Community
HealthEssentials

2014 Member Handbook

Silver Standard Plan

COMMUNITY HEALTH PLAN
of Washington™

COMMUNITY HEALTHESSENTIALS

Health Care Coverage Agreement
For
Individuals and Families

COMMUNITY HEALTHESSENTIALS is a health insurance plan for individuals and families offered by Community Health Plan of Washington ("CHPW" or "the Plan"). CHPW is a not-for-profit provider of quality, affordable health care with deep ties to the communities it serves. CHPW was created in 1992 by the Community Health Network of Washington - a network of Community Health Centers across Washington State that believed traditional health plans were not meeting the needs of their members. It is CHPW's collaboration with its Community Health Center delivery system that gives us the ability to provide individuals with choice, while meeting the comprehensive health needs of the communities we serve.

CHPW is a Washington State licensed Health Care Services Contractor duly registered under the laws of the State of Washington to provide health care coverage. This Health Care Coverage Agreement ("Agreement") sets forth the terms under which that coverage will be provided, including the rights and responsibilities of the contracting parties, the requirements for enrollment and eligibility, as well as the benefits to which those enrolled under this Agreement are entitled.

This Agreement is made between CHPW and the individual designated herein as the Subscriber. In consideration of timely payment of the Subscriber's portion of the subscription charge, CHPW agrees to provide the benefits of this Agreement subject to the terms and conditions of this Agreement, including any endorsements, amendments, and addenda to this Agreement which are signed and issued by CHPW.

This Agreement between CHPW and the Subscriber consists of the following documents:

- Health Care Coverage Agreement
- Signed Washington State Health Benefit Exchange Application
- Premium Schedule (Schedule A)

YOUR RIGHT TO RETURN THIS CONTRACT WITHIN TEN DAYS

If for any reason you are not satisfied with this Agreement, you may terminate it by returning it to CHPW or the producer through whom it was purchased, within 10 days of delivery to you. It is assumed that delivery will have occurred within three days of the date mailed by CHPW. In the event that the Agreement is returned within ten days, CHPW shall promptly refund all premium payments received from the Subscriber in connection with the issuance and the Agreement shall be void from the beginning. If CHPW does not refund payments within 30 days of its timely receipt of the returned Agreement, it must pay a penalty of 10 percent of such premium which will be added to your refund. CHPW may reduce the refund by the value of services received during the period to which the refund applies.

Table of Contents

WELCOME

Thank you for choosing COMMUNITY HEALTHESSENTIALS for your health care coverage. This Agreement explains your rights and responsibilities, what is covered, and what you pay as a Member of this health plan. Please read this Agreement in order to become familiar with the terms of your health care coverage.

This plan is offered by CHPW, referred to throughout this Agreement as "we," "us," or "our," in partnership with First Choice Health Network ("FCHN") and Vision Service Providers ("VSP"). COMMUNITY HEALTHESSENTIALS is referred to as "plan," "this plan" or "our plan." References to "you" and "your" refer to Members. The words "coverage" and "covered services" refers to the medical care and services and the Prescription Drugs available to you as a Member of CHPW. When we use the terms "Member" or "Members," we are referring to all persons enrolled in this plan. Other terms are defined in the *Definitions* section at the back of this Agreement or where they are first used and are designated by the first letter being capitalized.

Our partnership with FCHN ensures that you have access to a large network of health care Providers. We have also contracted with FCHN to perform certain administrative services associated with this plan. These administrative services include, but are not limited to, Customer Service, Claims Processing, Utilization Management, reviewing of Pre-Authorization requests and first level appeals, and optional Case Management as described in this Agreement.

Important contact information is on the back cover of this Agreement. Please call or write Customer Service for help with questions about benefits or Claims, care you receive, changes of address or other personal information, or to obtain written information about other CHPW health plans. You can use our web site to locate a health care Provider near you, get details about the types of expenses you are responsible for and this plan's benefit maximums.

LEGAL TERMS AND CONDITIONS

CHPW agrees to provide the benefits as set forth in this Agreement.

Premium Payments. For the initial term of this Agreement, the Subscriber shall submit to CHPW for all enrolled persons in his/her family unit the monthly premium set forth in the current premium schedule, which is incorporated into this Agreement by this reference. Premiums are payable on a calendar month basis on or before the first day of the month for which they become due, subject to a grace period of ten days. Premiums are subject to change by CHPW upon thirty (30) days written notice mailed to each Subscriber's address as it appears in CHPW's records.

Identification Cards. CHPW will furnish identification cards, for identification purposes only, to all Subscribers enrolled under this Agreement.

Administration of Agreement. CHPW may adopt reasonable policies and procedures to help in the administration of this Agreement. This may include, but is not limited to, policies or procedures pertaining to benefit entitlement and coverage determination.

Modification of Agreement. As permitted or required by law, this Agreement may be modified by CHPW upon thirty (30) days written notice mailed to each Subscriber's address, as it appears in CHPW's records. Failure to receive such notice shall not affect the modification or effective date thereof. No verbal statement of any person shall modify or otherwise affect the benefits, limitations or exclusions of this Agreement, convey or void any coverage, increase or reduce any benefits under this Agreement or be used in the prosecution or defense of a claim under this Agreement.

Evidence of Medical Necessity. CHPW has the right to require proof of medical necessity for any services or supplies you receive before we provide benefits under this plan. This proof may be submitted by you or on your behalf by your health care Providers. No benefits will be available if required proof is not provided or acceptable to us.

Intentionally False or Misleading Statements. If this plan's benefits are paid in error due to a Member's or Provider's commission of fraud or providing any intentionally false or misleading statements, CHPW shall be entitled to recover those amounts. Please see the *Right of Recovery* provision later in this section.

And, if a Member commits fraud or makes any intentionally false or misleading statements on any application or enrollment form that affects the Member's acceptability for coverage, CHPW may, at its option:

- Deny the Member's Claim;
- Reduce the amount of benefits provided for the Member's Claim; or
- Void the Member's coverage under this plan (void means to cancel coverage back to its Effective Date, as if it had never existed at all).

Finally, statements that are fraudulent, intentionally false or misleading on any form required by CHPW or the Washington State Health Benefits Exchange, and which affect the acceptability of a Member or the risks to be assumed by us, may cause this Agreement to be voided.

Please note: We cannot void your coverage based on a misrepresentation you made unless you have performed an act or practice that constitutes fraud, or made an intentional misrepresentation of material fact that affects your acceptability for coverage.

Member Cooperation. You are under a duty to cooperate with us in a timely and appropriate manner in our administration of benefits. You are also under a duty to cooperate with us in the event of a lawsuit.

Notice under This Agreement. Any notice required under this Contract shall be deemed to be properly given if written notice is deposited in the United States mail or with a private mail carrier. Notices to a Subscriber shall be sent to the Subscriber's last known address appearing in CHPW's records. If CHPW receives a United States Postal Services change of address form for a Subscriber, CHPW will update its records accordingly. Any notice to CHPW will not be deemed to have been given to and received by CHPW until physically received by CHPW. Notices to CHPW must be sent to CHPW's principal mailing address of:

Community Health Plan of Washington
720 Olive Way
Suite 300
Seattle, WA 98101

Your Contact Information. It is extremely important that CHPW maintains your current contact information, including your mailing address, throughout the term of your coverage. Please contact Customer Service at 1-800-930-0132 to provide your current contact information.

Choice of Law and Forum. This Contract shall be governed by and construed in accordance with the laws of the state of Washington, except to the extent pre-empted by federal law. All suits or legal proceedings brought against us by you or anyone claiming any right under this plan must be filed in Seattle, Washington within 3 years of the date we denied, in writing, the rights or benefits claimed under this plan, or of the completion date of the independent review process if applicable.

Compliance with Laws. CHPW and the Subscriber shall comply with all applicable state and federal laws and regulations in performance of this Agreement.

Confidentiality. Each party acknowledges that performance of its obligations under this Contract may involve access to and disclosure of data, procedures, materials, lists, systems, and information, including medical records, plan benefits information, Subscriber addresses, social security numbers, email addresses, phone numbers, and other confidential information regarding the Subscriber (collectively the "Confidential Information"). The Confidential Information shall be kept strictly confidential and shall not be disclosed to any third party other than: (i) representatives of the receiving party (as permitted by applicable state and federal law) who have a need to know such information in order to perform the services required of such party pursuant to this Agreement, or for the proper management and administration of the receiving party, provided that such representatives are informed of the confidentiality provisions of this Agreement and agree to abide by them, (ii) pursuant to court order; or (iii) to a designated public official or agency pursuant to the requirements of federal, state, or local law, statute, rule, or regulation. The disclosing party will provide the other party with prompt notice of any request the disclosing party receives to disclose information pursuant to applicable legal requirements, so that the other party may object to the request and/or seek an appropriate protective order against such request. Each party shall maintain the confidentiality of medical records and confidential patient and Subscriber information as required by applicable law.

Termination of Entire Agreement. This Agreement is a guaranteed renewable agreement and cannot be terminated without the mutual approval of each of the parties, except in the circumstances set forth below.

> **Nonpayment or Non-Acceptance of Premium.** Failure to make any monthly premium payment or contribution shall result in termination of this Agreement as of the premium due date. The Subscriber's failure to accept the revised premiums provided as part of the annual renewal process shall be considered nonpayment and result in non-renewal of this Agreement. The Subscriber may terminate this Agreement upon thirty (30) days written notice of premium increase. CHPW shall give the Subscriber five (5) days notice that the Agreement will terminate.

Nonpayment of Copayments or Coinsurance. Failure to pay Copayments or Coinsurance in accordance with this Agreement shall result in termination of this Agreement upon written notice by CHPW.

Nonpayment of Deductibles. Failure to pay Deductibles in accordance with this Agreement shall result in termination of this Agreement upon written notice by CHPW.

Withdrawal or Cessation of Services. CHPW may determine to withdraw from a Service Area after CHPW has demonstrated to the Washington State Office of the Insurance Commissioner that CHPW's clinical, financial or administrative capacity to serve the covered Subscribers would be exceeded. CHPW may determine to cease to offer the plan and replace the plan with another plan offered to all covered Subscribers within that line of business that includes all of the health care services covered under the replaced plan and does not significantly limit access to the services covered under the replaced plan. CHPW may also allow unrestricted conversion to a fully comparable CHPW product. CHPW will provide written notice to each covered Subscriber of the discontinuation or non-renewal of the plan at least ninety (90) days prior to discontinuation.

Nondiscrimination. CHPW and its vendors do not discriminate on the basis of race, color, national origin, ancestry, religion, gender, marital status, age, sexual orientation, the presence of physical or mental disabilities, or any other reason(s) prohibited by law in its employment practices and or in the provision of health care services.

Notice of Other Coverage. As a condition of receiving benefits under this plan, you must notify us of:

- Any legal action or claim against another party for a condition or Injury for which we provide benefits, and the name and address of that party's insurance carrier;
- The name and address of any insurance carrier that provides personal injury protection, underinsured motorist coverage, or uninsured motorist coverage;
- Any other insurance under which you are or may be entitled to recover compensation; and
- The name of any other group or individual insurance plans that cover you.

Right of Recovery. CHPW has the right to recover excess payment whenever CHPW has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. CHPW may recover excess payment from any person to whom or for whom payment was made or any other carrier. In addition, if the contract for this plan is rescinded as described above in the *Intentionally False or Misleading Statements* provision, we have the right to recover the amount of any Claims we paid under this plan and any administrative costs we incurred to pay those Claims.

Right to and Payment of Benefits. Benefits of this plan are available only to Members. Except as required by law, we won't honor any attempted assignment, garnishment or attachment of any right of this plan. In addition, Members may not assign a payee for Claims, payments or any other rights of this plan. At our option only and in accordance with the law, we may pay the benefits of this plan to:

- The Subscriber;
- A Provider;
- Another health insurance carrier;
- A Member;
- Another party legally entitled under federal or state medical child support laws; or
- Jointly to any of the above.

Payment to any of the above satisfies our obligation as to payment of benefits.

ACCESSING CARE

This plan makes available to you sufficient numbers and types of Providers to give you access to all covered services in compliance with applicable Washington State regulations governing access to Providers. Our Provider

network includes primary care providers, specialty physicians, Hospitals, and a variety of other types of Providers. Members of this plan may receive care from either In-Network or Out-of-Network Providers at any time. This plan's benefits and your Out-of-Pocket Expenses depend on which Providers you see. With the exception of emergencies, you can control your Out-of-Pocket Expenses by choosing to seek care from In-Network Providers. **If you receive care from a Non-Network Provider, you are always responsible for and will be billed for any amounts that exceed the Allowed Amount (this is known as "balance billing").**

In-Network Providers:

We have partnered with the First Choice Health Network to provide you with a comprehensive network of contracted Providers (our "In-Network Providers"). You will not be balance billed for covered services received from In-Network Providers because they agree to accept our Allowed Amount as payment in full. You are, however, responsible for all applicable Copays, Deductibles, Coinsurance, amounts in excess of stated benefit maximums, and charges for non-covered services and supplies.

We are please to inform our continuing CHPW members that the First Choice Health Network includes many of the same providers you may have received health care from. The First Choice Health Network includes local Community Health Center Providers that provide predominantly primary and preventive health care services and focus on treating the entire person.

To locate an In-Network Provider, including services offered at a Community Health Center, you may access our online Provider directory on our website at www.chpw.org or on the First Choice Health Network website at www.fchn.com. To request a paper copy, please contact Customer Service at 1-800-930-0132.

Non-Network Providers.

If the Provider you see is not in our network (a Non-Network Provider,), you will pay higher Out-of-Pocket Expenses for Covered Services and supplies because you are responsible for amounts above the Allowed Amount. When you are billed for the difference between the Allowed Amount and the Provider's actual charge, this is known as balance billing. In addition to balance billing when you receive care from a Non-Network Providers, you will be also responsible for applicable Copays, Deductibles, Coinsurance, amounts in excess of stated benefit maximums, and charges for non-covered services and supplies. Amounts in excess of the Allowed Amount do not accrue toward your Calendar Year Deductible or Out-of-Pocket Maximum.

Important Note: Services you receive in a network Facility from Recognized Providers will be paid at the In-Network Provider rate. However, you may be responsible for amounts over the Allowed Amount if you receive services from a Recognized Provider that is not part of our network. Amounts in excess of the Allowed Amount don't count toward any applicable Calendar Year Deductible, Coinsurance or Out-of-Pocket Maximum. Please see the definition of Recognized Providers in the *Definitions* Section for more information.

Pediatric Vision Providers

We have partnered with Vision Service Plan (VSP) to provide Members under the age of 19 with access to VSP's comprehensive network of optometrists, opticians, ophthalmologists, and other licensed vision care Providers who are qualified to practice vision care services and provide vision care materials. Essential pediatric vision benefits and services are only covered when they are provided by a participating VSP network Provider (VSP Network). Pediatric vision services provided outside the VSP Network will not be covered by this plan. To access VSP's online Provider directory, please go to www.vsp.com or call VSP at 1-800-877-7195 or TTY 1-800-428-4833. You may contact VSP network Providers directly to schedule an appointment. Be sure to let your Provider know that your CHPW pediatric vision benefits are accessed through the VSP Network.

UTILIZATION MANAGEMENT

Benefits listed in this Agreement that must be Medically Necessary are subject to review by CHPW and certain partners such as FCHN. Our staff and partners who make clinical decisions regarding care are licensed by the state of Washington. Supervisors who make clinical decisions are also licensed and have at least five years of experience as clinicians. Proof of the current active status of clinical licenses is kept on file at all times. CHPW and its partners use nationally recognized clinical criteria guidelines and community standards of practice to determine whether care is Medically Necessary by:

- Using guidelines such as the Milliman Care Guidelines® for inpatient care and FCHN Medical policy, HAYES Directory of New Medical Technologies' Status, NCCN Drugs & Biologics compendium, and other specialized criteria;
- Consulting internal and external doctors and experts, including specialists to help decide about complex cases; and
- Asking for help from an Independent Review Organization (IRO).

Medically Necessary health care services are used to evaluate, diagnose, or treat an Illness, Injury, or disease or its symptoms.

Medically Necessary services are covered when provided by a Provider who is practicing within the scope of their license and when all of the following conditions are met:

- It is required for the treatment or diagnosis of a covered medical condition;
- It is the most appropriate supply or level of intervention or service that is essential for the diagnosis or treatment of the Member's covered medical condition considering the potential benefits and harm to the Member;
- It is known to be effective in improving health outcomes for the Member's medical condition in accordance with sufficient scientific evidence, professionally recognized standards, convincing expert opinion and a comparison to alternative interventions, including no interventions;
- It is not furnished primarily for the convenience of the Member or provider of services; and,
- It represents economically efficient use of medical services, interventions and supplies that may be provided safely and effectively to the Member's condition.

The fact that an intervention, service or supply furnished, is prescribed or recommended by a physician or other Provider does not, of itself, make it Medically Necessary. An intervention, service or supply may be Medically Necessary in part only. If this occurs, the portion deemed Medically Necessary will be covered, subject to the limitations and exclusions of the plan.

Evaluation of New Technology

A Provider or Member can ask CHPW to cover a new technology. Our Medical Management is committed to keeping up with news and research about new tests, drugs, treatments, and devices and new ways to use current procedures, drugs, and devices. A Medical Director leads the research and review of the new technology based on

written medical literature, research studies and information received from clinical experts in the field. New technologies are approved based on standards that protect patient safety.

Pre-Authorizations

Pre-authorization review is the process of reviewing certain medical, surgical, and behavioral health services, items, and interventions to ensure medical necessity and appropriateness of care are met before services are received. The UM staff utilizes our approved list of clinical criteria. All requests are first reviewed by clinical staff and if they are unable to approve, the request is forwarded to a Medical Director. All denials are peer reviewed by a Medical Director. The Medical Director is available to discuss utilization management denials.

Except in the case of fraud or misrepresentation, Pre-Authorizations for Medical Necessity are binding if obtained at least 30 calendar days prior to the date the service is provided. We will send determinations on Pre-Authorization requests for Experimental or Investigational procedures or supplies within 20 business days of the request, if no additional information is required to make the determination.

Pre-Authorization Requirements

All inpatient admissions and certain outpatient services and procedures require pre-authorization, which is also noted in the *Schedule of Medical Benefits* section. If pre-authorization is not obtained on the services listed below, your Claims will be denied. You are responsible for obtaining pre-authorization; you may have your Provider contact CHPW for you, but you are ultimately responsible. Call 1-800-808-0450 for pre-authorization on medical services or 1-800-640-7682 for mental health or Chemical Dependency services.

Pre-authorization is required for:

- **Clinical trials** (any treatment provided under a clinical trial)
- **Durable Medical Equipment, medical supplies and prosthetics**
  - When purchase exceeds $2,000; or
  - When rental exceeds $500 per month
- **Experimental, Investigational or unproven services**
- **Genetic testing**
  - Over $500
- **Hemodialysis** (for chronic kidney disease) provided in the outpatient setting
- **Home health care services**
  - Home health visits
  - Home infusion therapy (enteral and IV)
  - Hospice
- **Hyperbaric therapy**
- **Imaging**
  - PET scans
- **Inpatient admissions**
  - Chemical Dependency and mental health admissions (including residential)
  - Inpatient hospice
  - Inpatient rehabilitation admissions
  - Long- term acute care facility
  - Medical/surgical admissions (excluding routine maternity deliveries)
  - Skilled Nursing Facility admissions
- **Medical injectables and other drugs**
  - Abatacept
  - Alpha- 1 proteinase inhibitor
  - Blood clotting factors
  - Botulinum toxin (all types and brands)
  - Cytarabine Liposome
  - Epoprostenol
  - Imiglucerase
  - Infliximab
  - Intravenous immunoglobulin (IVIG) therapy
  - IxabepilonePalivizumab (Synagis)
  - Ranibizumab
  - Rituximab
  - Sipuleucel-T (Provenge)
  - Ustekinumab
- **Organ and bone marrow transplants** (includes evaluation of and services for both recipient and donor)
- **Reconstructive procedures** - All procedures that may be considered cosmetic, including but not limited to:
  - Breast reduction
  - Eyelid surgery (i.e. blepharoplasty)
  - Removal of breast implants
  - Rhinoplasty
- **Surgery**
  - Cochlear Implants
  - Lumbar fusions
  - Orthognathic surgery

- Surgical interventions for sleep apnea
- Surgical treatment of gynecomastia
- Varicose vein procedure

As noted above, if you do not obtain pre-authorization for services which require it, your Claim will be denied. Payments made on Claims denied due to lack of pre-authorization do **not** apply toward your Calendar Year Deductible or Out-of-Pocket Maximums.

Your Provider may submit an advance request to CHPW for benefit or Medical Necessity determinations. If a service could be considered Experimental or Investigational for a given condition, we recommend a benefit determination in advance, since those services are not covered without a pre-authorization, except covered routine patient costs associated with an approved clinical trial. See *Clinical Trials* in the *Schedule of Medical Benefits* section.

Notification for Emergency Hospital Admissions
Hospital admissions directly from the emergency room do not require pre-authorization. However, notification is required within two (2) business days after the Hospital admission when admitted directly from the emergency room, or as soon as possible. You, or your Provider, may notify us by calling the Notification of Hospital Admission phone number located on the back of your ID card.

Concurrent Review and Discharge Coordination
Continued hospitalization is subject to periodic clinical review to ensure timely, quality care in the appropriate setting. Discharge coordination assists those transferring from the Hospital to home or another Facility.

Case Management

A catastrophic medical condition is a condition that requires lengthy hospitalization, extremely expensive therapies, or other care that would deplete a family's financial resources. A catastrophic medical condition may require long-term, perhaps lifetime care involving extensive services in a Facility or at home. With case management, a nurse case manager or Master's prepared licensed therapist monitors these patients and explores coordinated and/or alternative types of appropriate care. The case manager consults with the patient, family, and attending physician to develop a plan of care that may include:

- Offering personal support to the patient;
- Contacting the family for assistance and support;
- Monitoring Hospital or Skilled Nursing Facility stays;
- Addressing alternative care options;
- Assisting in obtaining any necessary equipment and services; and
- Providing guidance and information on available resources.

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

24-Hour Nurse Advice Line

You can call the free Nurse Advice Line to get health care information 24 hours a day, 7 days a week. The nurses can help you when you have questions about health concerns or need health information. To speak to a nurse, call toll free 1-866-418-1012 (voice) or 7-1-1 (TTY for speech or hearing impaired).

COST-SHARES

This section of your Agreement explains the types of expenses you must pay for Covered Services before the benefits of this plan are provided ("Cost-Shares"). To prevent unexpected Out-of-Pocket Expenses, it's important for you to understand what you're responsible for.

Copayments

Copayments (also referred to as "Copays") are fixed up-front dollar amounts that you are required to pay at the time of service. Specific Copay amounts are located under the *Schedule of Medical Benefits* section. Payment of a Copay does not exclude the possibility of being billed for additional charges if the service is determined not to be a Covered Service.

Emergency Room Copay

For each emergency room visit, you pay a $**250** Copay regardless of whether you receive services from In-Network or Out-of-Network Providers. If you are admitted directly to the Hospital as an inpatient from the emergency room within 24 hours, the Emergency Room Copay will be waived and services will be subject to Deductible and Co-insurance.

Professional Services – Office Visit Copay

You are required to pay an office visit Copay when you receive primary or specialty care or other services from an In-Network Provider. Office visit Copays are listed under Professional Services in the *Schedule of Medical Benefits*. Office visits that require a Copay do not apply to Deductibles and Co-insurance. Covered services provided at the doctor's office that are not part of the office visit are subject to Deductible and Co-insurance and may require Pre-authorization. Please see Pre-authorization Requirements section.

Separate Copays will apply for each separate Provider you receive services from even if those services are received on the same day. For more information contact Customer Service at 1-800-930-0132.

Primary Care Providers

You are required to pay a $**30** office visit Copay when you receive primary care from an In-Network Provider.

Specialist Providers

You are required to pay a $**55** office visit Copay when you receive specialty care from an In-Network Provider.

Calendar Year Deductible

The Calendar Year Deductible is the amount of expense you must incur in each 12-month period (January through December) for Covered Services and supplies before this plan provides certain benefits. Covered Services, except Prescription Drug services, received from In-Network Providers requiring a Copay do not apply to your Calendar Year Deductible. All Covered Services received from In-Network Providers that do not require a Copay will apply to your Calendar Year Deductible. The amount applied toward your Calendar Year Deductible for any Covered Service or supply will not exceed the Allowed Amount (please see the *Definitions* section in this Agreement). Copays do not count toward the Calendar Year Deductible. This plan has different Deductibles for services received from In-Network Providers and for services received from Out-of-Network Providers. The Deductible for services from Out-of-Network Providers is called the Out-of-Network Deductible.

Individual Deductible

The Individual Deductible is a fixed amount each Member must incur and satisfy before certain benefits of this plan are provided.

Please Note: Your Individual Deductible accrues toward the In-Network individual Out-of-Pocket Maximum. Some benefits have maximums on the number of visits or days of care that can be covered.

No Carryover

Expenses you incur for Covered Services and supplies in the last 3 months of a Calendar Year which satisfied all or part of the Calendar Year Deductible **will not** be used to satisfy all or part of the next year's Deductible.

Coinsurance

Coinsurance is a defined percentage of the Allowed Amount that you pay for Covered Services and supplies you receive. Coinsurance is the percentage you are responsible for, not including any applicable Copays and Calendar Year Deductible, when we pay benefits at less than 100%. This plan has separate Coinsurance percentages for services received from In-Network Providers and for services received from Out-of-Network Providers . Coinsurance for services from Out-of-Network Providers is called the Out-of-Network Coinsurance. The specified Coinsurance applicable to each benefit of this plan is located under the *Schedule of Medical Benefits* section.

Out-of-Pocket Maximum

The Out-Of-Pocket Maximum is the maximum amount each individual will pay each Calendar Year for Covered Services and supplies. The Out-of-Pocket Maximum for services and supplies furnished by In-Network Providers is called the In-Network Out-of-Pocket Maximum. Payments you make to Network Providers directly for Coinsurance, Copays, and any required Deductible for medical services apply to your Out-of-Pocket Maximum. There is no Out-of-Pocket Maximum limit for services received from of Out-of-Network Providers . However, benefits that always apply in-network, like ambulance services and emergency room services, apply toward the in-network Out-of-Pocket Maximum.

Once the individual Out-Of-Pocket Maximum has been satisfied, the benefits of this plan will be provided at 100% of the Allowed Amount for the remainder of that Calendar Year for Covered Services from Network Providers.

Out-of-Network expenses do not satisfy Out-of-Pocket Maximums and will be tracked separately.

American Indian or Alaska Native Members

If you are an American Indian or Alaskan Native whose income is less than 300% of the Federal Poverty Level, you will not be obligated to pay cost-sharing amounts for covered services or benefits. Regardless of your household income, if you are an American Indian or Alaskan Native, you will not be obligated to pay cost-sharing amounts for services furnished by or through Indian Health Care Providers. Indian Health Care Providers are medical and other healthcare Providers who provide healthcare services through programs operated by the federal Indian Health Service, or through tribes, tribal organizations, or urban Indian organizations.

BENEFITS

This section of the Agreement describes the specific benefits available for Covered Services and supplies. Benefits are available for a service or supply described in this section when it meets all of the following requirements:

- It must be furnished in connection with either the prevention, diagnosis or treatment of a covered Illness, disease or Injury;
- It must be Medically Necessary and must be furnished in a Medically Necessary setting. Inpatient care is only covered when you require care that could not be provided in an outpatient setting without adversely affecting your condition or the quality of care you would receive;
- It must not be excluded from coverage under this plan;
- The expense for it must be incurred while you are covered under this plan and after any applicable waiting period required under this plan is satisfied; and
- It must be furnished by a Provider who is performing services within the scope of his or her license or certification.

Benefits for some types of services and supplies may be limited or excluded under this plan. Please refer to the actual benefit provisions in the *Medical Benefits Details* section and the *Exclusions* section for a complete description of Covered Services and supplies, limitations and exclusions.

Services received from a Recognized Provider (See *Definitions* section) will be paid at the In-Network Provider level. An Allowed Amount will be obtained through usual, customary and reasonable data or a negotiated rate. If neither is available or appropriate, billed charges may be used as the Allowed Amount. You will be responsible for the difference (if any) between the Allowed Amount and the billed charges on Recognized Provider Claims and this difference would not apply to your Out-of-Pocket Maximum.

BENEFIT MAXIMUMS

Annual Deductible and Out-of-Pocket Maximums

Deductible and Out-of-Pocket Maximums	**In-Network**	**Out-of-Network**
Annual Deductible (per Calendar Year)		
Individual	$2,000	$5,000
Family	$4,000	$10,000
Coinsurance (plan pays)	70%	50%
Annual Out-of-Pocket Maximum (per Calendar Year)		
Individual	$6,350	N/A
Family	$12,700	N/A

SCHEDULE OF MEDICAL BENEFITS

COMMUNITY HEALTHESSENTIALS				
Benefit	**Copay**	**Applies to Deductible**	**In-Network Providers (plan pays)**	**Out-of-Network Providers (plan pays)**
Acupuncture 12 visits per Calendar Year (except when provided for Chemical Dependency treatment).	No	Yes	70%	50%
Ambulance Services	No	Yes	70%	50%
Anesthesia	No	Yes	70%	50%
Autologous Blood Donation/Blood Transfusion	No	Yes	70%	50%
Chemical Dependency (inpatient, residential and partial hospitalization services) Pre-authorization is required.				
• **Inpatient** (facility and professional)	No	Yes	70%	50%
• **Outpatient** (facility)	No	Yes	70%	50%
• **Outpatient** (professional)	No	Yes	70%	50%
• **Acupuncture** (when provided for Chemical Dependency conditions, services do not apply to the overall acupuncture maximum benefit)	No	Yes	70%	50%
Diabetic Education and Diabetic Nutrition Education				
• **In Office** (Primary Care Provider)	$0 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
• **In Office** (Specialist)	$0 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%

COMMUNITY HEALTHESSENTIALS				
Benefit	**Copay**	**Applies to Deductible**	**In-Network Providers (plan pays)**	**Out-of-Network Providers (plan pays)**
• **All other places of service**	No	Out-of-Network Providers only	100%	50%
Durable Medical Equipment Pre-authorization required if purchases exceed $2,000 or $500 per month rental.				
• **Breast Pumps**	No	Out-of-Network Providers only	100%	50%
• **Durable Medical Equipment**	No	Yes	70%	50%
• **Medical Supplies**	No	Yes	70%	50%
• **Orthopedic Appliances**	No	Yes	70%	50%
• **Prosthetic Devices**	No	Yes	70%	50%
Emergency Care Services				
• **Emergency Care Services** Copay waived if admitted as an inpatient within 24 hours	$250	No	100% after Copay	100% after Copay
• **Urgent Care**	$55 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
Family Planning				
• **Office visits**	$0 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
• **Devices, implants and injections**	$0 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%

COMMUNITY HEALTHESSENTIALS				
Benefit	**Copay**	**Applies to Deductible**	**In-Network Providers (plan pays)**	**Out-of-Network Providers (plan pays)**
• **Sterilization**	$0 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
• **Termination of pregnancy**	No	Yes	70%	50%
Genetic Services Pre-authorization required for genetic testing over $500.				
• **Genetic Counseling**	No	Yes	70%	50%
• **Genetic Testing**	No	Yes	70%	50%
Habilitation Services (Speech therapy, occupational therapy, physical therapy and aural therapy, and FDA-approved habilitative devices)				
• **Inpatient** (facility and professional) 30 days per Calendar Year	No	Yes	70%	50%
• **Outpatient** (facility and professional) 25 visit maximum for all habilitation therapy services combined per Calendar Year.	No	Yes	70%	50%
Hearing				
• **Routine hearing exams**	Not Covered			
• **Medically Necessary hearing exams**	Covered under *Lab and Radiology Services*			
• **Hearing aids/appliances**	Not Covered			
Home Health Care Pre-authorization required. Limited to 130 visits per Calendar Year.				
• **Home Health Care**	No	Yes	70%	50%
• **Phototherapy** (home)	No	Yes	70%	50%

COMMUNITY HEALTHESSENTIALS				
Benefit	**Copay**	**Applies to Deductible**	**In-Network Providers (plan pays)**	**Out-of-Network Providers (plan pays)**
• **Infusion Therapy** (as part of Home Health Care)	No	Yes	70%	50%
Hospice Pre-authorization required.				
• **Hospice Care**	No	Yes	70%	50%
• **Respite Care** 14 days lifetime maximum.	No	Yes	70%	50%
Hospital Inpatient Medical and Surgical Care Pre-authorization required.				
• **Facility services**	No	Yes	70%	50%
• **Inpatient doctor visits/consultations**	No	Yes	70%	50%
• **Inpatient professional (surgeon)**	No	Yes	70%	50%
• **Inpatient professional services** (assistant surgeon, radiologist, pathologist)	No	Yes	70%	50%
Hospital Outpatient Surgery and Services Pre-authorization required for certain outpatient services; see the *Pre-Authorization* section for details.				
• **Surgical facility services**	No	Yes	70%	50%
• **Ambulatory Surgical Center (ASC)**	No	Yes	70%	50%
• **Outpatient surgery professional services (surgeon)**	No	Yes	70%	50%
• **Outpatient surgery professional services** (assistant surgeon, radiologist, pathologist)	No	Yes	70%	50%

COMMUNITY HEALTHESSENTIALS				
Benefit	**Copay**	**Applies to Deductible**	**In-Network Providers (plan pays)**	**Out-of-Network Providers (plan pays)**
Infertility Diagnostic Services Limited benefit, see *Infertility Diagnostic Services* below for details.	No	Yes	70%	50%
Infusion Therapy	Coverage is based on place of service. Infusion therapies provided as part of an inpatient Hospital stay or Office Visit are covered under those benefits. Pre-Authorization is required is performed in the home (*see* Home Health Care benefit) or at a free-standing infusion site.			
Lab and Radiology Services (non-routine, facility and professional services) Pre-authorization required for PET scans.				
• **Hospital inpatient** (professional fees)	No	Yes	70%	50%
• **Hospital outpatient/ independent lab or x-ray facility/doctor's office**	No	Yes	70%	50%
Maternity and Newborn Care				
• **Prenatal Diagnosis of Congenital Anomalies**	No	Yes	70%	50%
• **Maternity care** (global professional fee and all prenatal and postnatal care)	$55 In-Network Providers only	Out of Network Providers Only	100% after Copay	50%
• **Maternity care** (delivery and all inpatient services)	No	Yes	70%	50%
• **Newborn care**	No	Yes	70%	50%
Mental Health Care (inpatient, residential and partial hospitalization services) Pre-authorization is required.				
• **Inpatient** (facility and professional)	No	Yes	70%	50%
• **Partial Day Treatment (PDT)**	No	Yes	70%	50%
• **Outpatient** (facility)	No	Yes	70%	50%

COMMUNITY HEALTHESSENTIALS				
Benefit	**Copay**	**Applies to Deductible**	**In-Network Providers (plan pays)**	**Out-of-Network Providers (plan pays)**
• **Outpatient** (professional)	No	Yes	70%	50%
Nutritional Counseling	See Preventive Care			
Nutritional and Dietary Formulas				
• **PKU Formula**	No	Yes	70%	50%
• **Other Formulas**	No	Yes	70%	50%
Oral Surgery	No	Yes	70%	50%
Orthognathic Surgery Pre-authorization required.	Covered only when related to Temporomandibular Joint (TMJ) Disorder, sleep apnea, or related to the repair of a Dependent child's congenital anomaly from the moment of birth. See *TMJ* benefit or *Plastic and Reconstructive Services* benefit for details.			
Prescription Drugs	Administered by Express Scripts, Inc.			
Retail Pharmacy – 30 day supply				
• **Tier 1 – Preferred Generic**	$15 In-Network Providers only	No	100% after Copay	0%
• **Tier 2 – Preferred Brand**	$50 In-Network Providers only	Yes	100% after Copay	0%
• **Tier 3 – Non-Preferred Brand/Generic**	No	Yes	50%	0%
Specialty Pharmacy				
• **Tier 4 – Specialty Drugs**	No	Yes	50%	0%
Plastic and Reconstructive Services Pre-authorization required. Limited benefit, see *Plastic and Reconstructive Services* for details.	No	Yes	70%	50%

COMMUNITY HEALTHESSENTIALS				
Benefit	**Copay**	**Applies to Deductible**	**In-Network Providers (plan pays)**	**Out-of-Network Providers (plan pays)**
Podiatric Care See *Podiatric Care* for details on routine foot care.				
• **In Office** (Primary Care Provider)	$30 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
• **In Office** (Specialist)	$55 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
• **All other places of service**	No	Yes	70%	50%
Preventive Care Limits listed below are a guideline only. These limits are not meant to be benefit limitations. Preventive Care Services 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.				
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 not covered.	$0 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
Periodic Exams (adult and child)	$0 In-Network Providers only	Out-of-Network Providers only	100% after $0 member Copay	50%
Nutritional Counseling 6 visits per Calendar Year, except for Diabetics. Additional visits may be allowed if determined to be Medically Necessary.	$0 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%

COMMUNITY HEALTHESSENTIALS				
Benefit	**Copay**	**Applies to Deductible**	**In-Network Providers (plan pays)**	**Out-of-Network Providers (plan pays)**
Screening Tests (adult and child) The first colonoscopy, sigmoidoscopy, fecal occult blood test and mammogram per Calendar Year are covered under the Preventive Care benefit, regardless of diagnosis. Subsequent colonoscopies, sigmoidoscopies, fecal occult blood tests and mammograms in the same Calendar Year are covered under the Lab & Radiology Services benefit, regardless of diagnosis.				
• **Bone Density Screening** (1 test every other plan year, women age 65, or, age 60 for those with increased risk for osteoporotic fractures)	$0 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
• **Colonoscopy** (beginning at age 50 or younger if at increased risk)	$0 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
• **Mammogram** (for women, beginning at age 40 or earlier for those with increased risk)	$0 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
• **Pap Test** (for women 18 and/or sexually active)	$0 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
• **Prostate Cancer Screening (PSA)** (for men, beginning age 50)	$0 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
• **Sigmoidoscopy** (beginning at age 50 or younger if at increased risk)	$0 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
• **Other Screening Tests**	$0 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
Professional/Physician Services (office visits)				

COMMUNITY HEALTHESSENTIALS				
Benefit	**Copay**	**Applies to Deductible**	**In-Network Providers (plan pays)**	**Out-of-Network Providers (plan pays)**
• **Primary Care Provider** (including naturopaths)	$30 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
• **Specialist**	$55 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
Rehabilitation Therapy				
• **Inpatient** (facility and professional). 30 days per Calendar Year.	No	Yes	70%	50%
• **Outpatient** (facility and professional) includes physical, speech, occupational and massage therapies. 25 visit maximum for all rehabilitation therapy services combined per Calendar Year.	No	Yes	70%	50%
Skilled Nursing Facility 60 days per Calendar Year	No	Yes	70%	50%
Spinal Manipulations 10 visits per Calendar Year.	No	Yes	70%	50%
Temporomandibular Joint (TMJ) Disorder Pre-authorization required if inpatient.				
• **Office visits**	$30 or $55 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
• **All other services**	No	Yes	70%	50%
Tobacco Cessation Program	No	No	70%	50%
Transplants (organ and bone marrow) Pre-authorization required. Subject to 90 day waiting period				

COMMUNITY HEALTHESSENTIALS				
Benefit	**Copay**	**Applies to Deductible**	**In-Network Providers (plan pays)**	**Out-of-Network Providers (plan pays)**
• **Recipient services** (facility and professional)	No	Yes	70%	50%
• **Donor services** (facility and professional)	No	Yes	70%	50%

Pediatric Vision (under age 19)	**Administered by Vision Service Plan (VSP)**		
	Applies to Deductible	**In-Network Providers (plan pays)**	**Out of Network Providers (plan pays)**
• **Routine Eye Exam** 1 exam per Calendar Year	No	100%	0%
• **Vision Hardware** Limited to children under age 19. One pair of prescription lenses or contacts every Calendar Year, including polycarbonate lenses and scratch resistant coating. One pair of frames per Calendar Year contact lenses (in lieu of lenses and frames). Includes fitting fee.	No	100%	0%
• **Low Vision Services** Limited to children under age 19.			
- Low vision optical devices	No	100%	0%
- Comprehensive low vision evaluation Once every 5 Calendar Years	No	100%	0%
- High power spectacles, magnifiers and telescopes as Medically Necessary, with reasonable limitations permitted.	No	100%	0%
- Follow up visits 4 visits in any 5 Calendar Year period	No	100%	0%

MEDICAL BENEFITS DETAILS

All covered benefits are subject to the limitations, exclusions and provisions of this plan. To be covered, medical services and supplies must be Medically Necessary for the treatment of an Illness or Injury (except for any covered

Preventive care). Also, a Provider practicing within the scope of his or her license must render the service. Please see the *Definitions* section in the back of this Agreement for descriptions of Medically Necessary and of the kinds of Providers who deliver Covered Services.

Acupuncture Services

Acupuncture services are covered when provided by an acupuncturist to treat a covered Illness or Injury. Benefits are subject to the acupuncture maximum benefit limit of this plan, except when provided to treat a chemical dependency condition (see *Chemical Dependency Services*).

Allergy Care

As part of primary care and specialist office visit benefits, this plan covers allergy tests, injections, and serums, though serum is covered only when received and administered within the Provider's office. If received from a Pharmacy, the serum may be covered under the Prescription Drugs benefit.

Ambulatory Patient Services

This plan covers Ambulatory Patient Services under several different benefits and described throughout this Agreement in the applicable provision and subject to those limitations. Ambulatory Patient Services means Medically Necessary services delivered to Members in settings other than a Hospital or Skilled Nursing Facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat Illness or Injury.

Ambulance Services for Emergency Transportation

This plan covers ambulance services for emergency transportation to the nearest Hospital equipped to provide treatment when any other form of transportation would endanger the Member's health and the purpose of the transportation is not for personal or convenience reasons. Covered ambulance services include licensed ground and air ambulance Providers.

Blood Products and Services

Benefits are provided for the cost of blood and blood derivatives, including blood storage and the services and supplies of a blood bank.

Clinical Trials

Coverage for participation in an approved clinical trial **requires pre-authorization** by CHPW. An approved clinical trial is defined as follows:

- Prior authorization for clinical trial participation has been granted as described below;
- The principal purpose of the trial intervention must be the therapeutic intent to potentially improve health outcomes, and not for diagnosis or supportive care; Phase 1 clinical trials are excluded;
- The clinical trial intervention must be intended for a condition covered by this plan;
- The clinical trial must be conducted as approved by a national organization such as the National Institutes of Health (NIH), the National Cancer Institute (NCI), the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention (CDC), the Agency for Healthcare Research and Quality (AHRQ), the federal Department of Veterans Administration (VA) or Defense (DOD), or the Centers for Medicare & Medicaid Services (CMS);
- The clinical trial must be conducted under a written research protocol approved by an appropriate Institutional Review Board's (IRB). This protocol must demonstrate that the trial is in compliance with Federal regulations relating to the protection of human subjects;
- The clinical trial must provide a thorough informed consent document to the participating Member, and this document must be signed by the Member and reviewed by the plan prior to Member's participation in the clinical trial; and
- All applicable plan limitations for coverage of out-of-network care along with all applicable plan requirements for precertification, registration, and referrals will apply to any costs associated with Member participation in the trial.

Costs associated with clinical trial participation may be covered as follows:

- Items or services that are typically provided for this disease absent a clinical trial (e.g., conventional/standard care);
- Items, services, or tests that are required to safely provide the investigational intervention to include clinically appropriate monitoring of the effects of the intervention; and
- Medically Necessary diagnosis and treatments for conditions that are medical complications resulting from the Member's participation in the clinical trial.

Costs that are not covered include:

- Investigational items, services, tests, or devices that are the object of the clinical trial;
- Interventions, services, tests, or devices provided by the trial sponsor without charge;
- Data collection or record keeping costs that would not be required absent the clinical trial; this exclusion extends to any activity (e.g. imaging, lab tests, biopsies) necessary only to satisfy the data collection needs of the trial; or
- Interventions associated with treatment for conditions not covered by the plan.

Dental Anesthesia

Inpatient and outpatient facility, including general anesthesia services, are covered for dental procedures when it is necessary to safeguard the health of an individual. This benefit provides coverage if the patient is under the age of seven (7) years old, is developmentally delayed, with a dental condition that cannot be safely and effectively treated in a dental office, or if the patient's physician has determined the patient's medical condition will place the patient at undue risk if the dental procedure is performed in a dental office. Benefits are not available for charges of a dentist or for services received in a dentist's office. This benefit includes services to prepare the jaw for radiation treatment of neoplastic disease.

Diabetic Education and Diabetic Nutrition Education

Diabetes Self-Management and Training

This benefit covers outpatient diabetes self-management training, education, nutritional counseling services for the treatment and management of diabetes when ordered by a Provider. Services must be provided by appropriately licensed or registered healthcare professionals including outpatient self-management training and education services provided through authorized ambulatory diabetes education facilities. Benefits under this section also include medical eye examinations (dilated retinal examinations) for Members with diabetes.

Diabetic Self-Management Items

Prescribed Insulin pumps and supplies for the management and treatment of diabetes are covered, based upon the medical needs of the Member. Insulin pumps and insulin infusion devices are subject to all the conditions of coverage stated under the Durable Medical Equipment benefit. Benefits for insulin, oral hypoglycemic agents, blood glucose monitors insulin syringes with needles, blood glucose and urine test strips, ketone test strips and tablets and lancets and lancet devices are covered by the Prescription Drugs benefit associated with this plan.

Dialysis Services

Dialysis services (for chronic renal failure) are covered when provided in the Hospital, outpatient facility and at home settings. Pre-authorization is required for outpatient and home dialysis.

Durable Medical Equipment

Durable Medical Equipment (DME) is Medical Equipment, including mobility enhancing equipment that can withstand repeated use, is not disposable, is used for a medically therapeutic purpose, is generally not useful in the absence of Illness or Injury and is appropriate for use in the home. DME may be rented or purchased (at our discretion) and total cost for rental must not exceed the purchase price. Repair or replacement is only covered

when needed due to normal use, a change in the patient's physical condition, or the growth of a child. Duplicate items are not covered. When more than one option exists, benefits will be limited to the least expensive model or item appropriate to treat the patient's covered condition.

Examples of DME include, but are not limited to:

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

This benefit also covers:

- Breast Pumps;
- Diabetic monitoring equipment, such as the initial cost of an insulin pump and supplies related to such equipment. Diabetic supplies such as insulin, syringes, needles, lancets, test strips, etc, are covered under the Prescription Drugs benefit;
- Medical supplies needed for the treatment or care of an appropriate covered condition, including but not limited to compression garments, mastectomy bras and supplies, and ostomy supplies. Supplies available over-the-counter are excluded;
- **Limited Medical Vision Hardware:** Benefits are provided for vision hardware for the following medical conditions of the eye: corneal ulcer, bullous keratopathy, recurrent erosion of cornea, tear film insufficiency, aphakia, Sjorgren's disease, congenital cataract, corneal abrasion and keratoconus; and
- State sales tax for durable medical and mobility enhancing equipment.

DME or supplies provided as part of home health care, hospice care, or by a Hospital would be paid under those benefits. Prosthetic devices requiring surgical implantation (including cochlear implants) would be covered under the appropriate surgical benefit.

DME and medical supply charges listed below are not covered:

- Biofeedback equipment;
- Electronic and/or keyboard communication devices;
- Equipment or supplies whose primary purpose is preventing Illness or Injury;
- Exercise equipment;
- Eyeglasses or contact lenses for conditions not listed as a covered medical condition or covered under the Pediatric Vision benefit, including routine eye care;
- Items not manufactured exclusively for the direct therapeutic treatment of an Illness or Injury;
- Items primarily for comfort, convenience, sports/recreational activities or use outside the home;
- Off-the shelf shoe inserts and orthopedic shoes;
- Over-the-counter items (except Medically Necessary crutches, walkers, standard wheelchairs, diabetic supplies and ostomy supplies are covered);
- Personal comfort items including but not limited to air conditioners, lumbar rolls, heating pads, diapers, or personal hygiene items;
- Phototherapy devices related to seasonal affective disorder;
- Supportive equipment/environmental adaptive items including, but not limited to, hand rails, chair lifts, ramps, shower chairs, commodes, car lifts, elevators, and modifications made to the patient's home, place of work, or vehicle; or
- The following Medical Equipment/supplies: regular or special car seats or strollers, push chairs, air filtration/purifier systems or supplies, water purifiers, allergenic mattresses, orthopedic or other special chairs, pillows, bed-wetting training equipment, whirlpool baths, vaporizers, room humidifiers, hot tubs or other types of tubs, home UV or other light units, home blood testing equipment and supplies (except diabetic equipment and supplies, and home anticoagulation meters).

Emergency Care Services

This plan covers Emergency Care services, including supplies, outpatient charges for patient observation, Facility costs, and medical screening exams that are required for the stabilization of a patient experiencing a Medical Emergency. Emergency Care services provided by network and non-network facilities are covered by this plan and include Medically Necessary detoxification services, including Chemical Dependency detoxification. Prescription medications associated with a Medical Emergency, including those purchased in a foreign country, are covered.

A Medical Emergency is a medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in: 1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.
Examples of a Medical Emergency are severe pain, suspected heart attacks and fractures. Examples of a non-Medical Emergency are minor cuts and scrapes. Examples of emergent conditions include severe pain, difficulty breathing, deep cuts or severe bleeding, poisoning, drug overdose, broken bones, unconsciousness, stab or gun-shot wounds, automobile accidents, and pain or bleeding during pregnancy.

In the case of an emergency, home or away, seek the most immediate care available. To receive network benefits, you must obtain all follow-up care from In-Network Providers. Pre-authorization is required for ongoing Out-of-Network care while travelling.

Family Planning

Voluntary sterilization procedures, including vasectomy and tubal ligation, and U.S. Food and Drug Administration ("FDA") approved birth control methods are covered, including the insertion/removal as required. FDA-approved over-the-counter contraceptive products for women are covered under the Prescription Drugs benefits, when prescribed by a qualified Provider. Oral, patch, and ring contraceptives are also covered under the Prescription Drugs benefit.

Termination of Pregnancy

Voluntary termination of pregnancy is covered for female Members of this plan.

Genetic Testing

Genetic testing, counseling, interventions, therapy and other genetic services are covered when determined to be Medically Necessary care or treatment of a covered condition, or a Medically Necessary precursor to obtaining prompt treatment of a covered condition. This benefit does not include genetic testing of a child's father as a part of prenatal or newborn care.

Habilitative Services

Benefits are provided for habilitative services when Medically Necessary and must be recognized by the medical community as efficacious:

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

Covered Services include

- Speech, occupational, physical and aural therapy services;
- FDA approved devices designed to assist a Member and require a prescription to dispense the device; and
- Habilitative services received at a school-based health care center unless delivered pursuant to federal Individuals with Disabilities Education Act of 2004 requirements pursuant to an individual educational plan

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

NOTE: Outpatient habilitative therapy services are subject to a combined total maximum of 25 visits per member per Calendar Year.

Home Health Care

Pre-authorization is required for home health care benefits. Home health care, including supplies, is covered when prescribed by your physician. The patient must be homebound and require Skilled Care services. Home health care is covered when provided as an alternative to hospitalization and prescribed by your physician. Benefits are limited to intermittent visits by a licensed home health care agency and home infusion services. For this benefit, a visit is a time-limited session or encounter with any of the following home health agency Providers:

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

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

Additional items and expenses covered when home health care is provided include:

- Approved medications and infusion therapies furnished and billed by an approved Home Health agency;
- Durable Medical Equipment when billed by a licensed home health agency; and
- Services and supplies required by the Home Health agency to provide the care.

Home health care listed below is not covered:

- Custodial Care;
- Private duty nursing;
- Housekeeping or meal services;
- Maintenance care; or
- Shift or hourly care services.

Hospice Care

Pre-authorization is required for hospice care. Hospice care, including supplies, is covered when provided as an alternative to hospitalizations and prescribed by your physician and s/he has determined that the patient is terminally ill and is eligible for hospice services. Services must be provided by a licensed Hospice agency. This benefit includes acute, respite, and home care to meet the physical, psychosocial, and special needs of a patient-family unit during the final stages of illness and dying. Hospice care is provided at a variety of levels to meet the individual needs of the patient-family unit. Levels offered are:

- Intermittent in-home visits are provided on an as needed basis by the hospice team, which includes health care professionals, support staff, and a twenty-four (24) hour a day “on-call” registered nurse. This level of care does not cover room and board while a Member resides in a Skilled Nursing Facility, adult family home, or assisted living facility;
- Inpatient Hospice care is needed when care cannot be managed where the patient resides. The care will be provided at an inpatient Facility until the patient’s condition stabilizes;
- Continuous home care is provided when a medical crisis occurs where the patient resides and care can be provided at the residence. During such periods, the hospice team can provide around-the-clock care for up to 5 days; and
- Inpatient and outpatient respite care is available to provide continuous care and to give the patient’s caregiver a rest from the duties of caring for the patient. Respite care is limited to a total of 14 days of inpatient or outpatient respite care per Subscriber’s lifetime. When respite care is provided for the patient at an inpatient facility, room and board costs are also covered.

When provided within the above defined Levels of Care, additional covered expenses include:

- Approved medications and infusion therapies furnished and billed by an approved hospice agency;
- Durable Medical Equipment when billed by a licensed hospice care program; and
- Services and supplies required by the Hospice agency to provide the care.

Any charges for hospice care that qualify under this benefit, and under any other benefit of this plan, will be covered under the most appropriate benefit as determined by CHPW.

Hospice care listed below is not covered:

- Custodial Care or maintenance care, except palliative care to the terminally ill patient subject to the stated limits;
- Financial or legal counseling services;
- Housekeeping or meal services;
- Services by a Subscriber or the patient's Family or Volunteers;
- Services not specifically listed as covered hospice services under this plan;
- Supportive equipment such as handrails or ramps; or
- Transportation.

Hospital Care: Inpatient, Outpatient, and Ambulatory Surgical Center

See the *Emergency Care Services* benefit in this Agreement for coverage of emergency services, including medical screening exams, in a Hospital's emergency room.

Inpatient Hospital Care

Pre-authorization is required for all non-emergency inpatient admissions to a Hospital or Facility. Inpatient Hospital care is covered when Medically Necessary, except when mental Illness is the primary diagnosis, (please see Mental Health Care benefit) and is provided in the most appropriate and cost effective setting. Upon the recommendation of the physician and with the Member's consent, CHPW will evaluate whether to cover care in an alternative setting.

Covered inpatient Hospital services include:

- Facility costs, including room and board;
- Provider and staff services, supplies and treatments provided during the inpatient Hospital stay;
- Operating room and surgery services, including anesthesia;
- Laboratory and radiology services;
- Inpatient Pharmacy services, including infusion therapy; and
- Medically Necessary inpatient detoxification services.

This benefit does not cover:

- Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient Hospital facilities, or unless your medical condition makes inpatient care Medically Necessary; or
- Any days of inpatient care exceeding the length of stay that is Medically Necessary to treat your condition.

Outpatient Hospital and Ambulatory Surgical Center

Certain outpatient surgery/procedures require pre-authorization; please see *Pre-authorization Requirements* for details. Outpatient Hospital and Ambulatory Surgical Center care is covered when Medically Necessary and includes outpatient surgery, procedures and services, operating room and anesthesia, radiology, facility costs, lab and Pharmacy services. **This benefit does not cover** over-the-counter drugs, solutions, or nutritional supplements

Infertility Diagnostic Services

Coverage is provided for only the initial evaluation and diagnosis of infertility. Examples of Covered Services for the initial diagnosis of infertility include: endometrial biopsy, hysterosalpingography, reproductive screening services,

or sperm count. A pre-authorization must be obtained if care is provided in an inpatient setting. Treatments and procedures for the purposes of producing a pregnancy are not covered.

Laboratory and Radiology Services

This plan covers laboratory and radiology services for diagnostic purposes when Medically Necessary and ordered by a qualified Provider. Services include, but are not limited to, blood work, X-ray, MRI, CT scan, PET scan, ultrasound imaging, cardiovascular testing, including pulmonary function studies and neurology/neuromuscular diagnostic procedures. Pre-authorization is required for PET scans.

Mammography

This benefit includes screening and diagnostic mammography services when referred by a Member's medical doctor, advanced registered nurse practitioner, or physician's assistant. 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 Laboratory and Radiology Services benefit, regardless of diagnosis.

Maternity Care

This benefit covers pre-natal and post-natal maternity (pregnancy) care, pre-natal testing for congenital disorders, childbirth (vaginal or cesarean), complications of pregnancy, and related conditions for a female Subscriber or Dependent. Please see the *Schedule of Benefits* for specific Cost-Sharing information. The services of a licensed physician, an advanced registered nurse practitioner (ARNP), a licensed midwife, or a certified nurse midwife (CNM), and Facility fees associated with childbirth delivery in a Hospital or birthing center are covered under this benefit. This benefit also covers the related routine nursery care of the newborn, including newly adopted children. Circumcisions are covered up to 28 days following birth. Circumcisions performed after 28 days must be Medically Necessary as determined by CHPW.

There is no limit for the mother and her newborn's length of inpatient stay. Where the mother is attended by a physician, the attending physician will determine an appropriate discharge time, in consultation with the mother. This benefit covers Medically Necessary supplies of a home birth for low risk Members.

Newborns' and Mothers' Health Protection Act of 1996

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

Mental Health and Chemical Dependency Services

This benefit covers inpatient, residential and outpatient Medically Necessary treatment of mental health and substance use disorder services. This benefit includes treatment of individuals requiring Chemical Dependency rehabilitation for substance use disorders such as alcohol or DEA-controlled oral, intravenous, or inhaled medications and materials, including Chemical Dependency detoxification. Covered Medically Necessary care under this benefit includes treatment and services for mental health and psychiatric conditions and substance use disorders for patients with a DSM category diagnosis, including behavioral health treatment for those conditions, except as excluded. All inpatient admissions related to mental health and substance use disorders **require pre-authorization** by calling (800) 640-7682, unless a person is involuntarily committed. Emergency admissions require notification as described in the Notification for Emergency Hospital Admissions in the *Utilization Management* section of this Agreement.

Care for mental health and substance use disorder services must be Medically Necessary and provided at the least restrictive level of care. A clear treatment plan containing measurable progress toward a rehabilitative goal(s), including but not limited to movement to a less restrictive setting (if applicable), or other Medically Necessary

goals as determined by your Provider and CHPW's Medical Management staff. Care may be received at a Hospital, a Chemical Dependency rehabilitation Facility, and/or received through residential treatment programs, partial hospital programs, intensive outpatient programs, through group or individual outpatient services, or in a home health setting.

Prescription Drugs prescribed during an inpatient admission related to mental health are covered. This benefit also covers services provided by a licensed behavioral health Provider practicing within the scope of their license for a covered diagnosis in a Skilled Nursing Facility as well as acupuncture treatment visits without application of the visit limitation requirements when provided for Chemical Dependency. Family counseling, psychological testing and psychotherapeutic programs are covered only if related to the treatment of a clinical mental health diagnosis, specifically, those noted as Axis I diagnoses per the DSM. Eating disorder treatment is covered when associated with a diagnosis of a DSM category diagnosis.

Mental health care listed below is not covered:

- Adventure-based and/or wilderness programs that focus primarily on education, socialization or delinquency;
- Biofeedback;
- Court-ordered assessments when not Medically Necessary;
- Custodial Care, including housing that is not integral to a Medically Necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite;
- Developmental delay disorders;
- Marriage and couples counseling;
- Family therapy, in the absence of a mental health diagnosis;
- Nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories;
- Sensitivity training;
- Sexual dysfunction; or
- Sexual and gender identity disorders (DSM codes 302.0 – 302.9).

Chemical Dependency care listed below is not covered:

- Alcoholics Anonymous or other similar Chemical Dependency programs or support groups;
- Biofeedback, pain management and/or stress reduction classes;
- Care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior;
- Chemical Dependency benefits not specifically listed;
- Court-ordered or other assessments to determine the medical necessity of court-ordered treatments;
- Court-ordered treatments or treatments related to deferral of prosecution, deferral of sentencing or suspended sentencing or treatments ordered as a condition of retaining driving rights, when no medical necessity exists; or
- Custodial Care, including housing that is not integral to a Medically Necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite, including:
    - Emergency patrol services;
    - Information or referral services;
    - Information schools;
    - Long-term or Custodial Care; or
    - Treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required.

Newborn Care

Medical services and supplies for a newborn child following birth to a female Subscriber or an enrolled dependant, including newborn Hospital nursery charges, the initial physical examination and a PKU test are covered. Benefits apply under the newborn's own coverage, in connection with nursery care for the natural newborn or newly adoptive child. Coverage for newborns (including newborns born to dependent female children) is provided

for the first 3 weeks of life as described in the *Schedule of Medical Benefits*, even if the newborn is not enrolled. Benefits will be provided at a level not less than the enrolled mother's coverage, even if there are separate Hospital admissions. In order for coverage to continue after the first 3 weeks of life, the newborn child must be eligible and enrolled, if applicable, as explained later in the *Eligibility* and *Enrollment* sections.

Nutritional and Dietary Formulas

Coverage for nutritional and dietary formulas is provided when Medically Necessary. The following conditions must be met:

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

Oral Surgery

Coverage for oral surgery is offered when Medically Necessary. Oral Surgery required for a dental diagnosis such as periodontal disease is not covered. Examples of Covered Services include:

- The reduction or manipulation of fractures of facial bones;
- Excision of lesions, cysts, and tumors of the mandible, mouth, lip or tongue; and
- Incision of accessory sinuses, mouth salivary glands or ducts.

Orthotics

Benefits are covered for the fitting and purchase of braces, splints, orthopedic appliances and Orthotic supplies or apparatuses used to support, align or correct deformities or to improve the function of moving parts of the body. This benefit does not cover off-the shelf shoe inserts and orthopedic shoes.

Pediatric Vision

Pediatric vision services, including professional fees, supplies and materials, are covered for children under the age of 19 according to the limitations described in the *Schedule of Benefits* section above. Covered services include:

- Routine vision screening and eye exam, with dilation and refraction;
- Prescription lenses or contacts, including polycarbonate lenses and scratch resistant coating;
- Lenses may include single vision, conventional lined bifocal or conventional lined trifocal, or lenticular;
- One pair of frames or contact lenses in lieu of lenses and frames, once each Calendar Year;
- Evaluation, fitting and follow up care; and
- Low vision optical devices, services, training and instruction.

In addition to the exclusions and plan limitations, the following services and materials are not covered by this pediatric vision benefit:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ± .50 diopter power); or two pair of glasses in lieu of bifocals;
- Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available;
- Medical or surgical treatment of the eyes (these services are covered under your Medical Benefits);
- Corrective vision treatments that are considered Experimental or Investigational;
- Costs for services and materials above the limitations indicated in the *Schedule of Benefits* section; or

Prescription Drugs

This benefit provides coverage for Prescription Drugs, when prescribed for your use outside of a medical facility and dispensed by a Participating Pharmacy. For the purposes of this plan, a Prescription Drug is any medical substance that, under federal law, must be labeled as follows: "Caution: Federal law prohibits dispensing without a prescription," and as further described in the *Definitions* section.

This Prescription Drugs benefit requires you to pay a cost-share of either a Copay or Coinsurance for each separate new prescription or refill you get from participating pharmacies.

This Prescription Drug Benefit has four Tiers:

Preferred Generic Formulary Drugs Tier 1	Generic drugs that are on CHPW's current Formulary and are preferred by CHPW.
Preferred Brand-Name Formulary Drugs Tier 2	Brand-Name Drugs that are on CHPW's current Formulary and are preferred by CHPW.
Non-Preferred Generic and Brand-Name Formulary Drugs Tier 3	Generic and Brand-Name Drugs that are included on CHPW's current Formulary but are not preferred by CHPW.
Specialty Drugs Tier 4	Specialty Drugs as described below, in the Specialty Drug Prescription benefit below.

If you need a list of Prescription Drugs in these tiers, a copy of CHPW's formulary, or information about how to be involved in decisions about benefits, please call us at 1-800-930-0132.

Please note: This Prescription Drug benefit does not cover immunizations administered by pharmacists in a pharmacy. Please refer to the Immunization benefit for immunization coverage.

Retail Pharmacy Benefit

The retail Pharmacy benefit only applies to Prescriptions filled at participating retail Pharmacies.

- **Participating Retail Pharmacies**
  After you've paid any required Copay, we'll pay the Participating Pharmacy directly.
- **Non-Participating Retail Pharmacies**
  You pay the full price for the Prescription Drugs.

If you need a list of participating pharmacies, please call us at 1-800-930-0132.

Prescription Drugs Cost-Sharing and Out-of-Pocket Maximum

Cost-Sharing for Prescription Drugs under this plan applies to Prescriptions filled by Participating Pharmacies only. If you have a Prescription filled by a non-participating Pharmacy, you are responsible for the entire cost of that Prescription. If you fill a Specialty Drug Prescription at a non-preferred Specialty Pharmacy, you will be responsible

for the entire cost of the Prescription and your Out-of Pocket Expenses will not apply toward your Calendar Year Deductible or Out-of-Pocket Maximum.

In the event you elect to purchase a Brand Name Drug or non-preferred Generic instead of the preferred Generic equivalent (if available), or if you elect to purchase a different Brand Name or Generic Drug than that prescribed by your Provider, and it is not determined to be Medically Necessary, you may be required to pay additional costs above the applicable Prescription Drug Cost-Share set forth in the *Schedule of Medical Benefits* above. For instance, you will be required to pay the difference in price between a Brand Name Drug and its Generic equivalent or its Biosimilar. However, your Out-of-Pocket Expenses to fill a prescription will not exceed the cost of the drug.

You or your Provider may request a substitution for a covered Prescription Drug. Your request is subject to a Pre-Authorization review and may require additional clinical documentation from your Provider. Substitutions of covered generic or formulary Prescription Drugs are permitted if: (1) the member does not tolerate the covered Prescription Drug; (2) the prescribing Provider determines that the covered Prescription Drug is not therapeutically efficacious for the member; or (3) the prescribing Provider determines that a dosage is required for clinically efficacious treatment that differs from CHPW's formulary dosage limitation for the covered Prescription Drug. If you choose to purchase the medication before the review has been completed, you will pay the full price for the drug. If the review verifies the Prescription Drug is Medically Necessary and dispensed by a Participating Pharmacy, then you may submit a claim for reimbursement.

In making substitution Pre-Authorization determinations, we may take into consideration evidence-based Medical Necessity criteria, recommendations of the manufacturer, the fact that the drug is available over-the-counter, the circumstances of the individual case, U.S. Food and Drug Administration guidelines including black box warnings, accepted peer reviewed clinical studies and standard reference compendia.

Your Cost-Sharing amounts for each tier of Prescription Drugs are shown below. Copays are required for prescription drugs in Tiers 1 and 2. Coinsurance is required for Tier 3 and Tier 4 Specialty Drugs. Prescription Drugs in Tiers 2,3 and 4 are subject to your Annual Deductible. When you fill your Prescription at a Participating Pharmacy, your Out-of-Pocket Expenses will apply to your Out-of-Pocket Maximum, regardless of which Tier your prescription falls under.

Retail Pharmacy Benefit Copay

Preferred Generic (Tier 1):	$**15** Copay
Preferred Brand (Tier 2):	$**50** Copay, subject to Deductible
Non-Preferred Generic/Brand (Tier 3):	**50%** Coinsurance, subject to Deductible

Dispensing Limit

This benefit applies to each 30-day supply. Copays for single and multiple 30-day supplies of a given prescription are payable upon dispensing. Prescriptions for self-administrable injectable medications are limited to thirty (30) day supplies at a time, other than insulin. Teaching doses of self-administrable injectable medications are limited to three (3) doses per medication per lifetime.

Specialty Drug Prescription Benefit

The Specialty Drug Prescription benefit only applies to drugs in Tier 4 dispensed by participating Specialty Pharmacies. Specialty Drugs are high cost drugs that are used to treat complex, rare or chronic conditions and often require special handling, storage, administration or patient monitoring. Specialty Drugs can either be oral or self-administered injectable drugs to treat conditions such as rheumatoid arthritis, hepatitis, multiple sclerosis, cancer or growth disorders (excluding idiopathic short stature without growth hormone deficiency). We have contracted with specific specialty pharmacies that specialize in the delivery and clinical management of Specialty Drugs. You and your health care provider must work with our participating specialty pharmacies to arrange ordering and delivery of these drugs

Please note: Specialty Drugs that are administered under the supervision of physician or within a medical facility are part of your medical benefits.

- **Participating Specialty Pharmacy:**
  Specialty Drugs in Tier 4 must be dispensed through a participating Specialty Pharmacy. Your Out-of-Pocket Expenses for Specialty Drugs will count towards your calendar year Out-of-Pocket Maximum if dispensed by a participating Specialty Pharmacy.
- **Non-Participating Specialty Pharmacy**:
  You will pay full price of the prescription is filled by a non-participating Specialty Pharmacy. Your Out-of-Pocket Expenses for Specialty Drugs will not count towards your calendar year Out-of-Pocket Maximum if dispensed by a non-participating Specialty Pharmacy.

Specialty Pharmacy Benefits
Specialty Drugs (Tier 4) for each Member:

- **50%** Coinsurance, subject to Deductible

Dispensing Limit
This benefit applies to each 30-day supply. Coinsurance is payable at the time of dispensing and/or upon order.

Please note: This plan will only cover specialty drugs that are dispensed by our participating Specialty Pharmacies. Contact Customer Service for details on which drugs are included in the Specialty Pharmacy program.

Scope of Prescription Drug Benefit
This benefit provides for the following formulary items when dispensed by a licensed pharmacy for use outside of a medical facility (limits apply when applicable):

- Prescription Drugs and vitamins (Federal Legend Drugs as prescribed by a licensed Provider);
- Medications recommended by the United States Preventive Services Task Force, when obtained with a prescription, including, but not limited to aspirin, fluoride, iron, and medications for tobacco use cessation;
- Oral and topical Federal Legend Drugs;
- Prescribed injectable medications for self-administration including formulary injectable diabetic drugs; and
- Hypodermic needles, and syringes used for insulin administration. Also covered are the following disposable diabetic testing supplies: test strips, glucagon emergency kits, testing agents and lancets.

Your normal cost-share for drugs received from a Participating Pharmacy is waived for certain drugs that meet the guidelines for preventive services described in the Preventive Care benefit.

Prescription Drug Benefit Exclusions

This benefit does not cover:

- Drugs and medicines that may be lawfully obtained over-the-counter (OTC) without a prescription. OTC drugs are excluded even if prescribed by a practitioner, unless otherwise stated in this benefit. Examples of such non-covered items include, but are not limited to non-Prescription Drugs and vitamins, food and dietary supplements, herbal or naturopathic medicines and nutritional and dietary supplements (e.g. infant formulas or protein supplements). This exclusion does not apply to OTC drugs that meet the guidelines for preventive services under the Patient Protection and Affordable Care Act;
- Non-prescription male contraceptive methods (e.g. jellies, creams, foams, condoms or devices);
- Drugs for the purpose of cosmetic use, or to promote or stimulate hair growth (e.g. wrinkles or hair loss);
- Drugs for Experimental or Investigational use;
- Biologicals, blood or blood derivatives;

- Compound Drugs not containing at least one Prescription Drug that has been approved by the FDA;
- Any prescription refilled in excess of the number of refills specified by the prescribing provider, or any refill dispensed after one year from the prescribing provider's original order;
- Drugs dispensed for use or administration in a health care facility or provider's office, or take-home drugs dispensed and billed by a medical facility. The exceptions are Prescription Drugs provided as part of our Specialty Pharmacy Program (see Specialty Pharmacy Benefits above);
- Replacement of lost or stolen medication;
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use, and injectable medications. (The exception is self-administered injectable diabetic drugs.)
- Drugs to treat infertility, including fertility enhancement medications;
- Drugs to treat sexual dysfunction;
- Weight management drugs;
- Therapeutic devices, appliances, medical equipment, medical supplies, diabetic equipment and accessories (except for those specifically stated as covered in this benefit). Please see the Durable Medical Equipment benefit for available coverage; or
- Immunization agents and vaccines, including the professional services to administer the medication.

Prescription Drug Benefit Management Programs
To promote appropriate medication use, certain drugs are subject to pre-dispensing medical necessity review. As part of this review, some prescriptions may require additional medical information from the prescribing provider, substitution of equivalent medication or failure of a preferred drug. If you choose to purchase the medication before the review has been completed, you will pay the full price for the drugs. If the review verifies the medicine use is Medically Necessary and dispensed by a Participating Pharmacy, then you may submit a claim for reimbursement. Please see the *Claims* section in this Agreement for more information.

In making these determinations, we take into consideration clinically evidence-based medical necessity criteria, recommendations of the manufacturer, the circumstances of the individual case, U.S. Food and Drug Administration guidelines, published medical literature and standard reference compendia. Contact Customer Service for details on which drugs are included in the pre-authorization program, or see the *Pharmacy* section on our Web site.

Right to Safe and Effective Pharmacy Services
State and federal laws establish standards to assure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan, what coverage limitations are in your contract, and how you may be involved in decisions about benefits. For more information about the Prescription Drug coverage policies under this plan, or if you have a question or a concern about your pharmacy benefit, please call Customer Service.

For more information about your rights under the law, or if you think anything you received from this plan may not conform to the terms of your contract, you may contact the Washington State Office of Insurance Commissioner at 1-800-562-6900. If you have a concern about the pharmacists or pharmacies serving you, please call the Washington State Department of Health at 360-236-4825.

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

Preventive Care, Screening and Immunization Services
The following services provided by or under the supervision of your Provider are covered, including:

- Routine physicals and exams;
- Adult, child and adolescent immunizations (immunizations for the sole purpose of travel, occupation, or residence in a foreign country are not covered by this plan);
- Colorectal cancer screening (Subscribers 50 years of age and older or under 50 years of age when high risk);
- Mammogram services; diagnostic and screening;
- Preventive and wellness services including chronic disease management;
- Prostate cancer screening; and
- Services, tests and screening as recommended by the:
    - Centers for Disease Control (CDC);
    - Health Resources and Services Administration; and
    - U.S. Preventive Services Task Force, which includes screening and tests for A and B recommendations for prevention and chronic care .

For more information on the recommendations of the CDC, US Preventive Services Task Force, and the Health Resources and Services Administration, visit the following website:
www.healthcare.gov/center/regulations/prevention/recommendations.html

Professional Services

This benefit applies to in-person and Telemedicine visits. Telemedicine services include audio and video communication services between a distant-site Provider, the patient and a consulting Practitioner when the originating (distant) site is a rural health professional shortage area as defined by the Centers for Medicare and Medicaid Services. Charges for care provided by phone, fax, e-mail, or Internet, other than covered Telemedicine visits, are not covered.

Plastic and Reconstructive Procedures

Reconstructive procedures when the primary purpose of the procedure is either to treat a medical condition or to improve or restore physiologic function. Reconstructive procedures include surgery or other procedures performed to correct or repair abnormal structures of the body caused by trauma, infection, tumors, disease, accidental Injury or prior surgery (if the prior surgery would be covered under this Plan). In the case of accidental Injury, services must be completed within 12 months of the initial Injury. Cosmetic Procedures are excluded from coverage. The fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury or Illness does not classify surgery (or other procedures done to relieve such consequences or behavior) as a reconstructive procedure.

This benefit also includes procedures that correct anatomical Congenital Anomalies (regardless of whether such procedures improve or restore physiologic function or could be considered cosmetic), and reconstructive breast surgery following a mastectomy that resulted from disease, Illness or Injury, as well as reconstruction of the non-affected breast to achieve symmetry. Other services required by the *Women's Health and Cancer Rights Act of 1998*, including internal or external breast prostheses and treatment of complications, are provided in the same manner and at the same level as those for any other Covered Service.

Prosthetics

This benefit covers prosthetic devices for functional reasons to replace a missing body part, including artificial limbs, external breast prostheses following a mastectomy and maxillofacial prostheses. Prosthetic devices or appliances that are surgically inserted into the body are covered under the appropriate facility provision in this section.

Rehabilitation Services

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

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

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

Inpatient Rehabilitation

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

Outpatient Rehabilitation

Outpatient rehabilitation benefits are subject to the following provisions:

- You must not be confined in a Hospital or other Medical Facility; and
- Services must be furnished and billed by a Hospital, physician, physical, occupational, speech or massage therapist.

Speech therapy is covered only when required as a result of brain or nerve damage secondary to an accident, disease or stroke. Once the benefits under this provision are exhausted, coverage may not be extended by using the benefits under any other provision.

NOTE: Outpatient rehabilitation therapy services are subject to a combined total maximum of 25 visits per member per Calendar Year.

Skilled Nursing Facility Services

Inpatient Skilled Nursing Facility care requires pre-authorization. Benefits include inpatient services and supplies of a Skilled Nursing Facility for treatment of an Illness, Injury or physical disability as well as Pharmacy services and Prescriptions filled in the Skilled Nursing Facility. Skilled Nursing Facility services are covered when provided as an alternative to hospitalization and prescribed by your Provider. Room and board is limited to a semi-private room, except when a private room is determined to be necessary. Care must be therapeutic or restorative and require in-facility delivery by licensed professional medical personnel, under the direction of a physician, to obtain the desired medical outcome, including services provided by a licensed behavioral health Provider for a covered diagnosis. Benefits are not covered for maintenance or Custodial Care.

Spinal Manipulations

Spinal manipulations are covered by a qualified Provider and are subject to the maximum benefit limit on these Services listed in the *Schedule of Medical Benefits* above. Coverage includes manipulation of the spine, diagnostic radiology, and diagnosis and treatment of musculoskeletal disorders when performed within the scope of the Provider's license.

Temporomandibular Joint (TMJ) Disorders

Pre-authorization is required for inpatient admissions related to TMJ. Inpatient and outpatient services are covered for the treatment of TMJ when Medically Necessary. Dental services and dentist charges related to the treatment of TMJ are not covered by this Plan.

Tobacco Cessation

CHPW's tobacco cessation benefit includes counseling from trained counselors, educational materials, and nicotine replacement therapy (patch or gum) to help you quit. In addition, CHPW's Prescription Drugs benefit covers tobacco cessation Prescription Drugs as prescribed.

Transplants

Organ, bone marrow and stem cell transplants, including artificial organ transplants, are covered when approved by us.

Transplant Waiting Period

You will not be eligible for any benefits related to a transplant until after the first ninety days of continuous coverage, inclusive of prior creditable coverage with this or any previous medical plan.

Pre-authorization is required for transplant services. Services directly related to organ transplants must be coordinated by your participating Provider. **Proposed transplants will not be covered if considered Experimental or Investigational for the Member's condition.** Pre-authorization approval for transplants is based on these criteria:

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

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

Recipient Services

Covered transplant recipient services include:

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

Donor Services

Donor expenses are covered if all criteria are met below:

- CHPW approves the transplant procedure;
- The recipient is enrolled in this plan;
- Expenses are for services directly related to the transplant procedure; and
- Donor services are not covered under any other health plan or government program.
- Reasonable travel and lodging expenses for the donor are covered.

Covered donor expenses include:

- Donor typing, testing and counseling; and
- Donor organ selection, removal, storage and transportation of the surgical/harvesting team and/or the donor organ or bone marrow.

When both the recipient and the donor are Members under this Plan, covered charges for all Covered Services and supplies received by both the donor and the recipient will be payable.

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

Transplant services listed below are not covered (organ and bone marrow):

- Animal-to-human transplants;
- Complications arising from the donation procedure if the donor is not a Member;
- Donor expenses for a Member who donates an organ or bone marrow, however complications arising from the donation would be covered as any other Illness to the extent they are not covered under the recipient's health plan;
- Transplants considered Experimental or Investigational, as defined by CHPW; and

Urgent Care

Urgent care services provided by an urgent care clinic or Provider is covered by this Plan. Examples of urgent conditions include cuts and lacerations, diarrhea, allergic reactions, sprains, urinary tract infections and vomiting. Urgent care services received by CHPW Provider Providers are generally provided at the lowest cost.

Women's Health Care

Female CHPW Members have the right to directly see Network Providers who offer women's health care services (MD, Doctor of Osteopathic Medicine, ARNP and Midwife). These services may include:

- Women's health care exams;
- Treatment of some reproductive problems;
- Contraceptive services; and
- Testing and treatment for sexually transmitted diseases.

Your women's health care Provider can also continue to treat you for routine services and follow-up treatment for problems found during your women's health care exam.

EXCLUSIONS, LIMITATIONS AND NON-COVERED SERVICES

In addition to exclusions listed throughout the Contract and this Agreement, the following benefits are either excluded, limited or not covered by this plan:

Aromatherapy

Athletic training, body-building, fitness training or related expenses

Autopsies

Bariatric Surgery and Supplies

Benefits from Other Sources

Unless covered under the *Coordination of Benefits* section, benefits aren't available under this plan to the extent that coverage is available through:

- Motor vehicle medical or motor vehicle no-fault
- Personal injury protection (PIP) coverage
- Commercial liability coverage
- Homeowner policy
- Other types of liability insurance
- Worker's Compensation or similar coverage

Benefits That Have Been Exhausted
Amounts that exceed the Allowed Amount or maximum benefit for a Covered Service.

Biofeedback Services and Equipment

Botanical or herbal medicines, as well as other over-the-counter medications

Care provided by phone, fax, e-mail, Internet, except covered Telemedicine

Broken Appointment Charges
Amounts that are billed for broken, late, or missed appointments.

Caffeine or Nicotine Dependency
Treatment of caffeine dependency; treatment of nicotine dependency except as stated in the Schedule of Medical Benefits under Tobacco Cessation.

Charges for Records or Reports
Separate charges from Providers for supplying records or reports, except those we request for utilization review or case management.

Chemical Dependency Coverage Exclusions

- Alcoholics Anonymous or other similar Chemical Dependency programs or support groups;
- Biofeedback, pain management and/or stress reduction classes;
- Care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior;
- Chemical Dependency benefits not specifically listed;
- Court-ordered or other assessments to determine the medical necessity of court-ordered treatments;
- Court-ordered treatments or treatments related to deferral of prosecution, deferral of sentencing or suspended sentencing or treatments ordered as a condition of retaining driving rights, when no medical necessity exists;
- Custodial Care, including housing that is not integral to a Medically Necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite, including:
    - Emergency patrol services;
    - Information or referral services;
    - Information schools;
    - Long-term or Custodial Care; and
    - Treatment without ongoing concurrent review to ensure that treatment is being provided in the least restrictive setting required.

Cosmetic Surgery and Services

- Services or supplies (including drugs) rendered for cosmetic purposes and plastic surgery, whether cosmetic or reconstructive in nature, regardless of whether rendered to restore, improve, correct or alter the appearance or shape of a body structure, including any direct or indirect complications and aftereffects thereof.

The only exceptions to this exclusion are:

- Repair of a defect that is the direct result of an Injury or Illness, providing such repair is completed within 12 months of the date of the event;
- Repair of a Dependent child's congenital anomaly from the moment of birth;
- Reconstructive breast surgery in connection with a mastectomy, except as specified under the Plastic and Reconstructive Procedures benefit; and
- Correction of functional disorders upon our review and approval.

Counseling, Educational or Training Services

- Community wellness classes and programs that promote positive health and lifestyle choices. Examples of these classes and programs are adult, child, and infant CPR, safety, babysitting skills, back pain prevention, stress management, bicycle safety and parenting skills;
- Counseling, education or training services, except as stated under the Chemical Dependency Services, Professional Services, Diabetic Education and Diabetic Nutrition Education, and Mental Health Care benefits or for services that meet the standards for preventive medical services in the Preventive Care benefit. This includes vocational assistance and outreach; social, sexual and fitness counseling; family and marital counseling; and family and marital psychotherapy, except when Medically Necessary to treat the diagnosed mental or substance use disorder or disorders of a Member;
- Nonmedical services, such as spiritual, bereavement, legal or financial counseling;
- Recreational, vocational, or educational therapy; exercise or maintenance-level programs;
- Social or cultural therapy; and
- Gym or swim therapy.

Court-Ordered Services

Court-ordered services, services related to deferred prosecution, deferred or suspended sentencing or to driving rights, except as deemed Medically Necessary by CHPW.

Custodial Care

Custodial Care, except hospice care (please see the Home Health and Hospice Care benefits).

Dental Services

Dental, oral surgery or orthodontic related services, such as (but not limited to) those listed below are not covered:

- Care of the teeth or dental structures;
- Tooth damage due to biting or chewing;
- Dental services following injury to sound natural teeth. However, services or appliances necessary for or resulting from medical treatment are covered if the service is: 1) emergency in nature; or 2) requires extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease;
- Dental X-rays;
- Extractions of teeth, impacted or otherwise (except as covered under the Plan);
- Orthodontia;
- Orthognathic surgery, except when related to TMJ, sleep apnea, or repair of a congenital anomaly; or
- Services to correct malposition of teeth.

DME and medical supply charges listed below:

- Biofeedback equipment;
- Electronic and/or keyboard communication devices;
- Equipment or supplies whose primary purpose is preventing Illness or Injury;
- Exercise equipment;
- Items not manufactured exclusively for the direct therapeutic treatment of an Illness or injured patient;
- Items primarily for comfort, convenience, sports/recreational activities or use outside the home;

- Over-the-counter items (except Medically Necessary crutches, walkers, standard wheelchairs, diabetic supplies and ostomy supplies are covered);
- Personal comfort items including but not limited to air conditioners, lumbar rolls, heating pads, diapers or personal hygiene items;
- Phototherapy devices related to seasonal affective disorder;
- Supportive equipment/environmental adaptive items including, but not limited to, hand rails, chair lifts, ramps, shower chairs, commodes, car lifts, elevators, and modifications made to the patient's home, place of work, or vehicle; and
- The following Medical Equipment/supplies: regular or special car seats or strollers, push chairs, air filtration/purifier systems or supplies, water purifiers, allergenic mattresses, orthopedic or other special chairs, pillows, bed-wetting training equipment, whirlpool baths, vaporizers, room humidifiers, hot tubs or other types of tubs, home UV or other light units, home blood testing equipment and supplies (except diabetic equipment and supplies, and home anticoagulation meters).

Drugs and Food Supplements

Over-the-counter drugs, solutions, supplies, food and nutritional supplements, except as specified under Nutritional and Dietary Formulas; over-the-counter contraceptive drugs, unless prescribed for a female, supplies and devices; herbal, naturopathic, or homeopathic medicines or devices; hair analysis; and vitamins that do not require a Prescription, except as required by law.

Environmental Therapy

Therapy designed to provide a changed or controlled environment.

Experimental or Investigational Services

Any service or supply that CHPW determines is Experimental or Investigational on the date it's furnished, and any direct or indirect complications and aftereffects thereof. Our determination is based on the criteria stated in the *Definitions* section under Experiment or Investigational. If CHPW determines that a service is Experimental or Investigational, and therefore not covered, you may appeal our decision.

> Please Note: This exclusion does not apply to certain Experimental or Investigational services provided as part of approved clinical trials. Benefit determination is based on the criteria specified under *Clinical Trials*.

Family Members or Volunteers

Services or supplies that you furnish to yourself or that are furnished to you by a Provider who lives in your home or is related to you by blood, marriage, or adoption. Examples of such providers are your spouse, parent or child. Services or supplies provided by volunteers, except as specified in the Home Health and Hospice Care benefits.

Gender Transformations

Treatment or surgery to change gender, including any direct or indirect complications and aftereffects thereof.

Governmental Medical Facilities

Any charges by a facility owned or operated by the United States or any state or local government unless the Subscriber is legally obligated to pay (excluding: (i) covered expenses rendered by a Medical Facility owned or operated by the United States Veteran's Administration when the services are provided to a Subscriber for a non-service related Illness or Injury, and (ii) covered expenses rendered by a United States military Medical Facility to Subscribers who are not on active military duty).

Hair Loss

- Drugs, supplies, equipment, or procedures to replace hair, slow hair loss, or stimulate hair growth; and
- Hair prostheses, such as wigs or hair weaves, transplants, and implants.

Hearing Care
Routine hearing examinations, programs or treatment for hearing loss including, but not limited to, externally worn or surgically implanted hearing aids, and the surgery and services necessary to implant them, except for cochlear implants, which are covered.

Home Health Care listed below:

- Custodial Care;
- Private duty nursing;
- Housekeeping or meal services;
- Maintenance care; or
- Shift or hourly care services.

Hospice Care listed below:

- Custodial Care or maintenance care, except palliative care to the terminally ill patient subject to the stated limits;
- Private duty nursing;
- Financial or legal counseling services;
- Housekeeping or meal services;
- Services by a Subscriber or the patient's Family or Volunteers;
- Services not specifically listed as covered hospice services under the Plan;
- Supportive equipment such as handrails or ramps; or
- Transportation.

Human Growth Hormone Benefit Limitations
Benefits for human growth hormone are only provided under the Specialty Pharmacy Program (please see the Prescription Drugs benefit) and are not covered to treat idiopathic short stature without growth hormone deficiency.

Infertility Treatment and Sterilization Reversal listed below:

- Treatment of infertility, including procedures, supplies and drugs;
- Any assisted fertilization techniques, regardless of reason or origin of condition, including but not limited to, artificial insemination, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT) and any direct or indirect complications thereof; or
- Reversal of surgical sterilization, including any direct or indirect complications thereof.

Mental Health Care Listed below:

- Adventure-based and/or wilderness programs that focus primarily on education, socialization or delinquency;
- Biofeedback, pain management, and stress reduction classes;
- Counseling in the absence of Illness, other than family counseling when the patient is a child or adolescent with a covered diagnosis and family counseling is part of the treatment for mental health services;
- Court-ordered assessments, unless Medically Necessary;
- Custodial Care, including housing that is not integral to a Medically Necessary level of care, such as care necessary to obtain shelter, to deter antisocial behavior, to deter runaway or truant behavior or to achieve family respite;
- Marriage and couples counseling;
- Family therapy, in the absence of a mental health diagnosis;
- Nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories;
- Sensitivity training;
- Sexual dysfunction;
- Sexual and gender identity disorders (DSM codes 302.0 – 302.9); or
- "V" code diagnosis (DSM) except for Medically Necessary services as defined in the code.

Military and War-Related Conditions, Including Illegal Acts listed below:

- Acts of war, declared or undeclared, including acts of armed invasion;
- Service in the armed forces of any country, including the U.S. Air Force, Army, Coast Guard, Marines, National Guard, Navy, or civilian forces or units auxiliary thereto. However, this exclusion does not apply to U.S. military personnel (active or retired) or their Dependents enrolled in the TRICARE program. The benefits of this plan will be provided on a primary basis to TRICARE beneficiaries consistent with federal law;
- A Member's commission of an act of riot or insurrection; or
- A Member's commission of a felony or act of terrorism.

No Charge or You Do not Legally Have to Pay

- Services for which no charge is made, or for which none would have been made if this plan weren't in effect; and
- Services for which you don't legally have to pay, except as required by law in the case of federally qualified health center services.

Not Covered By this Plan

- Services or supplies ordered when this plan is not in effect, or when the person isn't covered under this plan;
- Services or supplies provided to someone other than an ill or injured Member;
- Services or supplies directly related to any condition, or related to any other service or supply that isn't covered under this plan; and
- Services provided by Network Providers for "serious adverse events," "never events" and resulting follow-up care. "Serious adverse events" and "never events" are medical errors that are specific to a nationally published list. They are identified by specific diagnosis codes, procedure codes and specific present-on-admission indicator codes. A "serious adverse event" means a Hospital injury caused by medical management (rather than an underlying disease) that prolonged the hospitalization, and/or produces a disability at the time of discharge. Network Providers may not bill Members for such services and Members are held harmless.

Not In the Written Plan of Care

Services, supplies or providers not in the written plan of care or treatment plan, or not named as covered in the Home Health Care, Hospice Care, and Rehabilitation Therapy benefits.

Not Medically Necessary

- Services or supplies that are not Medically Necessary even if they're court-ordered. This also includes places of service, such as inpatient Hospital care;
- Hospital admissions for diagnostic purposes only, unless the services can't be provided without the use of inpatient Hospital facilities, or unless your medical condition makes inpatient care Medically Necessary;
- Any days of inpatient care that exceed the length of stay that is Medically Necessary to treat your condition; and
- Physical examinations, reports or related services for the purpose of obtaining or maintaining employment, insurance, or licenses or permits of any kind, school admission, school sports clearances, immigration, foreign travel, medical research, camps, or government licensure, or other reasons not related to medical needs.

Obesity Services (Surgical and Pharmaceutical)

Benefits are not provided for surgical and pharmaceutical treatments of obesity or morbid obesity, and any direct or indirect complications, follow-up services, or aftereffects thereof. This exclusion applies even if you also have an Illness or Injury that might be helped by weight loss.

On-Line or Telephone Consultations
Electronic, on-line, internet or telephone medical consultations or evaluations, except covered Telemedicine visits.

Orthodontia Services
Orthodontia, regardless of condition, including casts, models, x-rays, photographs, examinations, appliances, braces, and retainers.

Orthognathic Surgery and Supplies
Procedures to lengthen, shorten or augment the jaw (including orthognathic or maxillofacial surgery) are not covered, regardless of the origin of the condition that makes the procedure necessary. The only exception to this exclusion is repair of a child's congenital anomaly or surgery related to TMJ or sleep apnea.

Outside the Scope of a Provider's License or Certification
Services or supplies that are outside the scope of the provider's license or certification, or that are furnished by a provider that isn't licensed or certified by the state in which the services or supplies were received.

Outside the United States
Non-emergency health care services and supplies are not covered when provided or received outside of the United States.

Personal Comfort or Convenience Items
- Items for your convenience or that of your family, including Medical Facility expenses; services of a personal nature or personal care items, such as meals for guests, long-distance telephone charges, radio or television charges, or barber or beautician charges;
- Normal living expenses, such as food, clothing, and household supplies; housekeeping services, except for those of a home health aide as prescribed by the plan of care (please see the Home Health and Hospice Care benefit); and transportation services; and
- Dietary assistance, such as Meals on Wheels or similar programs.

Plastic and Reconstructive Services such as those listed below:
- Abdominoplasty/panniculectomy;
- Complications resulting from non-covered services;
- Cosmetic services, supplies or surgery to repair, modify or reshape a functioning body structure for improvement of the patient's appearance or self-esteem; or
- Dermabrasion, chemical peels or skin procedures to improve appearance or to remove scars or tattoos

Private Duty Nursing Services
Private duty nursing services provided in or outside the Hospital setting.

Repair or replacement of items not used in accordance with manufacturer's instructions or recommendations

Replacement of lost or stolen items, such as but not limited to Prescription Drugs, prostheses or DME

Routine or Preventive Care
- Charges for services or items that don't meet the federal guidelines for preventive services described in the Preventive Care benefit, except as required by law;
- Routine foot care for those who are not Diabetic; and
- Exams to assess a work-related or medical disability.

Services or supplies received without charge from a medical department maintained by an employer, a mutual benefit association, labor union, trustee or similar group

Services or supplies required by an employer as a condition of employment

Services provided by a spa, health club or fitness center

Services provided by clergy

Sexual Dysfunction
Diagnosis and treatment of sexual dysfunctions, regardless of origin or cause; surgical, medical or psychological treatment of impotence or frigidity, including drugs, medications, or penile or other implants; and, any direct or indirect complications and aftereffects thereof.

Skilled Nursing Facility Coverage Exclusions
- Custodial Care; and
- Care that is primarily for senile deterioration, mental deficiency or retardation or the treatment of Chemical Dependency.

Snoring treatment (surgical or other)

Special diets, nutritional supplements, vitamins and minerals or other dietary formulas or supplements except as covered by the Plan

Special education for the developmentally disabled, other than speech, occupational, physical and aural therapy services; and FDA approved devices designed to assist a Member and require a prescription to dispense the device.

Surrogate mother charges, unless the surrogate mother is eligible under the Plan at the time the services were rendered

Surgical procedures to correct refractive errors, astigmatism or reversals or revisions of surgical procedures which alter the refractive character of the eye.

Transplant Coverage Exclusions
- Animal-to-human transplants;
- Complications arising from the donation procedure if the donor is not a Plan Member;
- Donor expenses for a Plan Member who donates an organ or bone marrow, however complications arising from the donation would be covered as any other Illness to the extent they are not covered under the recipient's health plan.;
- Transplants considered Experimental or Investigational, as defined by the Plan; and

Transplants Waiting Period
Organ, bone marrow and stem cell transplants are subject to a 90 day waiting period. Benefits will not be provided for transplant related services for the first 90 days after your Effective Date. This plan's waiting periods for transplants may be reduced by periods of "creditable" coverage you've accrued under other health care plans prior to your "enrollment date" (see *Definitions*) for this plan. Most medical health care coverage is considered creditable (see list below).

You'll receive credit for prior creditable coverage that occurred without a break in coverage of more than 90 days. Any coverage you had before a break in coverage which exceeds 90 days won't be credited toward your waiting periods. Eligibility waiting periods won't be considered creditable coverage or a break in coverage.

Your prior employer or health insurance carrier will provide you with a certificate of health coverage that includes information about your prior health coverage. If you haven't received a certificate, or have misplaced it, you have the right to request one from a prior employer or health carrier within 24 months of the date your coverage under that plan terminated. If you can't get a certificate, please call Customer Service, because other kinds of proof that you had the coverage are also acceptable.

Creditable coverage shall mean coverage under one or more of the following types of health care coverage:

- Group health coverage (including self-funded plans and COBRA);
- Individual health coverage;
- Part A or B of Medicare;
- Medicaid;
- Military health coverage;
- Indian Health Service or tribal coverage;
- State high risk pool;
- Federal or any public health care plan, including state children's health care plans;
- Peace Corps Plan;
- Any other health insurance coverage; or
- Government health coverage provided for citizens or residents of a foreign country "Creditable" coverage doesn't include coverage under a limited policy such as an accident only coverage; disability income insurance; workers' compensation; limited scope dental or vision plans; liability insurance; automobile medical insurance; specified disease coverage; Medicare supplemental policy; or long-term care policy.

Vision Exams

Except as covered by the Pediatric Vision benefit, routine vision exams to test visual acuity and/or to prescribe any type of vision hardware are only covered as described under the Vision Exams benefit, if this plan includes one.

Vision Hardware

Except as covered by the Pediatric Vision benefit, the following is not covered:

- Vision hardware (and their fittings) used to improve visual sharpness, including eyeglasses and contact lenses, and related supplies are only covered as described in the Vision Hardware benefit and the Durable Medical Equipment benefit; and
- This plan never covers non-prescription eyeglasses or contact lenses, or other special purpose vision aids (such as magnifying attachments), sunglasses or light-sensitive lenses, even if prescribed.

Vision Therapy

Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics. Also not covered are treatment or surgeries to improve the refractive character of the cornea, including the treatment of any results of such treatment.

Vocational rehabilitation, work hardening or training programs regardless of diagnosis or symptoms that may be present, or for non-Medically Necessary education

Weight Loss and Weight Management Programs

Work-Related Conditions

- Any Illness, condition or Injury arising out of or in the course of employment, for which the Member is entitled to receive benefits, whether or not a proper and timely Claim for such benefits has been made under:
    - Occupational coverage required of, or voluntarily obtained by, the Member's employer
    - State or federal workers' compensation acts
    - Any legislative act providing compensation for work-related Illness or Injury

ELIGIBILITY

In order to be accepted for enrollment and continuing coverage under this Agreement, individuals must meet all applicable requirements set forth below and satisfy the requirements of the Washington State Health Benefit Exchange.

Service Area

Coverage under this Agreement is available to residents of the following Washington State counties: Adams, Benton, Chelan, Clark, Cowlitz, Douglas, Ferry, Franklin, Grant, Grays Harbor, King, Kitsap, Lewis, Okanogan, Pacific, Pend Oreille, Pierce, Skagit, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, and Yakima. These counties are referred to as the Service Area for this Agreement. You are not required to maintain permanent residency in the Service Area to continue to receive coverage under this Agreement.

Subscriber

Must establish and maintain eligibility for participation in the Washington State Health Benefits Exchange for the duration of enrollment.

Dependents

The Subscriber may also enroll the following that have established and maintain permanent eligibility for participation in the Washington State Health Benefits Exchange :

- The Subscriber's spouse, including state-registered domestic partners as required by Washington state law; or
- The Subscriber's children who are under the age of twenty-six (26). A "child" is defined as a child of the Subscriber or spouse, including children of a Subscriber's state-registered domestic partner, adoptive children, stepchildren, children for whom the Subscriber has a qualified court order to provide coverage, and any other children who reside permanently and regularly with the Subscriber.
    - Eligibility may be extended past the limiting age for a person enrolled as a Dependent on his/her twenty sixth (26^{th}) birthday if the Dependent is totally incapable of self-sustaining employment because of a developmental or physical disability incurred while eligible and enrolled under the Agreement, and is chiefly dependent upon the Subscriber for support and maintenance. Enrollment for such a Dependent may be continued for the duration of the continuous total incapacity, provided enrollment does not terminate for any other reason. Medical proof of incapacity and proof of financial dependence must be furnished to CHPW upon request, but not more frequently than annually after the two (2) year period following the Dependent's attainment of the limiting age.

Temporary Coverage for Newborns.

When a Subscriber or Member gives birth, the newborn will be entitled to the benefits set forth in the *Benefits* section from birth through three (3) weeks of age. After three (3) weeks of age, no benefits are available unless the newborn child qualifies as a Dependent and is enrolled under this Agreement. All contract provisions, limitations, and exclusions will apply.

ENROLLMENT

Application for Enrollment.
Application for enrollment must be made through the Washington State Health Benefit Exchange during open enrollment. Applicants will not be enrolled or premiums accepted until the completed application information has been received and approved by CHPW. CHPW reserves the right to refuse enrollment to any person whose coverage under any contract for medical coverage issued by CHPW has been terminated for cause.

Newly Eligible Persons
A written application for enrollment of a newborn child must be made to CHPW within 60 days following the date of birth, when there is a change in the monthly premium payment as a result of the additional Dependent. A written application for enrollment of an adoptive child must be made to CHPW within 60 days from the day the child is placed with the Subscriber for the purpose of adoption or the Subscriber assumes total or partial financial support of the child, if there is a change in the monthly premium payment as a result of the additional Dependent.

Limitation on Enrollment
Subject to prior approval by the Washington State Office of the Insurance Commissioner, CHPW may limit enrollment, establish quotas or set priorities for acceptance of new applications if it determines that CHPW's capacity, in relation to its total enrollment, is not adequate to provide services to additional persons.

Special Enrollment
CHPW will allow special enrollment for persons in the following circumstances:

- Marriage/Domestic Partnership – Application for coverage must be made within 31 days of the date of the marriage or the beginning of the state-registered domestic partnership;
- Birth – Application for coverage for the Subscriber and Dependents other than the newborn child must have been made within 60 days of the date of birth;
- Adoption or placement for adoption – Application for coverage for the Subscriber and Dependents other than the adopted child must be made within 60 days of the adoption, placement for adoption, or assumption of total or partial financial support in anticipation of the adoption;
- Eligibility for medical assistance, provided such person is otherwise eligible for coverage under this Contract, when approved and requested in advance by the Washington State Department of Social and Health Services (DSHS). The request for special enrollment must be made within 60 days of DSHS's determination that enrollment would be cost-effective;
- Coverage under a Medicaid or CHIP plan is terminated as a result of loss of eligibility for such coverage. Application for coverage must be made within 60 days of the date of termination under Medicaid or CHIP; and
- Applicable federal or state law or regulation otherwise provides for special enrollment.

Effective Date of Enrollment
Provided eligibility criteria are met and applications for enrollment are made as set forth in this *Enrollment* section, enrollment will be effective as follows:

- Enrollment for a newly eligible Subscriber and listed Dependents enrolled during open enrollment will be effective on January 1, 2014, provided the Subscriber's application has been submitted to and approved by CHPW.
- Enrollment for a newly dependent person, other than a newborn or adoptive child, is effective on the first day of the month following the date eligibility requirements are met.
- Enrollment for newborns is effective from the date of birth.
- Enrollment for adoptive children is effective from the date that the adoptive child is placed with the Subscriber for the purpose of adoption or the Subscriber assumes total or partial financial support of the child.

Commencement of Benefits for Persons Hospitalized on Effective Date
Members who are admitted to an inpatient facility prior to their enrollment date under the Contract will receive covered benefits beginning on their Effective Date, as set forth in the *Eligibility* section above. If a Member is hospitalized in a non-Network facility, CHPW reserves the right to require transfer of the Member to a Network facility. The Member will be transferred when a Network Provider, in consultation with the attending physician, determines that the Member is medically stable to do so. If the Member refuses to transfer to a Network facility, all services received will be covered under Non-Network Providers as outlined in the *Schedule of Medical Benefits*.

TERMINATION OF COVERAGE

Events That End Coverage
Coverage will end without notice on the last day of the month for which Premium Charges have been paid in which one of these events occurs:

- For the Subscriber and dependents when:
    - The Agreement is terminated;
    - The next monthly subscription charge isn't paid when due or within the grace period; or
    - The Subscriber dies or is otherwise no longer eligible as a Subscriber.
- For a spouse when his or her marriage to the Subscriber is annulled, or when he or she becomes legally separated or divorced from the Subscriber, including state-registered domestic partners, unless independent application for health coverage is made within 31 days.
- For a child when he or she cannot meet the requirements for dependent coverage shown under *Eligibility*.

The Subscriber must promptly notify the CHPW when an enrolled family member is no longer eligible to be enrolled as a dependent under this plan.

Termination of Agreement
No rights are vested under this plan. Termination of this Agreement completely ends all Members' coverage and all our obligations, except as otherwise provided in this Agreement.

Certificate of Creditable Coverage
When your coverage under this plan terminates, you will receive a Certificate of Creditable Coverage. The certificate will provide information about your coverage period under this plan. When you provide a copy of the certificate to your new health plan, you may receive credit toward certain waiting periods. Therefore, it's important for you to keep the certificate in a safe place.

If you haven't received a certificate, or have misplaced it, you have the right to request one from us within 24 months of the date coverage terminated. When you receive your Certificate of Creditable Coverage, make sure the information is correct. Contact us if any of the information listed isn't accurate.

FILING CLAIMS

Many providers will submit their bills to us directly. However, if you ever need to submit a Claim to us yourself, follow these simple steps:

Step 1: Complete a Claim Form. A separate Claim Form is necessary for each patient and each provider. You can obtain extra Claim Forms by calling Customer Service or by accessing our website, www.chpw.org.

Step 2: Attach the itemized bill. The itemized bill must contain all of the following information:

- Names of the Subscriber and the Member who incurred the expense;
- Identification numbers for both the Subscriber and the Member who incurred the expenses (these are shown on the Subscriber's identification card);
- Name, address and IRS tax identification number of the Provider;
- Information about other insurance coverage;
- Date of onset of the Illness or Injury;
- Diagnosis or diagnosis code from the most current edition of the International Classification of Diseases manual;
- Procedure codes from the most current edition of the Current Procedural Terminology manual, the Healthcare Common Procedure Coding manual, or the American Dental Association Current Dental Terminology manual for each service;
- Dates of service and itemized charges for each service rendered; and
- If the services rendered are for treatment of an Injury, the date, time, location and a brief description of the event.

Step 3: If you're also covered by Medicare, and Medicare is primary, you must attach a copy of the Explanation of Medicare Benefits.

Step 4: Check that all required information is complete. Bills received won't be considered to be Claims until all necessary information is included.

Step 5: Sign the Claim Form in the space provided.

Step 6: Mail your Claims to us at the mailing address shown on the back cover of this Agreement.

Timely Filing

You should submit all Claims within 90 days of the start of service or within 30 days after the service is completed.

The Plan must receive Claims:

- Within 365 days of discharge for Hospital or other Medical Facility expenses, or within 365 days of the date the expenses were incurred for any other services or supplies.
- For Members who have Medicare, within 90 days of the process date shown on the Explanation of Medicare Benefits, whichever is greater.

The Plan won't provide benefits for Claims we receive after the later of these 2 dates.

QUESTIONS, COMPLAINTS, GRIEVANCES AND APPEALS

As a CHPW Member, you have the right to offer your feedback, ask questions, voice complaints and request a formal appeal to reconsider decisions we have made.

Questions

Please call Customer Service with any questions you may have regarding your health benefit plan. Customer Service representatives are available to take your call during regular business hours, Monday through Friday. We suggest that you call your Provider when you have questions about the health care services they provide.

Complaints

You can call or write to us when you have a complaint about a benefit or coverage decision, customer service, or the quality or availability of a health care service. The complaint process allows Customer Service to quickly and informally correct errors, clarify benefits, or take steps to improve our service. We recommend, but don't require,

that you take advantage of this process when you have a concern about a benefit or coverage decision. There may be times when Customer Service will ask you to submit your complaint for review through the formal appeals process outlined below. We will review your complaint and notify you of the outcome and the reasons for our decision as soon as possible, but no later than 30 days from the date we received your complaint.

Grievance Procedure

Grievance means a written complaint submitted by or on behalf of you regarding anything that you are not happy with except for a denied service or referral for service.

If you have a Grievance concerning any matter, except an adverse utilization review determination, you, or your representative, may submit it to CHPW to:

Community Health Plan of Washington
Attn: Grievances
720 Olive Way, Suite 300
Seattle, WA 98101
Fax: (206) 613-8983

Your grievance must include:

- Member name; address; telephone number;
- CHPW Member number;
- The nature of the grievance;
- Why you are asking for reconsideration; and
- Anything that will help your grievance.

We will issue a written decision to you or to your representative within 20 business days after receiving a Grievance and all information necessary for our review of the Grievance. Additional time is permitted where we can establish the 20 day time frame cannot reasonably be met due to our inability to obtain necessary information from a person or entity not affiliated with or under contract with us. We will provide written notice of the delay to you. The notice will explain the reasons for the delay. In such instances, decisions must be issued within 20 days of our receipt of all necessary information.

If there is an adverse decision, the decision will contain:

- The names, titles and qualifying credentials of the person or persons participating in the first level grievance review process (the reviewers);
- A statement of the reviewers' understanding of the Member's grievance and all pertinent facts;
- The reviewers' decision in clear terms and the basis for the decision;
- A reference to the evidence or documentation used as the basis for the decision;
- Notice of your right to contact the Superintendent's office; and
- A description of the process to obtain a second level grievance review of a decision, the procedures and time frames governing a second level grievance review, and the second level grievance rights.

Appeals

If we declined to provide payment or benefits in whole or in part, and you disagree with that decision, you have the right to request that we review that adverse benefit determination through an appeals process. This plan's appeals process will comply with any new requirements as necessary under state and federal laws and regulations.

Adverse Benefit Determination

An adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make payment, in whole or in part, for services, based on:

- An individual's eligibility to participate in a plan or health insurance coverage;

- A determination that a benefit is not a covered benefit;
- A limitation on otherwise covered benefits;
- A utilization review determination; or
- A determination that a service is Experimental, Investigational, or not Medically Necessary or appropriate.

Any adverse benefit determination on the basis of Experimental or Investigational services must be made by us in writing within 20 working days of receipt of a fully documented request. Any extension of the review period beyond 20 working days may only be done with the informed written consent of the covered person.

Level I Appeals
After you are notified of an adverse benefit determination, you can request a Level I internal appeal. Your Level I internal appeal will be reviewed by individuals who were not involved in the initial adverse benefit determination. They will review all of the information relevant to your appeal and will provide a written determination. We will provide you a written notice acknowledging our receipt of your appeal request and will notify you in writing of our decision within 14 days of receipt of your appeal unless we notify you that an extension to 30 days is necessary to complete the appeal. If 30 days is needed to complete your appeal, we must obtain your written consent. If you are not satisfied with the decision, you may request a Level II appeal.

Level II Appeals
Your Level II internal appeal will be reviewed by a panel that includes a health care provider, if the adverse decision involved medical necessity, Experimental or Investigational or ongoing care, and other individuals who were not involved in the Level I appeal. You may participate in the Level II panel meeting in person or by phone to present evidence and testimony. We will provide you a written notice acknowledging our receipt of your appeal request and will notify you in writing of our decision within 14 days of receipt of your appeal unless we notify you that an extension to 30 days is necessary to complete the appeal. If 30 days is needed to complete your appeal, we must obtain your written consent. If delay of your appeal would jeopardize your life or health, we will expedite the process with either a written or an oral appeal and issue a decision within 72 hours of receipt of your appeal. Please contact us for additional information about this process.

Once the Level II review is complete, we will provide you with a written determination. If you are not satisfied with the final internal appeal decision, you may be eligible to request an external review, as described below.

Filing Appeals
You or your authorized representative, someone you have named to act on your behalf, may file an appeal. To appoint an authorized representative, you must sign an authorization form and mail or fax the signed form to the address or phone number listed above. This release provides us with the authorization for this person to appeal on your behalf and allows our release of information, if any, to them.

Please call us for an Authorization for Release form. You can also obtain a copy of this form on our web site at www.chpw.org.

You or your authorized representative may file an appeal by calling Customer Service or by writing to us at the address listed below. We must receive your appeal request as follows:
- For a Level I appeal, within 180 calendar days of the date you were notified of the adverse benefit determination; and
- For a Level II appeal, within 60 calendar days of the date you were notified of the Level I determination.

If you are hospitalized or traveling, or for other reasonable cause beyond your control, we will extend this timeline up to 180 calendar days to allow you to obtain additional medical documentation, physician consultations or opinions.

You may submit your written appeal request to:

Level I Appeals:
FIRST CHOICE HEALTH ADMINISTRATORS
Attn: Appeals Coordinator
600 University Street, #1400
Seattle, WA 98101
Fax: (206) 268-2920

Level II Appeals:
COMMUNITY HEALTH PLAN OF WASHINGTON
Attn: Appeals Department
720 Olive Way, Suite 300
Seattle, WA 98101

If you need help filing an appeal, or would like a copy of the appeals process, please contact the CHPW customer service team at 1-800-930-0132, Monday through Friday from 8am to 5pm, or email customercare@chpw.org. If you are hearing or speech impaired, please call TTY 1-866-816-2479 (toll free) or local 206-613-8875.

You can also get a description of the appeals process by visiting our web page at www.chpw.org.

Clinically Urgent Appeals
If your Provider believes that situation is urgent under law, your appeal will be conducted on an expedited basis. An urgent situation means one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for a decision on your appeal. You may request an expedited Level I or Level II appeal by calling Customer Service at the number listed on the back cover of this Agreement. If you are eligible for an external review, you may also request an expedited external review at the same time you request an expedited internal appeal.

Appeals Regarding Ongoing Care
If you appeal a decision to change, reduce or end coverage of ongoing care for a previously approved course of treatment because the service or level of service is no longer Medically Necessary or appropriate, we will suspend our denial of benefits during the internal appeal period. Our provision of benefits for services received during the internal appeal period does not, and should not be construed to, reverse our denial. If our decision is upheld, you must repay us all amounts that we paid for such services. You will also be responsible for any difference between our Allowed Amount and the provider's billed charge.

External Review
If you are not satisfied with the final Level II appeal determination based on medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit, you may have the right to have our decision reviewed by an Independent Review Organization (IRO). An IRO is an independent organization of medical reviewers who are certified by the State of Washington Department of Health to review medical and other relevant information. There is no cost to you for an external review.

We will send you an External Review Request form within 3 business days of the end of the Level II appeal process notifying you of your rights to an external review. We must receive your written request for an external review within 180 days of the date of the final internal adverse benefit determination. Your request must include a signed waiver granting the IRO access to medical records and other materials that are relevant to your request.

We will notify the IRO of your request for an external review. We will provide you with the name and contact information of the IRO within one day of giving the IRO notice of your request for review. The IRO will accept additional information in writing from you for up to five business days from the date we notify them of your request for external review. The IRO is required to consider any information you provide within this period when it

conducts its review. The IRO will let you, your authorized representative and/or your attending physician know where additional information may be submitted directly to the IRO and when the information must be provided. We will forward your medical records and other relevant materials for your external review to the IRO. We will also provide the IRO with any additional information they request that is reasonably available to us. Once the external review is completed, the IRO will notify you and us in writing of their decision. If you have requested an expedited external review, the IRO will notify you and us of their decision immediately by phone, e-mail or fax after they make their decision, and will follow up with a written decision by mail.

CHPW is bound by the decision made by the IRO. If the IRO overturned the final internal adverse benefit determination, we will implement their decision promptly. If the IRO upheld the final internal adverse benefit determination, there is no further review available under this plan's internal appeals or external review process. However, you may have other remedies available under State or Federal law, such a filing a lawsuit.

Urgent Review
If your provider believes that situation is urgent under law, your external review will be conducted on an expedited basis. An urgent situation means one in which your health may be in serious jeopardy or, in the opinion of your physician, you may experience pain that cannot be adequately controlled while you wait for an external review decision. You can request an expedited external review by calling Customer Service at the number listed on the back cover of this Agreement. If you request an expedited external review, we will respond as quickly as reasonably possible, but not longer than 72 from the time of your request.

COORDINATION OF BENEFITS

The coordination of benefits (COB) provision applies when a person has health care coverage under more than one plan. Plan is defined below.

The order of benefit determination rules govern the order in which each plan will pay a Claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits according to its policy terms without regard to the possibility that another plan may cover some expenses. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

Definitions (for this section only)

A plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. However, if COB rules do not apply to all contracts, or to all benefits in the same contract, the contract or benefit to which COB does not apply is treated as a separate plan.

(1) Plan includes: Group, individual or blanket disability insurance contracts, and group or individual contracts issued by health care service contractors or health maintenance organizations (HMO), closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: Hospital indemnity or fixed payment coverage or other fixed indemnity or fixed payment coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; benefits for nonmedical components of long-term care policies; automobile insurance policies required by statute to provide medical benefits; Medicare supplement policies; Medicaid coverage; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate plan. If a plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.

When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits. When this plan is secondary, it pays its benefits taking into account what the primary plan has already paid. Similarly, a tertiary plan pays benefits after taking into account what the primary and secondary plans have paid. When this plan is secondary to another plan, benefits will be calculated according to the following steps:

- First, this plan will calculate the amount it would have paid if it were your primary plan.
- Next, any payment made by your primary plan will be subtracted from this amount. The difference remaining (if any) will be the secondary payment made by this plan.

In addition, if this plan is secondary, it must calculate its savings (its amount paid subtracted from the amount it would have paid had it been the primary plan) and record these savings as a benefit reserve for the covered person. This reserve must be used to pay any expenses during that Calendar Year, whether or not they are an allowable expense under this plan. If this plan is secondary, it will not be required to pay an amount in excess of its maximum benefit plus any accrued savings.

Allowable expense is a health care expense, including Deductibles, Coinsurance and Copayments, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

(1) The difference between the cost of a semi-private Hospital room and a private Hospital room is not an allowable expense, unless one of the plans provides coverage for private Hospital room expenses.

(2) If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement method or other similar reimbursement method, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.

(3) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an allowable expense.

Closed panel plan is a plan that provides health care benefits to covered persons in the form of services through a panel of Providers who are primarily employed by the plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.

Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more plans, the rules for determining the order of benefit payments are as follows:

The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.

(1) Except as provided in subsection (2), a plan that does not contain a coordination of benefits provision that is consistent with this chapter is always primary unless the provisions of both plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage is excess to any other parts of the plan provided by the contract holder. Examples include major medical coverages that are superimposed over Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.

Each plan determines its order of benefits using the first of the following rules that apply:

(1) Nondependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, Subscriber or retiree is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, 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 (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, Subscriber or retiree is the secondary plan and the other plan is the primary plan.

(2) Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one plan the order of benefits is determined as follows:

(a) For a dependent child whose parents are married or are living together, whether or not they have ever been married:

- The plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or
- If both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.

(b) For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

(i) If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim determination periods commencing after the plan is given notice of the court decree;

(ii) 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;

(iii) If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above determine the order of benefits;
(iv) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subsection (a) above determine the order of benefits; or
(v) If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

- The plan covering the custodial parent, first;
- The plan covering the spouse of the custodial parent, second;
- The plan covering the noncustodial parent, third; and then
- The plan covering the spouse of the noncustodial parent, last.

(c) For a dependent child covered under more than one plan of individuals who are not the parents of the child, the provisions of subsection (a) or (b) above determine the order of benefits as if those individuals were the parents of the child.

(3) Active employee or retired or laid-off employee. The plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D(1) can determine the order of benefits.

(4) COBRA or state continuation coverage. If a person whose coverage is provided under COBRA or under a right of continuation provided by 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 COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule under section D(1) can determine the order of benefits.

(5) Longer or shorter length of coverage. The plan that covered the person as an employee, member, policyholder, Subscriber or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

(6) If the preceding rules do not determine the order of benefits, the allowable expenses must be shared equally between the plans meeting the definition of plan. In addition, this plan will not pay more than it would have paid had it been the primary plan.

Time Limits for COB

When this plan has been notified that more than one plan covers an enrollee who has submitted a Claim, this plan shall determine with the other plan which plan is primary within 30 calendar days. Once the primary plan and secondary plan have been identified, if the secondary plan receives a Claim without the primary plan's explanation of benefit information or other primary payment details needed to process the Claim, the secondary plan will notify the submitting Provider and/or enrollee within 30 calendar days of receipt of the Claim. If a primary plan has not adjudicated a Claim within 60 days of receipt of the Claim and all supporting documentation, the Provider or enrollee may submit the Claim and notice of the primary plan's failure to pay to the secondary plan which shall pay within 30 calendar days.

Effect on the Benefits of This Plan
When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a Claim determination period are not more than the total allowable expenses. In determining the amount to be paid for any Claim, the secondary plan will subtract the primary plan's payment from the amount the secondary plan would have paid if the secondary plan had been primary and then pay the difference, if any exists. In addition, the secondary plan must credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

Right to Receive and Release Needed Information
Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. CHPW may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. CHPW need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give CHPW any facts it needs to apply those rules and determine benefits payable.

Facility of Payment
If payments that should have been made under this plan are made by another plan, the issuer has the right, at its discretion, to remit to the other plan the amount it determines appropriate to satisfy the intent of this provision. The amounts paid to the other plan are considered benefits paid under this plan. To the extent of such payments, the issuer is fully discharged from liability under this plan.

Right of Recovery
The issuer has the right to recover excess payment whenever it has paid allowable expenses in excess of the maximum amount of payment necessary to satisfy the intent of this provision. The issuer may recover excess payment from any person to whom or for whom payment was made or any other issuers or plans.

Notice to Covered Persons
If you are covered by more than one health benefit plan, and you do not know which is your primary plan, you or your Provider should contact any one of the health plans to verify which plan is primary. The health plan you contact is responsible for working with the other plan to determine which is primary and will let you know within thirty calendar days.

Questions about Coordination of Benefits? Contact the Washington State Office of the Insurance Commissioner at 1-800-562-6900.

SUBROGATION AND REIMBURSEMENT

If we make Claims payment on your behalf for Injury or Illness for which another party is liable, or for which uninsured/underinsured motorist (UIM) or personal injury protection (PIP) insurance exists, we will be subrogated to any rights that you may have to recover compensation or damages from that liable party related to the Injury or Illness, and we would be entitled to be repaid for payments we made on your behalf out of any recovery that you obtain from that liable party after you have been fully compensated for your loss. The liable party is also known as the "third party" because it is a party other than you or us. This party includes a UIM carrier because it stands in the shoes of a third party tort feasor and because we exclude coverage for such benefits.

Definitions The following terms have specific meanings in this contract:

- Subrogation means we may collect directly from third parties or from proceeds of your recovery from third parties to the extent we have paid on your behalf for Illnesses or Injury caused by the third party and you have been fully compensated for your loss.

- Reimbursement means that you are obligated under the contract to repay any monies advanced by us from amounts you have received on your claim after you have been fully compensated for your loss.
- Restitution means all equitable rights of recovery that we have to the monies advanced under your plan.

Because we have paid for your Illness or Injury, we are entitled to recover those expenses from any responsible third-party once you have been fully compensated for your loss. To the fullest extent permitted by law, we are entitled to the proceeds of any settlement or judgment that results in a recovery from a third party, up to the amount of payments we have made on your behalf after you have been fully compensated for your loss. Our right to recover exists regardless of whether it is based on subrogation, reimbursement or restitution. In recovering payments made on your behalf, we may at our election hire our own attorney to prosecute a subrogation claim for recovery of payments we have made on your behalf directly from third-parties, or be represented by your attorney prosecuting a claim on your behalf. Our right to prosecute a subrogation claim against third-parties is not contingent upon whether or not you pursue the party at fault for any recovery. If you recover from a third party and we share in the recovery, we will pay our share of the legal expenses. Our share is that percentage of the legal expenses necessary to secure a recovery against the liable party that the amount we actually recover bears to the total recovery.

Before accepting any settlement on your claim against a third party, you must notify us in writing of any terms or conditions offered in a settlement, and you must notify the third party of our interest in the settlement established by this provision. In the event of a trial or arbitration, you must make a claim against, or otherwise pursue recovery from third-parties payments we have made on your behalf, and give us reasonable notice in advance of the trial or arbitration proceeding. You must also cooperate fully with us in recovering amounts paid by us 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 us directly from the settlement or recovery. If you fail to cooperate fully with us in the recovery of the payments we have paid on your behalf, you are responsible for reimbursing us for payments we have made on your behalf.

You agree, if requested, to hold in trust and execute a trust agreement in the full amount of payments we made on your behalf from any recovery you obtain from any third-party until such time as we have reached a final determination or settlement regarding the amount of your recovery that fully compensates you for your loss.

Agreement to Arbitrate
Any disputes that arise as part of this *Subrogation and Reimbursement* section will be resolved by arbitration. Both you and we will be bound by the decision of the arbitration proceedings. Disputes will be resolved by a single arbitrator. Either party may demand arbitration by serving notice of the demand on the other party. Each party will bear its own costs and share equally in the fees of the arbitrator. Arbitration proceedings pursuant to this provision shall take place in Seattle, Washington. This agreement to arbitrate will begin on the Effective Date of the contract, and will continue until any dispute regarding this plan's subrogation or reimbursement is resolved.

Uninsured and Underinsured Motorist/Personal Injury Protection Coverage
We have the right to be reimbursed for benefits provided, but only to the extent that benefits are also paid for such services and supplies under the terms of a motor vehicle uninsured motorist and/or underinsured motorist (UIM) policy, personal injury protection (PIP) or similar type of insurance or contract.

DEFINITIONS

Affordable Care Act: The Patient Protection and Affordable Care Act of 2010 (Public Law 111-148) as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

Allowed Amount: The Allowed Amount means one of the following:

- **Providers Who Have Agreements with Us or First Choice Health Network, Inc.:**
    - For any given service or supply, the amount these Providers have agreed to accept as payment in full pursuant to the applicable agreement between CHPW or FCHN and the Provider. These Providers agree to seek payment from us when they furnish Covered Services to you. You'll be responsible only for any applicable Calendar Year Deductibles, Copays, Coinsurance, charges in excess of the stated benefit maximums and charges for services and supplies not covered under this plan;
- For services received from Non-Network Providers (except emergency services), the Usual, Customary and Reasonable (UCR) rate (see related definition); and
- For non-network emergency services, the Allowed Amount is determined annually by CHPW 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.

Your liability for any applicable Calendar Year Deductibles, Coinsurance, Copays and amounts applied toward benefit maximums will be calculated on the basis of the Allowed Amount. Except as set forth below, the Allowed Amount for a Provider in Washington that doesn't have an agreement with us will be no greater than the maximum allowance that would have been allowed, if the Medically Necessary Covered Services had been furnished by a Provider that has an agreement in effect with us.

When you receive services from Providers that do not have agreements with us, your liability is for any amount above the Allowed Amount, and for your normal share of the Allowed Amount. We reserve the right to determine the amount allowed for any given service or supply.

Ambulatory Patient Services: Ambulatory Patient Services means Medically Necessary services delivered to Members in settings other than a Hospital or Skilled Nursing Facility, which are generally recognized and accepted for diagnostic or therapeutic purposes to treat Illness or Injury.

Ambulatory Surgical Center: A facility that's licensed or certified as required by the state it operates in and that meets all of the following:

- It has an organized staff of physicians;
- It has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; and
- It doesn't provide inpatient services or accommodations.

Biosimilar: A biological product that is highly similar to a US-licensed reference biological product notwithstanding minor differences in clinically inactive components, and for which there are no clinically meaningful differences between the biological product and the reference product in terms of the safety, purity, and potency of the product.

Brand Name Drugs: Prescription Drug that has a current patent and is marketed and sold by limited sources or is listed in widely accepted references as a Brand Name Drug based on manufacturer and price.

Calendar Year: The period of 12 consecutive months that starts each January 1 at 12:01 a.m. and ends on the next December 31 at midnight.

Chemical Dependency: A condition characterized by a physiological or psychological abuse/dependency of a controlled substance that is subject to regulation under Chapter 69.50 of the Revised Code of Washington and/or alcohol, and which causes, amongst other symptoms, substantial impairment or endangerment of the individual's health and/or substantial disruption to their social or economic function. 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 the Tobacco Cessation benefit)

Claim: Any request for a plan benefit made by you or your authorized representative. A subscriber or dependent making a Claim for benefits is a claimant.

Coinsurance: Your share of the cost of a Covered Service, expressed as a percentage.

Concurrent Claim: Any Claim that is reconsidered after an initial approval for ongoing treatment and results in a reduced or terminated benefit.

Community Health Center: Community Health Centers (also known as Federally Qualified Health Centers) comprising the Community Health Network of Washington are community–based organizations that provide comprehensive primary care and preventive health services to persons of all ages, regardless of their ability to pay or health insurance status. Community Health Centers focus on improving the health of underserved populations in order to eliminate health disparities and they are a critical component of the health care safety net.

Community Health Center Provider: The medical staff, clinic associate staff, and allied health professionals employed by the Community Health Centers and any other health care professional or Provider with whom the Community Health Centers have contracted to provide health care services to Members enrolled under this Agreement, including, but not limited to, physicians, podiatrists, nurses, physician assistants, social workers, optometrists, psychologists, physical therapists, and other professionals engaged in the delivery of health care services who are licensed or certified to practice in accordance with Title 18 Revised Code of Washington.

Community Mental Health Agency: An agency that's licensed as such by the State of Washington to provide mental health treatment under the supervision of a physician or psychologist.

Compound Drug: Two or more medications that are mixed together by the Pharmacist. To be covered, Compound Drugs must contain a Prescription Drug that has been approved by the FDA.

Congenital Anomaly of a Child: A defect in the development of body form, structure or function that is present at the time of birth.

Copayment ("Copay"): The specific dollar amount a Member is required to pay at the time of service for certain Covered Services under the Agreement, as set forth in this Agreement.

Cost-Shares: The amount that a Member has to pay when services or drugs are received. It includes any combination of the following three types of payments: (1) any Deductible amount a plan may impose before services or drugs are covered; (2) any fixed Copayment amount that a plan requires when a specific service or drug is received; or (3) any Coinsurance amount, a percentage of the total amount paid for a service or a drug, that a plan requires when a specific service or drug is received.

Custodial Care: Care for personal needs rather than Medically Necessary needs. Custodial Care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medications. This plan does not cover Custodial Care unless it is provided as other care you receiving in addition to daily skilled nursing care and/or skilled rehabilitation services.

Deductible: A specific amount a Member is required to pay for certain Covered Services before benefits are paid under the Agreement.

Effective Date: The date when your coverage under this plan begins. If you re-enroll in this plan after a lapse in coverage, the date that the coverage begins again will be your Effective Date.

Emergency Care: Covered Services that are: 1) rendered by a Provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize a Member with a condition considered a Medical Emergency. Stabilize means to provide such medical treatment of the Medical Emergency as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the Member from a Medical Facility.

Experimental/Investigational Services: Experimental or Investigational services include a treatment, procedure, equipment, drug, drug usage, medical device or supply that meets one or more of the criteria described below as determined by us. An Experimental/Investigative service is:

- A drug or device that can't be lawfully marketed without the approval of the U.S Food and Drug Administration, and hasn't been granted such approval on the date the service is provided;
- A service that is subject to oversight by an Institutional Review Board;
- For which no reliable evidence demonstrates that the service is effective, in clinical diagnosis, evaluation, management or treatment of the condition;
- A service that is the subject of ongoing clinical trials to determine its maximum tolerated dose, toxicity, safety or efficacy. However, services that meet the criteria under Clinical Trials in the *Medical Benefits* section of this Agreement will not be deemed Experimental or Investigational; or
- A service for which evaluation of reliable evidence indicates that additional research is necessary before the service can be classified as equally or more effective than conventional therapies.

Reliable evidence includes but is not limited to reports and articles published in authoritative peer reviewed medical and scientific literature.

Formulary: CHPW's list of selected Prescription Drugs. CHPW established its Formulary and reviews and updates it routinely. Drugs are reviewed and selected for inclusion in CHPW's Formulary by an outside committee of Providers, including physicians and Pharmacists.

Generic Drug: Prescription Drug that is equivalent to a Brand Name Drug, is marketed as a therapeutically equivalent and interchangeable product and is listed in widely accepted references (or specified by CHPW) as a Generic Drug. For the purposes of this definition, "equivalent" means the FDA ensures that the Generic Drug has the same active ingredients, meets the same manufacturing and testing standards and is absorbed into the bloodstream at the same rate and same total amount as the Brand Name Drug.

Hospital: A facility legally operating as a Hospital in the state in which it operates and that meets the following requirements:

- It has facilities for the inpatient diagnosis, treatment, and acute care of injured and ill persons by or under the supervision of a staff of physicians; and
- It continuously provides 24-hour nursing services by or under the supervision of registered nurses.

A Hospital will never be an institution that's run mainly:

- As a rest, nursing or convalescent home; residential treatment center; or health resort
- To provide hospice care for terminally ill patients
- For the care of the elderly
- For the treatment of Chemical Dependency or tuberculosis

Illness: A sickness, disease, medical condition or pregnancy.

Injury: Physical harm caused by a sudden and unforeseen accident or event at a specific time and place. An Injury is independent of Illness, except for infection of a cut or wound.

In-Network Provider: Our network of contracted health care providers which includes both the First Choice Health Network ("FCHN") Providers and the Community Health Center Providers.

Levels of Care: Refer to care levels 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.
- **Partial Hospitalization Programs** provide multi-disciplinary care for Mental Health or Chemical Dependency Condition at least 6 hours a day, 5 days a week, and schedule at least three distinct services per day. Services include individual and group therapy, medication evaluation and management, family therapy, activity therapy, occupational therapy, and education training directed at treating the Condition. Services for Mental Health Conditions must include evaluation by a psychiatrist within 48 hours and weekly thereafter. All programs must include a substance abuse evaluation. Treatment must follow a written plan of care.
- **Residential Treatment Programs** provide a 24-hour level of care 7 days a week for patients with long-term or severe Mental Health or Chemical Dependency Conditions. Care is medically monitored, with 24-hour medical and nursing availability. Services include treatment with a range of diagnostic and therapeutic behavioral health services that cannot be adequately provided through existing community programs. Residential care also includes family involvement in assessment, treatment and discharge planning, and offers training in the basic skills of living as determined necessary for each patient. Treatment must follow a written plan of care.
- **Chemical Dependency Rehabilitation Programs** provide 24-hour rehabilitation treatment 7 days a week for Substance Abuse Conditions. 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.

Maintenance Drug: Prescription Drug that CHPW determines is intended to treat a chronic Illness that requires long-term medication therapy.

Medical Emergency: A medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate attention to result in 1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.
Examples of a Medical Emergency are severe pain, suspected heart attacks and fractures. Examples of a non-Medical Emergency are minor cuts and scrapes.

Medical Equipment: Mechanical equipment that can stand repeated use and is used in connection with the direct treatment of an Illness or Injury. It's of no use in the absence of Illness or Injury.

Medical Facility (also called Facility): A Hospital, Skilled Nursing Facility, state-approved Chemical Dependency treatment program or hospice.

Medically Necessary: 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 service 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; and
- 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 an intervention, service or supply furnished, is prescribed or recommended by a physician or other Provider does not, of itself, make it Medically Necessary. An intervention, service or supply may be Medically Necessary in part only. If this occurs, the portion deemed Medically Necessary will be covered, subject to the limitations and exclusions of the plan.

Member (also called "you" and "your"): A person covered under this plan as a Subscriber or Dependent.

Mental Health Condition: A mental disorder listed on Axis I of 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 Mental Health Conditions or are covered under other benefits offered by this plan (subject to all terms, limitations and exclusions):

- Conditions related to Substance Use Disorders (see Chemical Dependency definition);
- Developmental Delays/Learning Disorders (see Neurodevelopmental Therapy benefit);
- Relational or behavioral issues (specifically those Claims submitted with DSM V code as a primary diagnosis); or
- Sexual and gender identity disorders (specifically DSM codes 302.0-302.9).

Obstetrical Care: Care furnished during pregnancy (antepartum, delivery and postpartum) or any condition arising from pregnancy, except for complications of pregnancy. This includes the time during pregnancy and within 45 days following delivery.

Orthotic: A support or brace applied to an existing portion of the body for weak or ineffective joints or muscles, to aid, restore or improve function.

Out-of-Network Provider: A Provider who is not an In-Network Provider.

Out-of-Pocket Expenses: Those Cost-Shares paid by the Member or Subscriber for Covered Services, which are applied to the Out-of-Pocket Maximum.

Out-of-Pocket Maximum: The maximum amount of Out-of-Pocket Expenses incurred and paid, during the Calendar Year for Covered Services received by the Member and his/her Dependents within the same Calendar Year. Copays, Charges in excess of UCR, services in excess of any benefit level, and services not covered by the Agreement are not applied to the Out-of-Pocket Maximum.

Pharmacist: Individual licensed to dispense Prescription Drugs, counsel a patient about how the drug works and its possible adverse effects and perform other duties as described in his or her state's Pharmacy practice act.

Pharmacy: Any duly licensed outlet in which Prescription Drugs are Dispensed.

Participating Pharmacy: A Pharmacy with which CHPW has a contract or a Pharmacy that participates **in** a network for which CHPW has contracted to have access. Participating Pharmacies have the capability of submitting Claims electronically.

Non-Participating Pharmacy: A Pharmacy with which CHPW neither has a contract nor has contracted access to any network it belongs to. Non-Participating Pharmacies may not be able to or choose not to submit Claims electronically.

Plan (also called this plan)**:** The benefits, terms and limitations set forth in the contract between us and you, of which this Agreement is a part.

Premium Charges: The monthly rates set by us as consideration for the benefits offered in this plan.

Prescription: A written prescription or oral request for Prescription Drugs issued by a Provider who is licensed to prescribe medications.

Prescription Drug: Medications and biological that relate directly to the treatment of an Illness or Injury legally cannot be dispensed without a Prescription and by law must bear the legend: Any "Caution: Federal law prohibits dispensing without a prescription." These drugs, including off-label use of FDA-approved drugs (provided that such use is documented to be effective in one of the standard reference compendia; a majority of well-designed clinical trials published in peer-reviewed medical literature document improved efficacy or safety of the agent over standard therapies, or over placebo if no standard therapies exist; or by the federal secretary of Health and Human Services) are covered. "Off-label use" means the prescribed use of a drug that's other than that stated in its FDA-approved labeling. Benefits aren't available for any drug when the FDA has determined its use to be contra-indicated, or for Experimental or Investigational drugs not otherwise approved for any indication by the FDA.

Primary Care Provider (PCP):A general practitioner, internist, family practitioner, general pediatrician, OB-GYN or Advanced Registered Nurse Practitioner (ARNP) chosen by a Subscriber or dependent to coordinate all health care needs.

Provider: A person who is in a provider category regulated under Title 18 or Chapter 70.127 RCW to practice health care related services consistent with state law. Such persons are considered health care providers only to the extent required by RCW 48.43.045 and only to the extent services are covered by the provisions of this plan. Also included is an employee or agent of such a person, acting in the course of and within the scope of his or her employment.

Providers also include certain health care facilities and other providers of health care services and supplies, as specifically indicated in the provider category listing below. Health care facilities that are owned and operated by a political subdivision or instrumentality of the State of Washington and other such facilities are included as required by state and federal law.

Covered licensed or certified categories of providers regulated under Title 18 and Chapter 70.127 RCW, will include, but are not limited to physicians, podiatrists, nurses, physician assistants, social workers, optometrists, psychologists, physical therapists and other professionals engaged in the delivery of health care services provided that the services they furnish are consistent with state law and the conditions of coverage described elsewhere in this plan are met.

The following health care facilities and other providers of health care services and supplies will be considered health care providers for the purposes of this plan, as long as they are licensed or certified by the State (unless otherwise stated), that the services they furnish are consistent with their lawful scope of practice as well as state law and the conditions of coverage described elsewhere in this plan are met:

- Ambulance Companies;
- Ambulatory Diagnostic, Treatment and Surgical Facilities;
- Audiologists (CCC-A or CCC-MSPA);
- Birthing Centers;
- Blood Banks;
- Community Mental Health Centers;
- Drug and Alcohol Treatment Facilities;
- Medical Equipment Suppliers;
- Mental Health Care Practitioners;
- Hospitals;
- Kidney Disease Treatment Centers (Medicare-certified);
- Psychiatric Hospitals; and
- Speech Therapists (Certified by the American Speech, Language and Hearing Association).

Recognized Providers: Providers acting within the scope of his/her license but for whom: 1) FCHN/CHPW does not offer agreements to his/her category of providers; or 2) In-Network providers are available, but the subscriber/member does not have the opportunity to choose which provider performs services. 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
- PKU formula
- Services of non-contracted providers when rendering care within a network facility, except a primary surgeon for a non-emergent admission
- TMJ providers
  - Dentist
  - Oral and Maxillofacial Surgeon

Self-Administrable Prescription Drugs: (also Self-Administrable Drugs or Self-Administrable Injectable Drugs) means, a Prescription Medication, determined by CHPW, which can be safely administered by you or your caregiver outside a Medical Facility (such as a Hospital, Physician office or clinic) and that does not require administration by a Provider. In determining what CHPW considers Self-Administrable Drugs, CHPW refers to information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity and other information that CHPW considers a relevant and reliable indication of safety and acceptability. CHPW does not consider your status, such as your ability to administer the drug, when determining whether a medication is self-administrable.

Service Area: Washington counties of Adams, Benton, Chelan, Clark, Cowlitz, Douglas, Ferry, Franklin, Grant, Grays Harbor, King, Kitsap, Lewis, Okanogan, Pacific, Pend Oreille, Pierce, Skagit, Snohomish, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, Whatcom, and Yakima.

Skilled Care: Care that's ordered by a physician and requires the medical knowledge and technical training of a licensed registered nurse.

Skilled Nursing Facility: A Medical Facility providing services that require the direction of a physician and nursing supervised by a registered nurse, and that's approved by Medicare or would qualify for Medicare approval if so requested.

Specialty Drug: Prescription Drugs that are used to treat complex or rare conditions and that require special handling, storage, administration or patient monitoring. They are high cost, often Self-Administered Injectable Drugs for the treatment of conditions such as rheumatoid arthritis, hepatitis, multiple sclerosis, or growth disorders (excluding idiopathic short stature without growth hormone deficiency).

Subscriber: The individual who has met the eligibility requirements of this plan and in whose name the application is filed and the coverage established.

Telemedicine: The use of medical information exchanged from one site to another via both synchronous and asynchronous electronic communications.

- **Synchronous** communication includes the use of audio and video equipment permitting two-way, real time interactive communication between the patient and Provider at a distant site (example: videoconference).
- **Asynchronous** (or "store and forward") communication includes the use of audio and video equipment that records and stores information to be sent to a Provider at a distant site to be interpreted at a later time

Temporomandibular Joint (TMJ) Disorders: 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; and
- An abnormal range of motion or limited motion of the temporomandibular joint.

MAIL YOUR CLAIMS TO
First Choice Health Administrators
Attn: Claims
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Seattle, WA 98111

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Customer Service

Mailing Address Phone Numbers
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Local and toll-free number:
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600 University St, Ste 1400
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Feedback

Community Health Plan of Washington
Attn: Customer Experience Manager
P.O. Box 91059
Seattle, WA 98111-9159

Appeals

Appeals Level I:
First Choice Health Administrators
Attn: Appeals Coordinator
600 University Street, #1400
Seattle, WA 98101
Phone: (577) 749-2031
Fax: (206) 268-2920

Appeals Level II:
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Attn: Appeals Coordinator
P.O. Box 91102
Seattle, WA 98111-9202

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