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First Choice Health®

– Detailed Benefit Summary

(For client audit and approval)

City of Pasco
Employee Health Care Plan

PERS Plan

Effective October 1, 2024

www.fchn.com

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Payment Provisions – PERS Plan

Highlights of Plan Provisions

- Your benefit coverage is greater, and your out-of-pocket costs less, when you choose a Network provider.
- Benefit payment is based on the Allowed Amounts agreed upon by Network providers. These providers cannot bill you the difference between the Allowed Amount and their billed charges.
- For services received from out-of-network providers (who are not covered under Recognized No Surprises Provider), you are responsible to pay the difference between the Plan payment and the provider's actual charges.
- Services received from a Recognized No Surprises Provider (see *Plan Definitions)* provided by out-of-network Emergency Departments and out-of-network providers, certain non-emergency services furnished by out-of-network providers at certain in-network facilities, and out-of-network air ambulances, the cost-sharing amount is determined by the Qualifying Payment Amount (see *Plan Definitions*)*.*
- Claims are processed according to the diagnoses and services billed by the provider(s). Billing disputes regarding services received should be addressed with the rendering provider.
- When you receive services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most that those providers may bill you is your Plan's lowest in-network cost-sharing amount. This applies to emergency services, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers cannot balance bill you and may not ask you to give up your protections. If you receive other services at these in-network facilities, out-of-network providers cannot balance bill you, unless you give written consent and give up your protections.
- Certain serious and complex care treatments may apply to the Continuity of Care section. See Continuity of Care under *How to Obtain Health Services* for care from a provider who leaves the network.

Annual Deductible

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

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

In addition, this Plan offers a Deductible Carry-over, which means covered expenses incurred and applied to the deductible during the last three (3) months of a Benefit year (October, November, and December) may be applied to the next Benefit year's deductible.

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

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

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

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum is the most you will need to pay in a Plan year for covered services. This Plan offers an Embedded Family Out-of-Pocket (OOP) Maximum, which means once each individual within a family meets the individual maximum, that individual will not be assessed further co-insurances. Also, the family will meet no more than the stated family maximum regardless of family size.

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

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

Benefit Maximums – PERS Plan

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

Annual Deductible and Out-of-Pocket Maximums

Deductible and Out-of-Pocket Maximums	Network	Out-of-Network
Annual Medical Deductible (per calendar year)		
Individual	$200	
Family	$600	
Annual Medical and Pharmacy Out-of-Pocket Maximum (per calendar year)		

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Individual	$2,200
Family	$13,200

Summary of Benefit Maximums – PERS Plan

Lifetime Maximum Benefits	
Hospice • Respite care	30 days within 12 months
Calendar Year Maximums	
Diabetic Nutritional Education	First 3 visits covered under the Preventive benefit (combined with Nutritional Education and Counseling)
Home Health Care Visits	130 visits
Nutritional Education and Counseling	First 3 visits covered under the Preventive benefit (combined with Diabetic Nutritional Education)

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Summary of Medical Benefits

PERS Plan **For services received from out-of-network providers (who are not covered under Recognized No Surprises Provider), you are responsible to pay the difference between the Plan payment and the provider's actual charges.*				
	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Network Providers**	***Tier 2 Out-of-Network Providers**
Allergy Care				
• **Testing**	✓	✓	80%	80%
• **Injections**	✓	✓	80%	80%
Alternative Care				
• **Acupuncture**	✓	✓	80%	80%
• **Massage Therapy**	✓	✓	80%	80%
Ambulance Services FCH pre-authorization required for non-emergent air ambulance.	✓	✓	80%	80%
• **First Responder Fees**	✓	✓	80%	80%
Anesthesia FCH pre-authorization required for anesthesia for dental services.	✓	✓	80%	80%
Applied Behavior Analysis (ABA) Therapy FCH pre-authorization required for inpatient services.	✓	✓	80%	80%
Autologous Blood Donation/Blood Transfusion	✓	✓	80%	80%
Bariatric Surgery	Not Covered.			
Biofeedback	Not Covered.			
Chemical Dependency FCH pre-authorization required for inpatient, residential and partial hospitalization.				
• **Inpatient** (facility and professional)	✓	✓	80%	80%

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	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Network Providers**	***Tier 2 Out-of-Network Providers**
• **Outpatient** (facility and professional)	✓	✓	80%	80%
Chiropractic Spinal Manipulation	✓	✓	80%	80%
Clinical Trials	Covered based on place of service and as specifically outlined under *Clinical Trials*.			
Dental Trauma FCH pre-authorization required for follow-up services, inpatient and anesthesia.				
• **Office Visits**	✓	✓	80%	80%
• **All Other Places of Service**	✓	✓	80%	80%
Diabetic Education and Diabetic Nutrition Education The first 3 Diabetic Nutrition Education visits or Nutritional Counseling visits per calendar year are considered preventive. This benefit applies after the first 3 visits per calendar year are exhausted.	✓	✓	80%	80%
Diagnostic Services – non-routine (facility and professional) FCH pre-authorization required for PET scans.				
• **Hospital Inpatient** (facility and professional)	✓	✓	80%	80%
• **Hospital Outpatient** (facility and professional)	✓	✓	80%	80%

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	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Network Providers**	***Tier 2 Out-of-Network Providers**
• **Independent Facility** Diagnostic Testing provided by an independent diagnostic testing provider, group, facility or office. Billed separately from the provider of care.	✓	✓	80%	80%
• **In Office**	✓	✓	80%	80%
Dialysis	Covered based on place of service.			
Durable Medical Equipment and Supplies				
• **Breastfeeding Supplies and Equipment**	N/A	N/A	100%	100%
• **Durable Medical Equipment**	✓	✓	80%	80%
• **Medical Supplies**	✓	✓	80%	80%
• **Oral Appliances**	✓	✓	80%	80%
• **Orthopedic Appliances/Braces**	✓	✓	80%	80%
• **Prosthetic Devices**	✓	✓	80%	80%
• **Wigs** Limited to one per lifetime. (Covered when hair loss is due to burns, surgery, radiation therapy, or chemotherapy)	✓	✓	80%	80%
Emergency Care				
• **Emergency Department** (facility)	✓	✓	80%	80%
• **Emergency Department** (professional)	✓	✓	80%	80%
• **Urgent Care**	✓	✓	80%	80%

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	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Network Providers**	***Tier 2 Out-of-Network Providers**
Family Planning				
• **Office Visits**	N/A	N/A	100%	100%
• **Devices, Implants and Injections**	N/A	N/A	100%	100%
• **Contraceptive Diagnostic Testing**	N/A	N/A	100%	100%
• **Sterilizations**				
– Female	N/A	N/A	100%	100%
– Male (not covered for dependent children)	✓	✓	80%	80%
• **Termination of Pregnancy** (not covered for dependent children) FCH pre-authorization required for inpatient services. *Limited benefit; see Family Planning section for details.*	✓	✓	80%	80%
Foot Orthotics	✓	✓	80%	80%
Gender Affirming Services FCH pre-authorization required for surgery.	Covered based on place of service.			
Genetic Services FCH pre-authorization required.				
• **BRCA Testing**	N/A	N/A	100%	100%
• **All Other Genetic Testing**	✓	✓	80%	80%
• **Genetic Counseling**	✓	✓	80%	80%

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	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Network Providers**	***Tier 2 Out-of-Network Providers**
Habilitative Services FCH pre-authorization required for inpatient services. (Services include physical, speech, aural, and occupational therapies)				
• **Inpatient** (facility and professional)	✓	✓	80%	80%
• **Outpatient** (facility and professional)	✓	✓	80%	80%
• **In Office**	✓	✓	80%	80%
Hearing				
• **Routine Hearing Exams**	Not Covered.			
• **Medically Necessary Hearing Exams**	✓	✓	80%	80%
• **Hearing Aids/Appliances**	Not Covered.			
Home Health Care FCH pre-authorization required for enteral formula, medical food and associated services.				
• **Home Health Care** 130 visits per calendar year.	✓	✓	80%	80%
• **Phototherapy** (home)	✓	✓	80%	80%
Hospice FCH pre-authorization required for inpatient hospice and respite care.				
• **Hospice Care**	✓	✓	80%	80%
• **Respite Care** 30 day maximum within 12 minths.	✓	✓	80%	80%

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	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Network Providers**	***Tier 2 Out-of-Network Providers**
Hospital Inpatient Surgery and Services FCH pre-authorization required.				
• **Inpatient Facility Services** First $1,000 per admission covered at 100%.	N/A	✓	80%	80%
• **Inpatient Doctor Visits/Consultations**	✓	✓	80%	80%
• **Inpatient Professional Services** (surgeon)	✓	✓	80%	80%
• **Inpatient Professional Services** (assistant surgeon)	✓	✓	80%	80%
Hospital Outpatient Surgery and Services FCH pre-authorization required for certain outpatient services; see *Pre-Authorization Requirements* for details.				
• **Outpatient Facility Services**	✓	✓	80%	80%
• **Ambulatory Surgery Center** (ASC)	✓	✓	80%	80%
• **Outpatient Professional Services** (surgeon)	✓	✓	80%	80%
• **Outpatient Professional Services** (assistant surgeon)	✓	✓	80%	80%
Infertility Diagnostic Services Limited benefit; see *Infertility Diagnostic Services* for details.	✓	✓	80%	80%

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	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Network Providers**	***Tier 2 Out-of-Network Providers**
Infusion Therapy (includes infusion therapy provided in the home) FCH pre-authorization required for certain infusion therapy drugs; see *Pre-Authorization Requirements* for details.	✓	✓	80%	80%
Maternity and Newborn Care				
• **Maternity Care**	✓	✓	80%	80%
• **Newborn Care**	✓	✓	80%	80%
Mental Health Care FCH pre-authorization required for inpatient, residential and partial hospitalization.				
• **Inpatient** (facility and professional)	✓	✓	80%	80%
• **Partial Day Treatment (PDT)**	✓	✓	80%	80%
• **Outpatient** (facility and professional)	✓	✓	80%	80%
Nutritional Counseling The first 3 Nutritional Counseling visits or Diabetic Nutrition Education visits per calendar year are considered preventive. This benefit applies when the first 3 visits per calendar year are exhausted.				
• **Outpatient Facility**	✓	✓	80%	80%
• **In Office**	✓	✓	80%	80%
Nutritional and Dietary Formulas FCH pre-authorization required.	✓	✓	80%	80%

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	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Network Providers**	***Tier 2 Out-of-Network Providers**
Oral Surgery	✓	✓	80%	80%
Pharmacy	Administered by MedImpact			
• **Retail** (up to 90-day supply)				
– Generic Drug	N/A	N/A	Patient Pays: $0	
– Brand Name Drug	N/A	✓	Patient Pays: Lesser of $150, or 20% of the allowed amount.	
Plastic and Reconstructive Services FCH pre-authorization required. Limited benefit; see *Plastic and Reconstructive Services* for details.				
• **Inpatient** (facility and professional)	✓	✓	80%	80%
• **Outpatient** (facility and professional)	✓	✓	80%	80%
Podiatric Care See *Podiatric Care* for details on routine foot care.	✓	✓	80%	80%

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	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Network Providers**	***Tier 2 Out-of-Network Providers**
Preventive Care				
• **Immunizations** Immunizations for children and adults are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention. See *Preventive Care* for details. Covered Immunizations provided at a pharmacy are covered at the In Network benefit level based on billed charges. Travel immunizations are not covered.	N/A	N/A	100%	100%
• **Periodic Exams** (adult and child)	N/A	N/A	100%	100%
• **Nutritional Counseling** – the first 3 nutritional counseling visits per calendar year. For visits 4 and beyond, refer to *Nutritional Counseling or Diabetic Education.*	N/A	N/A	100%	100%
• **Obesity Screening and Counseling –** for members with an obesity diagnosis.	N/A	N/A	100%	100%
• **Obesity Prevention Counseling** For women aged 40-60 who are normal weight or overweight.	N/A	N/A	100%	100%

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	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Network Providers**	***Tier 2 Out-of-Network Providers**
Screening Tests Screening tests are covered in accordance with the recommendations set forth by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See *Preventive Care* for more details.				
• **Bone Density Screening**	N/A	N/A	100%	100%
• **Colonoscopy** The first colonoscopy per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent colonoscopies in the same calendar year are covered under the medical benefits, regardless of diagnosis.	N/A	N/A	100%	100%
• **Fecal Occult Blood Test** The first fecal occult blood test per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent fecal occult blood tests in the same calendar year are covered under the medical benefits, regardless of diagnosis.	N/A	N/A	100%	100%
• **FIT-Fecal DNA** 1 per calendar year.	N/A	N/A	100%	100%

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	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Network Providers**	***Tier 2 Out-of-Network Providers**
• **Mammogram** The first mammogram per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent mammograms in the same calendar year are covered under the medical benefits, regardless of diagnosis.	N/A	N/A	100%	100%
• **Pap Test**	N/A	N/A	100%	100%
• **Prostate Cancer Screening (PSA)**	N/A	N/A	100%	100%
• **Sigmoidoscopy** The first sigmoidoscopy per calendar year is covered under the Preventive Care benefit, regardless of diagnosis. Subsequent sigmoidoscopies in the same calendar year are covered under the medical benefits, regardless of diagnosis.	N/A	N/A	100%	100%
• **All Other Screening Tests**	N/A	N/A	100%	100%
Professional/Physician Services – office visits, certain telemedicine visits and office surgeries.				
• **Office Visit**	✓	✓	80%	80%
• **Office Visit Related Services**	✓	✓	80%	80%

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	Applies to Deductible	**Applies to OOP Max**	**Tier 1 Network Providers**	***Tier 2 Out-of-Network Providers**
Rehabilitation Therapy FCH pre-authorization required for inpatient services.				
• **Inpatient** (facility and professional)	✓	✓	80%	80%
• **Outpatient** – includes physical, speech, massage, and occupational therapies (facility and professional)	✓	✓	80%	80%
Skilled Nursing Facility FCH pre-authorization required.	✓	✓	80%	80%
Temporomandibular Joint (TMJ) Disorder FCH pre-authorization required if inpatient or surgery.				
• **Office Visit**	✓	✓	80%	80%
• **All Other Services**	✓	✓	80%	80%
Tobacco Cessation	N/A	N/A	100%	100%
Transplants – organ and bone marrow FCH pre-authorization required.				
• **Recipient Services** (facility and professional)	✓	✓	80%	80%
• **Donor Services** (facility and professional)	✓	✓	80%	80%
Transportation & Lodging	Not Covered			
Vision – routine eye exams and hardware	Administered by VSP			

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The benefits represented within this benefit summary accurately reflect the plan provisions for the City of Pasco Employee Health Care Plan (PERS Plan), effective October 1, 2024.

Plan Name: City of Pasco Employee Health Care Plan PERS Plan

Name: Sara Matzen

Signature: Signed by: Sara Matzen 7B81C123D9CD42A...

Title: HR Director

Date: October 4, 2024

Please ensure this signed page is accompanied by all pages of the approved Detail Benefit Summary.