



NORTHWEST HOSPITAL  
& MEDICAL CENTER

UW Medicine

## Northwest Hospital & Medical Center

### Medical and Pharmacy Benefits

#### Preferred Plan

Effective January 1, 2011

[www.myFirstChoice.fchn.com](http://www.myFirstChoice.fchn.com)

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

# Table of Contents

---

Important Information about this Plan.....	1
• Grandfathering .....	2
Contacting First Choice Health Administrators .....	3
How to Obtain Health Services - Preferred Plan .....	4
• Preferred Plan .....	4
• Your ID Card.....	4
• Choosing a Provider.....	4
• Services Received outside of the U.S. ....	4
Medical Management .....	6
• Pre-authorization Requirements.....	6
• Notification for Emergency Admissions .....	7
• Notification for Maternity Admissions .....	7
• Concurrent Review and Discharge Coordination .....	7
• Case Management.....	8
Payment Provisions.....	9
• Highlights of Plan Provisions .....	9
• Annual Deductible .....	9
• Annual Out-of-Pocket Maximum .....	10
• Benefit Maximums .....	11
Summary of Medical Benefits.....	12
Medical Benefits .....	20
• Allergy Care.....	20
• Alternative Care.....	20
• Ambulance Services.....	21
• Anesthesia .....	21
• Autologous Blood Donation/Blood Transfusions .....	21
• Biofeedback.....	21
• Chemical Dependency .....	22
• Chiropractic Care .....	22
• Dental Trauma.....	22
• Durable Medical Equipment (DME).....	22
• Emergency and Urgent Care.....	23
• Family Planning.....	24
• Genetic Services .....	24

• Health Education .....	24
• Hearing .....	24
• Home Health Care .....	25
• Hospice Care .....	25
• Hospital Care and Surgical Services .....	26
• Infertility Diagnostic Services .....	26
• Infusion Therapy .....	27
• Lab and Radiology Services .....	27
• Maternity and Newborn Care .....	27
• Mental Health Care .....	28
• Neurodevelopmental Therapy .....	28
• Nutritional Counseling .....	29
• Nutritional and Dietary Formulas .....	29
• Oral Surgery .....	29
• Plastic and Reconstructive Services .....	29
• Podiatric Care .....	30
• Preventive Care .....	30
• Professional/Physician Services .....	31
• Rehabilitation Therapy .....	31
• Skilled Nursing Facility .....	32
• Temporomandibular Joint Syndrome (TMJ) .....	32
• Tobacco Cessation .....	32
• Transplants (Organ and Bone Marrow) .....	33
Plan Exclusions and Limitations .....	35
Summary of Pharmacy Benefits .....	40
Pharmacy Benefits .....	41
• Filling a Prescription .....	41
Pharmacy Exclusions and Limitations .....	43

# Important Information about this Plan

---

This booklet describes your coverage and payment levels and how to use your benefits under the Health Resources Northwest Employee Benefit Plan, otherwise known as the Northwest Hospital & Medical Center Plan, as of January 1, 2011. For information on eligibility and enrollment, terminating and continuing coverage, administration, claim and appeal procedures, definitions and other details, see the accompanying booklet titled “Summary Plan Description.”

Northwest Hospital & Medical Center (NWHMC), 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 Northwest Hospital & Medical Center Plan will be referred to throughout this document and the accompanying Summary Plan Description as the “Plan.” Please review this booklet carefully and share it with your family. If you have questions, contact the Plan’s Benefits Department (Plan Administrator) or FCHA.

**Coverage under this Plan will take effect for eligible employees and dependents when all eligibility requirements are satisfied. Northwest Hospital & Medical Center 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, co-payments, exclusions, limitations, definitions, eligibility and the like.**

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

**These materials do not create a contract of employment or any rights to continued employment with Northwest Hospital & Medical Center.**

## Grandfathering

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

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator (Northwest Hospital) at 9709 Third Ave NE, Suite 509, Seattle, WA 98115. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or [www.dol.gov/ebsa/healthreform](http://www.dol.gov/ebsa/healthreform). This website has a table summarizing which protections do and do not apply to grandfathered health plans.

# Contacting First Choice Health Administrators

---

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

First Choice Health Administrators  
Customer Service Department  
PO Box 12659  
Seattle, WA 98111-4659  
(888) 299-1051  
Local: (206) 268-2360  
Fax: (888) 206-3092  
Medical pre-authorization: (800) 808-0450  
Mental health/chemical dependency pre-authorization: (800) 640-7682  
TTY: (866) 876-5924  
[www.myFirstChoice.fchn.com](http://www.myFirstChoice.fchn.com)

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

You can access benefit information or your specific claim and enrollment status anytime at [www.myFirstChoice.fchn.com](http://www.myFirstChoice.fchn.com) or by calling FCHA Customer Service's automated voice response system at (888) 299-1051.

# How to Obtain Health Services - Preferred Plan

---

## Preferred Plan

Under the Preferred Plan, you must see a Network provider to receive benefits for covered services. No benefits are paid if you obtain care from a Non-Network provider.

## 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 (888) 299-1051, or logging into [www.myFirstChoice.fchn.com](http://www.myFirstChoice.fchn.com). Under no circumstances should you give your ID card to another person for their use.

## Choosing a Provider

To receive benefits for covered services you must seek care from Network providers. You may choose providers based on your specific geographic location, whether at home or traveling, from the PPO Networks listed in the chart below. Contact the networks directly, either by phone or through the web site addresses provided, for information on providers and/or provider directories.

Networks	State/Area	Phone	Websites
First Choice Health PPO Network	Washington, Alaska, Oregon and Idaho	(800) 231-6935	<a href="http://www.fchn.com">www.fchn.com</a>
Health InfoNet of Montana	Montana	(800) 231-6935	<a href="http://www.fchn.com">www.fchn.com</a>
Beech Street PPO Network	All other states/areas not served by FCHN or Health InfoNet of Montana	(800) 877-1444, ext.2	<a href="http://www.beechstreet.com">www.beechstreet.com</a>

## Services Received outside of the U.S.

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

- Participants must pay for medical services at the time of service.

- Upon returning to the United States, submit an itemized statement of charges that includes diagnosis and all charges paid. The exchange rate for foreign currency must also be noted on submitted forms.
- Charges submitted must be for an Emergency or Urgent Care as defined in the 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 noted in the *Summary of Medical Benefits*. Your claims will be denied if pre-authorization is not obtained on the services noted below. For any of the services noted you are responsible for obtaining pre-authorization directly from FCHA. You may have your provider contact FCHA for you, but you are ultimately responsible. Call (800) 430-3818 for pre-authorization on medical services or (800) 640-7682 for mental health or chemical dependency services. Pre-authorization is required for:

- **Ambulance** (except in life-threatening circumstances)
  - Air transport
  - Inter-facility transport
- **Dental trauma services** (follow-up services)
- **Durable medical equipment, medical supplies and prosthetics**
  - When purchase exceeds \$2,000; or
  - When rental exceeds \$500 per month
- **Experimental, investigational or unproven services**
- **Genetic testing** (excluding standard maternity)
  - Over \$1,000
- **Hemodialysis** (for chronic kidney disease)
- **Home health care services**
  - Home health visits
  - Home infusion therapy (enteral and IV)
  - Hospice (respite care only)
- **Hyperbaric therapy**
- **Imaging**
  - PET scans
- **Inpatient admissions**
  - Chemical dependency and mental health admissions (including residential)
  - Inpatient hospice
  - Inpatient rehabilitation admissions
  - Medical/surgical admissions (excluding routine maternity deliveries)
  - Skilled nursing admissions
- **Medical injectables and other drugs**
  - Blood clotting factors
  - Botox A & B
  - Intravenous immunoglobulin (IVIG) therapy
  - Synagis

- **Organ and bone marrow transplants** (includes evaluation of, services for both recipient and donor, and travel and lodging expenses)
- **Reconstructive procedures** - All procedures that may be considered cosmetic, including but not limited to:
  - Breast reduction
  - Eyelid surgery (i.e. blepharoplasty)
  - Removal of breast implants
  - Rhinoplasty
  - Varicose vein procedures
- **Surgical services**
  - Stereotactic radiosurgery (i.e. gamma knife, cyber knife, proton beam)
  - Surgical interventions for sleep apnea

As noted above, if you neglect to obtain pre-authorization for services which require it your claim(s) will be denied. Payments of claims denied for 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. If a service could be considered experimental and investigational for a given condition, we recommend a benefit determination in advance, since those services are not covered.

## Notification for Emergency Admissions

You do not need to pre-certify emergency care, nor do admissions directly from the emergency room require pre-authorization. However, notification is required within 24 hours from the start of the emergency care or emergency admission, or as soon as you are reasonably able to do so. Any follow-up care by a Non-Network provider must be certified by FCHA.

## Notification for Maternity Admissions

Pre-authorization is not required for maternity admissions. However, you are expected to notify FCHA of the admission.

## Concurrent Review and Discharge Coordination

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

## Case Management

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

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

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

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

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

# Payment Provisions

---

## Highlights of Plan Provisions

- To receive the best benefit for hospital care and surgical services (both inpatient and outpatient) and for certain diagnostic tests, care must be provided at NWHMC if NWHMC is able to provide that care. If care is provided at another Network provider when it could have been provided at NWHMC, the Network (or lower) benefit will be paid.
- In those instances where NWHMC does not perform or provide a particular surgical procedure or service the Plan will cover those at the higher benefit, as if they had been performed at NWHMC.
- If your home zip code is 75 miles or greater from NWHMC's zip code of 98133, you will receive the best benefit when you see another Network provider.
- Under the Preferred Plan, you must see a Network provider to receive benefits for covered services. No benefits are paid if you obtain care from a Non-Network provider.
- Multiple sessions of the same type of therapy, on the same day, will count as only one visit towards any applicable benefit maximum, unless care is furnished by different providers.
- Benefit payment is based on the Allowed Amounts agreed upon by Network providers.
- Services received from a Recognized Provider (See *Plan Definitions* within accompanying Summary Plan Description) will be paid at the Network level. An Allowed Amount will be obtained through Usual, Customary and Reasonable data, or a negotiated rate. If neither is available or appropriate, billed charges may be used as the Allowed Amount. You will be responsible for any difference (if any) between the Allowed Amount and the billed charges on Recognized Provider claims, and this difference would not apply to your Out-of-Pocket (OOP) maximum as discussed below.

## 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. Once the deductible is met, copayment and coinsurance amounts as noted in the *Summary of Medical Benefits* will be applied. Until then, the amount due a provider is your responsibility.

This Plan offers a “Traditional” deductible which means each individual will meet no more than the individual deductible, but together, the family will meet no more than the stated family deductible amount, regardless of family size. This means some individuals within the family may not need to meet his/her individual deductible if the family deductible has been met.

This Plan also offers a “Deductible Carry-over” which means covered expenses incurred and applied to the deductible during the last three (3) months of a Plan year may be applied to the next Plan year's deductible.

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 FCHA 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
- Charges that exceed annual or lifetime benefit maximums
- Charges for claims denied for lack of pre-authorization
- Copayments/Coinsurances
- Pharmacy deductible

*Important Note: If two or more family members are involved in the same accident, only one deductible will apply.*

## 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, similar to the deductible, offers a “Traditional” Out-of-Pocket Maximum arrangement which means each individual will meet no more than the individual Out-of-Pocket Maximum, but together, the family will meet no more than the stated family Out-of-Pocket Maximum, regardless of family size. This means some individuals within the family may not need to meet his/her individual Out-of-Pocket Maximum if the family Out-of-Pocket Maximum has been met.

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

- Annual medical 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 annual or lifetime benefit maximums
- Charges for claims denied for lack of pre-authorization
- Charges for services paid by the Plan at 100%
- Copayments, for pharmacy benefits

## Benefit Maximums

Your annual Deductible and Out-of-Pocket Maximum, as well as your lifetime and Plan year benefit Maximums are noted in the tables that follow:

### Annual Deductible, and Out-of-Pocket Maximums:

Deductible and Out-of-Pocket Maximums	Network
<b>Annual Deductible</b>	
Individual	\$200
Family	\$600
<b>Annual Out-of-Pocket Maximum</b>	
Individual	\$2,500
Family	\$7,500

### Summary of Benefit Maximums:

<b>Lifetime Maximum Benefits</b>	
<b>Hearing</b> (assessment, treatment and aids/appliances)	\$2,000 per ear/\$4,000 combined
<b>Hospice Care</b> - Inpatient	10 days
<b>Smoking Cessation</b>	\$500
<b>Temporomandibular Joint Syndrome (TMJ)</b>	\$5,000
<b>Plan Year Maximums</b>	
<b>Individual Aggregate</b>	\$1,000,000
<b>Home Health Care</b>	130 visits
<b>Hospice Care</b>	
• <b>Respite Care</b>	120 hours during each 3 month period
<b>Naturopathic Care</b>	\$500
<b>Neurodevelopmental Therapy</b>	45 Outpatient visits
<b>Preventive Care</b>	\$500
<b>Rehabilitation Therapy</b>	
• <b>Outpatient</b> - Speech, Occupational and, Physical Therapies	• 45 visits
<b>Temporomandibular Joint Syndrome (TMJ)</b>	\$1,000

# Summary of Medical Benefits

	Applies to Deductible	Applies to OOP Max	Northwest Hospital	Network Providers
<b>Allergy Care</b>				
• <b>Testing</b>	✓	n/a	n/a	100%
• <b>Injections</b>	✓	✓	n/a	100% after \$20 copay
<b>Alternative Care</b>				
Maintenance therapy is not covered.				
• <b>Acupuncture</b>	✓	✓	n/a	90% after \$20 copay
• <b>Massage Therapy</b> Prescription required.	✓	✓	n/a	90% after \$20 copay
• <b>Naturopathic Care</b> \$500 Plan year maximum	✓	✓	n/a	90% after \$20 copay
<b>Ambulance Services</b>				
FCHA pre-authorization required for non-emergent air ambulance and inter-facility transport.	✓	✓	n/a	80%
<b>Anesthesia</b>	✓	✓	n/a	100% after \$20 copay
<b>Autologous Blood Donation/Blood Transfusions</b>	✓	n/a	100%	100%
<b>Biofeedback</b> Limited benefit, see <i>Biofeedback</i> for details.	✓	✓	n/a	100% after \$20 copay
<b>Chemical Dependency</b>				
FCHA pre-authorization required for inpatient, residential and partial hospitalization.				
• <b>Inpatient Facility services</b>	✓	✓	90%	90%
• <b>Inpatient professional services</b>	✓	✓	n/a	100% after \$20 copay
• <b>Outpatient</b> - facility and professional	✓	✓	n/a	100% after \$20 copay
<b>Chiropractic Care</b> Maintenance therapy is not covered.	✓	✓	n/a	90% after \$20 copay

	Applies to Deductible	Applies to OOP Max	Northwest Hospital	Network Providers
<b>Dental Trauma</b> FCHA pre-authorization required for follow-up services.	✓	✓	n/a	90%
<b>Durable Medical Equipment</b> FCHA pre-authorization required if purchases exceed \$2,000 or \$500 per month rental. DME obtained from a non-network provider is paid at the network level.				
<ul style="list-style-type: none"> <li>• <b>Durable Medical Equipment</b></li> </ul>	✓	✓	n/a	80%
<ul style="list-style-type: none"> <li>• <b>Medical Supplies</b></li> </ul>	✓	✓	n/a	90%
<ul style="list-style-type: none"> <li>• <b>Oral appliances</b> (for treatment of obstructive sleep apnea and TMJ)</li> </ul>	✓	✓	n/a	80%
<ul style="list-style-type: none"> <li>• <b>Orthopedic Appliances</b></li> </ul>	✓	✓	n/a	80%
<ul style="list-style-type: none"> <li>• <b>Orthotics</b> (medically necessary requiring a prescription; does not include foot orthotics found over-the-counter)</li> </ul>	✓	✓	n/a	80%
<ul style="list-style-type: none"> <li>• <b>Prosthetic Devices</b></li> </ul>	✓	✓	n/a	90%
<b>Emergency Care</b> Non-network Emergency Room services are paid at the network level. FCHA pre-authorization required for follow-up care by a Non-Network provider.  FCHA notification of emergency care or admission required within 24 hours.				
<ul style="list-style-type: none"> <li>• <b>Emergency Room</b> (facility and professional services)                 Copay waived if admitted within 24 hours of ER visit. No coverage exists for non-emergency care within an emergency room.</li> </ul>	✓	✓	90% after \$75 copay	90% after \$75 copay
<ul style="list-style-type: none"> <li>• <b>Urgent Care</b> (facility and professional services)</li> </ul>	✓	✓	90% after \$20 copay	90% after \$20 copay
<b>Family Planning</b>				
<ul style="list-style-type: none"> <li>• <b>Office Visits and other professional services</b></li> </ul>	✓	✓	n/a	100% after \$20 copay
<ul style="list-style-type: none"> <li>• <b>Contraceptive supplies</b>; - devices, implants and injections (oral contraceptives covered under Pharmacy)</li> </ul>	✓	✓	n/a	90%

	Applies to Deductible	Applies to OOP Max	Northwest Hospital	Network Providers
<b>• Infertility Diagnostic Services</b>				
- In office	✓	n/a	n/a	100%
- Outpatient	✓	✓	n/a	90%
<b>• Sterilization</b>	✓	✓	n/a	100% after \$20 copay
<b>• Termination of Pregnancy</b>	✓	✓	n/a	100% after \$20 copay
<b>Foot Orthotics</b> Benefit does not include over-the-counter products.	✓	✓	n/a	80%
<b>Genetic Services</b>				
<b>• Genetic Testing/Counseling - facility</b>	✓	✓	n/a	90%
<b>• Genetic Testing/Counseling - professional</b>	✓	✓	n/a	100% after \$20 copay
<b>Health Education</b>	✓	✓	n/a	100% after \$20 copay
<b>Hearing</b> Benefit includes assessment, treatment and aids/appliances. \$2,000 maximum benefit per ear; \$4,000 combined.	✓	✓	n/a	90%
<b>Home Health Care (HHC)</b> FCHA pre-authorization required; 130 visits combined Plan year maximum				
<b>• Home Health Care</b>	✓	✓	n/a	90%
<b>• Phototherapy (home)</b>	✓	✓	n/a	90%
<b>• Infusion Therapy (as part of HHC)</b>	✓	✓	n/a	90%
<b>Hospice Care</b>				
<b>• Hospice</b> FCHA pre-authorization required; 10 inpatient day lifetime maximum.	✓	✓	n/a	90%
<b>• Respite Care</b> 120 hours maximum per every 3 months of hospice care.	✓	✓	n/a	90%

	Applies to Deductible	Applies to OOP Max	Northwest Hospital	Network Providers
<b>Hospital Inpatient Medical and Surgical Care</b> FCHA pre-authorization required. Plan will pay 90% at Network facilities if: (1) your home zip code is 75+ miles from NWHMC's 98133 zip code, or (2) NWHMC does not perform a particular surgery or service.				
• <b>Facility services</b>	✓	✓	90%	60%
• <b>Inpatient doctor visits/consultations</b>	✓	✓	n/a	100% after \$20 copay
• <b>Inpatient professional services</b> (surgeon, radiologist, pathologist)	✓	✓	n/a	100% after \$20 copay
<b>Hospital Outpatient Surgery and Services</b> FCHA pre-authorization required for certain outpatient services; see <i>Pre-authorization Requirements</i> . Plan will pay 90% at Network facilities if: (1) your home zip code is 75+ miles from NWHMC's 98133 zip code, or (2) NWHMC does not perform a particular surgery or service.				
• <b>Surgical facility services</b>	✓	✓	90%	60%
• <b>Ambulatory Surgery Center (ASC)</b>	✓	✓	90%	60%
• <b>Outpatient professional services</b> (surgeon, radiologist, pathologist)	✓	✓	n/a	100% after \$20 copay
<b>Infertility Diagnostic Services</b>	<i>See Family Planning.</i>			
<b>Infusion Therapy</b> (separate from Home Health Care)				
- <b>In office</b>	✓	✓	n/a	100% after \$20 copay
- <b>Outpatient</b>	✓	✓	90%	60%
<b>Lab and Radiology Services</b> (Non-routine, facility and professional services) FCHA pre-authorization required for PET Scans.				
• <b>Hospital Inpatient</b> - professional	✓	✓	90%	90%
• <b>Hospital Outpatient</b> - facility and professional	✓	✓	90%	90%
• <b>Diagnostic Tests</b> MRI, CT Scan, and Ultrasound	✓	✓	90%	60% after \$20 copay

	Applies to Deductible	Applies to OOP Max	Northwest Hospital	Network Providers
<ul style="list-style-type: none"> <li><b>Diagnostic Tests</b></li> </ul> PET Scans	✓	✓	n/a	90%
<ul style="list-style-type: none"> <li><b>Lab and x-ray facility</b></li> </ul> Lab or radiology services provided by an independent lab or radiology provider, group, facility or office, but billed separately from the provider of care	✓	✓	n/a	90%
<ul style="list-style-type: none"> <li><b>Doctor's office</b></li> </ul> Office based lab or radiology service provided as part of the office visit, and billed as part of the office visit	✓	n/a	n/a	100%
<b>Maternity and Newborn Care</b> FCHA notification required of maternity admissions; see <i>Medical Management</i> . For diagnostic testing billed outside the global fee, see <i>Lab and Radiology Services</i> .				
<ul style="list-style-type: none"> <li><b>Maternity and Newborn</b> (inpatient/outpatient care at facility)</li> </ul>	✓	✓	90%	60%
<ul style="list-style-type: none"> <li><b>Maternity care</b> (professional services provided inpatient or outpatient)</li> </ul>	✓	✓	n/a	90% after \$20 copay
<ul style="list-style-type: none"> <li><b>Maternity care</b> (office visits billed separately from the global fee)</li> </ul>	✓	✓	n/a	100% after \$20 copay
<ul style="list-style-type: none"> <li><b>Newborn care</b> (professional)</li> </ul>	✓	✓	n/a	90% after \$20 copay
<b>Mental Health Care</b> FCHA pre-authorization required for inpatient care.				
<ul style="list-style-type: none"> <li><b>Inpatient – facility</b></li> </ul>	✓	✓	n/a	90%
<ul style="list-style-type: none"> <li><b>Inpatient – professional/Residential Treatment</b></li> </ul>	✓	✓	n/a	100% after \$20 copay
<ul style="list-style-type: none"> <li><b>Inpatient doctor visits/consultations</b></li> </ul>	✓	✓	n/a	100% after \$20 copay
<ul style="list-style-type: none"> <li><b>Partial Day Treatment (PDT)</b></li> </ul>	✓	✓	n/a	90%
<ul style="list-style-type: none"> <li><b>Outpatient</b></li> </ul>	✓	✓	n/a	100% after \$20 copay
<b>Neurodevelopmental Therapy</b> (through age 6) 45 visits per Plan year maximum (whichever comes first)	✓	✓	n/a	90%
<b>Nutritional Counseling</b>	<i>See Health Education.</i>			
<b>Nutritional and Dietary Formulas</b>	✓	✓	n/a	90%

	Applies to Deductible	Applies to OOP Max	Northwest Hospital	Network Providers
<b>Oral Surgery</b> Limited benefit; see <i>Oral Surgery</i> for details.				
• <b>Inpatient/Outpatient</b> (facility and professional)	✓	✓	90%	90%
<b>Plastic and Reconstructive Services</b> FCHA pre-authorization required. Limited benefit; see <i>Plastic and Reconstructive Services</i> for details.				
• <b>Inpatient/Outpatient</b> (facility)	✓	✓	90%	60%
• <b>Inpatient/Outpatient Care</b> (professional)	✓	✓	n/a	100% after \$20 copay
<b>Podiatric Care</b> See <i>Podiatric Care</i> for details on Routine Foot Care.	✓	✓	n/a	100% after \$20 copay
<b>Preventive Care (\$500 Plan Year Maximum)</b>				
Important notes regarding your Preventive Care benefits:				
<ul style="list-style-type: none"> <li>• Claims for Preventive Care services received after the \$500 Plan year maximum is reached will be paid, if medically necessary, according to the applicable benefit and subject to the annual deductible (if applicable).</li> <li>• If your provider bills your visit as treatment for a medical condition instead of a routine physical exam, the services are not considered preventive.</li> <li>• A request for preauthorization to waive any recommended noted frequency of service may be made to FCHA. Such preauthorization must be requested through submittal of a pre-service claim.</li> <li>• Regardless of preauthorization, coverage will not be provided more often than once each Plan year if benefits described in this section have recommended frequencies of annually, or one every one to three years.</li> <li>• The Plan covers only one routine exam under the preventive care benefit each Plan year. If you have two visits for preventive care in the same Plan (also calendar) year, the Plan may deny payment for the second claim received even if the visit would otherwise be considered covered.</li> <li>• This list of preventive care benefits is not all inclusive.</li> </ul>				
<b>Immunizations</b>				
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.	n/a	✓	n/a	100% after \$15 copay
Travel immunizations are not covered.				

	Applies to Deductible	Applies to OOP Max	Northwest Hospital	Network Providers
<b>Office Visits</b>				
<ul style="list-style-type: none"> <li><b>Well Baby Care</b> Newborn through 2 years (newborn and at 2, 4, 6, 9, 12, 15 and 18 months)</li> </ul>	n/a	✓	n/a	100% after \$15 copay
<ul style="list-style-type: none"> <li><b>Well Child, Adolescent and Adult Preventive Care</b> (2 and older ) 1 well-child/adult exam annually</li> </ul>	n/a	✓	n/a	100% after \$15 copay
<b>Screening Tests</b>				
1 visit per Plan year unless otherwise indicated:				
<ul style="list-style-type: none"> <li><b>Body Mass Index</b> (screening for those overweight and/or with eating disorders)</li> </ul>	n/a	n/a	n/a	100%
<ul style="list-style-type: none"> <li><b>Chlamydia and gonorrhea screening</b> of all sexually active patients (once annually until age 25; 25+ if at risk)</li> </ul>	n/a	n/a	n/a	100%
<ul style="list-style-type: none"> <li><b>Cholesterol/Lipid</b> (1 every 5 years women 45 - 65 years, men from 35 – 65 years, and both after 65 at physician discretion)</li> </ul>	n/a	n/a	n/a	100%
<ul style="list-style-type: none"> <li><b>Colonoscopy</b> (once every 10 years for adults 50 and older, or younger for those at risk; will not be allowed if within 48 months of sigmoidoscopy)  <i>This service does not apply to the Preventive Care \$500 Plan year maximum.</i></li> </ul>	n/a	✓	n/a	100% after \$15 copay
<ul style="list-style-type: none"> <li><b>Fasting blood glucose</b> (for patients 19 and older, testing every 1 – 3 years for patients with an established diagnosis of hypertension or hyperlipidemia)</li> </ul>	n/a	n/a	n/a	100%
<ul style="list-style-type: none"> <li><b>Fecal occult blood test</b> (for colorectal cancer; performed as part of preventive health visit for patients 50 and older)</li> </ul>	n/a	n/a	n/a	100%
<ul style="list-style-type: none"> <li><b>Gynecological exams</b> (including pelvic and breast exams, Pap tests and self-exam instruction for females 13 and older)  <i>These services do not apply to the Preventive Care \$500 Plan year maximum.</i></li> </ul>	n/a	✓	n/a	100% after \$15 copay
<ul style="list-style-type: none"> <li><b>Hearing evaluation</b> (evaluations can be performed separately or in conjunction with preventive care visit)</li> </ul>	n/a	n/a	n/a	100%
<ul style="list-style-type: none"> <li><b>HIV screening</b> (for patients 8 and older, up to two tests annually for those at increased risk)</li> </ul>	n/a	n/a	n/a	100%

	Applies to Deductible	Applies to OOP Max	Northwest Hospital	Network Providers
<ul style="list-style-type: none"> <li>• <b>Mammogram</b> (age 40 and older) <i>This service does not apply to the Preventive Care \$500 Plan year maximum.</i></li> </ul>	n/a	✓	n/a	100% after \$15 copay
<ul style="list-style-type: none"> <li>• <b>Sigmoidoscopy</b> (once every 48 months for adults 50 and older, or younger if at risk) <i>This service does not apply to the Preventive Care \$500 Plan year maximum.</i></li> </ul>	n/a	✓	n/a	100% after \$15 copay
<ul style="list-style-type: none"> <li>• <b>Syphilis screening</b> (for patients 11 and older at risk)</li> </ul>	n/a	n/a	n/a	100%
<ul style="list-style-type: none"> <li>• <b>Testicular exam</b> (including self-exam instruction for males 15 and older)</li> </ul>	n/a	n/a	n/a	100%
<ul style="list-style-type: none"> <li>• <b>Vision evaluation</b> (evaluations can be performed separately or in conjunction with preventive care visit)</li> </ul>	n/a	n/a	n/a	100%
<b>Additional Preventive Care Services Covered</b>				
<ul style="list-style-type: none"> <li>• Oral fluoride supplements for children 6 months and older if primary water source is deficient in fluoride.</li> </ul>	n/a	n/a	n/a	100%
<b>Professional/Physician Services</b> (office/hospital/home visits)	✓	✓	n/a	100% after \$20 copay
<b>Rehabilitation Therapy</b>				
<ul style="list-style-type: none"> <li>• <b>Inpatient</b> FCHA pre-authorization required</li> </ul>	✓	✓	90%	60%
<ul style="list-style-type: none"> <li>• <b>Outpatient</b> - facility (includes physical, speech, occupational and massage therapies) 45 visit maximum per Plan year; all therapies combined</li> </ul>	✓	✓	90%	60%
<ul style="list-style-type: none"> <li>• <b>Outpatient</b> - professional (includes physical, speech, occupational and massage therapies) 45 visit maximum per Plan year; all therapies combined</li> </ul>	✓	✓	90% after \$20 copay	60% after \$20 copay
<b>Skilled Nursing Facility</b> FCHA pre-authorization required.	✓	✓	n/a	90%
<b>Temporomandibular Joint Syndrome (TMJ)</b> \$1,000 Plan year maximum; \$5,000 lifetime maximum. See <i>Durable Medical Equipment</i> for TM-related oral appliances.	✓	✓	n/a	90% after \$20 copay

	<b>Applies to Deductible</b>	<b>Applies to OOP Max</b>	<b>Northwest Hospital</b>	<b>Network Providers</b>
<b>Tobacco Cessation</b> (including prescribed drugs) \$500 lifetime maximum	n/a	✓	n/a	100%
<b>Transplants (Organ and Bone Marrow)</b> FCHA pre-authorization required.	✓	✓	90%	60%
<b>Vision Care</b>	Limited benefit, see <i>Preventive Care</i> for details.			

*Exclusions or benefit limitations may apply to the benefits defined within this Medical Benefits section; please see the “Plan Exclusions and Limitations” and “Summary of Benefit Maximums” sections prior to seeking services.*

# 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 and Pharmacy Benefits* and *Medical Limitations and Exclusions* for more details, along with *Plan Definitions* in the accompanying Summary Plan Description. Coverage is provided only when **all** these conditions are met:

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

In some circumstances the Plan may allow alternate benefits. Alternate benefits means payment for those services or supplies which are not otherwise covered expenses for the Plan, but that FCHA as the claims administrator, or NWH, as the Plan Administrator, believes to be medically necessary and cost effective. If FCHA or NWH approves payment for alternate benefits, the participant will be notified of such approval and its duration.

The fact that alternate benefits are paid by the Plan for one Plan participant shall not obligate the Plan to pay such benefits for other Plan participants. Nor shall it obligate the Plan to pay continued or additional alternate benefits for the same Plan participant. Payments for alternate benefits are covered expenses for purposes under the Plan.

## 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, massage therapist and/or naturopathic doctor to treat a covered and diagnosed illness or injury. Benefits are not offered for recreational purposes (for example, for tension relief purposes in the absence of a diagnosis of illness or injury) or maintenance therapy.

*Exclusions or benefit limitations may apply to the benefits defined within this Medical Benefits section; please see the “Plan Exclusions and Limitations” and “Summary of Benefit Maximums” sections prior to seeking services.*

## Ambulance Services

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

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

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

## Anesthesia

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

### General Anesthesia for Dental Care

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

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

## Autologous Blood Donation/Blood Transfusions

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

## 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, however, no coverage is provided when used as treatment for mental health.

*Exclusions or benefit limitations may apply to the benefits defined within this Medical Benefits section; please see the “Plan Exclusions and Limitations” and “Summary of Benefit Maximums” sections prior to seeking services.*

## Chemical Dependency

All inpatient admissions **require FCHA pre-authorization** by calling (800) 640-7682.

Emergency admissions require **notification** as described in the *Medical Management* section.

The plan covers treatment of individuals requiring chemical dependency rehabilitation for abuse of substances such as alcohol or DEA-controlled oral, intravenous or inhaled medications and materials. Care must be medically necessary and provided at the least restrictive level of care. A clear treatment plan containing measurable progress toward a rehabilitative goal(s), including but not limited to movement to a less restrictive setting (if applicable), or other medically necessary goals as determined by your provider and FCHA’s medical management.

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

## Chiropractic Care

Coverage includes manipulation of the spine, diagnostic radiology, and diagnosis and treatment of musculoskeletal disorders when performed within the scope of the chiropractor’s license.

Maintenance therapy is not covered.

## Dental Trauma

Not intended as dental coverage, this benefit coverage is provided for repair (or replacement if necessary) of sound natural teeth, and repair of the jaw bone or supporting tissues, due to accidental injury. After the initial examination by your dentist, a pre-authorization for further services is required by FCHA. All services related to the repair must be completed within one (1) year from the date of the injury. Any services received after one year has elapsed, or after you become disenrolled from this Plan regardless of whether one year has elapsed or not, are not covered.

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

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

## Durable Medical Equipment (DME)

DME is medical equipment that can withstand repeated use, is not disposable, is used for a medically therapeutic purpose, is generally not useful in the absence of sickness or injury and is appropriate for use in the home. DME may be rented or purchased (at FCHA’s discretion) and

*Exclusions or benefit limitations may apply to the benefits defined within this Medical Benefits section; please see the “Plan Exclusions and Limitations” and “Summary of Benefit Maximums” sections prior to seeking services.*

total cost for rental must not exceed the purchase price. Repair or replacement is only covered when needed due to normal use, a change in the patient’s physical condition or the growth of a child. Duplicate items are not covered. When more than one option exists, benefits will be limited to the least expensive model or item appropriate to treat the patient’s covered condition.

Examples of DME include, but are not limited to:

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

This benefit also covers:

- **Diabetic monitoring equipment**, such as the initial cost of an insulin pump and blood glucose monitor (including supplies related to such equipment). Diabetic supplies such as insulin, syringes, needles, lancets, etc, are covered under the pharmacy benefit.
- **Medical supplies** needed for the treatment or care of an appropriate covered condition, and ostomy supplies. Supplies available over-the-counter are excluded.
- **Oral Appliances** specific to the treatment of Sleep Apnea.
- **Orthopedic appliances**: These include appliances used to support abnormal joints, limit pressure on a joint after injury to allow it to heal or correct abnormal curves in the spine.
- **Prosthetic devices**: Benefits include external prosthetic appliances which are used to replace all or part of a missing body part and are necessary for the alleviation or correction of illness, injury, or congenital defect.

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

## Emergency and Urgent Care

Always seek the most immediate care available if you or a family member has a life-threatening emergency. Contact FCHA within 24 hours of any emergency care or admission. The Plan covers emergency room and urgent care visits in network and non-network facilities, though FCHA pre-authorization is required for follow-up care provided by a non-network provider. (*See Medical Management.*)

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.

*Exclusions or benefit limitations may apply to the benefits defined within this Medical Benefits section; please see the “Plan Exclusions and Limitations” and “Summary of Benefit Maximums” sections prior to seeking services.*

- 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.

## Family Planning

### Birth Control and Sterilization

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

Over-the-counter products are not covered. Oral contraceptives are covered under the pharmacy benefit.

### 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.

### Termination of Pregnancy

Voluntary termination of pregnancy within the first trimester is covered for an employee, spouse or dependent.

## 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.

## Health Education

Health education services and instruction is covered when needed to achieve and/or maintain physical and mental health or for preventing illness or injury. Nutritional counseling for chronic conditions such as diabetes is considered health education and covered as part of this benefit.

## Hearing

Benefits are available for services related to hearing loss, including assessment, treatment and devices.

*Exclusions or benefit limitations may apply to the benefits defined within this Medical Benefits section; please see the “Plan Exclusions and Limitations” and “Summary of Benefit Maximums” sections prior to seeking services.*

## Home Health Care

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

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

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

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

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

## Hospice Care

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

- **Intermittent in-home visits** are provided on an as needed basis by the hospice team, which includes health care professionals, support staff, and a twenty-four (24) hour a day “on-call” registered nurse. This level of care does not cover room and board while a member resides in a skilled nursing facility, adult family home, or assisted living facility.
- **Inpatient Hospice care** is needed when care cannot be managed where the patient resides. The care will be provided at an inpatient facility until the patient’s condition stabilizes. Coverage for room and board is covered at this level.
- **Continuous home care** is provided when a medical crisis occurs where the patient resides and care can be provided at the residence. During such periods, the hospice team can provide around-the-clock care for up to 5 days.
- **Inpatient respite care** is available to provide the patient’s caregiver a rest of up to 5 days at one period of time. This acknowledges that caring for a dying person can be difficult. Care for the patient is provided at an inpatient facility and includes room and board costs.

*Exclusions or benefit limitations may apply to the benefits defined within this Medical Benefits section; please see the “Plan Exclusions and Limitations” and “Summary of Benefit Maximums” sections prior to seeking services.*

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 Care and Surgical Services

### Hospital Inpatient Medical and Surgical Care

**FCHA pre-authorization is required** for all non-emergency inpatient admissions to a hospital or facility. Hospital inpatient and facility charges for medically necessary care are covered. Covered inpatient care includes semiprivate 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.

### Inpatient and Outpatient Hospital Care

To receive the highest level of reimbursement under the Plan, your services must be provided by NWHMC. Services provided at any other Network facility will be reimbursed at a reduced level, unless your home zip code is greater than 75 miles from NWHMC’s zip code of 98133.

If NWHMC does not perform a particular surgical procedure or offer a particular service, the Plan will pay for those procedures or services (if otherwise described herein as covered) at the NWHMC reimbursement.

## Infertility Diagnostic Services

*See Family Planning.*

*Exclusions or benefit limitations may apply to the benefits defined within this Medical Benefits section; please see the “Plan Exclusions and Limitations” and “Summary of Benefit Maximums” sections prior to seeking services.*

## **Infusion Therapy**

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

## **Lab and Radiology Services**

The plan covers lab and radiology services for diagnostic purposes when medically necessary and ordered by a qualified provider. To receive the highest level of reimbursement under the Plan, MRI, CT Scan and Ultrasound procedures need to be provided by NWHMC. If these procedures are provided at any other Network facility, they will be reimbursed at a reduced level after the applicable copay.

## **Maternity and Newborn Care**

Notification of a maternity admission is required within 2 business days, or as soon as possible. Pre-authorization is required on all non-network maternity admissions.

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

In accordance with the Newborn’ and Mothers’ Health Protection Act of 1996, this Plan 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.

Coverage for newborns is provided automatically for three weeks from the date of birth. For care to be covered after three weeks you must enroll the newborn as a dependent on this Plan. See the *Enrollment* section of the accompanying Summary Plan Description for more information and timelines. Benefits are subject to the newborn child’s own coinsurance and deductible requirements.

*Exclusions or benefit limitations may apply to the benefits defined within this Medical Benefits section; please see the “Plan Exclusions and Limitations” and “Summary of Benefit Maximums” sections prior to seeking services.*

Newborn care includes:

- Inpatient hospital care, including inpatient care separate from the maternity admission
- Circumcision
- Outpatient and emergency care for the medically necessary treatment of an illness or injury
- Professional care and medically appropriate follow-up care which includes services of home health agencies and registered nurses

## Mental Health Care

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

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

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

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

## Neurodevelopmental Therapy

Neurodevelopmental therapy services are covered to restore and improve function in neurodevelopmentally disabled children 6 and younger only. Children 7 years and older are not covered. The therapy must be part of a formal written treatment Plan prescribed by a physician. Benefits include:

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

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

*Exclusions or benefit limitations may apply to the benefits defined within this Medical Benefits section; please see the “Plan Exclusions and Limitations” and “Summary of Benefit Maximums” sections prior to seeking services.*

## Nutritional Counseling

See *Health Education*.

## Nutritional and Dietary Formulas

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

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

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

## Oral Surgery

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

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

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

## Plastic and Reconstructive Services

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

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

*Exclusions or benefit limitations may apply to the benefits defined within this Medical Benefits section; please see the “Plan Exclusions and Limitations” and “Summary of Benefit Maximums” sections prior to seeking services.*

### *Women’s Health and Cancer Rights Act of 1998*

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

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

## **Podiatric Care**

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

## **Preventive Care**

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

- Routine physicals
- Periodic examinations including the specific diagnostic testing/screening and laboratory services
- Adult, child and adolescent immunizations as recommended by the Centers for Disease Control

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

If your provider bills any service as treatment for a medical condition instead of as a routine physical exam, the services will not be processed as preventive. The plans cover only one routine exam under the preventive care benefit per calendar year. If you have two visits for preventive care in a calendar year, the plans may deny payment for the second claim received even if the visit would otherwise be covered.

For more information on recommended immunization schedules visit the following website:  
[www.cdc.gov/vaccines](http://www.cdc.gov/vaccines).

*Exclusions or benefit limitations may apply to the benefits defined within this Medical Benefits section; please see the “Plan Exclusions and Limitations” and “Summary of Benefit Maximums” sections prior to seeking services.*

## Professional/Physician Services

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

## Rehabilitation Therapy

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

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

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

## Inpatient Rehabilitation

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

## Outpatient Rehabilitation

Outpatient rehabilitation benefits are subject to the following provisions:

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

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

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

*Exclusions or benefit limitations may apply to the benefits defined within this Medical Benefits section; please see the “Plan Exclusions and Limitations” and “Summary of Benefit Maximums” sections prior to seeking services.*

## Skilled Nursing Facility

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

## Temporomandibular Joint Syndrome (TMJ)

**FCHA pre-authorization is required** for inpatient admissions related to TMJ. Medical, surgical and related hospital services are covered for the treatment of TMJ. Medical and surgical services are those which are:

- Effective for the control or elimination of one or more of the following conditions caused by a disorder of the Temporomandibular Joint:
  - Pain
  - Infection
  - Disease
  - Difficulty in speaking, or
  - Difficulty in chewing or swallowing
- Not experimental or investigational as determined by FCHA
- Not primarily for cosmetic purposes
- Reasonable and appropriate for the treatment of a disorder of the Temporomandibular Joint
- Recognized as effective according to the professional standards of good medical practice

## Tobacco Cessation

Coverage is provided for tobacco cessation programs. Proof of completion of an approved tobacco cessation program is required for reimbursement. To find a program call the Washington State Tobacco Quit Line at (877) 270-STOP, check with your county health district or your local FCHN preferred provider hospital. Certain tobacco cessation pharmacy products are covered when purchased in association with an approved tobacco cessation program.

For reimbursement send a copy of your proof of completion, with your receipts, to FCHA Claims Department, PO Box 12659, Seattle, WA 98111-4659.

*Exclusions or benefit limitations may apply to the benefits defined within this Medical Benefits section; please see the “Plan Exclusions and Limitations” and “Summary of Benefit Maximums” sections prior to seeking services.*

## Transplants (Organ and Bone Marrow)

**FCHA pre-authorization is required** for transplant service. Services directly related to organ transplants must be coordinated by your participating provider. **Proposed transplants will not be covered if considered experimental or investigational (see *Plan Definitions in Summary Plan Description*) 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, including transplant evaluation results, 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
- Services and supplies directly related to the transplant procedure, including transportation to/from the approved facility
- 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

*Exclusions or benefit limitations may apply to the benefits defined within this Medical Benefits section; please see the “Plan Exclusions and Limitations” and “Summary of Benefit Maximums” sections prior to seeking services.*

Covered donor expenses include:

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

Prescription drugs provided under the Pharmacy benefit are not subject to the Organ Transplant benefit lifetime maximum.

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

# 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 the Allowed Amount
- Any charges by a facility owned or operated by the United States or any state or local government unless the participant is legally obligated to pay (excluding: (i) covered expenses rendered by a medical facility owned or operated by the United States Veteran's Administration when the services are provided to a participant for a non-service related illness or injury, and (ii) covered expenses rendered by a United States military medical facility to participants who are not on active military duty)
- Any condition resulting from declared or undeclared acts of terrorism, war, military service, participation in a riot or civil disobedience
- Any procedure, regardless of medical necessity, outside the scope of the provider's license, registration and/or certification
- Any service not medically necessary for the diagnosis, treatment or prevention of injury or illness, even if it is not specifically listed as an exclusion (except for specific services offered through the Preventive Care benefit)
- Any service received before the participant's effective date of coverage or after the coverage termination date
- Aromatherapy, botanical or herbal medicines, as well as other over-the-counter medications
- Bariatric surgery, or any other surgical or non-surgical treatment, programs or supplies intended to result in weight reduction, regardless of diagnosis
- Care provided by phone, fax, e-mail, Internet or telemedicine
- Charges for failure to keep a scheduled visit, for the copying of medical records or for the completion of a claim or administrative forms
- Charges for non-covered services and complications that arise from non-covered services
- Charges for services or supplies submitted for payment more than 12 months (365 days) after such service or supply was received
- Charges for injury or illness incurred while committing a crime, participating in a riot or act of civil disobedience as defined by the government (local, state or federal) where the injury or illness occurred
- Chemical Dependency treatments listed below:
  - Alcoholics Anonymous or other similar chemical dependency programs or support groups
  - Any care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior
  - Biofeedback, pain management and/or stress reduction classes

- Care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior
- Chemical dependency benefits not specifically listed
- 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
- Information or referral services
- Information schools
- Long-term or custodial care
- Treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required
- DME and medical supply charges listed below:
  - Biofeedback equipment
  - Breast pumps
  - Electronic and/or keyboard communication devices
  - Equipment or supplies whose primary purpose is preventing illness or injury
  - Exercise equipment
  - Items not manufactured exclusively for the direct therapeutic treatment of an illness or injured patient
  - Items primarily for comfort, convenience, sports/recreational activities or use outside the home
  - Oral appliances except to treat obstructive sleep apnea
  - Over-the-counter items (except medically necessary crutches, walkers, standard wheelchairs, diabetic supplies and ostomy supplies are covered)
  - Personal comfort items including but not limited to air conditioners, lumbar rolls, heating pads, diapers or personal hygiene items
  - Phototherapy devices related to seasonal affective disorder
  - Supportive equipment/environmental adaptive items including, but not limited to, hand rails, chair lifts, ramps, shower chairs, commodes, car lifts, elevators, and modifications made to the patient's home, place of work, or vehicle.
  - The following medical equipment/supplies: regular or special car seats or strollers, push chairs, air filtration/purifier systems or supplies, water purifiers, allergenic mattresses, orthopedic or other special chairs, pillows, bed wetting training equipment, corrective shoes, whirlpool baths, vaporizers, room humidifiers, hot tubs or other types of tubs, home UV or other light units, home blood testing equipment and supplies (except diabetic equipment and supplies, and home anticoagulation meters)
  - Wigs
- Emergency room use for non-emergency conditions
- Experimental or investigational services as defined within *Plan Definitions*
- Hair analysis

- 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 or work
- Infertility treatments to achieve pregnancy (regardless of the cause) including but not limited to:
  - Artificial insemination
  - In vitro fertilization (IVF)
  - Gamete intra-fallopian transplant (GIFT)
- Learning disabilities, including dyslexia, or developmental delay treatment, services, educational testing or associated training
- Mental health care listed below:
  - Adventure-based and/or wilderness programs that focus primarily on education, socialization or delinquency
  - Biofeedback, pain management, and stress reduction classes
  - Court-ordered assessments
  - Custodial care, including housing that is not integral to a medically necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite
  - Developmental delay disorders
  - Family therapy, in the absence of a mental health diagnosis
  - Marriage and couples counseling
  - Nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories
  - Sensitivity training
  - Sexual dysfunction
  - Sexual and gender identity disorders (DSM codes 302.0 – 302.9)
- Oral surgery and/or dental services listed below:
  - Care of the teeth or dental structures
  - Dental implants
  - Extractions of teeth, impacted or otherwise (except as necessary due to damage caused by radiation therapy treatment while under this Plan)
  - Services to correct malposition of the teeth
  - Orthodontics
  - Orthognathic surgery (regardless of origin or cause)

- Orthotics that are not medically necessary
- 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, private hospital room, air conditioners, diapers or hygiene items
- Physical examinations, reports or related services or supplies for the purpose of obtaining or maintaining employment, insurance, or licenses or permits of any kind, school admission, school sports clearances, immigration, foreign travel, medical research, camps, or government licensure, or other reasons not related to medical needs
- Plastic and reconstructive services listed below:
  - Breast reduction
  - 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
- Private duty nursing
- Procedures, regardless of medical necessity, outside the scope of the provider's license, registration or certification
- Repair or replacement of items not used in accordance with manufacturer's instructions or recommendations
- Replacement of lost or stolen items, such as, but not limited to, prescription drugs, prostheses or DME
- Reversal of sterilization
- Routine foot care, except as covered by the Plan for diabetics
- Services for which a pre-authorization was required but not obtained, except in cases of life-threatening emergencies
- 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 for any injury sustained while practicing for, or competing in, a professional or semiprofessional sports activity when medical coverage is available through team organization(s)
- 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 provided by a family member (spouse, parent or child)
- Services provided by non-network providers, unless pre-certified by FCHA or included as a specific Plan benefit, such as with Recognized Providers (see Plan Definitions)
- Services provided by, or that could be provided by, a spa, health club or fitness center such as, but not limited to, athletic training, body-building or fitness training
- Sex change operations, treatment or implants for either sexual dysfunction or transsexualism, including related medications, implants, hormone therapy, surgery, medical or psychiatric treatment

- Special diets, nutritional supplements, vitamins and minerals or other dietary formulas or supplements except as covered by the Plan
- Surrogate mother charges, unless the surrogate mother is eligible under the Plan at the time the services were rendered
- Transplant services listed below (organ and bone marrow):
  - Animal-to-human transplants
  - Artificial or mechanical devices designed to replace human organs
  - Meals and lodging
  - Organ transplants not specifically listed as covered transplants
  - Prescription drugs dispensed after the recipient has been discharged from the transplant facility, except as may be covered under the Pharmacy benefit
  - Services, supplies or medications ordered or provided by a non-approved provider
  - Transplants considered experimental and investigational, as defined by the Plan
  - Transplants for unwarranted conditions
- Transportation, except as covered by the Plan
- Vision Care, the following vision benefits are not covered:
  - Contact lenses, or the measurement, fitting or adjustment of them
  - Eyeglasses, or the measurement, fitting or adjustment of them
  - 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 except as covered by the Plan, see Preventive Care
  - Services or supplies received principally for cosmetic purposes
- Vitamin B-12 injections except to treat Vitamin B-12 deficiency
- Vocational rehabilitation, work hardening or training programs regardless of diagnosis or symptoms that may be present, or for non-medically necessary education
- Weight management programs such as Weight Watchers, etc.
- Wigs

# Summary of Pharmacy Benefits

Pharmacy			
	Applies to Deductible	Applies to OOP Max	Network Providers
<b>Pharmacy</b>	<b>Administered by Navitus</b>		
• Retail (30 day supply)	✓	✓	Generic - \$10 copay Preferred - \$20 copay Non-preferred - 50% coinsurance
• Mail order (90 day supply)	✓	✓	Generic - \$10 copay Preferred - \$20 copay Non-preferred - \$40 copay

**Important Notes:**

- **You must use a Network pharmacy to receive benefits. Exceptions to this rule include emergencies, or if there is no network pharmacy available to you. In both cases, you must pay for the prescription in full and file a claim with Navitus for reimbursement. Your benefits will be paid at the Network level however; you may be responsible for additional payment if the non-network pharmacy charges exceed that of a Network pharmacy.**
- **Please see *Filling a Prescription* for details on where and how to obtain your prescription drugs, whether through a retail pharmacy or mail order.**
- **Certain prescription drugs require preauthorization through Navitus. Call Navitus at (866) 590-5890 for questions regarding drugs included on this list.**

# Pharmacy Benefits

---

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

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

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

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

Unless your physician states that a brand name drug is medically necessary, a generic drug will be dispensed when available. If your physician authorizes a generic drug and you elect to receive a brand name drug you will be required to pay the difference in cost between the generic drug and the brand name drug, in addition to the copay.

## Filling a Prescription

Following are details for filling a prescription through the retail network pharmacy or mail order.

### Retail Network Pharmacy

With the retail pharmacy program you may receive up to a 30-day supply of medication. An extensive nationwide network of pharmacies has agreed to dispense covered prescription drugs to Plan participants at a discounted cost. These pharmacies will only collect only the appropriate copay from you if you present your identification card. If you are unable to, and they cannot confirm your eligibility through Navitus, you may need to pay in full and later obtain reimbursement from Navitus.

If you need assistance in determining if your local, independent pharmacy is part of the Navitus network of retail pharmacies, you may call Navitus directly at (800) 218-1488.

## 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 may obtain a 90-day supply of ongoing medications through the Wellpartner mail order service process described below:

### How to use the Mail Order Program:

1. Complete the Wellpartner order form
2. Attach your prescription for a 90-day supply of medication to the form
3. Include a copy of your ID card
4. Include the applicable copay
5. Mail to the address below:

Wellpartner  
PO Box 5909  
Portland, OR 97228-5909

Please place your order for a refill by mail 3 weeks before your current supply runs out and allow 10–14 days for delivery of your medication. Your copay can be made by check or credit card. Do not send cash.

To obtain additional details about the mail order pharmacy benefit, please contact Wellpartner at (866) 624-5797 or [www.wellpartner.com](http://www.wellpartner.com).

# Pharmacy Exclusions and Limitations

---

The following prescription drugs and items are not covered:

- Anorexiant or any drug used for weight loss
- Anti-wrinkle agents
- Charges for the administration or injection of any drug
- Dietary supplements, except for PKU
- Hair restoration products such as (but not limited to) topical minoxidil
- Immunization agents, blood or blood plasma
- Infertility medications
- Injectable drugs except Chlorpheniramine/Epinephrine and Epinephrine
- Investigational or experimental drugs
- Medications taken while inpatient at a facility or institution that operates a dispensing pharmacy on its premises (will be billed as part of the overall inpatient stay and covered through the Medical Benefits)
- Minerals
- Non-approved medications
- Non-legend drugs
- Non-sedating antihistamines unless preauthorized by Express Scripts
- Off-label FDA-approved drugs unless the use is recognized as an effective treatment of a covered condition in one of the Standard Reference Compendia, in the majority of relevant peer-reviewed literature or by the Secretary of Health and Human Services
- Over-the-counter products
- Prescription medication for the treatment of a non-covered condition
- Products used for cosmetic purposes
- Refills dispensed after one year from the date of the prescription order
- Refills in excess of the number specified by the physician
- Therapeutic devices or appliances including needles, syringes, support garments and other non-medicinal substances, regardless of intended use, except those listed as covered
- Tobacco cessation medication and aids (see Medical Benefits for benefit)
- Tretinoin in all dosage forms, such as Retin A, for persons through age 25

- Unauthorized refills of any medication
- Vitamins, singly or in combination, except generic legend prenatal vitamins

**Important note: No benefits are provided for any drug when the FDA has determined that it is inappropriate for the condition it is being used to treat.**