First Choice Health

Healthy Employees. Healthy Companies.

Northwest Montana School's Consortium Health Plan
2019-2020

Benefit Summary

Comprehensive Medical Health Plans

Effective July 1, 2015

www.myFirstChoice.fchn.com

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

v.01.15

First Choice Health

Healthy Employees. Healthy Companies.

Comprehensive Major Medical Plan

Cost Sharing
Payment Provisions
Benefit Maximums
Benefit Summary

Pharmacy

v.01.15

First Choice Health

Healthy Employees. Healthy Companies.

Cost Sharing
Comprehensive Medical Plan

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

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

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

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

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

First Choice Health

Healthy Employees. Healthy Companies.

Payment Provisions
Comprehensive Medical Plan

Highlights of the Revised Medical Plan Provisions

- The Plan pays the first $500 of eligible expenses related to accidental injuries when such expenses are incurred within ninety (90) days of the date of the accident.
- Your benefit coverage is greater, and your out-of-pocket costs less, when you choose a Network provider.
- Benefit payment for services received from Network providers are based on the Allowed Amounts agreed upon by those providers.
- Benefit payment for services received from non-network providers (except emergency services, see below) is based on an amount established by a prevailing fee schedule for the geographic area in which the claim was incurred. This includes flat dollar benefits and preventive benefits. If no such fee schedule exists, a percentage of the provider's billed charges will be paid. See *Allowed Amount* in *Plan Definitions*.
- Benefit payment for emergency services received from non-network providers is determined annually and is based on the greatest of the following amounts: 1) the median of the contracted amounts agreed upon by network providers; 2) the Usual, Customary and Reasonable (UCR) amount (see related definition); or 3) the Medicare amount. See *Allowed Amount* in *Plan Definitions*.
- Services received from a Recognized Provider (See Plan Definitions under Section II - Summary Plan Description) will be paid at the Network level. An Allowed Amount will be obtained through Usual, Customary and Reasonable data or a negotiated rate. If neither is available or appropriate, billed charges may be used as the Allowed Amount. See Allowed Amount under *Plan Definitions.* ***You will be responsible for the difference (if any) between the Allowed Amount and the billed charges on Recognized Provider claims and this difference will not apply to your Out-of-Pocket (OOP) maximum as discussed below.***

First Choice Health

Healthy Employees. Healthy Companies.

Annual Deductible

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

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

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

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

Annual Out-of-Pocket Maximum

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

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

First Choice Health

Healthy Employees. Healthy Companies.

Benefit Maximums
Comprehensive Medical Plan

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

Summary of Benefit Maximums for the Comprehensive Medical Plan

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

First Choice Health

Healthy Employees. Healthy Companies.

Benefit Summary
Comprehensive Medical Plan

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
Accidental Injury Benefit (includes Dental Trauma) Plan pays first $500 on accidental injuries each Benefit Period; care must be received within 90 days of accident	N/A	N/A	100%	100%
Allergy Care	✓	✓	70%	70%
Alternative Care				
• **Acupuncture** 12 visits per Benefit Period combined with Chiropractic benefit, $25 per visit maximum	✓	✓	100%	100%
• **Naturopathic Care**	N/A	✓	100% after $35 copay	70%
Ambulance Services FCHA pre-authorization required for non-emergent air ambulance and inter-facility transport.	✓	✓	70%	70%
Anesthesia	✓	✓	70%	70%
Autism Spectrum Disorders (includes Applied Behavior Analysis (ABA Therapy) Mental Health and Habilitative Services. FCHA Pre-authorization required for ABA Therapy. Covered for children through age 18.				
• **Inpatient care -** facility and professional	✓	✓	70%	70%
• **Outpatient -** Facility and Professional First 3 visits per Benefit Period	N/A	N/A	100%	100%
• **Outpatient -** Facility and Professional 4th visit and after	N/A	✓	100% after $35 copay	70%

First Choice Health

Healthy Employees. Healthy Companies.

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
Autologous Blood Donation/Blood Transfusion	✓	✓	70%	70%
Biofeedback Limited benefit, see *Biofeedback* for details.	✓	✓	70%	70%
Chemical Dependency FCHA pre-authorization required for inpatient, residential and partial hospitalization.				
• **Inpatient care -** facility and professional	✓	✓	70%	70%
• **Outpatient care** - facility and professional First 3 visits per Benefit Period	N/A	N/A	100%	100%
• **Outpatient care -** facility and professional 4th visit and after	N/A	✓	100% after $35 copay	70%
Chiropractic Care				
• **Office visits/spinal manipulations** 12 visits per Benefit Period combined with Acupuncture benefit; $25 per visit maximum	✓	✓	100%	100%
• **Related radiology/x-rays** $100 per Benefit Period	✓	✓	70%	70%
Clinical Trials	Covered as specifically outlined under Clinical Trials in the *Medical Benefits* section below.			
Dental Trauma FCHA pre-authorization required for follow-up services.				
• **First $500 per plan year of eligible expenses** (applies to Accidental Injury Benefit)	N/A	N/A	100%	100%
• **Eligible expenses beyond first $500**				
– Office Visits	N/A	✓	100% after $35 copay	70%

First Choice Health

Healthy Employees. Healthy Companies.

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
– All other places of service	✓	✓	70%	70%
Diabetic Education (nutrition or otherwise) 5 visits per Benefit Period maximum	N/A	N/A	100%	100%
Durable Medical Equipment				
• **Breast Pumps**	✓ (OON only)	✓ (OON only)	100%	70%
• **Durable Medical Equipment**	✓	✓	70%	70%
• **Medical Supplies**	✓	✓	70%	70%
• **Oral Appliances**	✓	✓	70%	70%
• **Orthopedic Appliances**	✓	✓	70%	70%
• **Prosthetic Devices**	✓	✓	70%	70%
Emergency Care				
• **Emergency Room** (facility and professional services)	✓	✓	70%	70%
• **Urgent Care** (facility and professional services)	N/A	✓	100% after $35 copay	70%
Family Planning				
• **Office Visits**	✓ (OON only)	✓ (OON only)	100%	70%
• **Contraceptive devices, implants, injections**	✓ (OON only)	✓ (OON only)	100%	70%
• **Sterilization**	✓ (OON only)	✓ (OON only)	100%	70%
Genetic Services FCHA pre-authorization required for Genetic Testing if over $500.				
• **BRCA Testing**	✓ (OON only)	✓ (OON only)	100%	70%
• **All other Genetic Testing/Counseling**	✓	✓	70%	70%
Habilitative Services (excluding autism-related services. See Autism benefit)	✓	✓	70%	70%

First Choice Health

Healthy Employees. Healthy Companies.

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
Covered for children age 6 and younger only.				
Hearing Exams (non-routine)	✓	✓	70%	70%
Hearing Aids/Appliances are not covered. However, Cochlear implants and Bone Anchored Hearing Aids (BAHA) are covered under the surgical benefit, not the Hearing Aids/Appliances benefit. Please see page 46 under Hospital Outpatient Surgery and Services.				
Home Health Care (HHC) FCHA pre-authorization required.				
• **Home Health Care** 180 visits Benefit Period maximum, combined with Hospice Care.	✓	✓	70%	70%
• **Phototherapy** (home)	✓	✓	70%	70%
Hospice Care FCHA pre-authorization required; 180 visits per Benefit Period maximum, combined with Home Health visits.	✓	✓	70%	70%
Hospital Inpatient Medical and Surgical Care FCHA pre-authorization required.	✓	✓	70%	70%
Hospital Outpatient Surgery and Services FCHA pre-authorization required for certain outpatient services; see *Pre-authorization Requirements* for details.	✓	✓	70%	70%
Infusion Therapy (Includes infusion therapy provided in the home)	✓	✓	70%	70%
Lab and Radiology Services (non-routine, facility and professional services) FCHA pre-authorization required for PET scans.	✓	✓	70%	70%
• **Non-routine, facility and professional services**	✓	✓	70%	70%
• **Professional in office**	N/A	✓ (OON only)	100%	70%
Maternity and Newborn Care				

First Choice Health

Healthy Employees. Healthy Companies.

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
• **Office Visits**	N/A	✓	100% after $35 copay	70%
• **All Other Maternity/Newborn Care**	✓	✓	70%	70%
Medical Weight Loss Program (non-surgical) FCHA pre-authorization required and limited benefit; please see *Medical Benefits* section for more details.				
• **Office Visits** The first 4 office visits related to obesity will be covered as any other office visit. Once the maximum four obesity-related office visits have been exhausted, all obesity-related services will only be covered as part of the Medical Weight Loss Program benefits when pre-authorized by FCHA.	N/A	✓	100% after $35 copay	70%
• **All other place of service**	✓	✓	70%	70%
Mental Health Care FCHA pre-authorization required for inpatient, residential and partial hospitalization.				
• **Inpatient care -** facility and professional	✓	✓	70%	70%
• **Outpatient -** Facility and Professional First 3 visits per Benefit Period	N/A	N/A	100%	100%
• **Outpatient -** Facility and Professional 4th visit and after	N/A	✓	100% after $35 copay	70%
Nutritional Counseling (unrelated to diabetes)	N/A	✓	100% after $35 copay	70%
Nutritional and Dietary Formulas	✓	✓	70%	70%
Oral Surgery Limited benefit, see *Oral Surgery* for details**.**	✓	✓	70%	70%

First Choice Health

Healthy Employees. Healthy Companies.

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
• **Office Visit**	N/A	✓	100% after $35 copay	70%
• **All Other Place of Service**	✓	✓	70%	70%
Plastic and Reconstructive Services FCHA pre-authorization required. Limited benefit, see *Plastic and Reconstructive Services* for details.	✓	✓	70%	70%
Podiatric Care See *Podiatric Care* for details on routine foot care.				
• **In Office** (includes services billed as part of the office visit)	N/A	✓	100% after $35 copay	70%
• **All Other Places of Service**	✓	✓	70%	70%
Preventive Care The preventive services payable by this Plan are designed to comply with Health Care Reform (HCR) regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control (CDC), including but not limited to those listed in the Plan. Periodic updates that may be made to these requirements will be incorporated into the Plan as required by law. The list of the types of payable preventive services is available at: www.healthcare.gov/law/about/provisions/services/lists.html Claims submitted outside the frequency limits noted herein will be paid under the major medical benefits (deductible and coinsurance will apply)				
Immunizations Immunizations for children and adults are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention. See Preventive Care for details. Travel immunizations are covered.				
• **Immunizations**	✓ (OON only)	✓ (OON only)	100%	70%
Office Visits				
• **Well child exams -** children 0-36 months	✓ (OON only)	✓ (OON only)	100%	70%
• **Preventive exams -** adults and children 3 and older	✓ (OON only)	✓ (OON only)	100%	70%
Nutritional Counseling (counseling for a healthy diet) 3 visits per Benefit Period maximum. Subsequent visits are paid under the *Diabetic Education* or *Nutritional Counseling* medical benefits, as applicable.				

First Choice Health

Healthy Employees. Healthy Companies.

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
• **Nutritional Counseling**	✓ (OON only)	✓ (OON only)	100%	70%
Screening Tests - children 0-36 months Screening tests are covered in accordance with the recommendations set forth by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See Preventive Care for more details.				
• **Hemoglobin/hematocritic blood test**	✓ (OON only)	✓ (OON only)	100%	70%
• **Urinalysis**	✓ (OON only)	✓ (OON only)	100%	70%
• **Tuberculin test**	✓ (OON only)	✓ (OON only)	100%	70%
• **All other routine lab/radiology**	✓ (OON only)	✓ (OON only)	100%	70%
Screening Tests - adults and children 3 and older Screening tests are covered in accordance with the recommendations set forth by the US Preventive Services Task Force (USPSTF) and the Health Resources and Services Administration (HRSA). Below is a summary of the most commonly obtained preventive screening services (this is not meant to be an all-inclusive list). See Preventive Care for more details.				
• **Colonoscopy** The first colonoscopy per 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	✓ (OON only)	✓ (OON only)	100%	70%
• **Virtual 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	✓ (OON only)	✓ (OON only)	100%	70%

First Choice Health

Healthy Employees. Healthy Companies.

Comprehensive Medical Plan				
	Applies to Deductible	**Applies to OOP Max**	**Network Providers**	**Non-Network Providers**
• **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	✓ (OON only)	✓ (OON only)	100%	70%
• **Fecal occult blood tests** 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	✓ (OON only)	✓ (OON only)	100%	70%
• **Mammograms** 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	✓ (OON only)	✓ (OON only)	100%	70%
• **Pap tests** (1 per Benefit Period)	✓ (OON only)	✓ (OON only)	100%	70%
• **All other preventive lab/radiology**	✓ (OON only)	✓ (OON only)	100%	70%
Professional/Physician Services (office visits)				
• **Office Visit-** includes all services billed as part of the office visit.	N/A	✓	100% after $35 copay	70%
Rehabilitation Therapy				
• **Inpatient**	✓	✓	70%	70%

First Choice Health

Healthy Employees. Healthy Companies.

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

First Choice Health

Healthy Employees. Healthy Companies.

Pharmacy Plans - Payment Provisions

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

Highlights of the Pharmacy Plans

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

To assist in keeping your out-of-pocket costs down when purchasing a prescription, it may be helpful to know that three tiers exist within the pharmacy structure:

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

First Choice Health

Healthy Employees. Healthy Companies.

Pharmacy Plans - Benefit Summaries

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

Plan	Deductible Individual/Family	Out-of-Pocket Maximum Individual/Family
Revised 1000-70-3000	$100	$3,600 / $7,200
Revised 2000-70-4000	$100	$2,600 / $5,200
Revised 3000-70-5000	$100	$1,600 / $3,200

Revised Plan Pharmacy Benefits			
	Individual Deductible	**OOP Maximum**	**Copay/Coinsurance when received through MedImpact Network Providers**
30-day supply - Retail Pharmacy			
• **Generic**	N/A	✓	$10
• **Preferred**	✓	✓	$20
• **Non-Preferred**	✓	✓	$40
30-day supply - Specialty Pharmacy First prescription may be filled at a Network Retail pharmacy; subsequent refills must be filled through Diplomat.			
• **Generic**	N/A	✓	$10
• **Preferred**	✓	✓	$20
• **Non-Preferred**	✓	✓	$40
90-day supply - Mail Order	Excludes Specialty Pharmacy		
• **Generic**	✓	✓	$20
• **Preferred**	✓	✓	$40

• **Non-Preferred**	✓	✓	$80

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

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

First Choice Health

Healthy Employees. Healthy Companies.

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

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

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

First Choice Health

Healthy Employees. Healthy Companies.

Pharmacy Plan - Filling a Prescription

Customer Service

MedImpact, Inc., a separate entity from FCHA, administers the pharmacy benefit programs. If you have questions you may refer to www.myFirstChoice.fchn.com additional information.

Filling a Prescription

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

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

90-Day Supply of Medication – Mail Order

If you, or a covered family member, regularly take medication for chronic, long-term conditions such as diabetes, arthritis, high blood pressure, heart conditions, etc., the other option for obtaining a 90-day supply of ongoing medications:

- **Mail Order**. You may obtain a 90-day supply of medication through MedImpact's mail order program through Walgreens. Visit www.walgreenshealth.com for. This site offers information about the benefits of ordering 90-day supplies of medication and provides guidance for downloading the necessary mail service order forms.
- **Ridgeway Mail Order Pharmacy** You may also obtain a 90-day supply of medication through Ridgeway Mail Order Pharmacy which is located in Victor, Montana. Visit www.ridgewayrx.com for guidance on obtaining a 90-day supply of medication from Ridgeway. If you have questions about their mail service, please call (800) 630-3214.

Specialty Pharmacy - Limited to a 30-Day Supply

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

Step Therapy

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

First Choice Health

Healthy Employees. Healthy Companies.

Quantity Limits

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

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

First Choice Health

Healthy Employees. Healthy Companies.

Coordination of Benefits for Prescription Drugs

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

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

Ensure that your primary coverage information has been submitted to this Plan.

Submit your prescription drug receipt and explanation of benefits from the primary plan to MedImpact, along with a reimbursement request form. The pharmacy must indicate either “generic” or “brand” on the prescription drug receipt.

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

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

First Choice Health

Healthy Employees. Healthy Companies.

Pharmacy Plan Exclusions and Limitations

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

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

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

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

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