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Summary Plan Description

Effective January 1, 2019

www.fchn.com

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

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Highlights

This Summary Plan Description provides you with important information about the Ashland School District Group Benefit Plan as of January 1, 2019, including administration, eligibility, enrollment, continuation of coverage, coordination of benefits, subrogation, claim and appeal procedures and other legally required material.

Ashland School District (hereinafter referred to as Ashland School District or “the Plan”), the employer, Plan Administrator and Plan Sponsor of this self-funded Plan, delegates certain Plan services to First Choice Health Administrators (FCHA - a division of First Choice Health Network, Inc.) as Third Party Administrator (TPA). Ashland School District delegates the authority to make decisions on benefit coverage, medical management, claim payment and certain other administrative services according to the Ashland School District’s policies and procedures. However, Ashland School District retains at all times the ultimate fiduciary authority, responsibility and control over Plan assets, management and administration, unless stated otherwise in this document.

Please review this booklet carefully and share it with your family. If you have questions, contact the Plan Administrator (Ashland School District’s Human Resources Department) or FCHA.

Coverage under this Plan will take effect for eligible employees and dependents when all eligibility requirements are satisfied. Ashland School District 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.

This document is a summary description of the overall Ashland School District health benefits, hereafter referred to as “the Plan”. No oral interpretations can change this Plan. This booklet, combined with the Medical, Vision, Dental and Pharmacy Benefit Plan Document booklets, and the applicable provider directories, comprise the Plan document and summary plan description for the Ashland School District Group Benefit Plan.

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

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
(800) 918-7668
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 (800) 918-7668.

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 918-7668.

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 918-7668.

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' (800) 918-7668.

FCHA's Customer Service Department business hours are Monday through Friday, 7:00 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 (800) 918-7668.

Eligibility and Enrollment

Eligible Classes

Class 001 - Certified Staff

All active Ashland School District licensed employees who work 20 or more hours per week are eligible to enroll in medical, dental and vision.

Class 002 - Classified Staff

All active Ashland School District classified employees who work 30 or more hours per week are eligible to enroll in medical, dental and vision. An employee who works 20-29.99 hours per week is eligible for medical only.

Retirees

An eligible employee who is covered under this Plan and who retires under the Employer's supplemental retirement plan as defined by the current Collective Bargaining Agreement will be eligible to continue participating in the Plan upon retirement, provided the individual continues to make the required contribution.

Retirees may continue in this Plan until they are eligible for Medicare. The spouse of a Retiree can remain on the coverage after the Retiree reaches 65 and until the spouse becomes eligible for Medicare, provided the spouse pays the required contribution. Dependents of retirees are covered only if the dependents are enrolled in the plan prior to the eligible employee's retirement.

The following employees are not eligible for health benefits:

- Any employee working less than 20 hours per week,
- Leased or temporary employees,
- One that has not completed the applicable waiting period,
- Substitute employees,
- Student workers, and
- Tutors.

In order to be considered eligible, you must satisfy the applicable waiting period described below.

Other Eligible Class

Members who retire from Ashland School District and do not qualify for supplemental retirement benefits under a Collective Bargaining Agreement may be eligible to continue their health insurance under Oregon Revised Statute 243.303, which states:

243.303 Local government authority to make health care insurance coverage available to retired officers and employees, spouses and children.

1. As used in this section:
 - A. "Health care" means medical, surgical, hospital or any other remedial care recognized by state law and related services and supplies and includes comparable benefits for persons who rely on spiritual means of healing.
 - B. "Local government" means any city, county, school district or other special district in this state.
 - C. "Retired employee" means a former officer or employee of a local government who is retired for service or disability, and who received or is receiving retirement benefits, under the Public Employees Retirement System or any other retirement system or plan applicable to officers and employees of the local government."
2. The governing body of any local government that contracts for or otherwise makes available health care insurance coverage for officers and employees of the local government shall, insofar as and to the extent possible, make that coverage available for any retired employee of the local government who elects within 60 days after the effective date of retirement to participate in that coverage and, at the option of the retired employee, for the spouse of the retired employee and any unmarried children under 18 years of age. The health care insurance coverage shall be made available for a retired employee until the retired employee becomes eligible for federal Medicare coverage, for the spouse of a retired employee until the spouse becomes eligible for federal Medicare coverage and for a child until the child arrives at majority, and may, but need not, be made available thereafter. The governing body may prescribe reasonable terms and conditions of eligibility and coverage, not inconsistent with this section, for making the health care insurance coverage available. The local government may pay none of the cost of making that coverage available or may agree, by collective bargaining agreement or otherwise, to pay part or all of that cost."

Waiting Periods

If eligible, you must complete a waiting period before coverage becomes effective for you and your dependents. A waiting period is a period of time that must pass before an employee or dependent becomes eligible for coverage under the terms of this Plan.

- **New Classified Employee:** First day of the month following receipt of employee's first paycheck paying any required premium.
- **New Certified Employees:** Coverage is prorated based on the number of days worked during the current school year contract using this formula: number of contract days worked divided by total number of contract days = percentage of entitlement multiplied by 12 months = months of coverage.

There is no waiting period for pre-existing conditions.

Enrollment Periods

Enrollment periods for eligible employees and dependents are:

- Within thirty one (31) days of initial eligibility, or
- During any open enrollment.

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

How to Enroll

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

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

Open Enrollment

Annual open enrollment does not apply to Retirees or their Dependents.

Open enrollment is a defined period beginning November 1 and ending November 15th when you, if eligible, are allowed to enroll or make changes to your health care benefit coverage. Open enrollment occurs once each Plan year. Only a qualifying event would allow you to change your enrollment for the health plan outside of the annual open 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 for adoption, 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 31 days after the birth, adoption or placement (see also *Dependents*). If you decline Plan group health coverage and later experience a change in status (as described below) and become eligible to participate in a premium assistance program under Medicaid or the Children's Health Insurance Program (CHIP) Reauthorization Act of 2009, you have 60 days to enroll in the Plan.

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

A change in status includes:

- Marriage, divorce or legal separation
- Death of your spouse or dependent
- Birth, adoption, or placement for adoption of child
- A change in employment status for you or your spouse, 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 legal separation, divorce, death)
 - Termination of employment or the reduction in the number of hours of employment, or
 - 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 31 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.

Retirees are not eligible for special enrollment due to loss of other coverage. Similarly, retirees who are not currently participating in the Plan will not be eligible to enroll upon acquisition of a new Dependent.

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 Employee

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 requirements noted under *Eligible Classes of Employees*, 2) the waiting period and 3) the Plan is in receipt of the completed enrollment form.

Effective Date of Coverage for Dependents

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

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 the Plan's Human Resources Department 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 enroll within 31 days, the dependent will be considered a late enrollee. **Late enrollments are not accepted.**

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 enrollment of the eligible employee.

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 resides)
- Domestic Partner (same or opposite sex) who meets the criteria for eligibility and signs a Declaration of Domestic Partnership see section *Plan Definitions*;
- You (or your Domestic Partner's) natural child, adopted child, child placed with you for legal adoption, stepchild, or other legally designated ward up to age 26; or,
- You (or your Domestic Partner's) natural child, adopted child, child placed with you for legal adoption, stepchild, or other legally designated ward that a health care professional determines is not capable of self-sustaining employment due to a physical 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 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;
- 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 Rule

If an employee and spouse or domestic partner are each employees of Ashland School District and are eligible for benefits, employees may double cover each other as dependents.

Special Rules for Domestic Partners

- Domestic Partners who qualify for coverage under the terms and conditions of this Plan have the same special enrollment rights as qualified spouses.

- Federal law does not recognize domestic partners; therefore domestic partners are not eligible for continuation of coverage under COBRA. However, although not required, Ashland School District 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 Ashland School District employees may enroll under both parents' plans.

Natural Newborn Children

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

Adopted Children

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

If the enrollment form, with documentation to support legal guardianship, is received within 31 days of placement, coverage becomes effective on the first day of the month coinciding with or following the date of placement. The Plan Administrator may request additional information.

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 first day of

the month coinciding with or following the date of the order. The Plan Administrator may request additional 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).

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

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

A medical child support order:

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

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

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

If the medical child support order is a QMCSO:

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

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

The enrollment form with the notification of the medical child support order needs to be received within 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 the enrollment information is received.

Termination of Coverage

For participating employees, coverage ends at these events:

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

For participating dependents, coverage ends at these events:

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

If your coverage ends due to termination of employment or leave of absence and you later return to active work within 3 years, you are eligible for coverage on the date of return to active work for this employer.

If you return to work after the 3-year period, you must meet all requirements of a new Employee. Refer to the information on Family and Medical Leave Act or Uniformed Services Employment and Reemployment Act for possible exceptions, or contact the Plan's Human Resources Department.

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

Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA)

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

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

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

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

Who Is a COBRA Qualified Beneficiary?

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

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

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

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

Qualifying Events and Continuation Periods

Qualifying events and continuation periods are explained below:

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

When COBRA Coverage Ends

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

- The Plan no longer provides group health coverage to any employees
- The COBRA coverage premium is not paid within 31 days of the due date (the initial grace period is 45 days after the first COBRA election)
- The qualified beneficiary becomes covered under another group health plan with no applicable pre-existing condition exclusion or limit
- The qualified beneficiary enrolls in Medicare
- 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 was no longer disabled, the individual must notify the Plan Administrator within 31 days after the date of that determination. Coverage ends on the last day of the month through which contribution payments have been received, so long as that

date is within the first month that begins within 31 days after the final determination date, and after the initial 18-month COBRA coverage period.

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

Contribution Payment Requirements

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

If you are eligible and receive a disability extension under Title II or XVI of the Social Security Act, your contribution will be up to 150% of the full cost of coverage.

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

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

Election Requirements

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

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 forward 12 month period) for the following reasons:

- The birth or adoption of the employee's child
- Placement of a foster child in the employee's care
- To care for the employee's spouse, parent or child with a serious health condition
- An employee's own 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 an additional 26 weeks of leave each year (during a rolling forward 12 month period) for the following reasons:

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

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

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

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

Military Leave

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

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

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

Continuation of coverage due to disability

If your health benefits end while you are totally disabled, your health expenses will be extended as described below. To find out why and when your coverage may end, please refer to *When Coverage Ends*.

"Totally disabled" means that because of an **injury** or **illness**:

- You are not able to work at your own occupation and you cannot work at any occupation for pay or profit.
- Your dependent is not able to engage in most normal activities of a healthy person of the same age and gender.

Extended Health Coverage

- Medical Benefits (other than Basic medical benefits): Coverage will be available while you are totally disabled, for up to 12 months.
- Vision Benefits: Coverage will be available while you are totally disabled, for up to 12 months.
- Prescription Drug Benefits: Coverage will be available while you are totally disabled for up to 12 months.

When Extended Health Coverage Ends

Extension of benefits will end on the first to occur of the date:

- You are no longer totally disabled, or become covered under any other group plan with like benefits.
- Your dependent is no longer totally disabled, or he or she becomes covered under any other group plan with like benefits.

Please note: This does not apply if coverage ceased because the benefit section ceased for your eligible class.

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.

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 a 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.

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

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

Claim Types

- **Pre-service claim** means any claim for a Plan benefit for which the Plan requires approval before medical care is obtained.
- **Concurrent claim** means any claim reconsidered after initial approval for an ongoing course of treatment which results in a reduced or terminated benefit.
- **Post-service claim** means any claim for a Plan benefit that is not a pre-service claim and is a request for payment or reimbursement for covered services already received.
- **Urgent care claim** means a claim for medical care or treatment that, if normal pre-service standards are applied, would in the opinion of a physician with knowledge of the claimant's medical condition:

- Seriously jeopardize the claimant's life, health or ability to regain maximum function
- Subject the claimant to severe pain that cannot be adequately managed without the care or treatment requested.

Claim Procedure

First Choice Health Administrators (FCHA) has final authority over claims procedure as the appropriate named fiduciary, and 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 imposition of preexisting condition exclusions or other limits on otherwise covered benefits.

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

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

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

- A description of any additional material or information needed to support your claim and an explanation of why it is needed; and,

- A description of the available appeal process (including both internal and external review processes, as also outlined below), as well as information about how to initiate the appeal process.

Appeal Procedure

FCHA performs functions associated with the internal review of medical, dental and pharmacy appeals for this Plan. First Choice Health Administrators 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.

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, Dental and Pharmacy Appeals:

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

Internal Appeal Process

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

The appeal should include comments, documents, records and/or other information noting the reason you feel your claim should have been approved. 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 final decision regarding the appeal. FCHA will notify you in writing of the decision to either uphold the original denial or overturn it within 30 calendar days of pre-service claims or 60 calendar days if your appeal involves a post-service claim. If the determination is to uphold the original denial, the letter will also include information

on how to initiate the next level of appeal (External Review) if the determination is based on medical judgment. **Note: a decision regarding an urgent care claim will be made as soon as possible, but not later than 72 hours after receipt of a request for internal review if a delay would jeopardize the member's or their dependent's health.**

External Review

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. Denials that do not involve medical judgment (i.e., denials that involve only contractual or legal interpretation without any use of medical judgment) are not eligible for external review. You must first submit an internal appeal and receive a final internal adverse benefit determination before you may request external review. 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 of 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 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 Ashland School District. 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 receipt of a request for external review if a delay would jeopardize the member 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.

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 does not coordinate pharmacy 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. This Plan coordinates benefits using the “traditional method” of coordination of benefits. When this Plan is secondary to another plan, benefits will be calculated according to the following steps:

1. This Plan will credit any amounts to this Plan’s deductible that would have been credited if this Plan were primary.
2. This Plan will pay 100% of the remaining patient liability, not to exceed the lesser of: 1) the amount this Plan would have paid as primary, or 2) the amount that, when added to the Primary Plan payment, totals 100% of this Plan’s Allowed Amount.

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

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

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

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

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

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

person pursuant to COBRA or under a right of continuation pursuant to state or other federal law is the secondary plan.

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

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

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

- A. A change in the amount or scope of a plan's benefits;
- B. A change in the entity that pays, provides or administers the plan's benefits; or
- C. A change from one type of plan to another, such as, from a single employer plan to a multiple employer plan.

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

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

What if I'm Covered by Medicare?

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

If your Medicare entitlement is due to:

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

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

- **Disability:** If you are covered under this Plan as an active employee or dependent of an active employee (including Domestic Partners) and become entitled to Medicare due to disability, this Plan will be primary. Once you or your dependent is declared disabled by Social Security, the 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 (including domestic partners) and you become entitled to Medicare due to disability, 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 or COBRA qualified beneficiary.

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

Pre-authorization when this Plan is Secondary

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

Meaning of “Plan” for Coordination of Benefits

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 Ashland School District Group Benefit Plan
- 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 (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 (Benefits Department), Plan Sponsor Ashland School District 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 Ashland School District HIPAA Privacy Notice.

Disclosures to the Plan Sponsor

The Plan may disclose your health information to Ashland School District, 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 participants 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 participant contributions, then use these contributions to pay benefits directly to or for participants from the Plan's general assets. Participant 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 Ashland School District'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 Rights

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.
- 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.

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 Plan fiduciaries, who are responsible for your Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under 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. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the Plan Administrator's control. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the US Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim frivolous.

Continue Group Health Coverage

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:	Ashland School District Group Benefit Plan
Plan Year:	January 1 through December 31
Type of Plan:	Group health plan
Plan Number:	501
Funding Medium:	Claims are paid directly out of the general assets of the Plan Sponsor. Participant contributions are placed in the general assets of the Plan Sponsor and accounted for separately. Participant contributions shall only be used to pay medical or dental claims.
Source of Contributions:	The Plan Sponsor bears the entire cost of this benefit Plan, minus the participants' contribution.
Plan Sponsor	Ashland School District 885 Siskiyou Blvd Ashland, OR 97520
Plan Administrator	Ashland School District 885 Siskiyou Blvd Ashland, OR 97520
Agent for Service and Legal Process:	Ashland School District 885 Siskiyou Blvd Ashland, OR 97520
Named Fiduciary for claims and appeals	First Choice Health Administrators Attn: Appeals Coordinator 600 University Street, #1400 Seattle, WA 98101 Fax: (206) 268-2920
Named Fiduciary for claims and appeals	Ashland School District 885 Siskiyou Blvd Ashland, OR 97520
Plan Sponsor's Employer Identification Number:	93-6000507
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.

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. Aural therapy is 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 form (specified by the Plan) signed 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 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 Declaration 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, except as specifically outlined under the Clinical Trials benefit
- 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 Conditions 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, Idaho, Montana, Oregon, Alaska, Wyoming, North Dakota and South Dakota that is listed in the provider directory. Outside these states, participants must use the First Health Network for network providers.

Non-network provider means a provider who delivers or furnishes health care services but is not a contracted FCHN provider in Washington, Idaho, Montana, Oregon, Alaska, 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 Network provider.

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

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

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

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

- Construe and interpret the Plan document and to decide all questions of eligibility and participation,
- Make all findings of fact for Plan administration, including payment of reimbursements,
- Prescribe procedures to be followed and forms to be used by participants and beneficiaries,
- Request and receive from all participants 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.

Primary Care Provider (PCP) includes the following provider types:

- Family Practice
- Family Practice with OB
- Internal Medicine
- General practice
- Pediatrics
- Nurse Practitioner - Family Practice
- Nurse Practitioner - Pediatrics
- Nurse Practitioner - Adult
- Nurse Practitioner - Women's Health
- Nurse Practitioner - Geriatric Medicine

- Geriatric Medicine
- Obstetrics & Gynecology
- Gynecology
- Naturopathic Physicians
- Physician Assistants - designated at PCP

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

Provider directory is the listing of the network providers, hospitals, and other facilities that have agreed to provide covered services to participants or dependents of Plans contracted with 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)
- Radiologists
- Pathologists
- 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 allowed amount paid by FCHA for services received from non-network providers. This amount is determined based on various, yet consistently applied, criteria such as the state in which the provider practices, Medicare rates or geographic cost data obtained from an independent entity.