.....	50

• Waiting Period.....	50
• Enrollment Periods.....	50
• How to Enroll.....	50
• Open Enrollment.....	51
• Special Enrollment Periods.....	51
• Late Enrollment.....	52
• Effective Date.....	52
• Waiver of Group Health Plan Benefits.....	53
Dependents.....	54
• Dependent Eligibility.....	54
• Special Rules for Domestic Partners.....	54
• Dependents Acquired Through Marriage/Domestic Partnership.....	55
• Dependent Children.....	55
• Dependent Children Out of Area.....	56
• Continued Eligibility for a Disabled Child.....	56
• Qualified Medical Child Support Orders.....	57
Termination of Coverage.....	59
Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA).....	60
• Who Is a COBRA Qualified Beneficiary?.....	60
• Qualifying Events and Continuation Periods.....	61
• When COBRA Coverage Ends.....	61
• Contribution Payment Requirements.....	62
• Election Requirements.....	62
• What Coverage Must Be Offered When Electing COBRA?.....	62
Other Continuation of Coverage.....	64
• Leaves of Absence.....	64
• Continuation Coverage for Dependents of City of Kirkland Employees who Die in the Line of Duty.....	65
Claim and Appeal Procedures.....	67
• Claim.....	67
• How to File a Claim for Plan Benefits.....	67
• Claim Types.....	67
• Claim Procedure.....	68
• Adverse Benefit Determination.....	68
• Appeal Procedure.....	70
Coordination of Benefits.....	73

• Calculation of Benefit Payments	73
• How Do I Know Which Plan is my Primary Plan?	73
• What if I'm Covered by Medicare?	75
• Pre-authorization when this Plan is Secondary	76
• Meaning of Plan for Coordination of Benefits (COB)	76
• Claim Determination Period	77
• Right of Recovery.....	77
• Facility of Payment.....	77
• Right to Receive and Release Information	78
Subrogation	79
• Liable Third Parties and Insurers	79
• Uninsured/Underinsured Motorist Coverage.....	80
• Venue	80
• Subrogation Forms.....	80
Health Insurance Portability and Accountability Act of 1996	81
• Privacy Rights	81
• Disclosures to the Plan Sponsor	81
Plan Benefit Information.....	82
• Benefits, Contributions and Funding	82
• Plan Administrator's Power of Authority.....	82
• Discretionary Authority	83
• Collective Bargaining Agreements.....	83
• Clerical Error	83
Statement of Your Rights	84
• Prudent Actions by Plan Fiduciaries	84
• Enforce Your Rights	84
• Continue Group Health Coverage/Certificate of Creditable Coverage	85
• Assistance with Your Questions	85
Summary Plan Description and General Information.....	86
Plan Definitions	88

Important Information about this Plan

This booklet serves as your Plan Document and Summary Plan Description. The first section of the booklet describes your coverage and payment levels under the City of Kirkland Employee Health Benefit Plan as of January 1, 2020 and how to use your benefits. The second section contains information on eligibility and enrollment, terminating and continuing coverage, administration, claim and appeal procedures and other legally required material.

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

The City of Kirkland Plan will be referred to within this document as the "Plan." Under the Plan, you receive the higher network level of benefits when you see a network provider. If you receive care from a non-network provider, you will receive the lower network level of benefits.

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

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

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

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

Contacting First Choice Health Administrators

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

First Choice Health Administrators
Customer Service Department
PO Box 12659
Seattle, WA 98111-4659
(877) 749-2030
Local: (206) 268-2360
Fax: (888) 206-3092
Medical pre-authorization: (800) 808-0450
Mental health/chemical dependency pre-authorization: (800) 640-7682
TTY: (866) 876-5924
www.fchn.com

Spanish (Español): Para obtener asistencia en Español, llame al (877) 749-2030.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (877) 749-2030.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (877) 749-2030.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (877) 749-2030.

FCHA's Customer Service Department business hours are Monday through Friday, 8:00 AM to 5:00 PM Pacific Standard Time (PST). The office is closed on New Year's Day, Memorial Day, Independence Day (4th of July), Labor Day, Thanksgiving, and the day after Thanksgiving, Christmas Eve and Christmas Day. FCHA offices close at 3:00 PM on the day before Thanksgiving and on December 23rd (or on the Friday before if the 23rd falls on a weekend). If the holiday falls on a Saturday, the office is closed on Friday; if the holiday falls on Sunday, the office is closed Monday (the holiday is recognized during the same calendar week in which the holiday falls).

You can access benefit information or your specific claim and enrollment status anytime at www.fchn.com or by calling FCHA Customer Service's automated voice response system at (877) 749-2030.

How to Obtain Health Services

Your ID Card

Your ID card identifies you as a Plan participant and contains important information about your coverage and benefits. Please present your ID card each time you receive care. If you lose your ID card, you may order a new one either through contacting FCHA Customer Service at (877) 749-2030, 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 PPO Network	Washington, Alaska, Oregon, Idaho, Montana, Wyoming, North Dakota, South Dakota	(800) 231-6935	www.fchn.com
First Health	All states/areas not served by FCHN	(800) 226-5116	www.firsthealthcoventyhealthcare.com

Contact the networks directly, either by phone or through the websites 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 Section II - Summary Plan Description.
- Claims must be submitted in English.

Medical Management

Pre-authorization Requirements

All inpatient admissions and certain outpatient services and procedures **require FCHA pre-authorization**, as also noted in the *Summary of Medical Benefits*. If pre-authorization is not obtained on the services noted below, 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**
- **Biofeedback**
- **Chimeric Antigen Receptor (CAR) T-cell Therapy**
- **Clinical trials** (any interventions provided under a clinical trial)
- **Dental Trauma Services** (follow-up services)
- **Dialysis (all types)—for chronic kidney disease**
- **Durable Medical Equipment, Medical Supplies and Prosthetics**
 - Bone growth stimulators
 - Cranial orthotic devices
 - Custom and power operated wheelchairs and supplies
 - o Standard, manual wheelchair rental for transition of care for up to 3 months does not require pre-authorization
 - Custom fabricated knee braces
 - Electrical stimulators- spinal- external
 - Neuromuscular stimulators
 - Oscillatory devices and cough stimulating devices
 - Prosthetics
 - o Myoelectric prosthetic components for the upper limb
 - o Powered ankle-foot prosthesis, microprocessor-controlled ankle-foot prosthesis, and microprocessor-controlled knee prosthesis
 - Scooters
 - Speech generating devices
 - Tumor Treating Fields for Glioblastoma
- **Enteral Formula, Medical Food and Associated Services**
- **Facet Joint Injections, Medial Branch Blocks and Neurotomies** (any location)
- **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
 - Inpatient hospice
 - Inpatient rehabilitation admissions
 - Long-term acute care facility
 - Medical/surgical admissions (excluding routine maternity deliveries)
 - Partial hospitalization program admissions for chemical dependency or mental health
 - Skilled nursing facility 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 preauthorization. If you have questions, please call FCHA 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®)
 - Bevacizumab (Avastin®)
 - Blood clotting factors (all)
 - Bortezomib (Velcade®)
 - Botulinum toxin (all types and brands)
 - Brentuximab (Adcetris®)
 - Cetuximab (Erbix®)
 - Cerliponase alfa (Brineura™)
 - C1 Esterase inhibitors
 - Daratumumab (Darzalex®)
 - Ecallantide (Kalbitor®)
 - Edaravone (MCI-186, Radicava, Radicut®)
 - Elotuzumab (Empliciti™)
 - Epoprostenol (Flolan®)
 - Eteplirsen (Exondys 51™)
 - Infliximab (Remicade®) and Biosimilar
 - Inotuzumab Ozagamicin (Besponsa™)
 - Intravenous immunoglobulin (IVIG) therapy (all types and brands)
 - Ipilimumab (Yervoy®)
 - Mepolizumab (Nucala®)
 - Natalizumab (Tysabri®)
 - Nivolumab (Opdivo®)
 - Nusinersen (Spinraza™)
 - Omalizumab (Xolair®)

- Onasemnogene abeparvovec-xioi (Zolgensma®)
 - Ocrelizumab (Ocrevus™)
 - Palivizumab (Synagis)
 - Pegaptanib (Macugen®)
 - Pembrolizumab (Keytruda®)
 - Pemetrexed (Alimta®)
 - Ranibizumab (Lucentis®)
 - Rituximab (Rituxan®)
 - Romiplostim (Nplate®)
 - Sipuleucel-T (Provenge)
 - Taglicerase alfa (Eleyso™)
 - Tocilizumab (Actemra®)
 - Trastuzumab (Herceptin®)
 - Ustekinumab (Stelara®)
 - Vedolizumab (Entyvio™)
 - Velaglucerase alfa (VPRIV®)
 - Voretigene Neparvovec-Rzyl (Luxturna™)
 - Ziv-aflibercept (Zaltrap®)
- **Organ and Bone Marrow Transplants** 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**
 - Breast surgeries- selected (Pre-authorization is not required for breast reconstruction and nipple/areola reconstruction following mastectomy for breast cancer)
 - o Implant removal
 - o Mastectomy for gynecomastia
 - o Reduction mammoplasty
 - Cochlear Implants (surgical benefit applies)
 - Cosmetic or reconstructive surgery
 - Deep Brain Stimulation
 - Eyelid surgery (i.e. blepharoplasty)
 - Fetal/Intrauterine surgery
 - Gender reassignment 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)
 - o Artificial intervertebral disc
 - o Cervical fusions

- Lumbar fusions
- Minimally invasive, percutaneous & endoscopic spine surgery
- Percutaneous vertebroplasty, kyphoplasty, sacroplasty and coccygeoplasty
- Surgical interventions for sleep apnea
- Varicose vein procedures
- Ventricular assist devices and total heart replacement

- **Transcranial Magnetic Stimulation**

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

Your provider may submit an advance request to FCHA 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 FCHA). You, or your provider, may call FCHA at the number on your ID card.

Concurrent Review and Discharge Coordination

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

Case Management

A catastrophic medical condition may require long-term, perhaps lifetime care involving extensive services in a facility or at home. With case management, a nurse monitors these patients and explores coordinated and/or alternative types of appropriate care. The case manager consults with the patient, family and attending physician to develop a plan of care that may include:

- Offering personal support to the patient.
- Contacting the family for assistance and support.
- Monitoring hospital or skilled nursing facility stays.
- Addressing alternative care options.
- Assisting in obtaining any necessary equipment and services.
- Providing guidance and information on available resources.

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

Management, is voluntary. You, or your legal representative, the attending physician and the Plan Administrator must all agree to any such treatment plan.

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

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

First Choice Health COPE Program: Chronic Opioid Pain and Education

This program provides case management services specifically for members who wish to explore or pursue alternative measures for pain management, or who want assistance decreasing, eliminating, or avoiding the use of opioids.

First Choice Health Medical and Behavioral Health Case Managers will reach out to identified members and offer an assessment of their opioid prescription usage and overall health, and provide education and assistance in locating alternative pain management and local treatment providers.

Members may be directly (self) referred to this program, or may be identified by other means. The program includes both Registered Nurse and Behavioral Health clinicians who will provide outreach to members either by phone or mailings to:

- Complete an assessment with the member to determine if issues are related to chronic pain, an opioid use disorder, or both;
- Work with the member to assess the safety and effectiveness of all pain treatment;
- Work with the member on alternatives to narcotics for pain management when appropriate and assist the member in locating in-network providers for alternative treatments;
- Support the member in the goal of full participation in activities of daily living, such as work, family, and social involvement; and
- Assist the member in locating in-network chemical dependency providers if requested.

To refer members to this program, or to enroll, you must call First Choice Health Case Management at 1-800-808-0450. The Case Manager will provide support and clinical guidance through this complex process. **Case Management is a mandatory requirement for participation in this program and is provided at no cost to you (the member).**

Pain Management Program:

Any member with chronic pain may benefit from assistance with pain management. Chronic opioid use is not required to participate in the Pain Management Program.

Pain management is included in the COPE program described above. To realize any potential extended benefits under your Medical Plan, you must be enrolled in the FCH COPE program with mandatory case management.

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.

Payment Provisions

High Deductible Plan

Highlights of Plan Provisions

- Your benefit coverage is greater, and your out-of-pocket costs less, when you choose a Network provider.
- Benefit payment is based on the Allowed Amounts agreed upon by Network providers.
- 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.

Annual Deductible

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

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.

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

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

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

- Preventive care
- Pharmacy

Annual Out-of-Pocket Maximum

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

- Charges of non-covered services and treatment
- Charges for services that are denied as not medically necessary
- Charges over Usual, Customary and Reasonable (UCR) for non-network services as determined by FCHA
- Charges that exceed any applicable benefit maximum
- Claims denied for lack of pre-authorization
- Charges for services paid by the Plan at 100%
- Pharmacy

Benefit Maximums

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

Annual Deductible and Out-of-Pocket Maximums

Annual Deductible (per Plan Year)	Network	Non-Network
Employee only	\$1,500	
Family	\$3,000	
Annual Out-of-Pocket Maximum (per Plan Year)	Network	Non-Network
Employee only	\$2,500	
Family	\$5,000	
Annual Pharmacy Out-of-Pocket Maximum (per Plan Year)	Network	Non-Network
Employee only	\$4,100	Not Covered
Family	\$8,200	Not Covered

Summary of Benefit Maximums

Lifetime Maximum Benefits	
Hospice Care	12 months
Skilled Nursing Facility	365 days
Plan Year Maximums	
Acupuncture	12 visits
Chiropractic Spinal Manipulation	20 visits
Home Health Care	130 visits
Obesity screening and counseling	12 visits
Organ Transplants <ul style="list-style-type: none"> • Transportation and Lodging 	\$2,500 per transplant
Rehabilitation Therapy Inpatient	30 days
Wigs	\$500

Summary of Medical Benefits

High Deductible Plan

City of Kirkland High Deductible Plan				
*OON = Out-of-Network				
	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
Allergy Care (testing and injections)	✓	✓	80%	60%
Alternative Care				
<ul style="list-style-type: none"> • Acupuncture 12 visits per Plan Year maximum. 	✓	✓	80%	60%
<ul style="list-style-type: none"> • Chiropractic Spinal Manipulation 20 visits per Plan Year. 	✓	✓	80%	60%
<ul style="list-style-type: none"> • Massage Therapy RX Required. 	✓	✓	80%	60%
Ambulance Services FCHA pre-authorization required for non-emergent air ambulance.	✓	✓	80%	80%
Anesthesia	✓	✓	80%	80% if provided at a network facility
				60% if provided at a non-network facility
Applied Behavior Analysis (ABA) Therapy FCHA pre-authorization is required for inpatient services.	✓	✓	80%	60%

City of Kirkland High Deductible Plan				
*OON = Out-of-Network				
	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
Autologous Blood Donation/Blood Transfusion	✓	✓	80%	80%
Biofeedback Limited benefit, see <i>Biofeedback</i> for details.	✓	✓	80%	60%
Chemical Dependency FCHA pre-authorization required for inpatient, residential and partial hospitalization.				
• Inpatient (facility and professional)	✓	✓	80%	60%
• Outpatient (facility and professional)	✓	✓	80%	60%
Clinical Trials	Covered as specifically outlined under the Clinical Trials benefit			
Dental Trauma FCHA pre-authorization required for follow-up services and anesthesia.	✓	✓	80%	80%
Diagnostic Testing (Lab and Radiology Services, non-routine, facility and professional services) FCHA pre-authorization required for Positron Emission Tomography (PET) scans.				
• Hospital inpatient (professional fees)	✓	✓	80%	60%
• Hospital outpatient (facility and professional fees)	✓	✓	80%	60%
• Lab or x-ray facility	✓	✓	80%	60%

City of Kirkland High Deductible Plan				
*OON = Out-of-Network				
	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
<ul style="list-style-type: none"> • Doctor's office 	✓	✓	80%	60%
Diabetic Education and Diabetic Nutrition Education First 3 nutritional counseling visits per calendar year are covered under Preventive Care.	✓	✓	80%	60%
Durable Medical Equipment and Supplies FCHA pre-authorization is required for certain services (see <i>Medical Management</i> for a complete list)				
<ul style="list-style-type: none"> • Breast Pumps 	✓ (OON only)	✓ (OON only)	100%	60%
<ul style="list-style-type: none"> • Durable Medical Equipment 	✓	✓	80%	60%
<ul style="list-style-type: none"> • Medical Supplies 	✓	✓	80%	60%
<ul style="list-style-type: none"> • Oral Appliances Covered only when needed to treat Sleep Apnea. 	✓	✓	80%	80%
<ul style="list-style-type: none"> • Orthopedic Appliances/Braces 	✓	✓	80%	60%
<ul style="list-style-type: none"> • Prosthetic Devices 	✓	✓	80%	60%
<ul style="list-style-type: none"> • Wigs \$500 Plan Year maximum. 	✓	✓	80%	80%
Emergency Care				
<ul style="list-style-type: none"> • Emergency Department (facility and professional) 	✓	✓	80%	80%
<ul style="list-style-type: none"> • Urgent Care 	✓	✓	80%	60%

City of Kirkland High Deductible Plan				
*OON = Out-of-Network				
	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
Family Planning				
<ul style="list-style-type: none"> • Office visits and Diagnostic Services 	✓ (OON only)	✓ (OON only)	100%	60%
<ul style="list-style-type: none"> • Devices, implants and injections 	✓ (OON only)	✓ (OON only)	100%	60%
<ul style="list-style-type: none"> • Sterilization 	✓ (OON only)	✓ (OON only)	100%	60%
<ul style="list-style-type: none"> • Termination of pregnancy (covered for all enrolled female Plan members) 	Covered the same as any other medical service. Refer to place of service			
First Responder User Fees	✓	✓	80%	80%
Foot Orthotics	✓	✓	80%	60%
Genetic Services FCHA pre-authorization required for genetic testing over \$500.				
<ul style="list-style-type: none"> • BRCA Testing 	✓ (OON only)	✓ (OON only)	100%	60%
<ul style="list-style-type: none"> • FIT-Fecal DNA FCH pre-authorization required. 1 per calendar year 	✓	✓	80%	60%
<ul style="list-style-type: none"> • Genetic Testing and Counseling 	✓	✓	80%	60%
Habilitative Services	✓	✓	80%	60%
Hearing				
<ul style="list-style-type: none"> • Routine hearing exams 	✓ (OON only)	✓ (OON only)	100%	60%

City of Kirkland High Deductible Plan				
*OON = Out-of-Network				
	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
<ul style="list-style-type: none"> • Medically necessary hearing exams 	Covered same as any other diagnostic test. Refer to <i>Lab and Radiology Services</i>			
<ul style="list-style-type: none"> • Hearing aids/appliances 	Not Covered			
Home Health Care FCHA pre-authorization required for wound care, enteral formula, medical food and associated services and home hospice.				
<ul style="list-style-type: none"> • Home Health Care 130 visits per Plan Year. 	✓	✓	80%	60%
<ul style="list-style-type: none"> • Phototherapy (home) 	✓	✓	80%	60%
Hospice FCHA pre-authorization required for inpatient or home care. 12 months lifetime maximum.				
<ul style="list-style-type: none"> • Hospice Care 	✓	✓	80%	60%
<ul style="list-style-type: none"> • Respite Care 	✓	✓	80%	60%
Hospital Inpatient Medical and Surgical Care FCHA pre-authorization required.				
<ul style="list-style-type: none"> • Facility services 	✓	✓	80%	60%
<ul style="list-style-type: none"> • Inpatient doctor visits/consultations 	✓	✓	80%	60%
<ul style="list-style-type: none"> • Inpatient professional services (surgeon, radiologist, pathologist) 	✓	✓	80%	60%

City of Kirkland High Deductible Plan				
*OON = Out-of-Network				
	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
<ul style="list-style-type: none"> Inpatient professional services (assistant surgeon) 	✓	✓	80%	80% if provided at a network facility
				60% if provided at a non-network facility
Hospital Outpatient Surgery and Services FCHA pre-authorization required for certain outpatient services; see <i>Pre-authorization Requirements</i> for details.				
<ul style="list-style-type: none"> Surgical facility services 	✓	✓	80%	60%
<ul style="list-style-type: none"> Ambulatory Surgery Center (ASC) 	✓	✓	80%	60%
<ul style="list-style-type: none"> Outpatient professional services (surgeon, radiologist, pathologist) 	✓	✓	80%	60%
<ul style="list-style-type: none"> Outpatient professional services (assistant surgeon) 	✓	✓	80%	80% if provided at a network facility
				60% if provided at a non-network facility
Infertility Diagnostic Services Limited benefit, see <i>Infertility Diagnostic Services</i> for details.				
<ul style="list-style-type: none"> Office Visit/Consultation 	✓	✓	80%	60%

City of Kirkland High Deductible Plan				
*OON = Out-of-Network				
	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
<ul style="list-style-type: none"> Lab/Radiology 	Covered the same as any other diagnostic test. See <i>Lab/Radiology Services</i> for details.			
Infusion Therapy (includes infusion therapy provided in the home) FCHA pre-authorization required for certain infusion therapy drugs, see <i>Pre-Authorizations Requirements</i> .	Covered the same as any other medical service. Refer to place of service.			
Maternity and Newborn Care (covered for all enrolled female Plan members)	Covered the same as any other medical service. Refer to place of service.			
Mental Health Care FCHA pre-authorization required for inpatient, residential and partial hospitalization.				
<ul style="list-style-type: none"> Inpatient (facility and professional) 	✓	✓	80%	60%
<ul style="list-style-type: none"> Partial Day Treatment (PDT) 	✓	✓	80%	60%
<ul style="list-style-type: none"> Outpatient (facility) 	✓	✓	80%	60%
<ul style="list-style-type: none"> Outpatient (professional) 	✓	✓	80%	60%
Nutritional Counseling First 3 nutritional counseling visits per calendar year are covered under Preventive Care.	✓	✓	80%	60%
Nutritional and Dietary Formulas	Covered the same as any other medical service. Refer to place of service.			
Oral Surgery	✓	✓	80%	60%
Pharmacy	Administered by Caremark			

City of Kirkland High Deductible Plan

*OON = Out-of-Network

	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
<ul style="list-style-type: none"> Retail (34 day supply) 	N/A	Separate \$4,100 Subscriber \$8,200 Family OOP Max per plan year	Generic: \$4 copay Formulary Brand: \$15 copay Non-formulary Brand: \$35 copay	Not Covered
<ul style="list-style-type: none"> Mail order (90 day supply) 	N/A	Separate \$4,100 Subscriber \$8,200 Family OOP Max per plan year	Generic: \$8 copay Formulary Brand: \$30 copay Non-formulary Brand: \$70 copay	Not Covered
Plastic and Reconstructive Services FCHA pre-authorization required. Limited benefit, see <i>Plastic and Reconstructive Services</i> for details.	Covered the same as any other medical service. Refer to place of service.			
Podiatric Care See <i>Podiatric Care</i> for details on routine foot care.	Covered the same as any other medical service. Refer to place of service.			
Preventive Care *OON = Out-of-Network.				

City of Kirkland High Deductible Plan

*OON = Out-of-Network

	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
<p>Immunizations Immunizations for children and adults are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention. See <i>Preventive Care</i> for details. FluMist is covered. Covered immunizations received at pharmacy covered in network at 100% of billed. Travel immunizations are not covered.</p>	✓ (OON only)	✓ (OON only)	100%	60%
<p>Periodic Exams (adult and child)</p>	✓ (OON only)	✓ (OON only)	100%	60%
<p>Nutritional Counseling Visits - First 3 visits per calendar year 4th and subsequent visits are covered under the applicable medical benefit and are not considered preventive care.</p>	✓ (OON only)	✓ (OON only)	100%	60%
<p>Obesity screening and counseling 12 visits per calendar year.</p>	✓ (OON only)	✓ (OON only)	100%	60%
<p>Screening Tests Screening tests are covered in accordance with the recommendations set forth by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See <i>Preventive Care</i> for more details.</p>				
<ul style="list-style-type: none"> Bone Density Screening (1 every 2 Plan Years beginning at age 65, or age 60 if at increased risk) 	✓ (OON only)	✓ (OON only)	100%	60%

City of Kirkland High Deductible Plan				
*OON = Out-of-Network				
	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
<ul style="list-style-type: none"> • Colonoscopy (1 per Plan Year, regardless of diagnosis) Subsequent colonoscopies in the same Plan Year are paid under the regular medical benefits, regardless of diagnosis. 	✓ (OON only)	✓ (OON only)	100%	60%
<ul style="list-style-type: none"> • Mammogram (1 per Plan Year, regardless of diagnosis) Subsequent mammograms in the same Plan Year are paid under the regular medical benefits, regardless of diagnosis. 	✓ (OON only)	✓ (OON only)	100%	60%
<ul style="list-style-type: none"> • Pap Test (1 per Plan Year) 	✓ (OON only)	✓ (OON only)	100%	60%
<ul style="list-style-type: none"> • Prostate Cancer Screening (PSA) (1 per Plan Year, beginning at age 50) 	✓ (OON only)	✓ (OON only)	100%	60%
<ul style="list-style-type: none"> • Sigmoidoscopy (1 per Plan Year, regardless of diagnosis) Subsequent sigmoidoscopies in the same Plan Year are paid under the regular medical benefits, regardless of diagnosis. 	✓ (OON only)	✓ (OON only)	100%	60%
<ul style="list-style-type: none"> • All Other Screening Tests 	✓ (OON only)	✓ (OON only)	100%	60%
Professional/Physician Services				
<ul style="list-style-type: none"> • Office/Hospital Visits/Surgeries 	✓	✓	80%	60%
<ul style="list-style-type: none"> • Telemedicine – Doctor on Demand only. 	✓	✓	80%	N/A
Rehabilitation Therapy				

City of Kirkland High Deductible Plan				
*OON = Out-of-Network				
	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
<ul style="list-style-type: none"> Inpatient – (facility and professional) 30 days per Plan Year. 	✓	✓	80%	60%
<ul style="list-style-type: none"> Outpatient – (facility and professional, includes physical, speech, occupational and massage therapies) A written prescription is required for all outpatient rehabilitation therapies. 	✓	✓	80%	60%
Skilled Nursing Facility 365 days lifetime maximum.	✓	✓	80%	60%
Temporomandibular Joint (TMJ) Disorder	Not Covered			
Tobacco Cessation	Tobacco cessation medications are covered under the pharmacy benefits. Office visits for tobacco cessation are covered under the <i>Preventive Care</i> benefit. Tobacco cessation programs are not covered.			
Transgender Program FCHA pre-authorization and Case Management required. Limited benefit, see <i>Transgender Program</i> for details.	Payment is based on Place of Service and Provider type.			
Transplants (Organ and Bone Marrow) FCHA pre-authorization required. Benefit is subject to a 6-month waiting period.				
<ul style="list-style-type: none"> Recipient/donor services – (inpatient facility and professional) 	✓	✓	80%	60%
<ul style="list-style-type: none"> Recipient/donor services – (outpatient facility and professional) 	✓	✓	80%	60%

City of Kirkland High Deductible Plan				
*OON = Out-of-Network				
	Applies to Deductible	Applies to OOP Max	Network Providers	Non-Network Providers
<ul style="list-style-type: none"> • Recipient/donor services – (office visits) 	✓	✓	80%	60%
<ul style="list-style-type: none"> • Transportation and Lodging \$2,500 maximum per transplant. 	✓	✓	80%	60%
Vision Care (routine eye exams and hardware)	Not Covered			

Medical Benefits

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

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

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

Acupuncture

Refer to *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. If received from a pharmacy, the serum may be covered under the pharmaceutical benefit.

Alternative Care

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

Ambulance Services

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

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

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

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

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. Ongoing review is required and there must be an improvement in the behavior categories to support ongoing services.

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.

Blood Transfusions/Donation

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

Biofeedback

Biofeedback, a training program designed to develop one’s ability to control the involuntary nervous system, is covered when determined to be medically necessary. Coverage is excluded for treatment of mental health and chemical dependency. **FCH pre-authorization is required.**

Chemical Dependency

All inpatient admissions and partial hospitalization programs **require FCHA pre-authorization** by calling 800-640-7682. Emergency admissions and outpatient services require *notification* as described in the *Medical Management* section. The plan covers services provided to individuals requiring chemical dependency treatment for abuse of substances (e.g. alcohol or other drugs). Care must be medically necessary and provided at the least restrictive level of care. 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 FCHA's medical management.

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

An exception to the plan's exclusion of experimental or investigational treatments or services may be made for members receiving therapeutic interventions while participating in an approved clinical trial when this participation has been preauthorized.

An approved clinical trial is defined as follows:

- Prior authorization for clinical trial participation has been granted as described below.
- The clinical trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening disease or condition. A "life-threatening condition" is a disease or condition likely to result in death unless the disease or condition is interrupted. The principal purpose of the trial intervention must be the therapeutic intent to potentially improve health outcomes.
- The clinical trial intervention must be intended for a condition covered by the health plan.
- The approved clinical trial must be classed as one of the following:
 - A federally funded or federally approved trial.
 - A clinical trial conducted under a U.S. Food and Drug Administration (FDA) investigational new drug application.
 - A drug trial that is exempt from the requirement of an FDA investigational new drug application.
- The clinical trial must be conducted under a written research protocol approved by an appropriate Institutional Review Board (IRB). This protocol must demonstrate that the trial is in compliance with Federal regulations relating to the protection of human subjects.
- The clinical trial must provide a thorough informed consent document to the participating member, and this document must be signed by the member.
- All applicable plan limitations for coverage of out-of-network care along with all applicable plan requirements for pre-certification, 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 (but not replacement) of sound natural teeth, and repair of the jawbone or supporting tissues, due to accidental injury. After the initial examination by your dentist, a pre-authorization for further services is required by FCHA. 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. FCHA pre-authorization required on follow-up services and anesthesia

Diabetic Nutrition Education

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

Diagnostic 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

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

Examples of DME include, but are not limited to:

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

This benefit also covers:

- **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** when related to the treatment of Sleep Apnea
- **Orthopedic appliances/braces**: These include appliances used to support abnormal joints, limit pressure on a joint after injury to allow it to heal or correct abnormal curves in the spine.
- **Prosthetic devices**: Benefits include external prosthetic appliances that are used to replace all or part of a missing body part and are necessary for the alleviation or correction of illness, injury, or congenital defect.
- **Wigs** - covered when needed due to chemotherapy, radiation therapy or surgery.

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

Emergency and Urgent Care

The Plan covers emergency Department and urgent care visits at in-network and out-of-network facilities.

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

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

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

Family Planning

Voluntary sterilization procedures and FDA-approved birth control methods are covered.

Over-the-counter products are not covered except medications required under the Patient Protection and Affordable Care Act. Oral, patch and ring contraceptives are covered under the prescription drug benefit.

Termination of Pregnancy

Voluntary termination of pregnancy is covered for all enrolled female Plan members.

First Responder User Fee

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

Foot Orthotics

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

Genetic Services

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

condition, or a medically necessary precursor to obtaining prompt treatment of a covered condition.

Habilitative Services

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

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

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

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

Hearing Exams

Routine hearing exams and medically necessary hearing exams are covered when needed to detect or prevent auditory deterioration.

Home Health Care

FCHA pre-authorization is required for wound care, 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 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 FCHA determines care in a skilled nursing facility or a hospital is more cost-effective. Any charges for home health care that qualify under this benefit and under any other benefit of this plan will be covered under the most appropriate benefit, as determined by FCHA.

Hospice Care

FCHA pre-authorization is required for inpatient and home hospice care. Hospice care is covered when prescribed by your physician and s/he has determined that life expectancy is 12 months or less and a palliative, supportive care treatment approach has been chosen. *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 for.
 - **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 FCHA.

Hospital Inpatient Medical and Surgical Care

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

Hospital Outpatient Surgery and Services

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

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

Infertility Diagnostic Services

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

Infusion Therapy

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

Massage Therapy

Refer to *Alternative Care*

Maternity and Newborn Care

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

Coverage for pregnancy and childbirth, for all enrolled female Plan members in a hospital or birthing center, is provided on the same basis as any other medical condition, as are complications of pregnancy. Medically necessary screening(s) and diagnostic procedures during pregnancy for prenatal diagnosis of congenital disorders of the fetus are covered. The services of a licensed physician, an advanced registered nurse practitioner (ARNP), a licensed midwife (in-network only), or a certified nurse midwife (CNM, in-network only) are covered under this benefit.

Coverage for newborns is provided automatically for the first 21 days of life when no other coverage is in effect during the first 21 days of life (this includes newborns of dependent children). In order for coverage to continue beyond day 21, the newborn must be enrolled as a dependent under this Plan (see *Eligibility and Enrollment* for details). Benefits are subject to the newborn child's own coinsurance and deductible requirements.

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

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

Newborns' and Mothers' Health Protection Act of 1996

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

Mental Health Care

All inpatient admissions and partial hospitalization programs **require FCHA pre-authorization** by calling (800) 640-7682. Emergency admissions require notification as described under *Medical Management*. The plan covers treatment of mental health or psychiatric conditions.

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

Pursuant to the Mental Health Parity Act of 1996 (MHPA) and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Nutritional Counseling

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

Nutritional and Dietary Formulas

Coverage for nutritional and dietary formulas is provided when medically necessary. 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 of teeth damaged due to radiation therapy that occurred while under this Plan

Pharmacy

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

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

You may order up to a 34-day supply from a retail network pharmacy. Alternatively, if you or a family member regularly take medication for chronic, long-term conditions you may order up to a 90-day supply through Caremark's mail order service. If you use the mail order service, you pay the 90-day copay even if your prescription is written for less than a 90-day supply. See *Filling a Prescription* below for more detailed information on how and where you can obtain your prescription drugs.

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

- **Tier 1 or Generic Drugs** - The generic version of a drug has the same chemical compound as its brand counterpart. Generic drugs offer a simple, safe alternative to help reduce prescription costs.
- **Tier 2 or Formulary Brand Drugs** - This level includes preferred brand-name drugs.
- **Tier 3 or Non-formulary Brand Drugs** - This level includes brand drugs that are not listed in Tier 2. In most cases, there are reasonable alternatives in Tier 1 or 2 for drugs found in this highest tier.

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

To check if your prescription drug is generic, preferred brand or non-preferred brand:

- 1) Visit CVS Caremark online at www.caremark.com
- 2) Register to use the formulary
- 3) Click on *Check Drug Cost* under *Member Quick Links*
- 4) Type in the drug's exact name

Filling a Prescription

Following are details for filling a prescription through the retail network pharmacy or mail order. Contact CVS Caremark for any questions on filling a prescription. If you need assistance in determining if your local, independent pharmacy is part of the CVS Caremark network of retail pharmacies refer to their website at www.caremark.com.

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

Retail Network Pharmacy

With the retail pharmacy program, you may receive up to a 34-day supply of medication. To find a participating pharmacy you must:

- 1) Visit CVS Caremark online at www.caremark.com
- 2) Register to use pharmacy locator
- 3) Click on *Find a Local Pharmacy* under *Member Quick Links*
- 4) Enter your zip code or search by pharmacy name

Mail Order Service

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

Mail Order. You may obtain a 90-day supply of medication through a mail order program with CVS Caremark.

1. Forms are available at Human Resources or at www.caremark.com.
2. Order refills by phone (888) 202-1654 or online at www.caremark.com, click on *Mail Service*
3. Click on *Refill a Prescription* under *Member Quick Links*

Please place your order for a refill by mail three (3) weeks before your current supply runs out and allow fourteen (14) days for delivery of your medication. Your copay can be made by check or credit card. Do not send cash.

Prior Authorizations

There may be instances when a medication you are prescribed is not covered under the plan design or drug coverage. If your physician deems this medication to be medically necessary for you to take, and there are no other suitable options, they can request a prior authorization to have the drug covered. Have your physician call into Caremark's Prior Authorization team at 1-800-626-3046 to begin the process.

Step Therapy

As part of your prescription plan design, certain drugs require that a generic medication is taken first before a brand name medication can be used; this is called generic step therapy. If you feel that a generic medication does not work for you, or has caused problems during prior trials, you can have your physician call the prior authorization number to request an exception to this program.

Quantity Limits

As part of your prescription plan design, certain drugs have quantity limits that regulate how much of the drug can be dispensed over a given period of time. This is done to ensure safe practices are followed for the dispensing and utilization of these drugs. If your physician feels that you need a higher regularity of a drug than that quantity limit allows, advise your physician to call the prior authorization number to request an exception to this plan design. Please note that not all medications are eligible for prior authorizations.

Specialty Guideline Management (SGM)

This program is included in your prescription benefits specific to specialty medications. Specialty medications are comprised of medications used to treat rare and chronic conditions that require high levels of awareness and adherence. This program requires that all specialty medication utilizers obtain a prior authorization from Caremark to dispense the medication. This is done to ensure safe utilization, promote adherence and counseling opportunities, and monitor utilization. For all SGM related prior authorizations please have your physician call 1-866-814-5506.

Plastic and Reconstructive Services

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

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

Women's Health and Cancer Rights Act of 1998

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

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

Podiatric Care

Coverage is provided for certain surgical podiatric services, including incision and drainage of infected tissue of the foot, removal of lesions of the foot, removal or debridement of infected toenails, and treatment of fractures and dislocations of bones of the foot. Routine foot care, such as the treatment of corns, calluses, non-surgical care of toenails, fallen arches and other symptomatic complaints of the feet are covered for members with peripheral vascular disease and diabetes only.

Preventive Care

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

- Routine physicals and well-child visits
- 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/center/regulations/prevention/recommendations.html

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) received from Doctors on Demand only.

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

Rehabilitation Therapy

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

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

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

Inpatient Rehabilitation

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

Outpatient Rehabilitation

Outpatient rehabilitation benefits are subject to the following provisions:

- You must not be confined in a hospital or other medical facility.
- Services must be billed by a hospital, physician, physical, occupational or speech therapist or any provider licensed to practice medical massage therapy. A written prescription is required for outpatient rehabilitation

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

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

Skilled Nursing Facility

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

Transgender Program

This program covers services for members who wish to explore or pursue gender reassignment. Services included mental health, gender reassignment surgery, related medication and medical services. The services are provided as any other benefit (cost shares are indicated in the *Summary of Benefits*). **Pre-authorization is required for any gender reassignment surgery and inpatient admission.**

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

Transplants, Organ and Bone Marrow

FCHA pre-authorization is required for transplant service; and, there is a **6-month waiting period** for this benefit. The waiting period can be offset by providing documentation that would show proof of coverage from your prior health Plan(s). The waiting period will be reduced by the number of months of prior coverage, as long as it did not occur before a significant break in coverage of more than 63 days. Services directly related to organ transplants must be coordinated by your participating provider. **Proposed transplants will not be covered if considered experimental or investigational for the participant's condition.** FCHA pre-authorization approval for transplants is based on these criteria:

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

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

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

Recipient Services

Covered transplant recipient services include:

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

Donor Services

Donor expenses are covered if all criteria are met below:

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

Covered donor expenses include:

- Donor typing, testing and counseling

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

When both the recipient and the donor are participants under this Plan, covered charges up to the organ and bone marrow transplant lifetime maximum benefit for all covered services and supplies received by both the donor and the recipient will be payable. The covered donor and recipient will each be eligible to receive the organ and tissue transplant lifetime benefit maximum.

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

Travel expenses

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

Plan Exclusions and Limitations

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

- Adoption expenses
- Amounts over and above Usual, Customary and Reasonable (UCR), as defined by the Plan
- Amounts for which the covered person has no obligation to pay
- Any charges by a facility owned or operated by the United States or any state or local government unless the participant is legally obligated to pay (excluding: (i) covered expenses rendered by a medical facility owned or operated by the United States Veteran's Administration when the services are provided to a participant for a non-service related illness or injury, and (ii) covered expenses rendered by a United States military medical facility to participants who are not on active military duty)
- Any condition resulting from participation in declared or undeclared acts of terrorism, war, military service, participation in a riot or civil disobedience
- Any service not medically necessary for the diagnosis, treatment or prevention of injury or illness, even if it is not specifically listed as an exclusion (except for specific services offered through the Preventive Care benefit)
- Any service received before the participant's effective date of coverage or after the coverage termination date
- Applied Behavior Analysis – the following are not covered:
 - Providers accompanying children or family members to health care appointments that are not part of the direct provision of ABA services
 - Services by more than one program manager for each child/family (program development, treatment planning, supervision)
 - Training of therapy assistants and family members (as distinct from supervision)
 - Parent training or classes, except for one-on-one or one-on-two direct training of the parents of one identified patient
 - Services provided in a home school, or public/private school environment that are part of a child's schooling as distinct from specific ABA treatment services (e.g. acting as the "Teacher's Aide," or helping a child with homework)
- Aromatherapy
- Athletic training, body-building, fitness training or related expenses
 -
- Autopsies
- Bariatric surgery, prescription drugs for weight loss, gym memberships, prescription or non-prescription nutritional and/or food supplements including weight loss shakes, exercise programs and equipment, other surgical procedures primarily for reduction of adipose tissue, abdominoplasty and other cosmetic surgery/liposuction
- Botanical or herbal medicines, as well as other over-the-counter medications

- Charges for failure to keep a scheduled visit, for the copying of medical records or for the completion of a claim or administrative forms
- Claims for services that are the result of any injury or illness incurred by a participant while that participant is participating in the commission of a felony, unless the injury or illness is the result of domestic violence or a physical or mental health condition
- Chemical Dependency treatments listed below:
 - Alcoholics Anonymous or other similar chemical dependency programs or support groups
 - Care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior
 - Court-ordered or other assessments to determine the medical necessity of court-ordered treatments
 - Court-ordered treatments or treatments related to deferral of prosecution, deferral of sentencing or suspended sentencing or treatments ordered as a condition of retaining driving rights, when no medical necessity exists
 - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
 - Emergency patrol services
 - Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program
 - Information or referral services
 - Information schools
 - Long-term or custodial care
 - Non-substance related disorders
 - Pain management and/or stress reduction classes
 - Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs
 - Treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required
- Court ordered examinations or treatment of any kind, except when medically necessary
- Day habilitation services designed to provide training, structured activities and specialized assistance to adults, chore services to assist with basic needs, vocational and custodial services are not covered.
- Dental, oral surgery or orthodontic related services, such as (but not limited to) those listed below (unless accident related or otherwise specifically covered by the Plan):
 - Care of the teeth or dental structures
 - Tooth damage due to biting or chewing
 - Dental implants
 - Dental X-rays
 - Extractions of teeth, impacted or otherwise (except as covered under the Plan)
 - Orthodontia
 - Procedures in preparation for dental implants, except as covered under the Dental Trauma benefits
 - Services to correct malposition of teeth
- Durable Medical Equipment (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 comfort, convenience, or sports/recreational activities
- Oral appliances except to treat obstructive sleep apnea
- Over-the-counter items (except medically necessary crutches, walkers, standard wheelchairs, diabetic supplies and ostomy supplies are covered)
- Personal comfort items including but not limited to air conditioners, lumbar rolls, heating pads, diapers or personal hygiene items
- Phototherapy devices related to seasonal affective disorder
- Supportive equipment/environmental adaptive items including, but not limited to, hand rails, chair lifts, ramps, shower chairs, commodes, car lifts, elevators, and modifications made to the patient's home, place of work, or vehicle.
- The following medical equipment/supplies: regular or special car seats or strollers, push chairs, air filtration/purifier systems or supplies, water purifiers, allergenic mattresses, orthopedic or other special chairs, pillows, bed-wetting training equipment, corrective shoes, whirlpool baths, vaporizers, room humidifiers, hot tubs or other types of tubs, home UV or other light units (light boxes or specialized lamps or bulbs), home blood testing equipment and supplies (except diabetic equipment and supplies, and home anticoagulation meters)
- Wigs, except when needed due to chemotherapy, radiation therapy or surgery
- Experimental, investigational, or unproven services, except as outlined under the Clinical Trials Benefit
- FDA-approved drugs, medications or other items for non- approved indications, except when an FDA-approved drug has been proven clinically effective to treat such indication and is supported in peer-reviewed scientific medical literature
- Hearing aids/appliances, including Bone Anchored Hearing Aids (BAHAs) or any related services
- Home births provided by non-network providers
- Home health care listed below:
 - Custodial care
 - Housekeeping or meal services
 - Maintenance care
 - Shift or hourly care services
- Hospice care listed below:
 - Custodial care or maintenance care, except palliative care to the terminally ill patient subject to the stated limits
 - Financial or legal counseling services
 - Housekeeping or meal services
 - Services by a participant or the patient's family or volunteers
 - Services not specifically listed as covered hospice services under the Plan
 - Supportive equipment such as handrails or ramps
 - Transportation
- Immunizations for travel
- Infertility services or treatments to achieve pregnancy (regardless of the cause) including but not limited to:
 - Artificial insemination

- In vitro fertilization (IVF)
- Gamete intra-fallopian transplant (GIFT)
- Injuries while under the influence of a controlled substance and/or alcohol
- Lab and/or radiology services not ordered by a qualified health care provider
- Learning disabilities and related services, educational testing or associated training.
- Medication therapy management
- Mental health care listed below:
 - Adventure-based and/or wilderness programs that focus primarily on education, socialization or delinquency
 - Court-ordered assessments
 - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
 - Marriage and couples counseling
 - Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program
 - Nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories
 - Pain management and/or stress reduction classes
 - Sensitivity training
 - Sexual dysfunctions, sexual dysphoria, personality disorders, and paraphilic disorders
 - Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar program
- 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
- Orthodontic treatment, appliances or services; dentures or related services
- Over-the-counter products, except as covered by the Plan
- Personal, convenience or comfort services, supplies, or items including but not limited to phones, TVs, guest services, deluxe or suite hospital room, air conditioners, diapers or hygiene items
- Pharmacy services listed below:
 - Anorectics (any drug used for the purpose of weight loss)
 - Any prescription refilled in excess of the number specified by the physician, or any refill dispensed after one year from the physician's original order
 - Charges for the administration or injection of any drug
 - Diagnostic tests
 - Drugs labeled "Caution: Limited by federal law to investigational use" or experimental drugs, even though a charge is made to the individual
 - Drugs used for cosmetic purposes, including but not limited to drugs such as Botox, Minoxidil (Rogaine), Tretinoin (Retin A, covered through age 25)
 - Immunological agents, biological sera, blood or blood plasma
 - Impotency drugs, including but not limited to Viagra
 - Infertility medications
 - Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed medical facility, rest home, sanitarium, extended care facility, convalescent medical facility, nursing home, or similar institution which

operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals

- Non-legend drugs other than insulin
 - Non-systemic contraceptives and implants, such as diaphragms, IUDs, cervical caps which would be covered through the medical benefits; or condoms which are over-the-counter, except certain over-the-counter items required under the Patient Protection and Affordable Care Act or covered by the Plan
 - Nutritional supplements
 - Prescriptions which an eligible individual is entitled to receive without charge from any Workers' Compensation laws
 - Renova
 - Replacement of lost or stolen medications/items
 - Therapeutic devices or appliances, including support garments and other non-medical substances, regardless of intended use, except those listed above
 - Vitamins, singly or in combination, except prenatal and federal legend vitamins to treat covered medical conditions
- Physical examinations, reports or related services for the purpose of obtaining or maintaining employment, insurance, or licenses or permits of any kind, school admission, school sports clearances, immigration, foreign travel, medical research, camps, or government licensure, or other reasons not related to medical needs.
 - Plastic and reconstructive services such as those listed below:
 - Abdominoplasty/panniculectomy
 - Complications resulting from non-covered services
 - Cosmetic services, supplies or surgery to repair, modify or reshape a functioning body structure for improvement of the patient's appearance or self-esteem(except for gender reassignment surgery);
 - Dermabrasion, chemical peels or skin procedures to improve appearance or to remove scars or tattoos
 - Procedures, regardless of medical necessity, outside the scope of the provider's license, registration or certification
 - Professional services listed below:
 - Professional services provided by fax or email.
 - Follow up phone calls from provider for test results, referrals, prescription refills or reminders that occur within 7 days of an in-person office visit
 - Calls to nurse line or to obtain educational material are also not covered
 - Repair or replacement of items not used in accordance with manufacturer's instructions or recommendations
 - Replacement of lost or stolen items, such as but not limited to prescription drugs, prostheses or DME
 - Respite care, except as covered by the Plan
 - Reversal of sterilization
 - Routine foot care, except as covered by the Plan for members with peripheral vascular disease and diabetes
 - Services for any condition, illness or injury that arises from or during the course of work for wages or profit that is covered by state insurance workers' compensation and federal act or similar law

- Services or supplies for the treatment of male or female sexual dysfunction such as, but not limited to, treatment of erectile dysfunction (including penile implants), anorgasmia, and premature ejaculation
- Services or supplies payable under a contract or insurance for uninsured or underinsured (UIM) coverage, motor vehicle, motor vehicle no-fault, or personal injury protection (PIP) coverage, commercial premises or homeowner's medical premise coverage or other similar type of contract or insurance
- Services or supplies received without charge from a medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar group
- Services or supplies required by an employer as a condition of employment
- Services provided by a family member (spouse, parent or child)
- Services provided by a spa, health club or fitness center, except covered medically necessary services provided within the scope of the provider's license
- Services provided by clergy
- Services provided in a school setting (such as early learning and K-12)
- Smoking and Tobacco cessation programs
- Snoring treatment (surgical or other)
- Special diets, nutritional supplements, vitamins and minerals or other dietary formulas or supplements except as covered by the Plan
- Special education for the developmentally disabled
- Surrogate mother charges, unless the surrogate mother is eligible under the Plan at the time the services were rendered
- Temporomandibular Joint (TMJ) Syndrome
- Tooth damage due to biting or chewing
- Transportation, except as covered by the Plan
- Transgender Program related travel and lodging, and services that are considered cosmetic including but not limited to:
 - Abdominoplasty
 - Blepharoplasty
 - Breast augmentation
 - Calf Implants
 - Cheek/malar implants
 - Chin augmentation (reshaping or enhancing the size of the chin)
 - Collagen injections
 - Cryothyroid approximations (voice modification surgery)
 - Electrolysis (hair removal)
 - Face-lift
 - Facial bone reduction
 - Forehead lift
 - Hair transplantation
 - Laryngoplasty (reshaping of laryngeal framework/voice modification surgery)
 - Lip reductions/enhancement (decreasing/increase lip size)
 - Liposuction
 - Mastopexy (breast lift)

- Neck tightening
- Pectoral implants
- Reduction thyroid chondroplasty (trachea shave)
- Rhinoplasty
- Transplant services listed below (Organ and Bone Marrow):
 - Animal-to-human transplants
 - Artificial or mechanical devices designed to replace human organs
 - Complications arising from the donation procedure if the donor is not a Plan participant
 - Donor expenses for a Plan participant who donates an organ or bone marrow, however complications arising from the donation would be covered as any other illness to the extent they are not covered under the recipient's health plan.
 - Transplants considered experimental and investigational, as defined by the Plan
- Treatment furnished without charge or paid directly or indirectly by any government or for which a government prohibits payment of benefits
- Vision Care, the following vision benefits are not covered:
 - Non-prescription sunglasses or safety glasses
 - Radial keratotomy, Lasik or any other refractive surgery, orthoptics, pleoptics, visual analysis therapy or training related to muscular imbalance of the eye; optometric therapy
 - Routine eye exams,
 - Services or supplies received principally for cosmetic purposes other than contact lenses selected in place of eyeglasses
 - Vision hardware and any related services, Frames, lenses, and contact lenses needed to treat a medical condition, or needed as a result of a medical condition are covered under the Durable Medical Equipment benefit
- Vitamin B-12 injections except to treat Vitamin B-12 deficiency
- Vocational rehabilitation, work hardening or training programs regardless of diagnosis or symptoms that may be present, or for non-medically necessary education
- Weight management programs

Eligibility and Enrollment

Eligible Classes of Employees

In order to enroll, active employees must be employed by the City of Kirkland and must work a minimum of 20 hours per week or 80 hours per month.

The following categories of employees of the group are eligible for coverage under this plan:

- Non-uniformed employees who are eligible for a rate contribution by their employer.
- LEOFF I employees who are law enforcement officers or firefighters hired prior to October 1, 1977, and who are members of the LEOFF system as defined in Sections (3) and (4), CH 131, Law of 1972 1st Ex. Session.
- LEOFF II employees who are law enforcement officers or firefighters hired on or after October 1, 1977, and who are not members of the LEOFF system as defined in Sections (3) and (4), CH 131, Law of 1972 1st Ex. Session.

In order to be considered eligible, you must satisfy the probationary Waiting Period described below.

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

- Leased or temporary employees,
- One that is enrolled as a dependent on another City of Kirkland employee's plan, or
- One that has not completed the probationary Waiting Period.

Waiting Period

The waiting period is the time between the first day of employment and the first day of coverage under the Plan. Coverage under this Plan begins on the first of the month coinciding with or following an employee's date of hire.

Enrollment Periods

Enrollment periods for eligible employees and dependents are:

- Within 30 days of initial eligibility, or
- 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 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 unless you qualify under a special enrollment period.

Special Enrollment Periods

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

Change in Status

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

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

A change in status includes:

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

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

Involuntary Loss of Other Coverage

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

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

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

Late Enrollment

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

Effective Date

Effective Date of Coverage for You

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

Effective Date of Coverage for Your Dependents

Coverage for dependents of employees becomes effective on the subscriber's effective date. One exception to this is: coverage for dependents of LEOFF I employees becomes effective on the first day of the month following the date of employment.

Only dependents for which you have submitted an enrollment form and paid any required premiums will be covered. Your dependent will be considered a late enrollee if we do not receive the enrollment form and premium payment within 31 days (60 days in the case of birth, adoption or placement for adoption) of the date he or she is eligible for coverage. **Late enrollments are not accepted.**

Deferred Effective Date of Your Coverage or an Increase in Coverage

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

your coverage or any increase in benefits will not become effective until the date you return to full-time basis.

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

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

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

Special Rule

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

Children whose parents are both City of Kirkland employees may enroll under one or both parents.

Waiver of Group Health Plan Benefits

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

Dependents

Dependent Eligibility

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

- Lawful spouse (as defined by state law where the employee permanently resides)
- The registered Domestic Partner (same or opposite sex) or Domestic Partner who meets the criteria for eligibility (with a signed affidavit regarding eligibility of the Domestic Partner); see section *Plan Definitions*;
- Your (or your Domestic Partner's) natural child, adopted child, child placed with you for legal adoption, stepchild, or other legally designated ward up to age 26 (through their 25th year); or,
- Your (or your Domestic Partner's) natural child, adopted child, child placed with you for legal adoption, stepchild, dependent child of or other legally designated ward that a health care professional determines is not capable of self-sustaining employment due to a physical handicap or developmental disability. Proof of such incapacity must be furnished to the Plan Administrator within 31 days prior to the date the child reaches age 26. Thereafter, employees are required to resubmit proof of continued disability not more than once per year.

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

Dependents do not include:

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

Special Rules for Domestic Partners

Federal law does not recognize domestic partners, therefore, domestic partners are not eligible for continuation of coverage under COBRA. However, although not required, the City of Kirkland will offer a COBRA-like continuation of coverage to domestic partners and their dependent children under the same conditions as that offered to an eligible spouse/dependent child under COBRA.

Dependents Acquired Through Marriage/Domestic Partnership

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

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

Dependent Children

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

Children whose parents are both City of Kirkland employees may enroll under one or both parents.

Natural Newborn Children

If you acquire a new dependent through birth, the Plan Administrator must receive the enrollment form within 60 days after the date of birth. Coverage is provided for the newborn child for up to 21 days following birth when the participant or participant's spouse is eligible for the maternity benefits provided by the Plan (this includes newborns of dependent children). This automatic coverage is provided only when the newborn has no other coverage in effect during the first 21 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 21 days of life, the Plan will exercise the right to recover the excess payments from any person(s), insurer(s) or other organizations, as the Plan deems appropriate. Benefits will be provided after day 21 only if the newborn is enrolled within 60 days after the date of birth. If the newborn is enrolled within 60 days of birth, coverage becomes effective on the date of birth.

Adopted Children Acquired

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

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

Children Acquired Through Legal Guardianship

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

Children Covered Under Qualified Medical Child Support Orders

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

Dependent Children Out of Area

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

The First Health is available for network benefits to:

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

A full description of the provider networks is in Section I - Medical, Vision and Pharmacy Benefits, under *How to Obtain Health Services*.

Continued Eligibility for a Disabled Child

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

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

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

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

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

The participant must also submit the following:

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

A 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 City of Kirkland 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 31 days of the order in order for coverage to become effective on the date of the order. If the enrollment information is received after 31 days of the order, coverage will become effective on the first of the month following the date we receive the enrollment information for coverage.

Termination of Coverage

For participating employees, coverage ends at these events:

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

For participating dependents, coverage ends at these events:

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

Related Details

- Coverage is automatically extended through the last day of the month of the termination, provided the applicable contribution for the coverage period has been paid. Participants receive a Certificate of Creditable Coverage (see *Continue Group Health Coverage/Certificate of Creditable Coverage*) that shows the coverage period under this Plan. (Contact the Plan Administrator for more information.)
- If your share of the Plan contribution is paid on a pre-tax basis through a §125 Cafeteria Plan, enrollment into this Plan is a 1 year commitment. You can opt out of the Plan mid-year only as permitted under §125 regulations. Refer to your §125 Cafeteria Plan Summary Plan 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.
- An employee who is rehired will be treated as a new hire for benefit purposes.
- The Plan requires 31 days written notice for dependent coverage termination.

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

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

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

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

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

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

Who Is a COBRA Qualified Beneficiary?

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

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

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

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

Qualifying Events and Continuation Periods

Qualifying events and continuation periods are explained below:

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

When COBRA Coverage Ends

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

- The Plan no longer provides group health coverage to any employees
- The COBRA coverage premium is not paid within 31 days of the due date (the initial grace period is 45 days after the first COBRA election)
- The qualified beneficiary enrolls in Medicare
- If an extension from 18 to 29 months was granted due to a disability and the individual receives a final determination from the Social Security Administration stating the individual is no longer disabled the individual must notify the plan administrator within 31 days after the date of that determination. Coverage ends on the last day of the month through which contribution payments have been received, so long as that date is within the first month that begins within 31 days after the final determination date, and after the initial 18-month COBRA coverage period

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

Contribution Payment Requirements

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

If you are eligible and receive a disability extension under Title II or XVI of the Social Security Act, your contribution will also be 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 to COBRA Management Services, LLC, PO Box 53525, Bellevue, WA 98015. If you have COBRA related questions, you should contact COBRA Management Services, LLC at (866) 517-7580.

Election Requirements

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

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

What Coverage Must Be Offered When Electing COBRA?

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

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

- **Modification of coverage** – if an employer modifies coverage for similarly situated active employees; the coverage for qualified beneficiaries must be modified similarly. Some examples of modifications include benefit enhancements, elimination of coverage and changes in carriers

Other Continuation of Coverage

Leaves of Absence

Family Medical Leave Act of 1993 (FMLA) Leaves

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

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

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

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

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

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

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

**FMLA Leave may be extended through the City of Kirkland's Shared Leave program. Should extended leave be approved, medical benefits will continue on an active basis until Shared Leave is exhausted. Entitlement to COBRA at your expense will occur once Shared Leave is exhausted.*

Military Leave

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

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

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

All Leaves of Absence

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

Continuation Coverage for Dependents of City of Kirkland Employees who Die in the Line of Duty

Commissioned Police

The City of Kirkland agrees to continue payment of the employer portion of the premium for the spouse and eligible dependents medical premiums for a period of twelve (12) calendar months following the death of an active police officer whose death is the direct result of injuries incurred in the line of duty. In the event the surviving spouse remarries within that twelve (12) month period, the City of Kirkland payment of premiums shall cease with payment of the premium for the month in which the marriage occurs. This provision shall specifically not apply to presumptive illnesses, which cause the death of the officer.

Non-Commissioned Police

The City of Kirkland agrees to continue payment of the employer portion of the premium for the spouse and eligible dependents medical premiums for a period of twelve (12) calendar months following the death of an active corrections or parking enforcement employee whose death is the direct result of injuries incurred in the line of duty. In the event the surviving spouse

remarries within that twelve (12) month period, the City of Kirkland payment of premiums shall cease with payment of the premium for the month in which the marriage occurs. This provision shall specifically not apply to presumptive illnesses that cause the death of the officer.

PSEU

In the event an employee is killed in the course of his/her official duty, the City of Kirkland agrees to continue to provide existing medical coverage to the surviving dependents for a period of one year or until re-marriage of the surviving spouse occurs, whichever occurs first.

IAFF

In the event an employee is killed in the course of his/her official duty, the City of Kirkland agrees to continue to provide existing medical coverage to the surviving dependents for a period of one year or until re-marriage of the surviving spouse occurs, whichever occurs first.

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

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

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

Claim Types

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

- **Post-service claim** means any claim for a Plan benefit that is not a pre-service claim and is a request for payment or reimbursement for covered services already received.
- **Urgent care claim** means a claim for medical care or treatment that, if normal pre-service standards are applied, would 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 (City of Kirkland) has final authority over appeals as the appropriate named fiduciary, however the Plan delegates to FCHA, 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. FCHA 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 FCHA.

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	FCHA Notice of Incorrectly Filed Claim – Notice to Claimant	FCHA Notice of Incomplete Claim – Notice to Claimant	Initial Benefit Determination by FCHA
Pre-Service Claim	5 days	Not required (may be part of extension notice)	Reasonable period = 15 days 15-day extension with notice to claimant Reasonable period suspended up to 45 days on incomplete claim
Concurrent Claim	N/A	N/A	In time to permit appeal and determination before treatment ends or is reduced
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 FCHA 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:

- For pre-service claims, the standards for medical necessity relied upon in making the adverse benefit determination (denial) (for example, an explanation of the scientific or clinical judgment used in making the decision) if applicable;
- 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.

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

FCHA performs functions associated with the internal review of medical appeals for this Plan. Pharmacy Appeals are handled by Caremark, The City of Kirkland has final authority over appeals as the appropriate named fiduciary.

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

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

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

Medical Appeals:

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

Pharmacy Appeals:

Prescription Claim Appeals MC109
CVS Caremark
PO Box 52084
Phoenix, AZ 85072-2084

Internal Appeal Process

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

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

FCHA's designated Appeals Coordinator will prepare your documents and any applicable documentation from the Summary Plan Document for review and discussion by the FCHA Appeals Committee or Medical Director (the individual who made the original adverse benefit determination will not be involved in the internal appeal process). The committee or Medical Director will review the information and make a recommendation to the Plan Fiduciary to either uphold or overturn the original adverse benefit determination, and such recommendation will be sent to City of Kirkland for a final decision. FCHA will provide you with any new or additional evidence or rationale and any other information and documents used in the appeal review of your claim without regard to whether such information was considered in the initial determination. Any such new or additional evidence or rationale and information will be provided to you sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. FCHA will notify you in writing of the decision to either uphold the original denial or overturn it within 30 days of pre-service claims or 60 days if your appeal involved a post-service claim. If the determination is to uphold the original denial, the letter will also include information on how to initiate the next level of appeal (External Review) if the determination is based on medical judgment. **Note: a decision regarding an urgent care claim will be made as soon as possible, but not later than 72 hours after receipt of a request for internal review if a delay would jeopardize the member or their dependent's health.**

External Review

If the decision upon internal appeal review is to uphold the original denial, and such denial is based on medical judgment, this Plan offers an external review. **You must first submit an internal appeal and receive a final internal adverse benefit determination before you may request external review.** The request for external review must be received within 125 calendar days of receipt of the final internal adverse benefit determination.

Within 5 calendar days of the receipt of a request for external review, FCHA will conduct a preliminary review to determine whether the claim is eligible for external review, and will send you notification if its decision within one business day thereafter. This notice will include the following:

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

If eligible for external review, FCHA will forward your appeal (including all information and documentation considered in the both the original denial and the internal review, as well as any additional documentation you submit) to an Independent Review Organization (IRO) within 6 business days of the receipt of a request for external review. The IRO consists of independent physicians or other specialists that are not associated with FCHA or the City of Kirkland. If applicable, they will also possess medical training specific to the appeal.

The IRO will notify you that your appeal has been received, and will allow you at least 10 business days to submit any additional information to the IRO that you wish to be considered in reviewing your appeal. The IRO will review all information submitted, make a determination, and notify both you and FCHA of the results within 45 calendar days. **Note: a decision regarding an urgent care claim will be made as soon as possible, but not later than 72 hours after within**

24 hours of receipt of a request for external review if a delay would jeopardize the member's or their dependent's health.

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

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

Coordination of Benefits

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

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

This Plan coordinates pharmacy benefits if you have other pharmacy coverage. Please call CVS/Caremark at 888-202-1654 for details about pharmacy coordination of benefits.

Calculation of Benefit Payments

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

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

1. This Plan will determine which of the two plans (Primary Plan and this Plan) has the higher Allowed Amount (see *Plan Definitions*).
2. This Plan will credit any amounts to this Plan's deductible that would have been credited if this Plan were primary.
3. This Plan will pay 100% of the remaining patient liability, not to exceed: 1) the amount this Plan would have paid as primary, and 2) the amount that, when added to the Primary Plan payment, totals 100% of the highest Allowed Amount as determined in step 1.
4. This Plan will calculate its savings (its amount paid subtracted from the amount it would have paid had it been primary) and record these savings as a benefit reserve for you. This reserve will be used to pay any expenses you incur during that calendar year, whether or not they are an allowable expense under this Plan.

Important note: Using this calculation method, you may still owe a balance to the provider after both plans have paid if your deductible on this Plan has not been met.

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

How Do I Know Which Plan is my Primary Plan?

The rules in this section determine the order in which your plans pay benefits (i.e. which plan is your Primary Plan, and which is your Secondary Plan, also known as the order of benefits). **If you have**

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

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

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

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

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

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

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

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

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
- e. 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.

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

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

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

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

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

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

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

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

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

What if I'm Covered by Medicare?

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

If your Medicare entitlement is due to:

- **Age:**

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

If you are covered under this Plan as a retiree or dependent of a retiree and you become entitled to Medicare because of reaching age 65, Medicare will be primary.

If you are covered under this Plan as a Domestic Partner, same-sex spouse or COBRA qualified beneficiary and are also entitled to Medicare based on age, Medicare is primary

- **Disability:**

If you are covered under this Plan as an active employee or dependent of an active employee (including Domestic Partners and same-sex spouses) and become entitled to Medicare due to disability, this Plan will be primary. Once you or your dependent is declared disabled by Social Security, the disabled individual should apply for coverage under Medicare Parts A and B.

If you are covered under this Plan as a retiree or dependent of a retiree and you become entitled to Medicare because of reaching age 65, Medicare will be primary.

If you are covered under this Plan as a COBRA qualified beneficiary and are also entitled to Medicare based on disability, Medicare is primary

- **End Stage Renal Disease (ESRD):**

If you become entitled to Medicare on the basis of ESRD, this Plan will pay primary during the initial coordination period (refer to the Medicare Secondary Payer Manual at www.cms.gov/manuals/downloads/msp105c02.pdf for more information regarding the initial coordination period). After this initial coordination period, this Plan will pay secondary to Medicare. This is true even if you are covered under this Plan as a Domestic Partner, same sex spouse or COBRA qualified beneficiary.

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

Pre-authorization when this Plan is Secondary

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

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

if the policy is purchased through payroll deduction at a premium savings to the insured since the insured would have the right to maintain or renew the policy independently of continued employment with the employer.)

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

“Plan” does not include:

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

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

Claim Determination Period

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

Right of Recovery

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

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

Facility of Payment

When another plan makes payments that should have been made under this Plan and in accordance with this provision, the Plan may, at its sole discretion, elect to reimburse to the

other plan the amount necessary to satisfy the intent of this COB provision. Any amount paid under this subsection will be considered benefits paid under this agreement, and the Plan will be fully discharged from liability under this agreement to the extent of those payments.

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

Right to Receive and Release Information

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

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

Subrogation

Liable Third Parties and Insurers

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

To the fullest extent permitted by law, the Plan is entitled to the proceeds of any settlements or judgments that result in the recovery from a first or third party, up to the amount of benefit paid by the Plan for the condition. The “common fund rule” and any similar common law or statutory doctrines will not apply with the respect to any recovery from a third party. The Plan may enforce the right of reimbursement regardless of whether you are made whole or restored financially; therefore, the “make whole rule” and any other similar statutory or common law doctrines will not apply with respect to any recovery (including any insurer or other employee benefit plan). In recovering those amounts, the Plan Administrator (Human Resources), Plan Sponsor (City of Kirkland) and/or FCHA may either hire their own attorney or be represented by your attorney. If the Plan chooses to be represented by your attorney, the Plan will pay, on a contingent basis, a reasonable portion of the attorney’s fees necessary for asserting right of recovery in the case. This portion will not exceed 20% of the amount the Plan seeks to recover. The Plan will not pay for any legal costs incurred by or for you, and you won’t be required to pay any portion of the costs incurred by or for the Plan.

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

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

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

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

Uninsured/Underinsured Motorist Coverage

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

Venue

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

Subrogation Forms

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

Health Insurance Portability and Accountability Act of 1996

Privacy Rights

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

Disclosures to the Plan Sponsor

The Plan may disclose your health information to City of Kirkland, the Plan Sponsor of the Plan, to carry out plan administration functions performed by the Plan Sponsor on behalf of the Plan. The plan documents have been amended in accordance with federal law to permit this use and disclosure.

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

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

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

Plan Benefit Information

Benefits, Contributions and Funding

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

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

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

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

Plan Administrator's Power of Authority

The Plan Administrator role for this Plan rests with the City of Kirkland's Human Resources Department. The Plan Administrator is responsible for:

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

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

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

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

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

Discretionary Authority

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

Collective Bargaining Agreements

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

Clerical Error

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

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

Statement of Your Rights

This Plan is a governmental (sponsored) plan and as such, it is exempt from the requirements of the Employee Retirement Income Security Act of 1974 (also known as ERISA), which is a federal law that regulates employee welfare and pension plans. Your rights as a participant in the Plan are governed by the plan documents and applicable state law and regulations. This Plan shall be deemed automatically to be amended to conform as required by any applicable law, regulation or order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations.

As a participant in the Plan, you are entitled to certain rights and protection. All Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, and a copy of the latest annual report.
- Obtain, on written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts, collective bargaining agreements, copies of the latest annual report and an updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report, if any is required to be prepared. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to obtain any denial, all within certain time schedules. Under the Plan, there are steps you can take to enforce the above rights. If you have a claim for benefits which is denied or ignored, in whole or in part, and if you have exhausted the claims procedures available to you under the Plan, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning qualified status of a medical child support order, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may file suit in federal court. The court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for examples, if it finds your claim frivolous.

Continue Group Health Coverage/Certificate of Creditable Coverage

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

Assistance with Your Questions

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

Summary Plan Description and General Information

Plan Name:	City of Kirkland Employee Health Benefit Plan
Employer Name:	City of Kirkland
Plan Year:	January 1 through December 31
Type of Plan:	Group health plan
Plan Coverage Status:	This is a “non-grandfathered health plan” under the Patient Protection and Affordable Care Act.
Funding Medium:	Claims are paid directly out of the general assets of the Company. Employee contributions are placed in the general assets of the company and accounted for separately in the accounting records of the Company. Employee contributions shall only be used to pay medical or dental claims.
Source of Contributions:	The company bears the entire cost of this benefit Plan, minus the participants’ contribution.
Plan Sponsor, Administrator, Fiduciary and Agent for Service of Legal Process:	City of Kirkland 123 Fifth Avenue Kirkland, WA 98033 (425) 587-3221
Plan Sponsor’s Employer Identification Number:	91-6001255
Third Party Administrator:	First Choice Health Network, Inc. d.b.a. First Choice Health Administrators 600 University Street, Suite 1400 Seattle, WA 98101 (800) 430-3818/Local (206) 268-2360 www.fchn.com
Plan Description:	The written Plan Description consists of this entire document plus benefit summary booklets and provider directories.

Plan Definitions

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

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

For non-network emergency services, the Allowed Amount is determined annually by FCHA 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 Allowed Amount and the provider's actual charges.

Applied Behavior Analysis (ABA) is a term describing principles, techniques and interventions used in assessment and treatment to increase behaviors that are helpful, reduce behaviors that are harmful and demonstrate that the interventions employed are responsible for the improvement of behavior in individuals with autism. ABA incorporates many techniques for understanding and changing behavior and may involve a multi-disciplinary approach to increase language and communication skills, improve attention, focus, social skills and memory. ABA is flexible in that it can be adapted to meet the needs of each individual.

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

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

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

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

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

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

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

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

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

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

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

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

Domestic partners mean 2 individuals, either opposite or same sex, who are registered as Domestic Partners with the State of Washington, or who meet all the following criteria:

- Must be 18 or older
- Must have an intimate, committed relationship of mutual caring that has existed for at least 12 months
- Must be financially interdependent and share the same residence
- Neither partner can be married or legally separated from any other person or involved in another domestic partner relationship
- Partners must not be blood relatives of a degree of closeness that would prohibit marriage
- The partners must complete during the enrollment process the Affidavit of Domestic Partnership (and be responsible for keeping a copy of the original and providing copies when requested by the Plan Administrator).

Emergency 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.

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

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

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

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

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

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

- **Intensive Outpatient Programs** provide services for Mental Health or Chemical Dependency Conditions on an outpatient basis through planned, structured services available at least two hours per day and three days per week. Services include group, individual and when indicated family or multi-family group treatment. Medical monitoring, evaluation and adjunctive services are available. Treatment must follow a written plan of care.
- **Inpatient Psychiatric Hospitalization Programs** provide around-the-clock psychiatric and nursing interventions in secure, State-licensed psychiatric facilities for individuals diagnosed with a mental health disorder. These facilities operate under the supervision of a licensed and Board eligible/certified psychiatrist who evaluates the patient within 24 hours of admission. Subsequent face-to-face visits with a psychiatrist or psychiatric ARNP occur at least once every 24 hours along with daily medication management. Treatment must follow a written plan of care and include psychosocial and substance abuse evaluations. Individual, group, and/or family therapy occurs daily. The focus of the program is stabilization of client's psychiatric symptoms through the use of assessment, medication management, evidenced-based treatment strategies, group and individual therapy, behavior management, and active family engagement/therapy.
- **Partial Hospitalization Programs** provide multi-disciplinary care for Mental Health or Chemical Dependency Condition at least 6 hours a day, 5 days a week, and schedule at least three distinct services per day. Services include individual and group therapy, medication evaluation and management, family therapy, activity therapy, occupational therapy, and education training directed at treating the Condition. Services for Mental Health Conditions must include evaluation by a psychiatrist within 48 hours and weekly thereafter. All programs must include a substance abuse evaluation. Treatment must follow a written plan of care.
- **Mental Health Residential Treatment Program** provides around-the-clock behavioral health services that do not need the high level of physical security and psychiatric and nursing interventions that are available in an acute inpatient program. Care is medically monitored with on-site nursing and medical services. The focus of

the program is an improvement of client's psychiatric symptoms through the use of assessment, evidenced-based treatment strategies, group and individual therapy, behavior management, medication management and active family engagement/therapy. Treatment must follow a written plan of care. The facility must be state licensed for residential treatment. Residential settings not meeting these criteria, such as group homes, halfway houses or adult/child foster homes, are not considered to be Mental Health Residential Treatment Programs.

- **Chemical Dependency Rehabilitation/Residential Programs** provide 24-hour rehabilitation treatment 7 days a week for Substance Related Conditions. Care is medically monitored, with 24-hour medical and/or nursing availability. Services include group, individual and when indicated family or multi-family group. The facility must offer sufficient availability of medical and nursing services to manage ancillary detoxification needs. Treatment must follow a written plan of care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Usual, Customary and Reasonable (UCR) is the 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 Plan will allow 50% of the billed charges. Coinsurance, copayments, deductible or non-covered services are applied against UCR amount as patient responsibility. The provider can balance bill the member the difference between the Plan payment and providers actual charges.