



COMMUNITY HEALTH PLAN  
of Washington™



Silver/ 6 Plan

# 2017 Member Handbook

Community **HealthEssentials** Plus **Silver**



## Community HealthEssentials Plus

### Health Care Coverage Agreement For Individuals and Families

**Community HealthEssentials Plus** is a health insurance plan for individuals and families offered by Community Health Plan of Washington (“CHPW” or “the Plan”). 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 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. **You will find information about CHPW, and about the unique benefits of our Community HealthEssentials Plus plans, on page 1 of this Agreement.**

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, or addenda to this Agreement required by state or federal law and 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. The delivery date is the 5th day after the postmark date. In the event that the Agreement is returned within 10 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% 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.

**Access to Language Assistance.** If you, or someone you're helping, has questions about Community HealthEssentials Plus, you have the right to get help and information in your language at no cost. To talk to an interpreter, call 1-800-930-0132.

Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Community HealthEssentials Plus, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-800-930-0132.

如果您，或是您正在協助的對象，有關於[插入SBM項目的名稱 Community HealthEssentials Plus 方面的問題，您有權利免費以您的母語得到幫助和訊息。洽詢一位翻譯員，請撥電話 [在此插入數字 1-800-930-0132。

Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Community HealthEssentials Plus, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-800-930-0132.

만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Community HealthEssentials Plus 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-800-930-0132 로 전화하십시오.

Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Community HealthEssentials Plus, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-800-930-0132.

Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Community HealthEssentials Plus, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-930-0132.

Якщо у Вас чи у когось, хто отримує Вашу допомогу, виникають питання про Community HealthEssentials Plus, у Вас є право отримати безкоштовну допомогу та інформацію на Вашій рідній мові. Щоб зв'язатись з перекладачем, задзвоніть на 1-800-930-0132.

ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពី Community HealthEssentials Plus បើ អ្នកម្នាក់សិរីលោកសិរីលោកស្រី ឬស្រីម្នាក់ ចៅកន្លងកាល រស់អ្នក ចោយមិនអ្សប្រាក់ ។ បើមិនយាយជាមួយអ្នកក៏ដូចជា ប្រសូម 1-800-930-0132.

ご本人様、またはお客様の身の回りの方でも、Community HealthEssentials Plus についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-800-930-0132 までお電話ください。

እርስዎ፣ ወይም እርስዎ የሚያገዙት ግለሰብ፣ ስለ Community HealthEssentials Plus ጥያቄ ካላችሁ፣ ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ 1-800-930-0132 ይደውሉ።

Isin yookan namni biraa isin deeggartan Community HealthEssentials Plus irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-800-930-0132 tiin bilbilaa.

يفق حل اكي دلف ، Community HealthEssentials Plus صوص خب قلى س اهدع است صخش ى دل و ا كى دل ن ا ن ا  
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1-800-930-0132.

ਜੇ ਤੁਹਾਨੂੰ, ਜਾਂ ਤੁਸੀਂ ਜਜਸ ਦੀ ਮਦਦ ਕਰ ਰਹੇ ਹੋ, Community HealthEssentials Plus ਕੋਈ ਸਵਾਲ ਹੈ ਤਾਂ, ਤੁਹਾਨੂੰ  
ਜਿਨਾ ਜਕਸੇ ਕੀਮਤ 'ਤੇ ਆਪਣੀ ਭਾਸ਼ਾ ਜਵਿੱਚ ਮਦਦ ਅਤੇ ਜਾਣਕਾਰੀ ਪਰਾਪਤ ਕਰਨ ਦਾ ਅਜਿਕਾਰ ਹੈ . ਦੁਭਾਸ਼ੀਏ ਨਾਲ ਗਿੱਲ  
ਕਰਨ ਲਈ, 1-800-930-0132 ਤੇ ਕਾਲ ਕਰੋ.

Falls Sie oder jemand, dem Sie helfen, Fragen zum Community HealthEssentials Plus haben, haben Sie  
das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher  
zu sprechen, rufen Sie bitte die Nummer 1-800-930-0132 an.

ຖ້າທ່ານ, ຫຼື ຄົນທີ່ທ່ານກຳລັງຊ່ວຍເຫຼືອ, ມີ ຄຳຖາມກ່ຽວກັບ Community HealthEssentials Plus,  
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ການໂອ້ນລັກບັນຍາຍພາສາ, ໃຫ້ໂທຫາ 1-800-930-0132.

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## WELCOME

Thank you for choosing CHPW and Community HealthEssentials Plus for your 2017 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.

**What makes Community HealthEssentials Plus different?** Community HealthEssentials Plus is offered by CHPW in partnership with First Choice Health Network (“FCHN”). This partnership provides Members with access to one of Washington State’s largest and most comprehensive groups of In-Network Providers, including primary care and specialty care providers, as well as hospitals and other facilities. **Community HealthEssentials Plus also offers Members a unique benefit: \$0 Office Visit Copays when you receive primary care services through any of the 19 Community Health Centers that make up the Community Health Network of Washington.** For more information, see the *Accessing Care* Section of this Agreement.

**About Community Health Plan of Washington.** 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 our Members with choice, while meeting the comprehensive health needs of the communities we serve.

**Our Partnership with First Choice Health Network.** 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.

**Contact Information.** 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.

**References.** Throughout this Agreement, CHPW is referred to as “we,” “us,” or “our.” Community HealthEssentials Plus 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. Use of the terms “includes” or “including” throughout this Agreement is not intended to be and shall not be interpreted as exclusive. 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.

## 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 FCHN for all enrolled persons in the Subscriber's family unit, the monthly premium set forth in the current premium schedule, Schedule A, 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 the applicable grace period (30 days for Members not receiving a federal premium tax credit, and 90 days for Members who receive a federal premium tax credit). Premiums are subject to change by CHPW upon 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 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  
1111 Third Ave, Suite 400  
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 30 days written notice of premium increase. CHPW shall give the Subscriber 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 90 days prior to discontinuation. CHPW must provide the Washington State Office of the Insurance Commissioner at least 60 days advance notice in the event of discontinuation of this plan. In the event of cancellation, services received prior to the effective date of such cancellation shall be covered in accordance with the terms of this Agreement.

**Nondiscrimination.** CHPW and its vendors and other contracted partners comply with all applicable federal, state, and local civil rights laws and do not discriminate, exclude, or treat people differently on the basis of race, color, national origin, ancestry, religion, sex, 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.

CHPW provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and providing written information in other formats, including large print, audio, accessible electronic formats and others. CHPW also provides free language services to people whose primary language is not English, such as qualified interpreters, and information written in other languages.

If you need these types of services, contact the Appeals and Grievances Department.

If you believe that CHPW has failed to provide these services, or has discriminated against you in another way, you can file a grievance. You may file a grievance in person or by mail, fax, or email to:

Community Health Plan of Washington  
Appeals and Grievances Department  
1111 Third Ave, Suite 400  
Seattle, WA 98101  
Phone: 1-800-440-1561 or TTY Relay: Dial 7-1-1  
Fax: 206-613-8984  
Email: [appealsgrievances@chpw.org](mailto:appealsgrievances@chpw.org)

If you need help filing a grievance, the Appeals and Grievances Department is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at: <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independent Ave. SW, Room 509F  
HHH Building, Washington, DC 20201  
Phone: 1-800-868-1019 or for TDD 1-800-537-7697.

**Notice of Other Coverage.** CHPW does not prohibit you from freely contracting to obtain health care services outside of this plan. As a condition of receiving benefits under this plan, however, 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, who are contracted in writing with us ("In-Network Providers"). Members of this plan may also choose to receive care from Providers who are not contracted with our network ("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 an Out-of-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 robust and comprehensive network of contracted, In-Network Providers. When you receive care from an In-Network Provider, you are responsible for all applicable Copays, Deductibles, Coinsurance, amounts in excess of stated benefit maximums, and charges for non-covered services and supplies. You will not be balance billed for Covered Services received from In-Network Providers, because In-Network Providers agree to accept our Allowed Amount as payment in full.

**\$0 Office Visit Copay Primary Care Providers.** As a Community HealthEssentials Plus Member, your primary care Office Visit Copay is \$0 when you receive primary care services from Providers at your local Community Health Network of Washington Community Health Centers (“Community Health Center Providers”). Please see the *Cost Shares* section below for more information on Copays. Community Health Center Providers are In-Network, and offer the unique benefit of \$0 Office Visit Copays for primary care services. Community Health Center Providers provide primary and preventive health care services, and focus on treating the entire person.

To locate a Community Health Center Provider, or other In-Network Provider, near you, access our online Provider Directory on the First Choice Health Network website at <http://www.fchn.com/splash/CHE/>. To request a paper copy, please contact Customer Service at 1-800-930-0132.

In the event your primary care Provider’s contract with First Choice Health Network is terminated, you may continue to receive care from them under the same terms for at least sixty (60) days following notice of termination.

### **Out-of-Network Providers.**

If you elect to receive Covered Services and supplies from an Out-of-Network Provider, you will be balanced billed for and will be responsible to pay all amounts charged by the Out-of-Network Provider that are above the Allowed Amount. This means you may pay higher Out-of-Pocket Expenses for Covered Services and supplies you receive from Out-of-Network Providers. In addition to balance billing, when you receive care from an Out-of-Network Provider, you will also be responsible for any applicable Copay, Deductible, 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 an In-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 VSP Vision Care Inc. (“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. 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](http://www.vsp.com) or call VSP at 1-800-877-7195 or TTY 1-800-428-4833. Contact a listed VSP Network Provider directly to schedule an appointment, and be sure to let them know that your Community HealthEssentials Plus pediatric vision benefits are available 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.

Through our partner, FCHN, we provide clinical rationale, scientific judgment, plan definitions, and plan language used to make a Utilization Management determination for medical necessity or medical appropriateness, or experimental or investigative services. These are available free of charge to any current or potential Member, beneficiary, or contracting Provider upon request, within a reasonable time, and in a manner that provides reasonable access to the requestor. This applies with respect to medical or surgical and mental health or substance use disorder benefits under the plan.

### **Evaluation of New Technology**

A Provider or Member can ask CHPW to cover a new technology. Our Medical Management team 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. Utilization Management staff uses our approved list of clinical criteria to make these determinations. Each request for Pre-Authorization is first reviewed by a clinical staff person. If clinical staff is unable to approve a request, the request is forwarded to a Medical Director for further review, sometimes called peer review. All denials are peer reviewed by a Medical Director. The Medical Director is available to discuss Utilization Management denials with your Provider.

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. In addition, if Pre-Authorization is not obtained for the services and supplies listed below, your Claim(s) will be denied. You are ultimately responsible for obtaining Pre-Authorization; you may have your Provider contact CHPW for you, but it is your responsibility to obtain Pre-Authorization for any services or supplies for which it is required. Call 1-800-808-0450 for Pre-Authorization for medical services, or 1-800-640-7682 for mental health or Chemical Dependency services.

Pre-Authorization is required for:

- **Ambulance** (except in life-threatening circumstances)
  - Air transport - elective
  - Air transport- emergent. This will be retrospectively reviewed for medical necessity
- Applied Behavioral Analysis (“ABA”) Therapy
- **Clinical trials** (any treatment or interventions provided under a clinical trial)
- **Dental trauma services** (follow-up services)
- **Dialysis - all types** (for chronic kidney disease)
- **Durable Medical Equipment, medical supplies and prosthetics**
  - Bone Growth Simulators
  - Specialized Hospital Beds and Traction
    - Standard semi-electric bed for transition of care and rental for up to 3 months does not require Pre-Authorization
  - Custom Fabricated Braces
  - Dynamic Splinting Systems
  - Electrical stimulators- Spinal- external Neuromuscular stimulators and TENS
  - Prosthetics
    - Myoelectric Prosthetic components for the upper limb
    - Powered Ankle-Foot Prosthesis, Microprocessor-Controlled Ankle-foot Prosthesis, and Microprocessor-Controlled Knee Prosthesis
  - Speech Generating Devices
  - Custom and power operated wheelchairs and supplies
    - Standard manual wheelchair for transition of care and rental
- Scooters
- Wearable Defibrillators
- **Facet joint injections and Neurotomy (any location)**
- **Genetic testing**
  - Over \$500
- **Home health care services**
  - Home health visits (for wound therapy only)
  - Home infusion therapy (enteral and IV)
  - Hospice
- **Hyperbaric oxygen therapy**
- **Imaging**
  - PET scans
- **Inpatient admissions**
  - Chemical Dependency and mental health admissions (including residential and Partial Hospital Program admissions)
  - Inpatient hospice
  - Inpatient rehabilitation admissions
  - Long- term acute care facility
  - Medical/surgical admissions (excluding routine maternity deliveries)
  - Skilled Nursing Facility admissions
- **Intensive Outpatient Programs (IOP) for chemical dependency or mental health**
- **Medical injectables and other drugs**
  - Abatacept (Orencia<sup>®</sup>)
  - Ado-trastuzumab emtansine ( Kadcyla™)
  - Aflibercept (Eylea<sup>®</sup>)
  - Agalsidase Beta (Fabrazyme<sup>®</sup>)
  - Alglucosidase Alfa (Lumizyme<sup>®</sup>)
  - Belimumab (Benlysta<sup>®</sup>)
  - Bevacizumab (Avastin<sup>®</sup>)
  - Blood clotting factors (all)

- Bortezomib (Velcade®)
- Botulinum toxin (all types and brands)
- Cetuximab (Erbix®)
- Epoprostenol (Flolan®)
- Intravenous immunoglobulin (IVIG) therapy (all types and brands)
- Ipilimumab (Yervoy®)
- Iron infusions (all brands)
- Natalizumab (Tysabri®)
- Omalizumab (Xolair®)
- Palivizumab (Synagis)
- Pegaptanib (Macugen®)
- Pembrolizumab (Keytruda®)
- Pemetrexed (Alimta®)
- Ranibizumab (Lucentis®)
- Rituximab (Rituxan®)
- Romiplostim (Nplate®)
- Sipuleucel-T (Provenge)
- Taglicerase alfa (Eleyso™)
- Tocilizumab (Actemra®)
- Tositumomab and 1-131 Iodine Tositumomab ( Bexxar regime)
- Trastuzumab (Herceptin®)
- Ustekinumab Stelara®)
- Vedolizumab ( Entyvio™)
- Velaglucerase alfa ( VPRIV®)
- Ziv-aflibercept (Zaltrap®)
- **Organ and bone marrow transplants**  
(includes evaluation of and services for both recipient and donor, including travel and lodging expenses)
  - Notification only for evaluation
  - Pre-authorization for services or recipient and donor
  - Pre-authorization for travel and lodging
- **Radiation Therapy**
  - Stereotactic Body Radiation Therapy (SBRT)
  - Proton Beam or Helium Radiation Therapy
  - Stereotactic radiosurgery (Gamma Knife, Cyberknife)
- **Surgery**
  - Abdominoplasty/panniculectomy
  - \*BAHA-Bone Anchored Hearing Aid (surgical benefit applies)
  - \*Bariatric surgery
  - Breast Surgeries – selected (Pre-authorization is not required for breast reconstruction and nipple/areola reconstruction following mastectomy for breast cancer)
    - o Implant removal
    - o Mastectomy for gynecomastia
    - o Prophylactic mastectomy
    - o Reduction mammoplasty
  - Cosmetic or reconstructive surgery
  - \*Cochlear Implants (surgical benefit applies)
  - Deep Brain Stimulation
  - Eyelid surgery (i.e. blepharoplasty)
  - Fetal/Intrauterine surgery
  - \*Gender Reassignment surgery
  - Orthognathic surgery
  - Outpatient total knees
  - Outpatient total hip
  - Rhinoplasty
  - Spinal surgery – selected
    - o Lumbar fusions
    - o Cervical fusions
    - o Artificial Intervertebral Disc
  - Surgical interventions for sleep apnea
  - TMJ surgery
  - Varicose vein procedures
  - Ventricular Assist Device
- **Transcranial Magnetic Stimulation**

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, because these services are not covered without Pre-Authorization, except when covered as Routine Patient Costs associated with an approved clinical trial. See Clinical Trials in the *Schedule of Medical Benefits* section for more information.

### **Notification for Emergency Hospital Admissions**

Hospital admissions directly from the emergency room do not require Pre-Authorization. However, notification is required within 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 and perhaps lifetime care, often involving extensive services in a Facility or at home. With case management, a nurse case manager or Master's prepared licensed therapist monitors a patient with a catastrophic medical condition, 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 or TTY Relay: Dial 7-1-1 for speech or hearing impaired.

### **Second Opinions**

A second opinion by a qualified Provider regarding any medical diagnosis or treatment plan is covered by this plan. Coverage, including the amounts you are responsible to pay for Covered Services and supplies ("Cost-Shares"), depends on whether you see an In-Network or Out-of-Network Provider. Please see the *Cost Shares* section.

## **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 is important for you to understand what amounts you are responsible for.

### **Copayments**

Copayments (referred to as "Copays") are fixed, up-front dollar amounts that you are required to pay at the time and place you receive a service or supply. 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 **\$100** 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 the services you receive 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 you are not required to pay Co-insurance for these visits. Covered Services provided during an office visit, which are not part of the office visit, are subject to Deductible and Co-insurance, and may require Pre-Authorization. Please see the *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, or at the same location. For more information contact Customer Service at 1-800-930-0132.

### **Primary Care Providers**

Community HealthEssentials Plus offers you two options for accessing In-Network primary care services. When you receive primary care from a Community Health Center Provider, your Office Visit Copay is always **\$0**. When you receive primary care from other In-Network Providers, you pay a **\$3** Office Visit Copay.

### **Specialist Providers**

You are required to pay a **\$8** Office Visit Copay when you receive specialty care from an In-Network Provider.

### **Calendar Year Deductible**

The Calendar Year Deductible is the amount of expenses you must incur in each 12-month period (January 1 through December 31) for Covered Services and supplies before this plan provides certain benefits. Copays do not count toward the Calendar Year Deductible. Covered Services received from In-Network Providers, except Prescription Drug services, that require 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). This plan has different Deductibles for services and supplies received from In-Network Providers, and for services and supplies 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 the 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 In-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, such as 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 In-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 Shares 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 Shares 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 requirements under this plan are 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 (see *Definitions* section), 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 will 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
<b>Annual Deductible (per Calendar Year)</b>		
Individual	\$0	\$5,000
Family	\$0	\$10,000
<b>Coinsurance (plan pays)</b>	90%	50%
<b>Annual Out-of-Pocket Maximum (per Calendar Year)</b>		
Individual	\$1,250	N/A
Family	\$2,500	N/A

## SCHEDULE OF MEDICAL BENEFITS

Community HealthEssentials Plus Silver				
Benefit	Copay	Applies to Deductible	In-Network Providers (plan pays)	Out-of-Network Providers (plan pays)
<b>Acupuncture</b> 12 visits per Calendar Year, except when provided for Chemical Dependency treatment.	No	Yes	90%	50%
<b>Ambulance Services</b>	No	Yes	90%	50%
<b>Anesthesia</b>	No	Yes	90%	50%
<b>Autologous Blood Donation/Blood Transfusion</b>	No	Yes	90%	50%

Community HealthEssentials Plus Silver				
Benefit	Copay	Applies to Deductible	In-Network Providers (plan pays)	Out-of-Network Providers (plan pays)
<b>Chemical Dependency</b> Inpatient, residential and partial hospitalization services require Pre-Authorization.				
<ul style="list-style-type: none"> <li><b>Inpatient</b> (facility and professional)</li> </ul>	No	Yes	90%	50%
<ul style="list-style-type: none"> <li><b>Outpatient</b> (facility) Includes outpatient treatment and services provided by a hospital, an outpatient treatment center, and partial hospitalization or an Intensive Outpatient program.</li> </ul>	No	Yes	90%	50%
<ul style="list-style-type: none"> <li><b>Outpatient</b> (professional)</li> </ul>	See Professional/Physician Services (office visits)			
<ul style="list-style-type: none"> <li><b>Acupuncture</b> When provided for Chemical Dependency conditions, services do not apply to the overall acupuncture maximum benefit.</li> </ul>	No	Yes	90%	50%
<b>Diabetic Education and Diabetic Nutrition Education</b>				
<ul style="list-style-type: none"> <li><b>In Office</b> (Primary Care Provider)</li> </ul>	\$0 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
<ul style="list-style-type: none"> <li><b>In Office</b> (Specialist)</li> </ul>	\$0 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
<ul style="list-style-type: none"> <li><b>All other places of service</b></li> </ul>	No	Out-of-Network Providers only	100%	50%
<b>Dialysis Services</b>	No	Yes	90%	50%
<b>Durable Medical Equipment</b> Pre-authorization required if purchases exceed \$2,000 or \$500 per month rental.				

<b>Community HealthEssentials Plus Silver</b>				
<b>Benefit</b>	<b>Copay</b>	<b>Applies to Deductible</b>	<b>In-Network Providers (plan pays)</b>	<b>Out-of-Network Providers (plan pays)</b>
• <b>Breast Pumps</b>	No	Out-of-Network Providers only	100%	50%
• <b>Durable Medical Equipment</b>	No	Yes	90%	50%
• <b>Medical Supplies</b>	No	Yes	90%	50%
• <b>Orthopedic Appliances</b>	No	Yes	90%	50%
• <b>Prosthetic Devices</b>	No	Yes	90%	50%
<b>Emergency Care Services</b>				
• <b>Emergency Care Services</b> Copay waived if admitted as an inpatient within 24 hours.	\$100	No	100% after Copay	100% after Copay
• <b>Urgent Care</b>	\$8 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
<b>Family Planning</b>				
• <b>Office visits</b>	\$0 In-Network Providers only	Out-of-Network Providers only	100%	50%
• <b>Devices, implants and injections</b>	\$0 In-Network Providers only	Out-of-Network Providers only	100%	50%
• <b>Sterilization</b>	\$0 In-Network Providers only	Out-of-Network Providers only	100%	50%
• <b>Termination of pregnancy</b>	No	Yes	90%	50%
<b>Genetic Services</b> Pre-authorization required for genetic testing over \$500.				

Community HealthEssentials Plus Silver				
Benefit	Copay	Applies to Deductible	In-Network Providers (plan pays)	Out-of-Network Providers (plan pays)
• <b>BRCA Testing</b>	\$0 In-Network Providers only	Out-of-Network Providers only	100%	50%
• <b>All Other Genetic Testing</b>	No	Yes	90%	50%
• <b>Genetic Counseling</b>	\$0 In-Network Providers only	Out-of-Network Providers only	100%	50%
<b>Habilitation Services</b> Speech therapy, occupational therapy, physical therapy and aural therapy, and FDA-approved habilitative devices. When provided to treat a DSM diagnosis, these services are not subject to the visit limitation described below.				
• <b>Inpatient</b> (facility and professional) 30 days per Calendar Year.	No	Yes	90%	50%
• <b>Outpatient</b> (facility and professional) 25 visit maximum for all habilitation therapy services combined per Calendar Year, <i>except when provided to treat a DSM diagnosis.</i>	No	Yes	90%	50%
<b>Hearing</b>				
• <b>Routine hearing exams</b>	Not Covered			
• <b>Medically Necessary hearing exams</b>	Covered under <i>Lab and Radiology Services</i>			
• <b>Hearing aids/appliances</b>	Not Covered			
• <b>Cochlear Implants</b>	No	Yes	90%	50%
<b>Home Health Care</b> Pre-authorization required. Limited to 130 visits per Calendar Year.				
• <b>Home Health Care</b>	No	Yes	90%	50%

Community HealthEssentials Plus Silver				
Benefit	Copay	Applies to Deductible	In-Network Providers (plan pays)	Out-of-Network Providers (plan pays)
<ul style="list-style-type: none"> <li>• <b>Phototherapy</b> (home)</li> </ul>	No	Yes	90%	50%
<b>Hospice</b>				
Pre-authorization required.				
<ul style="list-style-type: none"> <li>• <b>Hospice Care</b></li> </ul>	No	Yes	90%	50%
<ul style="list-style-type: none"> <li>• <b>Respite Care</b> 14 days lifetime maximum</li> </ul>	No	Yes	90%	50%
<b>Hospital Inpatient Medical and Surgical Care</b>				
Pre-authorization required.				
<ul style="list-style-type: none"> <li>• <b>Facility services</b></li> </ul>	No	Yes	90%	50%
<ul style="list-style-type: none"> <li>• <b>Inpatient doctor visits/consultations</b></li> </ul>	No	Yes	90%	50%
<ul style="list-style-type: none"> <li>• <b>Inpatient professional</b> (surgeon)</li> </ul>	No	Yes	90%	50%
<ul style="list-style-type: none"> <li>• <b>Inpatient professional services</b> (assistant surgeon, radiologist, pathologist)</li> </ul>	No	Yes	90%	50%
<b>Hospital Outpatient Surgery and Services</b>				
Pre-authorization required for certain outpatient services; see the <i>Pre-Authorization</i> section for details.				
<ul style="list-style-type: none"> <li>• <b>Surgical facility services</b></li> </ul>	No	Yes	90%	50%
<ul style="list-style-type: none"> <li>• <b>Ambulatory Surgical Center (ASC)</b></li> </ul>	No	Yes	90%	50%
<ul style="list-style-type: none"> <li>• <b>Outpatient surgery professional services</b> (surgeon)</li> </ul>	No	Yes	90%	50%
<ul style="list-style-type: none"> <li>• <b>Outpatient surgery professional services</b> (assistant surgeon, radiologist, pathologist)</li> </ul>	No	Yes	90%	50%
<b>Infertility Diagnostic Services</b> Limited benefit, see <i>Infertility Diagnostic Services</i> below for details.	No	Yes	90%	50%

Community HealthEssentials Plus Silver				
Benefit	Copay	Applies to Deductible	In-Network Providers (plan pays)	Out-of-Network Providers (plan pays)
<b>Infusion Therapy</b> Includes infusion therapy provided in the home.	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 if performed in the home or at a free-standing infusion site.			
<b>Lab and Radiology Services</b> (non-routine, facility and professional services) Pre-authorization required for PET scans.				
• <b>Hospital inpatient</b> (professional fees)	No	Yes	90%	50%
• <b>Hospital outpatient/ independent lab or x-ray facility/doctor's office</b>	No	Yes	90%	50%
<b>Maternity and Newborn Care</b>				
• <b>Prenatal Diagnosis of Congenital Anomalies</b>	No	Yes	90%	50%
• <b>Maternity care</b> (global professional fee and all prenatal and postnatal care, except for Preventive Services)	\$8 In-Network Providers only	Out of Network Providers Only	100% after Copay	50%
• <b>Maternity care</b> (delivery and all inpatient services)	No	Yes	90%	50%
• <b>Newborn care</b>	No	Yes	90%	50%
<b>Mental Health Care</b> Admission to an inpatient facility, residential treatment and partial hospitalization services require Pre-Authorization.				
• <b>Inpatient</b> (facility and professional)	No	Yes	90%	50%
• <b>Partial Day Treatment (PDT)</b>	No	Yes	90%	50%

Community HealthEssentials Plus Silver				
Benefit	Copay	Applies to Deductible	In-Network Providers (plan pays)	Out-of-Network Providers (plan pays)
<ul style="list-style-type: none"> <li><b>Outpatient (facility)</b> Includes outpatient treatment and services provided by a hospital, an outpatient treatment center, and partial hospitalization or an Intensive Outpatient program.</li> </ul>	No	Yes	90%	50%
<ul style="list-style-type: none"> <li><b>Outpatient (professional)</b></li> </ul>	See Professional/Physician Services (office visits)			
<b>Nutritional Counseling</b>	See Preventive Care			
<b>Nutritional and Dietary Formulas</b>				
<ul style="list-style-type: none"> <li><b>PKU Formula</b></li> </ul>	No	Yes	90%	50%
<ul style="list-style-type: none"> <li><b>Other Formulas</b></li> </ul>	No	Yes	90%	50%
<b>Oral Surgery</b>	No	Yes	90%	50%
<b>Orthognathic Surgery</b> 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 <i>TMJ</i> benefit or <i>Plastic and Reconstructive Services</i> benefit for details.			
<b>Prescription Drugs</b>	Administered by Express Scripts, Inc.			
<b>Retail Pharmacy – 30 day supply</b>				
<ul style="list-style-type: none"> <li><b>Tier 1 – Preferred Generic</b></li> </ul>	\$3 In-Network Providers only	No	100% after Copay	0%
<ul style="list-style-type: none"> <li><b>Tier 2 – Preferred Brand</b></li> </ul>	\$8 In-Network Providers only	Yes	100% after Copay	0%
<ul style="list-style-type: none"> <li><b>Tier 3 – Non-Preferred Brand/Generic</b></li> </ul>	No	Yes	50%	0%
<b>Specialty Pharmacy</b>				



Community HealthEssentials Plus Silver				
Benefit	Copay	Applies to Deductible	In-Network Providers (plan pays)	Out-of-Network Providers (plan pays)
• Tier 4 – Specialty Drugs	No	Yes	50%	0%
<b>Plastic and Reconstructive Services</b> Pre-authorization required. Limited benefit, see <i>Plastic and Reconstructive Services</i> for details.	No	Yes	90%	50%
<b>Podiatric Care</b> <i>Podiatric Care</i> includes <i>Routine Foot Care</i> , which is covered for diabetics only.				
• In Office (Primary Care Provider)	\$0 Community Health Center Providers	Out-of-Network Providers only	100% after Copay	50%
	\$3 Other In-Network Providers only			
• In Office (Specialist)	\$8 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
• All other places of service	No	Yes	90%	50%
<b>Preventive Care</b> 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 <i>Preventive Care</i> for more details.				

Community HealthEssentials Plus Silver				
Benefit	Copay	Applies to Deductible	In-Network Providers (plan pays)	Out-of-Network Providers (plan pays)
<b>Immunizations</b> Immunizations for children and adults are covered in accordance with the recommendations set forth by the Centers for Disease Control and Prevention. See <i>Preventive Care</i> for details. Travel immunizations are not covered.	\$0 In-Network Providers only	Out-of-Network Providers only	100%	50%
<b>Periodic Exams</b> (adult and child)	\$0 In-Network Providers only	Out-of-Network Providers only	100%	50%
<b>Nutritional Counseling</b> 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%	50%
<b>Screening Tests</b> (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.				
<ul style="list-style-type: none"> <li> <b>Bone Density Screening</b>                1 test every other plan year, women age 65, or, age 60 for those with increased risk for osteoporotic fractures             </li> </ul>	\$0 In-Network Providers only	Out-of-Network Providers only	100%	50%
<ul style="list-style-type: none"> <li> <b>Colonoscopy</b>                Beginning at age 50, or younger if at increased risk.             </li> </ul>	\$0 In-Network Providers only	Out-of-Network Providers only	100%	50%
<ul style="list-style-type: none"> <li> <b>Depression Screening – Adult</b>                Including pregnant and postpartum women             </li> </ul>	\$0 In-Network Providers only	Out-of-Network Providers only	100%	50%

Community HealthEssentials Plus Silver				
Benefit	Copay	Applies to Deductible	In-Network Providers (plan pays)	Out-of-Network Providers (plan pays)
<ul style="list-style-type: none"> <li> <b>Mammogram</b>  For women, beginning at age 40, or earlier for those with increased risk. </li> </ul>	\$0 In-Network Providers only	Out-of-Network Providers only	100%	50%
<ul style="list-style-type: none"> <li> <b>Pap Test</b>  For women 18 and/or sexually active. </li> </ul>	\$0 In-Network Providers only	Out-of-Network Providers only	100%	50%
<ul style="list-style-type: none"> <li> <b>Prostate Cancer Screening ("PSA")</b>  For men, beginning at age 50. </li> </ul>	\$0 In-Network Providers only	Out-of-Network Providers only	100%	50%
<ul style="list-style-type: none"> <li> <b>Sigmoidoscopy</b>  Beginning at age 50, or younger if at increased risk. </li> </ul>	\$0 In-Network Providers only	Out-of-Network Providers only	100%	50%
<ul style="list-style-type: none"> <li> <b>Other Screening Tests</b> </li> </ul>	\$0 In-Network Providers only	Out-of-Network Providers only	100%	50%
<b>Professional/Physician Services</b> (office visits)				
<ul style="list-style-type: none"> <li> <b>Primary Care Provider</b>  (including naturopaths) </li> </ul>	\$0 Community Health Center Providers	Out-of-Network Providers only	100% after Copay	50%
	\$3 Other In-Network Providers only			
<ul style="list-style-type: none"> <li> <b>Specialist</b> </li> </ul>	\$8 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%

<b>Community HealthEssentials Plus Silver</b>				
<b>Benefit</b>	<b>Copay</b>	<b>Applies to Deductible</b>	<b>In-Network Providers (plan pays)</b>	<b>Out-of-Network Providers (plan pays)</b>
<ul style="list-style-type: none"> <li><b>Mental Health and Chemical Dependency Providers</b></li> </ul>	\$8 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
<b>Quit For Life® (tobacco cessation) Program</b>	No	No	90%	50%
<b>Radiation Services</b>	No	Yes	90%	50%
<b>Rehabilitation Therapy</b>				
<ul style="list-style-type: none"> <li><b>Inpatient</b> (facility and professional). 30 days per Calendar Year.</li> </ul>	No	Yes	90%	50%
<ul style="list-style-type: none"> <li><b>Outpatient</b> (facility and professional) Includes physical, speech, occupational and massage therapies. 25 visit maximum for all rehabilitation therapy services combined per Calendar Year.</li> </ul>	No	Yes	90%	50%
<b>Skilled Nursing Facility</b> 60 days per Calendar Year	No	Yes	90%	50%
<b>Spinal Manipulations</b> 10 visits per Calendar Year.	No	Yes	90%	50%
<b>Temporomandibular Joint (“TMJ”) Disorder</b> Pre-authorization required if inpatient.				
<ul style="list-style-type: none"> <li><b>Office visits</b></li> </ul>	\$8 In-Network Providers only	Out-of-Network Providers only	100% after Copay	50%
<ul style="list-style-type: none"> <li><b>All other services</b></li> </ul>	No	Yes	90%	50%
<b>Transplants</b> (organ and bone marrow) Pre-authorization required.				

Community HealthEssentials Plus Silver				
Benefit	Copay	Applies to Deductible	In-Network Providers (plan pays)	Out-of-Network Providers (plan pays)
<ul style="list-style-type: none"> <li><b>Recipient services</b> (facility and professional)</li> </ul>	No	Yes	90%	50%
<ul style="list-style-type: none"> <li><b>Donor services</b> (facility and professional)</li> </ul>	No	Yes	90%	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)
<ul style="list-style-type: none"> <li><b>Routine Eye Exam</b> 1 exam per Calendar Year.</li> </ul>	No	100%	0%
<ul style="list-style-type: none"> <li><b>Vision Hardware</b> 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, or contact lenses (in lieu of lenses and frames). Includes fitting fee.</li> </ul>	No	100%	0%
<ul style="list-style-type: none"> <li><b>Low Vision Services</b> Limited to children under age 19.</li> </ul>			
<ul style="list-style-type: none"> <li>– Low vision optical devices</li> </ul>	No	100%	0%
<ul style="list-style-type: none"> <li>– Comprehensive low vision evaluation Once every 5 Calendar Years</li> </ul>	No	100%	0%
<ul style="list-style-type: none"> <li>– High power spectacles, magnifiers and telescopes as Medically Necessary, with reasonable limitations permitted.</li> </ul>	No	100%	0%
<ul style="list-style-type: none"> <li>– Follow up visits 4 visits in any 5 Calendar Year period</li> </ul>	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 for a description of the term 'Medically Necessary' and a list of the types of Providers that may 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; however, serum is covered only when received and administered at a Provider's office. If received from a Pharmacy, serum to treat allergies may be covered under the Prescription Drugs benefit.

### **Ambulatory Patient Services**

This plan covers Ambulatory Patient Services under several different benefits. Coverage of Ambulatory Patient Services is described throughout this Agreement in the applicable provisions, and is subject to the limitations of those provisions. 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 transportation to the nearest Hospital emergency room, including treatment provided as part of the ambulance service, 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.

### **Applied Behavior Analysis Therapy**

This plan covers Applied Behavior Analysis ("ABA") Therapy only when prescribed and performed by a Provider qualified in ABA Therapy, for a diagnosis of an autism spectrum disorder. ABA Therapy services **require Pre-Authorization** and must meet specific criteria to be covered by the plan.

### **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**. Clinical trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, which is funded and approved by:

- one of the National Institutes of Health (NIH);
- an NIH cooperative group or center including, but not limited to, the NCI Clinical Cooperative Group and the NCI Community Clinical Oncology Program;
- the federal Departments of Veterans Affairs or Defense;
- an institutional review board (IRB) of a Washington institution that has a multiple project assurance contract approval by the Office of Protection from Research Risks of the NIH; or
- a qualified research entity meeting that meets the criteria for NIH Center Support Grant eligibility.

An approved clinical trial meets the following requirements:

- Prior authorization for clinical trial participation has been granted;
- The principal purpose of the trial intervention is the therapeutic intent to potentially improve health outcomes;

- The clinical trial intervention is intended for a condition covered by this plan;
- The clinical trial is conducted under a written research protocol, approved by an appropriate IRB, which demonstrates that the trial is in compliance with Federal regulations relating to the protection of human subjects; and
- The clinical trial provides a thorough informed consent document to the participating Member, the Member has signed this document, and the document has been reviewed by the plan prior to Member's participation in the clinical trial.

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 the Member's participation in the trial. The plan may require Member to use an In-Network provider participating in a clinical trial if the provider will accept the member as a participant. A Member participating in an approved clinical trial conducted outside the Member's state of residence will be covered if the plan otherwise provides Out-of-Network coverage for Routine Patient Costs.

Costs associated with clinical trial participation are covered as follows:

- Routine Patient Costs, defined as: Items or services that are typically provided under the plan for a member not enrolled in a clinical trial (e.g., usual care/standard care).

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;
- Services or interventions clearly not consistent with widely accepted and established standards of care for the member's particular diagnosis; or
- Interventions associated with treatment for conditions not covered by the plan.

### **Dental Anesthesia**

Inpatient and outpatient facility services, including general anesthesia services, are covered for dental procedures when anesthesia is necessary to safeguard the health of an individual. This benefit provides coverage if the patient is under the age of 7 years old and 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. Dental Anesthesia 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 under this plan's Prescription Drugs benefit.

### Dialysis Services

Dialysis services for chronic renal failure are covered when provided in a Hospital, an outpatient facility or in the home. Pre-Authorization is required for dialysis performed in an outpatient facility or at home.

### 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 the discretion of the plan; the total cost of any DME rental may not exceed the purchase price. Repair or replacement is covered only 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:

- 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. Please note that supplies available over-the-counter are excluded from this benefit;
- **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, Sjogren's disease, congenital cataract, corneal abrasion and keratoconus; and
- State sales tax for durable medical and mobility enhancing equipment.

Surgically implanted devices may be covered under the appropriate surgical benefit and are not considered DME. Benefits for DME are determined by the type of device and its intended use, and not by the entity that provides or bills for the device.

DME and medical supply charges listed below are not covered:

- Biofeedback equipment;
- 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 In-Network and Out-of-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 also 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 gunshot 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**

All U.S. Food and Drug Administration ("FDA") approved contraceptive methods are covered by this plan. FDA-approved contraceptive services provided in the office or outpatient setting, such as intrauterine devices (IUDs) and subdermal implants, including the insertion and removal, and voluntary sterilization procedures, including vasectomy and tubal ligation, are covered under the Family Planning benefit with no Cost-Sharing when provided by In-Network providers. Contraceptive methods that require a prescription, including oral contraceptives, transdermal patches, the vaginal ring, Medroxyprogesterone injections and emergency contraceptives, are covered under the Prescription Drug benefit and located in the Formulary. FDA-approved over-the-counter contraceptive products for women, such as sponges and spermicides, are covered under the Prescription Drug benefit only when prescribed by a qualified Provider.

### **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; or
- 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 which 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, such as pursuant to an individual educational plan.

Day habilitation services designed to provide training, structured activities, or specialized assistance to adults, chore services to assist with basic needs, and 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, unless provided to treat a DSM diagnosis.

## Home Health Care

**Pre-authorization is required** for home health care benefits. 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. A home health care visit is defined as: a time-limited session or encounter with any of the following home health agency Providers:

- Nursing service providers (RN, LPN);
- Licensed or registered physical, occupational or speech therapist (or an assistant working under the supervision of one of these providers);
- Home health aide/assistant working directly under the supervision of one of the above Providers;
- Licensed Social Worker (Master's prepared); or
- Registered dietician.

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 hospitalization. Hospice care must be prescribed by your physician, based on his or her determination that you are terminally ill and are 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, provided on an as needed basis by the hospice team, which includes health care professionals, support staff, and a 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 and care cannot be managed where the patient resides. Care will be provided at an inpatient Facility until the patient’s condition stabilizes.
- Continuous home care, provided when a medical crisis occurs where the patient resides and care can be provided at the residence. During such periods, the hospice team can provide around-the-clock care for up to 5 days.
- Inpatient 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, inpatient or outpatient, 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, including admission to a long-term care facility following a hospitalization. Inpatient Hospital care is covered when Medically Necessary, except when mental illness is the primary diagnosis (please see the Mental Health Care benefit), and 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 and supplies, 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 cannot 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 the *Pre-Authorization Requirements* section for details. Outpatient Hospital and Ambulatory Surgical Center care is covered when Medically Necessary, and includes outpatient surgery, procedures and services and supplies, operating room and anesthesia, radiology, facility costs, and 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. Pre-Authorization is required for services provided in an inpatient setting. Treatments and procedures for the purposes of producing a pregnancy are not covered.

### **Infusion Therapy**

**Pre-Authorization is required** if performed in the home or a free-standing infusion suite. This benefit covers the administration of medications using intravenous, subcutaneous, and epidural routes (into the bloodstream, under the skin, and into the membranes surrounding the spinal cord). Drug therapies commonly administered via infusion include: antibiotics, chemotherapy, pain management, parenteral nutrition, and immune globulin. Diagnoses commonly requiring infusion therapy include infections that are unresponsive to oral antibiotics; cancer and cancer-related pain; gastrointestinal diseases or disorders which prevent normal functioning of the gastrointestinal system; congestive heart failure; and immune disorders. Nursing visits associated with infusion therapy are covered under the *Home Health Care* benefit, regardless of whether the patient is home bound.

### **Laboratory and Radiology Services**

This plan covers laboratory and radiology services and laboratory supplies for diagnostic purposes when Medically Necessary and ordered by a qualified Provider. Services include 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); in utero treatment for the fetus; complications of pregnancy such as fetal distress, gestational diabetes, and toxemia; and related conditions for a female Subscriber or Dependent. Preventive pre-natal care is covered under the Preventive Care, Screening and Immunization Services benefit. 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), as well as 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. Covered post-natal care includes lactation support and counseling.

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. 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. An insurer may not require that a Provider obtain authorization, from the insurer, the insurance issuer, or the insurer's Third Party Administrator, 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 disorders. This benefit includes services provided to individuals requiring Chemical Dependency treatment for substance use disorders, including Chemical Dependency detoxification. Covered Medically Necessary care under this benefit includes treatment and services for mental health and psychiatric conditions, including neurodevelopmental therapies, and substance use disorders, for patients with a DSM category diagnosis, including behavioral health treatment for those conditions, except as excluded. Neurodevelopmental therapies consist of physical, occupational and speech therapy and maintenance to restore or improve function based on developmental delay. Neurodevelopmental therapies under this benefit will not be combined with rehabilitative services for the same condition. All inpatient admissions related to mental health and substance use disorders **require Pre-Authorization**, unless the patient is involuntarily committed. To obtain Pre-Authorization for an inpatient admission related to a mental health or substance use disorder, call (800) 640-7682. Emergency admissions require notification as described in the Notification for Emergency Hospital Admissions in the *Utilization Management* section of this Agreement.

Care and services for mental health and substance use disorders must be Medically Necessary and provided at the least restrictive level of care. Facilities offering an inpatient level of care must have a medical model with physician and/or nursing staffing on-site 24 hours a day. A clear treatment plan must be established on admission, and must include measurable progress toward a rehabilitative goal or goals, including movement to a less restrictive setting, if applicable, or other Medically Necessary goals as determined by your Provider and the plan's Medical Management staff. Care may be received at a Hospital or treatment facility, 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 or substance use disorders 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. When provided to treat Chemical Dependency, the acupuncture maximum benefit limit of this plan does not apply. Family counseling, psychological testing and psychotherapeutic programs are covered only if related to the treatment of an approved Mental Health Condition, specifically, those noted in the DSM. Eating disorder treatment is covered when associated with the treatment of a DSM category diagnosis. The following DSM "V" code diagnoses are also covered under this benefit: medically necessary services for parent-child relational problems for children under 5 years of age; bereavement for children under 5 years of age; and gender dysphoria.

Mental health care listed below is not covered:

- Adventure-based 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;
- Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program;
- Marriage and couples counseling;
- Family therapy, in the absence of an approved mental health diagnosis;
- Nontraditional or alternative therapies not based on American Psychiatric and American Psychological Association accepted techniques and theories;
- Sensitivity training;
- Treatment for sexual dysfunctions, and paraphilic disorders; and
- Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and wilderness programs, or other similar programs.

Chemical Dependency care listed below is not covered:

- Alcoholics Anonymous or other similar Chemical Dependency programs or support groups;
- Biofeedback, pain management and stress reduction classes;
- Care necessary to obtain shelter, to deter antisocial behavior, or 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 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, including:
  - Emergency patrol services;
  - Information or referral services;
  - Information schools;
  - Long-term or Custodial Care; and
  - Treatment without ongoing concurrent review to ensure that the treatment is being provided in the least restrictive setting required;
- Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program;
- Non substance related disorders; and
- Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and wilderness programs, or other similar programs.

### **Newborn Care**

Medical services and supplies for a newborn child following birth to a female Subscriber or an enrolled Dependent, 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 a natural newborn or newly adopted 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 in the event of separate Hospital admissions. For coverage to continue after the first 3 weeks of life, the newborn child must be eligible and enrolled, as explained in the *Eligibility* and *Enrollment* sections.

### **Nutritional and Dietary Formulas**

Coverage for nutritional and dietary formulas, including elemental formulas, and medical foods, 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 provided when medically necessary and related to trauma or injury and where such services or appliances are necessary for or resulting from emergency medical treatment, or where the extraction of teeth is required to prepare the jaw for radiation treatments of certain conditions. 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**

This benefit covers 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 or 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*. 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 trifocal, or lenticular lenses;
- One pair of frames or contact lenses, in lieu of lenses and frames, once per Calendar Year;
- Evaluation, fitting and follow up care; and
- Low vision optical devices, services, training and instruction.

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

- Orthoptics or vision training and any associated supplemental testing;
- Plano lenses (less than  $\pm .50$  diopter power);
- 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; and
- Costs for services and materials above the limitations indicated in the *Schedule of Benefits*.

### **Prescription Drugs**

This benefit provides coverage for Prescription Drugs 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 is further described in the *Definitions* section.

Your 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 a Participating Pharmacy.

**This Prescription Drug Benefit has four Tiers:**

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

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 Cost-Share, 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 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. If you fill a Specialty Drug Prescription at a Non-Participating 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.

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, you may submit a claim for reimbursement.

In making Pre-Authorization determinations for Prescription Drug substitutions, we may consider 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, FDA 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 Prescription Drugs in Tier 3, and Tier 4 Specialty Drugs. Prescription Drugs in Tiers 2, 3 and 4 are subject to your Calendar Year 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):	<b>\$3</b> Copay
Preferred Brand (Tier 2):	<b>\$8</b> Copay, subject to Deductible
Non-Preferred Generic/Brand (Tier 3):	<b>50%</b> Coinsurance, subject to Deductible
Specialty Drugs (Tier 4):	See Specialty Drug Prescription Benefit section below

#### **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 3 doses per medication per lifetime.

#### **Specialty Drug Prescription Benefit**

The Specialty Drug Prescription benefit only applies to Specialty 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 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 ("Participating Specialty Pharmacies"). 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 if 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 or upon order.

**Please note:** This plan will only cover Specialty Drugs that are dispensed by our Participating Specialty Pharmacies. If you need a list of Specialty Drugs covered under this Specialty Drug Prescription benefit, please call us at 1-800-930-0132.

### **Scope of Prescription Drug Benefit**

This benefit provides for the following formulary items when dispensed by a licensed Participating 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), including prescriptive oral agents for controlling blood sugar levels;
- Medications recommended by the United States Preventive Services Task Force, when obtained with a prescription, including: 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.

### **Formulary Exceptions**

Your provider may have prescribed a Prescription Drug that is not on our Formulary, or that has special coverage rules or requirements in order to be covered by this plan. If you require a Prescription Drug that is not covered in the way you or your provider would like it to be, you may request an exception.

To request a Formulary Exception you or your provider must call or submit your request in writing to:

Express Scripts, Inc.  
Attn: Prior Authorization  
Mail Stop B401-03  
8640 Evans Road  
St. Louis, MO 63134  
Phone: 1-800-753-2851

After your request for a Formulary Exception has been reviewed, you will receive written notification of our decision to approve or deny your request. For standard formulary exception requests we will issue a decision and notify the enrollee or enrollee's agent and the enrollee's prescriber within 72 hours of receipt of receiving the initial request. For expedited formulary exception requests we will issue a decision and notify the enrollee or enrollee's agent and the enrollee's prescriber within 24 hours of receipt of the initial request. If your request is denied, this plan will not cover the requested drug, and you will be responsible for any costs associated with the requested drug. If you do not agree with the plan's determination, you have the right to appeal our decision, or to seek external review through an Independent Review Organization ("IRO"). See the *Appeals* section of this Agreement for information about seeking external review or filing an Appeal.

## Requesting Changes to the Formulary

If you or your Provider would like to request that a new or existing medication be added to the Formulary, a letter (including copies of relevant research articles and journal citations) indicating the significant evidence-based advantages of the drug product over current Formulary medications should be mailed to the following address:

Community Health Plan  
Director of Pharmacy  
1111 Third Ave, Suite 400  
Seattle, WA 98104

## 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 non-covered OTC items include: 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, or prevent wrinkles;
- Drugs for Experimental or Investigational use;
- Biologicals, blood or blood derivatives;
- Compound Drugs not containing at least one FDA approved Prescription Drug;
- Any prescription refilled in excess of the number of refills specified by the prescribing provider, or any refill dispensed more than one year from the prescribing Provider’s original order, or any controlled substance prescription filled beyond its maximum refill limit or more than six months 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, unless covered under the Specialty Drug Prescription Benefit;
- Replacement of lost or stolen medication;
- Infusion therapy drugs or solutions and drugs requiring parenteral administration or use (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 immunization.

## Prescription Drug Benefit Management Programs

To promote appropriate medication use, certain drugs are subject to Pre-Authorization to review and confirm Medical Necessity prior to dispensing. 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, 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, FDA guidelines, published

medical literature and standard reference compendia. Contact Customer Service for details on which drugs require Pre-Authorization, 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 us at 1-800-930-0132.

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, 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, 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);
- Depression screening for all adults, including pregnant and postpartum women;
- 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.

### **Professional Services**

This benefit applies to in-person and Telemedicine provider office visits, and includes supplies and services associated with such visits. Infusion therapy and therapeutic injections provided in the office setting are also covered under this benefit. 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 an originating site permitted under RCW 41.05.700. Care provided by phone, fax, e-mail, or Internet, other than covered Telemedicine visits, is not covered.

### **Plastic and Reconstructive Procedures**

This benefit covers reconstructive procedures only when the primary purpose of the procedure is 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 *Hospital Care* benefit.

### **Rehabilitation Services**

Coverage for disabling conditions is provided through inpatient and outpatient rehabilitation therapy services. Examples of such services include: 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 transplant or heart and lung transplants.

### **Inpatient Rehabilitation**

Inpatient rehabilitation services require 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 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 billed by a Hospital, physician, or 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 for a particular condition, 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 Medically 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. Maintenance and Custodial Care are not covered.

### **Spinal Manipulations**

Spinal manipulations by a qualified Provider are covered, and are subject to the maximum benefit limit 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.

### **Therapeutic Injections**

This benefit covers therapeutic injections, including serums, needles and syringes, provided at your doctor's office. This plan covers three teaching doses per injectable drug, per lifetime, provided in a doctor's office or other clinic setting. All other self-injectable specialty drugs are covered under the *Specialty Drug Prescription* benefit.

### **Tobacco Cessation – Quit For Life<sup>®</sup> Program**

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

### **Transplants**

Organ, including artificial organs when medically approved by your doctor and in accordance with the manufacturer's recommendations, bone marrow and stem cell transplants are covered when clinical coverage criteria are met and the transplant is approved by us.

**Pre-authorization is required** for transplant services. Services directly related to organ transplants must be coordinated by your In-Network Provider. **A proposed transplant 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 an Experimental or Investigational treatment for your condition;
- The procedure is performed at a facility, and by a Provider, approved by us; and
- Upon evaluation, you are accepted into the approved facility's transplant program and you 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 the criteria below are met:

- We approve the transplant procedure;
- The recipient is enrolled in this plan; and
- Expenses are for services directly related to the transplant procedure.

Covered donor expenses include:

- Donor typing, testing and counseling;
- Donor organ selection, removal, storage and transportation of the surgical/harvesting team and/or the donor organ or bone marrow; and
- Reasonable travel and lodging expenses for the donor are covered.

When both the recipient and the donor are Members of 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, your donor expenses are not covered unless the recipient is also enrolled in this plan. Services to treat complications arising from the donation are covered to the extent that they are not covered under the recipient's health plan.

Transplant services listed below are not covered for organ or bone marrow transplants:

- 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, except for treatment of complications arising from the donation, which are covered as any other illness, to the extent they are not covered under the recipient's health plan; and
- Transplants considered Experimental or Investigational, as defined by CHPW.

### **Urgent Care**

Urgent care services, including provider services, facility costs, and supplies, provided by an urgent care clinic or Provider are 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 from In-Network Providers are generally provided at the lowest cost to you.

### **Weight Loss and Weight Management Programs**

Obesity screening is a preventive care service that is covered for all adult Members on this plan without cost sharing when provided by an In-Network Provider. Weight loss and weight management therapies are covered for adult members and children age 6 and older with a documented body mass index (BMI) of 30 kg/m<sup>2</sup> or higher, when provided by an In-Network provider. The following multicomponent behavioral interventions are covered by the plan:

- High intensity group and individual counseling sessions (12-26 sessions within a year),
- Behavioral management activities, such as weight-loss goals,
- Improving diet or nutrition and increasing physical activity,
- Addressing barriers to change,
- Self-monitoring, and
- Strategizing how to maintain lifestyle changes.

The following weight-loss services are not covered by this plan:

- Exercise programs or use of exercise equipment,

- Weight-loss diet supplements, such as Optifast liquid protein meals, NutriSystems pre-packaged foods, Medifast foods, phytotherapy,
- Jenny Craig, Weight Watchers, Diet Center, Zone diet or other similar programs.

### **Women’s Health Care**

Female Members have the right to directly access In-Network Providers who offer women’s health care services (MD, Doctor of Osteopathic Medicine, ARNP and Midwife). These services 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 excluded, limited, or not covered under 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 coverage; | • A homeowner’s policy;                      |
| • Personal injury protection (“PIP”) coverage;              | • All other types of liability insurance; or |
| • Commercial liability coverage;                            | • 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 and 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;
- Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program;
- Non substance related disorders;
- Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs

### **Cosmetic Surgery and Services**

- Services or supplies (including drugs) rendered for cosmetic purposes or 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; or
- Correction of functional disorders upon our review and approval.

### **Counseling, Educational or Training Services**

- Community wellness classes and programs that promote health and lifestyle choices. Examples of these classes and programs are adult, child, or infant CPR, safety classes, babysitting skills, back pain prevention, stress management, bicycle safety, or parenting skills;
- Counseling, education or training services, except as stated under the Chemical Dependency Services, Professional Services, Diabetic Education and Diabetic Nutrition Education, or 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 a 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, including:

- 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 emergency in nature, or 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; and
- 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 air conditioners, lumbar rolls, heating pads, diapers or personal hygiene items;
- Phototherapy devices related to seasonal affective disorder;
- Supportive equipment and environmental adaptive items including: 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, and food and nutritional supplements, except as specified under Nutritional and Dietary Formula benefits; over-the-counter contraceptive supplies, devices, and drugs, unless

prescribed for a female; 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 is furnished, and any direct or indirect complications or 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 the *Clinical Trials* benefit.

### **Family Members or Volunteers**

Services or supplies that you furnish to yourself or that are furnished to you by a Provider who 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.

### **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, and 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, hair weaves, transplants, and implants.

### **Hearing Care**

Routine hearing examinations and programs or treatment for hearing loss including externally worn or surgically implanted hearing aids, and the surgery and services necessary to implant them. The exception to this exclusion is cochlear implants, which are covered.

### **Home Health Care listed below:**

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

### **Hospice Care listed below:**

- Custodial Care or maintenance care, except palliative care for a terminally ill patient, subject to stated limits;
- Private duty nursing;
- Financial or legal counseling services;
- Housekeeping or meal services;
- Services provided 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; and
- Transportation.

**Human Growth Hormone Benefit Limitations**

Coverage for human growth hormone is provided under the Specialty Drug Prescription benefit only. Human growth hormone is 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;
- All assisted fertilization techniques, regardless of reason or origin of condition, including artificial insemination, in-vitro fertilization, and gamete intra-fallopian transplant (GIFT), and any direct or indirect complications thereof; and
- 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;
- Housing for individuals in a Partial Hospital Program or Intensive Outpatient Program;
- Marriage and couples counseling;
- Family therapy, in the absence of an approved mental health diagnosis;
- Nontraditional, alternative therapies that are not based on American Psychiatric and American Psychological Association acceptable techniques and theories;
- Sensitivity training;
- Sexual dysfunctions, personality disorders, and paraphilic disorders;
- Therapeutic group homes, residential community homes, therapeutic schools, adventure-based and/or wilderness programs or other similar programs; and
- DSM "V" code diagnoses, except for as covered under the Mental Health and Chemical Dependency Services benefit.

**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. This exclusion does not apply to active or retired U.S. military personnel or their Dependents, who are 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; and
- 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 was not in effect; and
- Services for which you do not 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 recipient is not covered under this plan;
- Services or supplies provided to someone other than a Member;
- Services or supplies directly related to any condition, or related to any other service or supply, that is not covered under this plan; and
- Services provided by In-Network Providers for "serious adverse events," "never events" and any resulting follow-up care. "Serious adverse events" and "never events" are medical errors that are specific to a nationally published list. These events are identified by specific diagnosis codes, procedure codes and present-on-admission indicator codes. A "serious adverse event" means a Hospital injury caused by medical management, rather than an underlying disease, and that prolonged the hospitalization, or produces a disability at the time of discharge. In-Network Providers may not bill Members for such services and Members are held harmless for charges for all such services.

**Not Medically Necessary**

- Services or supplies that are not Medically Necessary, even if the service or supply is court-ordered. This exclusion includes places of service, such as inpatient Hospital care;
- Hospital admissions for diagnostic purposes only, unless the services cannot be provided without the use of inpatient Hospital facilities, or 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, 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, or 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 the underlying 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, regardless of the underlying condition. The only exceptions to this exclusion are the repair of a child's congenital anomaly and 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, and 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 benefits); 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; and
- 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 the manufacturer's instructions or recommendations****Replacement of lost or stolen items such as Prescription Drugs, prostheses, or DME****Routine or Preventive Care**

- Charges for services or items that do not 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, except covered, Medically Necessary services provided within the scope of the Provider's license****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, and 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 which require a prescription to dispense**

**Specialized intraocular lenses, associated with cataract surgery, that correct vision disorders, such as multifocal or toric lenses**

**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 are covered as any other illness, to the extent they are not covered under the recipient's health plan; and
- Transplants considered Experimental or Investigational, as defined by the plan.

#### **Vision Exams**

Except as covered under the Pediatric Vision benefit, routine vision exams to test visual acuity 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, contact lenses, and related supplies, are covered only as described in the Vision Hardware benefit, if this plan includes one, or the Durable Medical Equipment benefit; and
- Non-prescription eyeglasses and contact lenses, sunglasses, light-sensitive lenses, and other special purpose vision aids, such as magnifying attachments, are never covered under this plan, even if prescribed.

#### **Vision Therapy**

Vision therapy, eye exercise, or any sort of training to correct muscular imbalance of the eye (orthoptics), and pleoptics. Treatment or surgery to improve the refractive character of the cornea, including the treatment of any results of such treatment or surgery, is also not covered by this plan.

**Non-Medically Necessary education and vocational rehabilitation, work hardening or other training programs, regardless of diagnosis or symptoms**

#### **Weight Loss and Weight Management Programs**

Weight loss and weight management programs not included in the description located in the *Medical Benefits Details* Section are not covered by this plan.

### **Work-Related Conditions**

- Any Illness, Injury, or other condition 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; or
  - 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, Douglas, Ferry, Franklin, Grant, Lewis, Pacific, Pend Oreille, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, 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**

The 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 Dependents 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; and
- The Subscriber’s children who are under the age of 26. A “child” is defined as a child of the Subscriber or their spouse, including children of a Subscriber’s state-registered domestic partner, adopted 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 or her 26<sup>th</sup> 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 that 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 2-year period following the Dependent’s attainment of the limiting age.

### **Temporary Coverage for Newborns.**

When a Subscriber or Member gives birth, their newborn child will be entitled to the benefits set forth in the *Benefits* section from birth through 3 weeks of age. After 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, and premiums will not be 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, if there is a change in the monthly premium payment as a result of the additional Dependent. A written application for enrollment of an adopted child must be made to CHPW within 60 days from the date 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 circumstances in which applicable federal or state law or regulation provides for special enrollment, called Qualifying Events. Following the occurrence of a Qualifying Event listed below, the individual experiencing the Qualifying Event has a 60 day special enrollment period to apply for coverage, including coverage for any Dependents. Applications for coverage must be received within 60 days of the occurrence of the Qualifying Event. We may ask you to provide reasonable proof or documentation that you have experienced a Qualifying Event.

- Marriage or Domestic Partnership, including eligibility as a dependent of an individual marrying or entering into a domestic partnership;
- Birth, placement for or adoption of the person for whom coverage is sought;
- A permanent change in residence, work, or living situation, whether or not within the individual's choice, where the health plan under which the individual was covered does not provide coverage in that person's new service area or where a permanent change in the individual's residence results in new eligibility for previously unavailable qualified health plans;
- Loss of Coverage as a result of the dissolution of a marriage or termination of a domestic partnership, or for a Dependent on a group plan where such loss is due to the Dependent's age;
- Loss of Other Coverage, including:
  - The loss of minimum essential coverage, including employer-sponsored coverage, or the loss of coverage of a person under whose policy the applicant was enrolled, unless the loss is based on the previously covered individual's misrepresentation of material fact affecting coverage or for fraud related to the discontinued health coverage;
  - Coverage by a qualified health plan is discontinued by the Washington State Health Benefits Exchange and the 3 month grace period for continuation of coverage has expired;
  - If the applicant has discontinued coverage under a health plan offered pursuant to Chapter 48.41 RCW;
  - A situation in which a plan no longer offers any benefits to the class of similarly situated individuals that includes the individual applying for coverage;
  - Loss of coverage due to errors by the Washington State Health Benefits Exchange staff or the U.S. Department of Health and Human Services; and

- Loss of coverage under COBRA, including exhaustion of COBRA coverage due to failure of the employer to remit premium, and loss of COBRA coverage where the individual has exceeded the lifetime limit in the plan and no other COBRA coverage is available;
- The loss of eligibility for Medicaid or a public program providing health benefits;
- The applicant demonstrates to the Washington State Health Benefits Exchange that the qualified health plan in which they were enrolled violated a material provision of the coverage contract in relation to the applicant;
- The applicant or their Dependent(s), as defined in R.C.W. 48.43.005, who were not previously a U.S. citizen, national, or lawfully present individual, gains such status;
- The applicant becomes newly eligible or newly ineligible for advance payment of premium tax credits, has a change in eligibility for cost-sharing reductions, or the applicant's Dependent, as defined in 26 C.F.R. 54.9801-2, becomes newly eligible; or
- The applicant or their Dependent who is currently enrolled in employer sponsored coverage is determined newly eligible for advance payment of premium tax credit pursuant to the criteria established in 45 C.F.R. 155.120(d)(6)(iii).

Please note that for qualified individuals who are an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, enrollment in a qualified health plan, or change from one qualified health plan to another, is permitted 1 time per month without requiring an additional Qualifying Event triggering 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 their listed Dependents enrolled during open enrollment will be effective on January 1, 2017, provided that the Subscriber's application has been submitted to and approved by the Washington State Health Benefits Exchange and CHPW has received the Subscriber's first premium payment, including any amounts due for Subscriber's listed Dependents.
- Enrollment for a newly eligible Subscriber and/or their listed Dependents enrolled in a Special Enrollment period will be effective the first day of the next month after all eligibility requirements are met including payment of applicable premium amounts, except where one of the following applies:
  - If the Subscriber enrolls after the 20<sup>th</sup> day of the month, enrollment will be effective the 1<sup>st</sup> day of the second month after the application is received and all eligibility requirements are met.
  - Enrollment for newborns is effective from the date of birth.
  - Enrollment for an adopted child is effective from the date that the adopted 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 this Agreement will receive covered benefits beginning on their Effective Date, as set forth in the *Eligibility* section above. If a Member is hospitalized in an Out-of-Network facility, CHPW reserves the right to require transfer of the Member to an In-Network facility. The Member will be transferred when an In-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 an In-Network facility, all services received will be covered under Out-of-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 a month for which Premium Charges have been paid, and in which one of the following events occurs:

- For the Subscriber and their 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 an independent application for health coverage is made within 31 days; or
- For a child when he or she does not meet the requirements for dependent coverage described in the *Eligibility* section.

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 a certificate from us within 24 months of the date your coverage terminated. When you receive your Certificate of Creditable Coverage, make sure the information is correct. Contact us if any of the information listed is not 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 the form online at [www.fchn.com/splash/CHE](http://www.fchn.com/splash/CHE) or through your Member Portal at [www.myFirstChoice.fchn.com](http://www.myFirstChoice.fchn.com).

**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, if different;
- Identification numbers for both the Subscriber and the Member who incurred the expenses, if different (these are shown on the Subscriber's identification card);
- Name, address and IRS tax identification number of the Provider;
- Information about any 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 rendered;
- 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:** Check that all required information is complete. Bills received won't be considered to be Claims until all necessary information is included.

**Step 4:** Sign the Claim Form in the space provided.

**Step 5:** 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. The plan will not provide benefits for Claims we receive after these dates.

## **QUESTIONS, COMPLAINTS, GRIEVANCES AND APPEALS**

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

### **Feedback and Questions**

Please call Customer Service with any feedback or questions you may have regarding your health benefit plan. Customer Service representatives are available to take your call during regular business hours, from 8:00 AM to 5:00 PM, Monday through Friday. We suggest that you call your Provider when you have feedback or questions about the health care services they provide.

### **Complaints**

You may call or write to us when you have a complaint about a benefit or coverage decision, customer service, the quality or availability of a health care service, or other matters. Our complaint process allows Customer Service to quickly and informally correct errors, clarify benefits, or take steps to improve our service. We recommend, but do not 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. In those instances, 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 receive your complaint.

### **Grievance Procedure**

A Grievance means a written complaint submitted by you, or on your behalf, regarding anything that you are not happy with except for an adverse utilization review determination, such as a denied service or referral for service.

If you have a Grievance, you or your representative may submit it to us at:

Community Health Plan of Washington  
Attn: Grievances  
1111 Third Ave, Suite 400  
Seattle, WA 98101 Fax: (206) 613-8983

Your Grievance must include:

- Member name, address, and 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 your representative within 20 business days after receiving your Grievance and all information necessary for us to review the Grievance. We may take additional time to complete our review if we establish that 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, which will explain the reasons for the delay. In such instances, we must issue our decisions within 20 days of receiving all necessary information.

If our decision is adverse to you, the decision will contain:

- The names, titles and qualifying credentials of the person or persons participating in the first level Grievance review process;
- 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 their decision;
- A reference to the evidence or documentation used as the basis for the decision;
- Notice of your right to contact the Washington State Office of the Insurance Commissioner; and
- A description of the process to obtain a second level review of a Grievance, the procedures and time frames governing a second level review, and your rights related to a second level review of your Grievance.

## **Appeals**

If we decline 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 our determination through an appeals process. This plan's appeals process will be modified to comply, as necessary, with any new requirements under state and federal law or regulation.

### **Important Information about Your Appeal Rights**

**What if I need help understanding a denial?** Contact us at 1-800-930-0132 Monday through Friday between 8AM - 5PM if you need assistance understanding a notice we send you or our decision to deny you a service or coverage.

**What if I don't agree with this decision?** You have a right to appeal any decision that does not provide you or pay for any item or service in whole or in part.

**How do I file an appeal?** You can submit a letter of appeal. You may attach any additional information or documentation you feel will support your appeal. You have 180 days from the receipt of this notice to submit your request. Send to:

Appeals Coordinator  
First Choice Health Administrators  
600 University Street, Suite 1400  
Seattle, WA 98101

If you have any questions about this process, please contact us at 1-800-930-0132 Monday through Friday between 8AM - 5PM.

**Who may file an appeal?** You or someone you name to act for you (your authorized representative) may file an appeal. Once you have designated someone else to represent you, all communication is sent to that person. To designate a Representative, you must complete a Designated Representative form. This form is not necessary when you appeal on your own behalf. Please contact us at 1-800-930-0132 Monday through Friday between 8AM - 5 PM (Pacific Time) to obtain this form.

**Can I provide additional information about my claim?** Yes, you may supply additional information. You may submit any additional information with your appeal request or give testimony in person or by phone.

**Can I request copies of information relevant to my claim?** Yes, you may request copies (free of charge) by contacting us at 1-800-930-0132, Monday through Friday between 8 am - 5 pm.

**What happens next?** If you appeal, we will review our decision and provide you with a written determination. If we continue to deny the payment, coverage, or service requested or you do not receive a timely decision, you may be able to request an external review of your claim by an independent third party, who will review the denial and issue a final decision.

**Other resources to help you:** For questions about your appeal rights, this notice, or for assistance, you can contact the Washington State Office of the Insurance Commissioner at 1-800-562-6900.

Español: Para obtener asistencia en Español , llame al 1-800-930-0132  
All Other Languages Contact 1-800-930-0132

### **Adverse Benefit Determination**

An adverse benefit determination means a denial, reduction, or termination of, or a failure to provide or make payment for, in whole or in part, 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 an otherwise covered benefit;
- 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 may request a Level I internal appeal. Your Level I internal appeal will be reviewed by individuals who were not involved in making 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 our decision, you may request a Level II internal 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 services, 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 decision. If you are not satisfied with the Level II internal appeal decision, you may be eligible to request an external review, as described below.

### **Filing Appeals**

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 within the following timelines:

- 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  
1111 Third Ave, Suite 400  
Seattle, WA 98101

If you need help filing an appeal or would like a copy of the appeals process, please contact Customer Service at 1-800-930-0132, Monday through Friday from 8am to 5pm, or email [customercare@chpw.org](mailto:customercare@chpw.org). If you are hearing or speech impaired, please call TTY Relay: Dial 7-1-1.

### **Clinically Urgent Appeals**

If your Provider believes that your situation is urgent under the law, your appeal will be reviewed 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 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 a final internal 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, notifying you of your rights to an external review, within 3 business days of the end of the Level II appeal process. We must receive your written request for an external review within 180 days of the date of our 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 1 day of giving the IRO notice of your request for review. The IRO will accept additional information in writing from you for up to 5 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, if any, or your attending physician know where to submit any additional information and when the information must be provided. We will forward your medical records and other relevant materials for your external review directly 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 overturns our final internal adverse benefit determination, we will implement their decision promptly. If the IRO upholds the final internal adverse benefit determination, there is no further review available under this plan's internal appeals or external review process. You may, however, have other remedies available under state or federal law, such as filing a lawsuit.

### **Urgent Review**

If your Provider believes that your situation is urgent under the 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 hours 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. The term ‘plan,’ as used in this section, 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 or between those separate contracts. However, if COB rules do not apply to each separate contract, or to all benefits within 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; group or individual contracts issued by health care service contractors or health maintenance organizations; closed panel plans or other forms of group coverage; medical care components of long-term care contracts, such as skilled nursing care; and state or federal governmental plans, as permitted by law.

(2) Plan does not include: Hospital indemnity, 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 this Agreement providing the health care benefits to which the COB provision applies, and which may be reduced because of the benefits available under other plans. Any other part of this Agreement 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 a Member 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 and 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 (the amount paid subtracted from the amount this plan 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 the Calendar Year in which it is generated, 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 Coinsurance and Copays and without reduction for any applicable Deductible, that is covered at least in part by any plan covering the person. When coordinating benefits, any secondary plans must pay an amount which, together with the payment made by the primary plan, cannot be less than the same allowable expense as the secondary plan would have paid if it was the primary plan. In no event

will a secondary plan be required to pay an amount in excess of its maximum benefit plus accrued savings. When Medicare is primary, Medicare's allowable amount is the allowable expense. 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.

A 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 COB 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 that provides that the 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 fails to timely adjudicate a Claim, the Provider or enrollee should submit the Claim and notice of the primary plan's failure to pay to the secondary plan which shall pay within 30 calendar days.

CAUTION: All health plans have timely claim filing requirements. If you or your provider fail to submit your claim to a secondary health plan within that plan's claim filing time limit, the plan can deny the claim. If you experience delays in the processing of your claim by the primary health plan, you or your provider will need to submit your claims to the secondary health plan within its claims filing time limit to prevent a denial of the claim.

### **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 an uninsured or 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 will 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. A third party includes a UIM carrier, because the UIM carrier stands in the shoes of the third party tortfeasor 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 any 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 any 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 and 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 a third party or parties is not contingent on whether or not you pursue the party at fault for any recovery. Our right of recovery is not subject to reduction for attorney's fees and costs under a 'common fund' theory or any other doctrine. However, if you recover from a third party or parties, and we share in such 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 a third-party or parties for any payments we have made on your behalf, and you must 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 for 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 this Agreement, and will continue until any dispute regarding this plan's subrogation or reimbursement is resolved.

### **Uninsured and Underinsured Motorist/Personal Injury Protection Coverage**

If we pay for services and supplies that are covered or otherwise provided under the terms of a UIM or PIP policy, or similar type of insurance or contract, we have the right to be reimbursed for such benefits, but only to the extent that such benefits were also paid for under the other policy 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 Out-of-Network Providers (except emergency services), the Usual, Customary and Reasonable ("UCR") rate (see related definition); and
- For Out-of-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 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 does not have an agreement with us or FCHN (an "Out-of-Network" Provider), will be no greater than the maximum amount 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 Out-of-Network Providers, 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, and 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 does not 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 of or dependency on alcohol or a controlled substance that is subject to regulation under Chapter 69.50 of the Revised Code of Washington, which is further characterized by frequent or intense patterns of pathological use to the extent that the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if use is reduced or discontinued; and the user's health is substantially impaired or endangered or his or her social or economic function is substantially disrupted. 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); and
- Non substance related disorders

**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 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 of the 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 a 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 a part of daily skilled nursing care or skilled rehabilitation services you are receiving

**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;
- A service for which no reliable evidence demonstrates that the service's effectiveness 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 reports and articles published in authoritative peer-reviewed medical and scientific literature. In determining whether services are experimental or investigational, the plan will consider whether the services are in general use in the medical community in the state of Washington, whether the services are under continued scientific testing and research, whether the services show a demonstrable benefit for a particular illness or disease, and whether they are proven to be safe and efficacious.

**Formulary:** CHPW’s list of selected Prescription Drugs that are covered under this plan. 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:** A 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 that the FDA has ensured 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 is run mainly:

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

**Illness:** A sickness, disease, or medical condition, including 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 providers, which includes both First Choice Health Network (“FCHN”) Providers and Community Health Center Providers, and who are contracted in writing with us and agree to look to us, according to the terms of this Agreement, for payment for health care services rendered to persons covered under this plan.

**Levels of Care:** Refers to levels of care applicable 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 Conditions at least 6 hours a day, 5 days a week, and schedule at least 3 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(s). Services for Mental Health Conditions must include evaluation by a psychiatrist within 48 hours, and weekly thereafter. All programs must include a substance abuse evaluation. Treatment must follow a written plan of care.

- **Mental Health Residential Treatment Programs** provide around-the-clock behavioral health services that do not need the high level of physical security and psychiatric and nursing interventions that are available in an acute inpatient program. Care is medically monitored with on-site nursing and medical services. The focus of the program is an improvement of a client's psychiatric symptoms through the use of assessment, evidenced-based treatment strategies, group and individual therapy, behavior management, medication management and active family engagement and therapy. Treatment must follow a written plan of care. The facility must be state licensed for residential treatment. Residential settings not meeting these criteria, such as group homes, halfway houses, and adult or child foster homes, are not considered to be Mental Health Residential Treatment Programs.
- **Chemical Dependency Rehabilitation/Residential Programs** provide 24-hour rehabilitation treatment 7 days a week for Chemical Dependency Conditions. Care is medically monitored, with 24-hour medical or nursing availability. Services include group, individual and, when indicated, family or multi-family group. The facility must offer sufficient availability of medical and nursing services to manage ancillary detoxification needs. Treatment must follow a written plan of care.

**Maintenance Drug:** A 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, is used in connection with the direct treatment of an illness or injury, and is 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 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 in 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 Related and Addictive Disorders (see Chemical Dependency definition);
- Relational, family and lifestyle stressors absent a primary psychiatric diagnosis; and
- Sexual dysfunctions, personality disorders and paraphilic disorders.

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

**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 or her Dependents within the same Calendar Year. Charges in excess of UCR, services in excess of any benefit level, and services not covered by this Agreement are not applied to the Out-of-Pocket Maximum.

**Pharmacist:** An individual licensed to dispense Prescription Drugs, counsel a patient about how the drug(s) works and any 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 does not have a contract, including contracted access to any network to which the Pharmacy belongs. Non-Participating Pharmacies may not be able to or may 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 products that relate directly to the treatment of an Illness or Injury, which legally cannot be dispensed without a Prescription and by law must bear the legend: “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 is other than that stated in the drug's 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 the Member's 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 such services are covered by the provisions of this plan. Also included in this definition 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 include 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), and 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 or her license but for whom: 1) FCHN or CHPW does not offer agreements to his or her category of provider; or 2) In-Network Providers are available, but the Member does not have the opportunity to choose which Provider performs services. Examples of both types are listed below:

- Ambulance services providers;
- Anesthesiologists;
- Assistant surgeons;
- Blood banks;
- For dental services covered by the plan, provider types may include:
  - Dentists;
  - Oral and Maxillofacial Surgeons; and
  - Otolaryngologists (Ear, Nose & Throat specialist, or ENT);
- Non-contracted laboratories used by an In-Network Provider;
- Ocular prosthetics providers;
- PKU formula providers;

- Services of Out-of-Network Providers when rendering care within an In-Network facility, except in the case of a primary surgeon for a non-emergent admission; and
- TMJ providers, such as
  - Dentists; or
  - Oral and Maxillofacial Surgeons.

**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’s office or clinic) and that does not require administration by a Provider. In determining whether a medication is a Self-Administrable Drug, CHPW refers to information from the manufacturer, scientific literature, practice standards, Medicare practices, Medical Necessity criteria, and any other information that CHPW considers to be 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, Douglas, Ferry, Franklin, Grant, Lewis, Pacific, Pend Oreille, Spokane, Stevens, Thurston, Wahkiakum, Walla Walla, and Yakima.

**Skilled Care:** Care that is 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 is 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, such as through 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; or
- An abnormal range of motion or limited motion of the temporomandibular joint.

**Usual, Customary and Reasonable (“UCR”)** is the 80th percentile of cost data for a given geographic area. This data is obtained from an independent, nationally recognized vendor.

**MAIL YOUR CLAIMS TO**

First Choice Health Administrators  
Attn: Claims  
PO Box 12659  
Seattle, WA 98111

**PRESCRIPTION DRUG CLAIMS****Mail Your Prescription Drug Claims To**

Express Scripts, Inc.  
Attn: Commercial Claims  
P.O. Box 14711  
Lexington, KY 40512-4711 Fax: (608) 741-5475

**Customer Service****Mailing Address Phone Numbers**

First Choice Health Administrators  
One Union Square  
600 University St, Ste 1400  
Seattle, WA 98101  
1-800-930-0132

Community Health Plan of Washington  
1111 Third Ave, Suite 400  
Seattle, WA 98101  
Local and toll-free number:  
1-800-440-1561

**Visit Our Web Site**

[www.chpw.org](http://www.chpw.org)

**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: (877) 749-2031  
Fax: (206) 268-2920

**Appeals Level II:**

Community Health Plan of Washington  
Attn: Appeals Coordinator  
1111 Third Avenue, Suite 400  
  
Seattle, WA 98101  
Phone: 1-800-440-1561  
Fax: 206-613-8984



**1-800-930-0132**  
(TTY Relay: Dial 7-1-1)

1111 Third Avenue, Suite 400  
Seattle, WA, 98101