COMMUNITY HEALTH PLAN of Washington™

The power of community

INDIVIDUAL & FAMILY PLANS

2024 Evidence of Coverage

Cascade Select

Gold | Silver | Bronze

COMMUNITY HEALTH PLAN
of Washington™
The power of community
INDIVIDUAL & FAMILY PLANS

Community Health Plan of Washington Cascade Select Gold Silver Bronze

Health Care Coverage Agreement for Individuals and Families

Community Health Plan of Washington Cascade Select is a health insurance plan for individuals and families offered by Community Health Plan of Washington ("CHPW"). 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 for Individuals and Families ("Agreement") sets forth the terms under which health care 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 more information about CHPW and about the unique benefits of our Cascade Select plans on page 5 of this Agreement.**

This Agreement is made between CHPW, and the individual designated herein as the Subscriber. In consideration of timely payment of the applicable premium, 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 or permitted by state or federal law and signed and issued by CHPW.

This Agreement consists of the following documents:

- This Health Care Coverage Agreement for Individuals and Families; and
- Signed Washington Health Benefit Exchange Application; or
- Signed CHPW Cascade Select Individual Enrollment Application.

YOUR RIGHT TO RETURN THIS AGREEMENT WITHIN 10 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 date the Agreement is delivered is the date we provide you access to the Agreement electronically, or the 5th day after the postmark date if a copy is mailed. 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 back to its Effective Date. If CHPW does not refund payments within 30 days of its timely receipt of the returned Agreement, CHPW must pay a penalty of 10% of such premium, which will be added to your refund. CHPW may reduce your refund in an amount equal to the cost of any benefits we paid before you terminated the Agreement.

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-866-907-1906 (TTY: 711).

Español (Spanish) ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-866-907-1906 (TTY: 711).

Tiếng Việt (Vietnamese) CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-866-907-1906 (TTY: 711).

繁體中文 (Chinese) 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-866-907-1906 (TTY: 711)。

Af Soomaali (Somali) DIGTOONI: Haddii aad ku hadasho Af Soomaali, adeegyada caawimada luqadda, oo lacag la'aan ah, ayaa laguu heli karaa adiga. Wac 1-866-907-1906. (TTY: 711).

Русский (Russian) ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-866-907-1906 (телетайп: 711).

(Arabic) العربية ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-866-907-1906 (طابعة هاتفية: 711).

አማርኛ (Amharic) ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-866-907-1906 (መስማት ለተሳናቸው: 711).

توجه برای دری (Dari) اگر به زبان دری صحبت می کنید، خدمات مساعدت زبان، طور رایگان برای شما موجود می باشد. با شماره 1906-907-866-1 (TTY: 711) تماس بگیرید.

ትግርኛ (Tigrinya) ምልክታ፡ ትግርኛ ትዛረብ ተኾይንካ ኣገልግሎት ሓገዝ ቋንቋ ንዓኻ ብናጻ ይርከብ። ደውል 1-866-907-1906 (TTY: 711)።

ဗမာ (Burmese) သတိျပဳရန္ - အကယ္၍ သင္သည္ ျမန္မာစကား ကို ေျပာပါက၊ ဘာသာစကား အကူအညီ၊ အခမဲ့၊ သင့္အတြက္ စီစဥ္ေဆာင္ရြက္ေပးပါမည္။ ဖုန္းနံပါတ္ 1-866-907-1906 (TTY: 711) သုိ႔ ေခၚဆိုပါ။

ਪੰਜਾਬੀ (Panjabi) ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-866-907-1906 (TTY: 711) 'ਤੇ ਕਾਲ ਕਰੋ।

한국어 (Korean) 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.1-866-907-1906 (TTY: 711) 번으로 전화해 주십시오.

توجه (Farsi): اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای **فارسی** شما فراهم می باشد. با 1-866-907-1906 (TTY: 711) تماس بگیرید.

Українська (Ukrainian) УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-866-907-1906 (телетайп: 711).

ភាសាខ្មែរ (Khmer) កត់ចំណាំ៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ សេវាជំនួយភាសាមិនគិតថ្លៃមានសម្រាប់អ្នក។ សូមទូរសព្ទមកលេខ 1-866-907-1906 (TTY: 711)។

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WELCOME

Thank you for choosing Community Health Plan of Washington (CHPW) Cascade Select for your 2024 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.

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, built around a network of Community Health Centers across Washington State.

What makes Community Health Plan of Washington Cascade Select different? CHPW provides comprehensive coverage options for our Cascade Select Members. CHPW's Cascade Care Affiliates Network is made up of a diverse set of providers and centered around participating Community Health Centers. CHPW is accredited by the National Committee for Quality Assurance, and provides comprehensive health service and medical management functions, including utilization management, care management, transitions of care, and pharmacy services to CHPW Members.

Contact Information. Important contact information is on the last page 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 your health plan. You can find up-to-date information about the CHPW Cascade Care Affiliates Network and our Network Providers on our website at: individualandfamily.chpw.org.

References. Throughout this Agreement, CHPW is referred to as "we," "us," or "our." Community Health Plan of Washington Cascade Select is referred to as "plan," "this plan" or "our plan." References to "you" and "your" refer to Members. The words "coverage" and "covered services" refer to the health care and services, including 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 capitalized terms used in this Agreement are defined in the *Definitions* section of this Agreement or where they are first used.

LEGAL TERMS AND CONDITIONS

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

Premium Payments. For the term of this Agreement, the Subscriber shall submit to CHPW for all enrolled persons in the Subscriber's family unit, the applicable monthly premium. 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). Where permitted or required by law, premiums are subject to change by CHPW upon 30 days' written notice mailed to each Subscriber's address or, if applicable, mailed electronically to Subscriber's email address, as it appears in CHPW's records.

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

Administration of Agreement. CHPW may adopt reasonable policies and procedures to help in the administration of this Agreement. These may include policies and procedures pertaining to benefit entitlement and coverage determinations.

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 or if applicable, mailed electronically to Subscriber's email 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 that any services or supplies you receive are Medically Necessary 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 in this section.

If a Member commits fraud or makes fraudulent or intentionally false or misleading statements on any form that affects the Member's acceptability for coverage or the risks to be assumed by us, including any application or enrollment form required by CHPW or the Washington Health Benefits Exchange, CHPW may, at its option:

- Deny the Member's Claim(s);
- Reduce the amount of benefits provided for the Member's Claim(s); 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).

We will not 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 a material fact that affects your acceptability for coverage.

Member Cooperation. You have a duty to cooperate with us in a timely and appropriate manner in our administration of benefits under this Agreement.

Notice under This Agreement. Any notice required to be given by CHPW under this Agreement shall be in writing and will be sent to the most recent address or, if applicable, email address, appearing in CHPW's records for the Subscriber. Notice required to be given by CHPW will be deemed to be properly given upon deposit in the United States mail or with a private mail carrier, postage prepaid or, if applicable, upon electronic transmission to the electronic mailbox provided by the Subscriber for such purposes. Any notice required to be provided to CHPW must be in writing and will be deemed to have been properly given upon receipt by CHPW at CHPW's principal mailing address of:

Community Health Plan of Washington
1111 3rd 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 1-866-907-1906 to confirm or report changes to your contact information. If CHPW receives a United States Postal Service change of address form for a Subscriber, CHPW will update its records accordingly.

Choice of Law and Forum. This Agreement is governed by and will be construed in accordance with the laws of the state of Washington, except to the extent pre-empted by federal law. Any suit or legal proceeding 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 any independent review process.

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

Privacy Practices. For a full explanation of how we protect your privacy, please see our Notice of Privacy Practices here: individualandfamily.chpw.org/member-center/member-resources/plan-documents

Termination or Non-Renewal of Agreement. This Agreement is a guaranteed renewable contract 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 a premium increase.

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.

Failure to Meet Eligibility Requirements. A Member's failure to meet the ongoing eligibility requirements for coverage under this plan, including the Service Area and Subscriber requirements set forth in the Eligibility section, will result in termination of this Agreement as of the date the Member failed to meet the applicable requirements**.**

Breach or Violation. A Member's material breach of this Agreement or a Member's violation of this plan's published policies that have been approved by the Washington State Office of the Insurance Commissioner, will result in termination of this Agreement upon written notice by CHPW.

Fraud. Fraud committed by a Member, or a Member's intentionally false or misleading statements that affect the Member's eligibility for coverage under this plan, will result in termination of this Agreement as of the date of the fraud, or intentionally false or misleading statement(s).

Change in Law. A change in state or federal law that no longer permits CHPW to continue offering coverage under this plan will result in a termination of this Agreement as of the effective date of the change in law.

Withdrawal or Cessation of Services. If CHPW withdraws from all or part of the Service Area as allowed by law, or if we discontinue this plan to all those covered under this plan as allowed by law, we will terminate this Agreement. CHPW may discontinue this plan if it chooses to discontinue all individual health coverage offered in Washington State, in which case we will provide written notice to each covered Subscriber of the discontinuation of the plan at least 180 days prior to discontinuation. CHPW must provide the Washington State Office of the Insurance Commissioner at least 180 days' advance notice in the event of discontinuation of this plan. In the event of discontinuation, services received prior to the effective date of such discontinuation 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 (including gender identity and gender expression), 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 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, please contact Customer Service at 1-866-907-1906.

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:

Appeals & Grievances
1111 3rd Ave, Suite 400
Seattle, WA 98101
Phone: 1-866-907-1906 or for TTY 711
Fax: (206) 613-8984
AppealsGrievances@chpw.org

If you need help filing a grievance, contact Appeals & Grievances to help you.

You can also file a complaint by contacting the Office of the Insurance Commissioner online at: insurance.wa.gov/file-complaint-or-check-your-complaint-status or by phone at: 1-800-562-6900.

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: ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Ave. SW Room 509F HHH Building
Washington, DC 20201
Phone: 1-800-368-1019 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, under insured 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 the Subscriber or any Dependent(s), or any other source of health care benefits a Member receives or is entitled to.

Right of Recovery. CHPW has the right to recover any amounts paid in excess of the amount necessary to satisfy its obligations under this Agreement. CHPW may recover excess payment from any person to whom or for whom payment was made, or any other carrier. In addition, if this Agreement is terminated as described above in the *Fraud* provision, we have the right to recover the amount of any Claim(s) we paid under this plan and reasonable administrative costs we incurred to pay such Claim(s) or recover such amounts.

Right to and Payment of Benefits. Benefits of this plan are available only to Members. Except as required by law, we will not honor any attempted assignment, garnishment or attachment of any right of this plan. 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 shall satisfy our obligation as to payment of benefits.

ACCESSING CARE

This plan is an Exclusive Provider Organization (EPO), which means that services are covered only when received from Network Providers, with limited exceptions such as Emergency Care. This plan makes available to you a comprehensive network of high-quality primary care and specialty Providers, Hospitals, and other health care providers. Except in the limited circumstances described in this Agreement, or as required by law, if you receive care from an Out-of-Network Provider, you are responsible for all costs associated with the Out-of-Network services received, expect as required by applicable state and federal law or regulation, including the Washington State Balance Billing Protection Act and the federal No Surprises Act and their respective implementing regulations.

Network Providers. When you receive care from a 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 do not need a referral to obtain specialty care from Network Providers.

Primary Care Providers. You are required to select a Primary Care Provider from one of our Network Community Health Centers. You may select any Community Health Center Primary Care Provider in our network, and each Member may select a different Primary Care Provider. Your Primary Care Provider will provide timely, high-quality, and comprehensive primary care and preventive health services, responsive to your health needs. Your Primary Care Provider will coordinate care received from other health care providers, including obtaining appropriate referrals for Out-of-Network specialty care, and ensuring applicable Pre-Authorization requirements are met, as needed.

If you do not select a Primary Care Provider, we will assign you a Primary Care Provider. If your Primary Care Provider is unavailable, you may receive care from any Community Health Center Provider at their Community Health Center. You may choose a new Primary Care Provider, or ask to be re-assigned, at any time by contacting Customer Service, and that change will be effective on the first day of the following month. In the event your Primary Care Provider's contract with us 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. In general, you must receive Covered Services from Network Providers. Except as otherwise stated in this Agreement, services received from Out-of-Network Providers are not covered. You will be responsible for 100% of the cost of services from Out-of-Network Providers, and these costs will not apply to your Deductible or Maximum Out-of-Pocket (MOOP) expense, expect as required by applicable state and federal law or regulation, including the Washington State Balance Billing Protection Act and the federal No Surprises Act and their respective implementing regulations.

Referrals. If a covered service is not available from a Network Provider, your Primary Care Provider will assist you in obtaining a referral to an appropriate Out-of-Network Provider. When you obtain a referral, you can obtain Out-of-Network benefits at the Network benefit level.

Emergency Care. There are some services you may receive from Out-of-Network Providers without a referral, such as Emergency Care and emergency transportation or ambulance. This includes Emergency Care when you are out of the Service Area of the plan.

Contact Us. If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. If you have questions, please contact Customer Service.

UTILIZATION MANAGEMENT

Benefits listed in this Agreement must be Medically Necessary and are subject to review by CHPW. Our Utilization staff who make clinical decisions regarding care are licensed nurses, social workers, pharmacists, and physicians. 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 evidence-based criteria such as the MCG® and other specialized criteria;
- Consulting internal and external physicians and clinical experts, including specialists, to review complex cases; and
- Peer review from an Independent Review Organization ("IRO").

Certain services, such as visiting a PCP or an in-network specialist, do not require utilization management review. Additionally, no utilization management review of any kind, including, but not limited to, prior, concurrent or post service authorization is required for an initial evaluation and management visit or a number of visits stated in your *Schedule of Benefits* with a contracted provider for a new episode of care of chiropractic, physical therapy, occupational therapy, massage therapy, or speech and hearing therapies. Medically Necessary health care services are those 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. 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 Clinical Services 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 the patient.

PRE-AUTHORIZATION

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 Physician known as a Medical Director for review. All denials of prior authorization requests are made by a physician or pharmacist. The Medical Director is available to discuss Utilization Management denials with your Provider.

Pre-Authorization Requirements
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. For more information surrounding services that require Pre-Authorization, please contact Customer Service at 1-866-907-1906.

Services and supplies that require prior authorization are listed on the following prior authorization lists by category of service: Medical and Surgical Services, Behavioral Health Services, and Professionally Administered Medications. Pre-Authorization requirements can be found on individualandfamily.chpw.org/provider-center/prior-authorization. You may request a paper copy be mailed to you by calling Customer Service.

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.

Notification for Emergency Hospital Admissions
Hospital admissions directly from the emergency room do not require Pre-Authorization. However, notification is required within 24 hours or the next business day after the Hospital admission when admitted directly from the emergency room, or as soon as possible. The facility or your provider will notify us if you are admitted to a hospital.

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 1-866-418-2920 (voice) or 711 (TTY 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 Benefits*.

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. Copays charged to the member shall never exceed the cost of the actual service.

Emergency Room
For each emergency room visit, you pay a Copay/Coinsurance regardless of whether you receive services from 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/Coinsurance will be waived and the services you receive will be subject to Deductible and Coinsurance.

Professional Services – Office Visit
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 Benefits*. Office visits that require a Copay do not apply to Deductibles and you are not required to pay Coinsurance for these visits. Covered Services provided during an office visit, which are not part of the office visit, are subject to Deductible and Coinsurance, and may require Pre-Authorization. Please see the *Pre-Authorization* section.

Separate Copays/Coinsurance 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 1-866-907-1906.

Primary Care Providers
You are required to pay an Office Visit Copay when you receive primary care from your Primary Care Provider (PCP).

Specialist Providers
You are required to pay a Specialty Office Visit Copay when you receive specialty care from a 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. Please see the Schedule of Benefits to determine which copays and coinsurance amounts may be applied to your 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).

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

Family Deductible
The Family Deductible is the fixed amount each Member family must incur and satisfy before certain benefits of this plan are provided. An individual member may not pay more than the individual deductible amount, even if the Member is on a family plan.

Please Note: Your Individual or Family Deductible accrues toward the Network individual Out-of-Pocket Maximum. Some benefits have maximums on the number of visits or days of care that can be covered. Out-of-Network expenses do not satisfy your Individual or Family Deductible amount, expect as required by applicable state and federal law or regulation, including the Washington State Balance Billing Protection Act and the federal No Surprises Act and their respective implementing regulations.

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%.

Out-of-Pocket Maximum (MOOP)
The Out-Of-Pocket Maximum (MOOP) is the maximum amount each individual will pay each Calendar Year for Covered Services and supplies. Payments you make to Network Providers directly for Coinsurance, Copays, and any required Deductible for medical services apply to your Out-of-Pocket Maximum. Payments you make for services for Out-of-Network Providers typically do not accrue to your Out-of-Pocket Maximum except as required by applicable state and federal law or regulation, including the Washington State Balance Billing Protection Act and the federal No Surprises Act and their respective implementing regulations. Benefits apply in-network, such as emergency room services, apply toward the Out-of-Pocket Maximum. Once the individual Out-Of-Pocket Maximum has been satisfied, the benefits of this plan will be provided at 100% of the

Allowed Amount for the remainder of that Calendar Year for Covered Services from Network Providers. Out-of-Network expenses do not satisfy Out-of- Pocket Maximums, except as required by applicable state and federal law or regulation, including the Washington State Balance Billing Protection Act and the federal No Surprises Act and their respective implementing regulations.

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 health care Providers who provide health care 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 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.

MEDICAL BENEFITS DETAILS

All covered benefits are subject to the limitations, exclusions and provisions of this plan. Medical and Surgical Services, Behavioral Services, and Professional Administered Medications have specific pre- authorization guidelines and can be found on individualandfamily.chpw.org/provider-center/prior-authorization. Paper copies can be mailed to you, once requested through calling Customer Service. In addition, 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.

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

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, from which the likelihood of death is probable unless the course of the disease or condition is interrupted, 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 next ends 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 or 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 health care 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, when Medically Necessary for 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.

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:

- 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;
- External Prosthetics Devices used to replace absent body limbs
- 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, which 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, handrails, 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

This plan covers Emergency Care, including services and 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 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, mental health, or a substance use disorder condition which manifests itself by acute symptoms of sufficient severity (including severe pain or emotional distress) 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 (broken bones). Other examples of emergent conditions include difficulty breathing, deep cuts or severe bleeding, and pain that is best treated on an outpatient basis. 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 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 Network Providers.

Reimbursement will occur for 12-month refills of contraceptive drugs obtained at one time, unless the member requests a small supply. Contraceptive drugs can be received at the provider's office, if available. 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 contraceptives, including oral contraceptive drugs and devices, products, and barrier methods, including condoms which are required to be covered by state or federal law are covered when provided by an in-network provider, including purchases ordered online with the in-network provider or pharmacy. Coverage for approved over-the-counter contraceptives does not require a prescription regardless of the gender or sexual orientation of the covered person and regardless of whether they are to be used for contraception or exclusively for prevention of sexually transmitted infections. For information on how to submit an over-the-counter claim reimbursement, see the Claims section of this document.

Termination of Pregnancy
Voluntary termination of pregnancy is covered under this plan.

Gender Affirming Care
Gender Affirming Care includes health care services prescribed to treat any condition related to the individual's gender identity and may include primary care visits, specialty care, outpatient mental health services, prescription drug benefits, and surgical services.

Please see the gender affirming surgery medical necessity clinical coverage criteria policy located on our website: Transgender_Health_Policy_Clinical_Coverage_Criteria_-_MM166.pdf (chpw.org). CHPW's clinical criteria policy is aligned with the World Professional Association for Transgender Health Standards of Care for the Health of Transgender and Gender Diverse People, Version 8 recommendations for adolescents.

Genetic Testing
Genetic testing, counseling, interventions, therapy, and other genetic services are covered when determined to be Medically Necessary care for diagnosis 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 recognized by the medical community as efficacious:

- For partial or full development;
- For improved skills and functioning for daily living;
- 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 an Individual Educational Plan (IEP).

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 Medically Necessary to treat a DSM (Behavioral Health) diagnosis.

Home Health Care

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

Hospice care, including supplies, is covered. 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 healthcare 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* benefit in this Agreement for coverage of Emergency Care, including medical screening exams, in a Hospital's emergency room.

Inpatient Hospital Care
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. Treatments and procedures for the purposes of producing a pregnancy are not covered.

Infusion Therapy
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 homebound. For specific information regarding cost-sharing associated with place of service, contact Customer Service at 1-866-907-1906.

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.

Mammography
This benefit includes screening and diagnostic mammography services when referred by a Member's medical provider. 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 prenatal and post-natal maternity (pregnancy) care; prenatal 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 prenatal 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 postnatal care includes lactation support and counseling. Costs are covered for breast pumps, including double electric breast pumps (including pump parts and maintenance) and it may be either a rental unit or a new one you can keep, and breast milk storage.

There is no limit for the mother and her newborn's Medically Necessary 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. Substance Use Disorder is an Illness characterized by a physiological or psychological dependence, or both, on a controlled substance and/or alcohol. It is further characterized by a frequent or intense pattern of use to the extent 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 of the alcohol or controlled 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. 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. Court-ordered, Medically Necessary treatment for mental health and substance use disorder treatment is a covered under this benefit. Neurodevelopmental therapies consist of physical, occupational and speech therapy and maintenance to restoreor improve function based on developmental delay. Neurodevelopmental therapies under this benefit will not be combined with rehabilitative services for the same condition. Emergency admissions require notification as described in the Notification for Emergency Hospital Admissions in the *Utilization Management* section of this Agreement. Inpatient admissions, including residential facilities, related to substance use disorder do not require Prior Authorization. This plan covers a minimum of 2 business days, excluding weekends and holidays, of inpatient or residential substance use disorder service for all Members. Inpatient or residential substance use disorder services in excess of 2 business days are subject to ongoing plan authorization.

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. 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 or on an outpatient basis 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 assessments when not Medically Necessary;
- 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;
- Nonsubstance 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 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**.**

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;
- Services to prepare the jaw for radiation treatments of neoplastic disease;
- 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. Coverage for foot care appliances for prevention of complications associated with diabetes, is also included in this benefit. 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;
- Comprehensive eye exam, with dilation and refraction;
- One comprehensive low vision evaluation every five years;
- 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 ± .50 diopter power);
- Two pairs 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 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:

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

If you need a list of Prescription Drugs in these tiers, a copy of CHPW's formulary, or information about how to be involved in decisions about benefits, please call us at 1-866-907-1906 or visit the following website: individualandfamily.chpw.org/member-center/member-resources/prescription-drug-coverage.

Please note: This Prescription Drug benefit covers certain immunizations when administered by a pharmacist in a pharmacy setting. Covered vaccines include flu, pneumonia, shingles, diphtheria/tetanus/pertussis, hepatitis, HPV, meningitis, MMR/Childhood, rabies and travel vaccines. 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 1-866-907-1906 or visit our website at individualandfamily.chpw.org/member-center/member-resources/prescription-drug-coverage.

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.

CHPW applies third party payments made on your behalf for Prescription Drugs, including payments made through application of a manufacturer drug coupon or other manufacturer discount, toward your annual Cost-Sharing obligations, including applicable Deductibles, Copays, Coinsurance, and Out-of-Pocket Maximums**.**

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 can vary depending on your benefit (Gold, Silver or Bronze). Cost-Sharing, Copay and Coinsurance details are found on the benefit schedule chart under Prescription Drugs. 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.

Dispensing Limit
Tier 1 and Tier 2 drugs are available at up to a 90-day supply at participating retail pharmacies or through mail order. Cost-shares are payable upon dispensing. This benefit provides up to a 30-day supply on Tier 3 and Tier 4 drugs. Cost-shares are payable upon dispensing.

Prescription Medication Synchronization
To facilitate appropriate coordination of medication refills for a patient taking two or more medications, this benefit allows for medication synchronization of new medications in quantities necessary to achieve medication synchronization with other medications. Medication synchronization allows for prescription fills of more or less than a one-month supply in order to synchronize future refills with other routine medications. Applicable copays and coinsurance will be adjusted if less than a standard refill amount is provided during medication synchronization.

Prescription Eye Drop Refills
Based on the judgment of the dispensing pharmacist, this benefit will allow one early refill of a prescription eye drop after seventy percent of the predicted days of use from the last dispense date. The pharmacist authorization will be allowed without requiring consultation with a physician or obtaining a new prescription or refill from a physician provided that the refill is not in excess of the original number of refills prescribed by the physician.

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). Participating Specialty Pharmacies specialize in the delivery and clinical management of Specialty Drugs. You and your health care provider must work with our Participating Specialty Pharmacies to arrange ordering and delivery of these drugs.

Please note: Specialty Drugs that are administered under the supervision of physician, through home infusion 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 toward 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 toward your calendar year Out-of-Pocket Maximum if dispensed by a Non-Participating Specialty Pharmacy.

Please note: This plan will only cover Specialty Drugs that are dispensed by our Participating Specialty Pharmacies. If you need a list of Participating Specialty Pharmacies, covered under this Specialty Drug Prescription benefit, please call us at 1-866-907-1906 or visit our website at individualandfamily.chpw.org/member-center/member-resources/prescription-drug-coverage.

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.
- Pre-exposure prophylaxis (PrEP) for the prevention of HIV infection are covered without cost-sharing for people at high risk of HIV infection

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.

If you were charged a Cost Share for any of the medications above while taking them for preventive reasons or reasons that are in accordance with the recommendations of the United States Preventive Services Task Force, you may request a Cost Share review and request reimbursement. A Cost Share review may be required for certain preventive medications to qualify for a Cost Share waiver. To request a Cost Share review, you or your authorized representative must submit a completed Benefit Coverage Request Form. You can get a copy of the Benefit Coverage Request Form on our website at individualandfamily.chpw.org/member-center/member-resources/prescription-drug-coverage/or by calling Customer Service at 1-800-907-1906. You or your provider will need to complete the form and mail or fax it to:

Express Scripts
Attn: Benefit Coverage Review Department
PO Box 66587 St Louis, MO 63166-6587
Fax: 877-328-9660

Prior Authorization Process
You may contact us to request a Prior Authorization (PA) for a prescription drug. Standard Request: We will make a determination on your standard request once all necessary information is received within 3 calendar days (excluding holidays) for electronic requests and within 5 calendar days for non-electronic requests. If additional information is needed to make a determination on your Prescription Drug PA request, we will request that information within 1 calendar day of submission. Except for requests received non electronically where additional information will be requested within 5 calendar days of submission. Once the provider submits additional information, we will approve or deny the request within 4 calendar days of receipt of the additional information. If additional information is not provided, we may deny your Prescription Drug PA request.

Urgent Request: You may request an urgent review of a Prescription Drug PA in cases where the passage of additional time could seriously jeopardize your health. We will make a determination on your urgent request once all necessary information is received within 1 calendar day for electronic requests and 2 calendar days for non-electronic requests. If additional information is needed to make a determination on your Prescription Drug PA request, we will request that information within 1 calendar day of submission. Once the provider submits additional information, we will approve or deny the request within 2 calendar days of receipt of the additional information. If additional information is not provided, we may deny your Prescription Drug PA request.

If we deny your request for Prior Authorization, you will get a letter telling you why the request was denied. In the letter we will tell you how you or your authorized representative may appeal our decision. You can also review the “Appeals” Section of this Agreement.

If you have questions about our Prescription Drug Prior Authorization process, you can contact us. You may also request a copy of the process.

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.

Express Scripts
Attn: Benefit Coverage Review Department
PO Box 66587
St Louis, MO 63166-6587
Fax: 877-328-9660
Phone: 1-800-753-2851

After your request for a Formulary Exception has been reviewed, you will receive written notification

if our decision is to deny your request. For standard formulary exception requests, we will issue a decision and notify the member or member's agent and the member'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 member or member's agent and the member'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, alternatively, to ask for an External Review by an Independent Review Organization ("IRO").

To request External Review of a denied Formulary Exception request, you can contact Customer Service. We will provide you or your representative with our decision whether to grant your request for External Review no later than 72 hours after receiving your request, or within 24 hours if your original request for a Formulary Exception was an expedited request. See the *Appeals* section of this Agreement for information about 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:

CHPW Director of Pharmacy
1111 3rd Ave, Suite 400
Seattle, WA 98101

Off-Label Drugs Coverage

No drug shall be excluded from coverage on this prescription drug benefit for a particular indication on the grounds that the drug has not been approved by the Federal Food and Drug Administration for that same particular indication if such drug is recognized as effective for treatment of such indication:

- In one of the standard reference compendia;
- In the majority of relevant peer-reviewed medical literature if not recognized in one of the standard reference compendia; or
- By the Federal Secretary of Health and Human Services.
- Coverage of a prescription drug required by this section shall also include medically necessary services associated with the administration of the drug.
- This regulation shall not be construed to require coverage for any drug when the Federal Food and Drug Administration has determined its use to be contraindicated.
- This regulation shall not be construed to require coverage for experimental drugs not otherwise approved for any indication by the Federal Food and Drug Administration.

Emergency Fill

Emergency Fill means the dispensing of a Prescription Drug that is subject to Prior Authorization under this plan, toa Member by a Participating Pharmacy provider, who has used his or her professional judgment to identify that the Member has an "urgent medical need," without first obtaining Prior Authorization. An urgent medical need means that lack of access to the requested Prescription Drug could result in:

- 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, or
    - serious impairment to bodily functions, or
    - serious dysfunction of any bodily organ or part.

If the Participating Pharmacy provider determines the Member has an urgent medical need, the provider will determine the quantity necessary to meet the Member's urgent medical need, up to a 30-day supply. An emergency fill is applicable when:

- The dispensing pharmacy cannot reach the issuer's prior authorization department by phone as it is outside of that department's business hours; or
- An issuer is available to respond to phone calls from a dispensing pharmacy regarding a covered benefit, but the issuer cannot reach the prescriber for full consultation.

Only the Emergency Fill dosage of the Prescription Drug is covered. In the event that the Prescription Drug is continued for treatment beyond the approved Emergency fill, standard formulary restrictions and utilization management procedures will apply.

You will be responsible for a 30-day supply Cost Share, including applicable Deductibles, Coinsurance, and Copayments. Please refer to the Schedule of Benefits for details. The cost share is based on the tier in which the Prescription Drug is included in the formulary.

CHPW covers Emergency Fills for the drugs on our formulary with the following limitations:

- Emergency Fills are not available for certain Specialty Drugs, such as oncology drugs, hepatitis C, biologics, multiple sclerosis treatments, and enzyme replacements, which do not meet the criteria for "urgent therapeutic need"
- Emergency Fills are not covered at Non-Participating Pharmacies
- More information can be found at individualandfamily.chpw.org/member-center/member-resources/prescription-drug-coverage

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;

- Drugs for the purpose of cosmetic use, or to promote or stimulate hair growth, or prevent wrinkles; except when used as gender affirming treatment;
- Drugs for Experimental or Investigational use;
- Biologicals, blood or blood derivatives;
- Compound Drugs not containing at least one FDA approved Prescription Drug beyond its maximum refill limit;
- 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 or Family Planning Benefit;
- Replacement of lost or stolen medication;
- 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 are covered, but described in Preventive Care, Screening and Immunization Services. Infusion therapy is also covered but described in the Infusion Therapy section.

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 *Prescription Drug Coverage* section on our website.

Right to Safe and Effective Pharmacy Services
State and federal laws establish standards to ensure safe and effective pharmacy services, and to guarantee your right to know what drugs are covered under this plan, what coverage limitations apply, and how you can be involved in decisions about pharmacy 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- 866-907-1906. For more information about your rights under the law, or if you have concerns about your

plan's pharmacy benefits, contact the Washington State Office of Insurance Commissioner at 1- 800-562-6900 or www.insurance.wa.gov. If you have a concern about the pharmacists or pharmacies serving you, call the Washington State Department of Health at 360-236-4700, www.doh.wa.gov.

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 Subscribers with diabetes.

Preventive Care, Screening and Immunization Services

Your plan covers all preventive services and immunizations under the Patient Protection and Affordable Care Act (PPACA) provided by or under the supervision of your Provider, including:

- Routine physicals and exams;
- Adult, child and adolescent immunizations;
- Colorectal cancer screening (Subscribers at least 45 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, including tomosynthesis (3D mammography);
- 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.
- Costs are covered for breast pumps, including double electric breast pumps (including pump parts and maintenance) and it may be either a rental unit or a new one you can keep, and breast milk storage.

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 are covered when the originating site is one of the following:

- Hospital,
- Rural Health Clinic,
- Federally Qualified Health Center,
- Physician's or other health care provider's office,
- Licensed or certified behavioral health agency,

- Skilled Nursing Facility,
- Home or any location determined by the individual receiving the services, or
- Renal dialysis center, except an independent renal dialysis center.

Care provided by fax, e-mail, or internet, other than covered Telemedicine visits, is not covered, except as required by applicable state or federal law or regulation.

Community Health Plan of Washington offers access to Telemedicine services to members through CHPW's Virtual Care platform. For more information regarding our virtual care services, please refer to our website at individualandfamily.chpw.org/member-center/plan-benefits/virtual-care.

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 except facial feminization surgeries and other facial gender affirming treatment, such as tracheal shaves, hair electrolysis, and other care such as mastectomies, breast reductions, breast implants, or any combination of gender affirming procedures, including revisions to prior treatment. 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. External Prosthetics not requiring surgery are covered under the appropriate Durable Medical Equipment (DME) benefit. The medical necessity criteria for these devices are found in the CHPW Clinical Coverage Criteria policy MM158 Prosthetics, Orthotics, and Therapeutic Diabetic Shoes.

Rehabilitation Services

Coverage for disabling conditions is provided through inpatient and outpatient rehabilitation therapy services. Examples of such services include: physical therapy, speech therapy, occupational therapy and cochlear implants.

The following conditions must be met:

- Services are to keep, restore and significantly improve function that was previously present but lost orimpaired due to disability, 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 problem, such as myocardial infarction, chronic stable angina, heart transplant, or heart and lung transplants.

Inpatient Rehabilitation

Inpatient rehabilitation services must be 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.

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

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 Benefits.* 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
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® 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 showing that the transplant is Medically Necessary, and the transplant has been approved by CHPW.

Services directly related to organ transplants must be coordinated by your 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 CHPW; 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;
- Supplies and treatment including the transplant donor facility fees performed in either a hospital setting or outpatient setting;
- 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 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 children aged 6 and older who qualify as obese and adult members with a documented body mass index (BMI) of 30 kg/m2 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;
- Counseling women aged 40 to 60 years with normal or overweight body mass index (BMI) (18.5- 29.9 kg/m2) to maintain weight or limit weight gain to prevent obesity. Counseling may include individualized discussion of healthy eating and physical activity;
- 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, Nutrisystem pre-packaged foods, Medifast foods, phytotherapy;
- Jenny Craig, Weight Watchers, Diet Center, Zone diet or other similar programs; or
- Bariatric surgery.

Withdrawal Management Services

This plan covers withdrawal management services provided by In-Network and Out-of-Network behavioral health agencies; CHPW is not responsible for reimbursing the Out-of-Network behavioral health agency at the greater rate than would be paid to an In-Network agency; and the behavioral health agency may not balance bill you. Withdrawal management services means 24-hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from alcohol or drugs, which may include induction on medications for addiction recovery. Withdrawal management services do not require Prior Authorization and this plan covers a minimum of 3 days of withdrawal management services for all Members. Withdrawal management services in excess of 3 business days are subject to ongoing plan authorization. Coverage includes:

- Room and Board;
- In-Network physician services;
- Medication; and
- Dependency recovery services, education and counseling.

Women's Health Care

Female Members have the right to directly access 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 this Agreement, the following benefits are excluded, limited, or not covered under this plan:

Aromatherapy

Athletic training, bodybuilding, 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;
- Personal injury protection ("PIP") coverage;
- Commercial liability coverage;
- A homeowner's policy;
- All other types of liability insurance; or
- 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

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

Care provided by phone, fax, e-mail, Internet, except covered Telemedicine
Caffeine or Nicotine Dependency
Treatment of caffeine dependency; treatment of nicotine dependency as described in the Tobacco Cessation –Quit For Life® Program section under this Policy.

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 assessments when not Medically Necessary;
- Court-ordered treatments or treatments related to deferral of prosecution, deferral of sentencing orsuspended 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 carenecessary 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;
- Nonsubstance 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, except facial feminization surgeries and other facial gender affirming treatment, such as tracheal shaves, hair electrolysis, and other care such as mastectomies, breast reductions, breast implants, or any combination of gender affirming procedures, including revisions to prior treatment.

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: handrails, 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; 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 U.S. Department of Veterans Affairs 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 adolescentwith 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 carenecessary 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
- Neither Members, nor this plan, are responsible for payment for services provided by In-Network Providers that constitute "serious adverse events" or "never events," or for any follow-up care related toa "serious adverse event" or "never event." "Serious adverse events" and "never events" are medical errors included on a nationally published list found on the CMS Website: cms.gov. These events are identified by specific diagnosis codes, procedure codes and present-on-admission indicator codes. In-Network Providers may not bill Members for services related to a "serious adverse event" or a "never event," or for any related or follow-up care, and Members are held harmless for charges for all such services.
    - 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.
    - A "never event" is an event that should never occur, such as a surgery on the wrong patient or body part, or the wrong surgery is performed. Not all medical errors are "serious adverse events" or "never events."

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 Telephonic Care
Health care services provided electronically, on-line, or via the internet or telephone including facsimile or email, 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; except facial feminization surgeries and other facial gender affirming treatment, such as tracheal shaves, hair electrolysis, and other care such as mastectomies, breast reductions, breast implants, or any combination of gender affirming procedures, including revisions to prior treatment, 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 complete a CHPW Cascade Select Individual Enrollment Application, including necessary signatures and other acknowledgements, or have enrolled through the Washington Health Benefit Exchange, and must meet the eligibility requirements set forth herein.

Service Area
Coverage under this Agreement is available to residents of the following Washington State counties: Adams, Asotin, Benton, Chelan, Clallam, Columbia, Douglas, Ferry, Franklin, Grant, Jefferson, King, Kitsap, Kittitas, Lewis, Mason, Okanogan, Pierce, Snohomish, Spokane, Stevens, Thurston, Walla Walla, Whitman, Yakima. These counties are referred to as the Service Area for this Agreement. You must maintain your primary permanent residency in the Service Area to continue to receive coverage under this Agreement.

Subscriber
The Subscriber must not be 65 years or older, or entitled to or enrolled in Medicare, on the date coverage under this Agreement would begin. A Subscriber must not have had any prior contract for health care coverage issued by CHPW terminated for cause.

Dependents
The Subscriber may also enroll the following Dependents that have established and maintain the eligibility requirements under this Agreement:

- The Subscriber's spouse, including state-registered domestic partners; 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 upon assumption of a legal obligation for partial or total support of a child in anticipation of adoption, 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*th* birthday, if the Dependent is totally incapable of self-sustaining employment because of a developmental or physical disability incurred while eligible and enrolled under the Agreement, and is chiefly dependent upon the Subscriber for support and maintenance. Enrollment for such a Dependent may be continued for the duration of the continuous total incapacity, provided 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 Health Benefit Exchange, or by completing a CHPW Cascade Select Individual Enrollment Application, 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 the enrollment of 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.

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, including Dependent coverage, as a result of legal separation or the dissolution of a marriage or termination of a domestic partnership;
- Loss of Dependent status due to 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;
    - Loss of coverage due to the death of an employee under whose coverage the individual was a Dependent;
    - Loss of coverage, including Dependent coverage, due to termination of employment, a reduction in the number of hours worked, or discontinuation of employer contributions;
    - Coverage by a qualified health plan is discontinued by the Washington Health Benefit 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 48.41RCW;
    - 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 Health Benefit Exchange staff or the U.S. Department of Health and Human Services;
    - Discontinuation of coverage under the Washington State Health Insurance Pool (WSHIP); 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 Health Benefit 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 RCW 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 of 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.155.420(d)(6)(iii).

Please note that for qualified individuals who are American Indians or Alaska Natives, or are otherwise defined as "Indian" under applicable federal law, 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 (the "Effective Date") as follows:

- Enrollment for a newly eligible Subscriber and their listed Dependents enrolled during open enrollment (November 1, 2023-January 15, 2024) will be effective on January 1, 2024 unless the Subscriber and their Dependents enroll after December 31, 2023. Subscribers and their Dependents who enroll January 1 through January 15, 2024 will have their coverage begin February 1, 2024. These Effective Dates are based on the following criteria:
    - The Subscriber has either enrolled through the Washington Health Benefit Exchange or CHPW has approved the Subscriber's CHPW Cascade Select Individual Enrollment Application, and
    - CHPW has received the Subscriber's first premium payment, including any amounts due for the 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 20th day of the month, enrollment will be effective the 1st day of the second month after the application is received and all eligibility requirements are met.
    - Enrollment for newborns is effective from the moment of birth.
    - Enrollment for an adopted child is effective from the date of adoption or the date the adopted child is placed with the Subscriber for adoption, whichever comes first, 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 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 CHPW when an enrolled family member is no longer eligible to be enrolled as a Dependent under this plan.

We will not terminate coverage under this Agreement retroactively unless:

- A Member, or someone acting on their behalf, performs an act, practice, or omission that constitutes fraud, or makes an intentional misrepresentation of material fact, as prohibited under this Agreement
- Termination of coverage is effective retroactively only to the extent applicable Premiums or other contributions toward the cost of coverage have not been made.

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. Sometimes when you get medical care or a prescription drug, you may pay directly. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back for services you have already paid. It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs that are covered by our plan.

To be paid back by the plan for covered services or drugs you have already paid, please send us your request along with your bill and documentation of the payment you made. To make sure you are giving us all the information we need, you can fill out our claim form to make your request for payment. You don't have to use the form, but it will help us process the information faster. Please call Customer Service at 1-866-907-1906 to ask for the form.

For Prescription Drug Coverage payments, please mail your request for payment together with any bills or receipts to us at this address:

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

For Medical Coverage payments, including over-the-counter contraceptives, please mail your request for payment together with any bills or receipts to us at this address:

CHP Claims
PO Box 269002
Plano, TX 75026-9002

You should submit all Claims the provider does not submit for you within 90 days of the start of service, or within 30 days after the service is completed.

The claim must be submitted to us within 365 days of the date you received the service, item, or drug.

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 timeframes 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 1-866-907-1906 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 an oral or written appeal. You may attach any additional information or documentation you feel will support your appeal. You have 180 days from the receipt of an adverse benefit decision to submit your request to:

Appeals Coordinator
Community Health Plan of Washington
1111 3rd Avenue, Suite 400
Seattle, WA 98101
Fax: (206) 613-8984
Phone: 1-866-907-1906

If you have any questions about this process, please contact us at 1-866-907-1906 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 an appeal consent form. This form is not necessary when you appeal on your own behalf. Please contact us at 1-866-907-1906 Monday through Friday between 8am - 5pm (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 1-866-907-1906, Monday through Friday between 8am - 5pm.

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. The Washington State Office of the Insurance Commissioner's Consumer Protection Division provides ombudsman services for Washington consumers who have questions or complaints about health care appeals. You can contact the Washington State Office of the Insurance Commissioner at:

Washington State Office of the Insurance Commissioner
Phone: 1-800-562-6900
TDD: 360-725-7080
Fax: 360-586-2018
Email: CAP@oic.wa.gov

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 inwriting 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.

Internal Review
After you are notified of an adverse benefit determination, you may request an appeal, or internal review, of the adverse benefit determination. Your Appeal must be received within 180 days of the date of your receipt of an adverse benefit determination. Your 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, including any information you submit prior to our determination of your appeal, and will provide a written determination. If the adverse benefit determination involves medical judgment, the reviewer will have, or consult with a health care professional who has, appropriate training and experience in the relevant medical field(s) encompassing your condition, and will make a determination that is within the applicable clinical standard of care.

We will provide you a written notice acknowledging our receipt of your appeal request within seventy-two (72) hours of receipt of your appeal. We will provide you with any new evidence or rationale we consider in reviewing your appeal at no cost to you. You can request additional time to respond to any new evidence or rationale we consider. We 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 will notify you in writing of the extension and the reason for the extension. If we need more than 30 days from the day we receive your appeal, we must obtain your written consent for any extension over 30 days. If you are not satisfied with our 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 180 calendar days of the date you were notified of the adverse benefit 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 oral or written appeal request to:

Community Health Plan of Washington Cascade Select
Attn: Appeals Coordinator
1111 Third Avenue, Suite 400
Seattle, WA 98101
Fax: (206) 652-7050 Tel: 1-866-907-1906

If you need help filing an appeal or would like a copy of the appeals process, please contact Customer Service at 1-866-907-1906, Monday through Friday from 8am to 5pm. If you are hearing or speech impaired, please dial TTY 711.

Expedited Appeals
You or your authorized representative may request an Expedited Appeal if: you are currently receiving or have been prescribed treatment or benefits that would end because of the adverse benefit determination; or if your Provider believes that a delay in treatment based on the standard review time may seriously jeopardize your life, overall health, or ability to regain maximum function, or would subject you to severe and intolerable pains; or if the adverse benefit determination is related to an admission, availability of care, continued stay, or emergency health services and you have not been discharged from the emergency room or transport services. You may request an expedited Appeal orally, or in writing, by contacting Customer Service as shown above. 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.

You may submit information to assist in our review of your request. We will consider all information you submit prior to making a determination. You may also review and copy our records and information relevant to your Appeal at no cost. Your request will be reviewed by appropriate clinician(s) in the same or similar specialty as would typically manage the case being reviewed, and who were not involved in making the initial adverse benefit determination.

We will respond to your request for an Expedited Appeal as soon as possible, and in no event longer than 72 hours from receipt of your request for an Expedited Appeal. We may inform you of our decision orally, but we will also send you a written copy of our decision within 72 hours of the date of the decision. If we need additional information to make a determination, we will request this information as soon as possible after receiving your request for an Expedited 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, including any External Review period. Our provision of benefits for services received during the internal appeal period does not, and will 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
You may request review of a CHPW determination by a certified Independent Review Organization ("IRO") when: (i) If you are not satisfied with our resolution of your Appeal, or we have granted your request for an external review of Formulary Exception request or (iii), you have received an adverse determination under the Washington State Balance Billing Protection Act or federal No Surprises Act. An IRO is an independent organization of medical reviewers who are certified by the Commissioner to review medical and other relevant information. Review by an IRO is called External Review. There is no cost to you for an external review.

We must receive your written request for an external review within 180 days of the date of our final internal adverse benefit determination. You may also request External Review if we do not meet the timelines above for resolving your appeal, and we do not have good cause for the delay. We may require that you complete our Internal Review process prior to requesting External Review. If we waive this requirement, and later reverse our adverse benefit determination, we will notify you, and the IRO, immediately.
Your request for External Review must be made in writing and sent to:

Community Health Plan of Washington Cascade Select
Attn: Independent Review Request
1111 Third Avenue, Suite 400
Seattle, WA 98101
Fax: (206) 652-7050 Tel: 1-866-907-1906

Once we receive your request for External Review, or we approve your request for External Review of a Formulary Exception request, we will arrange for review by a certified IRO, which we select on a rotating basis. 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 External 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. We will forward your medical records and other materials relevant to your request for External Review directly to the IRO. We will also provide the IRO with any additional information they request that is reasonably available to us. Upon your written request, we will provide you or your authorized representative copies of all materials we provided to the IRO. 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, email 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.

You may request an expedited External Review if our adverse benefit determination concerns either:

- An admission, availability of care, continued stay, or health care service for which you received Emergency Care but you have not yet been discharged from a facility; or
- A medical condition for which the standard External Review time frame would seriously jeopardize the life or health of a Member or jeopardize a Member’s ability to regain maximum function; or
- You have requested expedited Internal Review and we waive the requirement to complete Internal Review prior to requesting External Review.

Upon receipt of a valid request for expedited External Review, the IRO must make a determination to uphold or reverse our adverse benefit determination as soon as possible, but in no event more than 72 hours after the IRO receives your request for expedited External Review. The IRO will notify you, and us, of their decision. If the IRO provides oral notification of their decision, they must also send written notice within 48 hours of their decision.

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 healthcare 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.

(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.

(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 a member 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 member within 30 calendar days of receipt of the Claim. If a primary plan fails to timely adjudicate a Claim, the Provider or member 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 section of the Agreement:

- 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 this Agreement 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:

- **In-Network Providers:**
    - For any given service or supply, the amount the In-Network Provider has agreed to accept as payment in full. In-Network 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;
- **Out-of-Network Providers:**
    - For services covered under the Washington State Balance Billing Protection Act, a commercially reasonably amount, based on payments for the same of similar services provided in a similar geographic area;
    - For all other services received from Out-of-Network Providers (except Emergency Care), the Usual, Customary and Reasonable ("UCR") rate (see related definition); and
- For Out-of-Network Emergency Care, 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 does not have an agreement with us (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 U.S.-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 (Substance Use Disorder): 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.

Community Health Center: Community Health Center refers to Washington State Federally Qualified Health Centers that comprise Community Health Plan of Washington. Community Health Centers 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 Center Provider: The medical staff, clinic associate staff, and allied health care professionals employed or contracted by a Community Health Center to provide primary care services, and to provide and coordinate the provision of other 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.

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) within the capability of an emergency department of a hospital, including ancillary services routinely available to the emergency department, and 2) necessary to evaluate a medical, mental health, or substance use disorder emergency or to stabilize a Member experiencing a medical, mental health, or substance use disorder emergency. Stabilize means to provide such medical treatment of the Medical Emergency as may be necessary to ensure, 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 facility or, in the case of a pregnant woman who is having contractions, to deliver.

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 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 (See: *Network Provider*): Our network of 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 2 hours per day and 3 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 7days 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 thepatient's covered medical condition;
- It is known to be effective in improving health outcomes for the patient's medical 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.

Network Provider: Our network of 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.

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 (MOOP): 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 applicable to your health care coverage under this Agreement.

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 Community Health Center Provider that is a general practitioner, internist, family practitioner, general pediatrician, OB-GYN, Advanced Registered Nurse Practitioner ("ARNP"), or Registered Nurse ("RN"), selected by a Subscriber or Dependent, or assigned by the plan, to coordinate the Member's health care needs, including assisting Members in seeking specialty care and ensuring that referral and prior authorization requirements are met.

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) CHPW does notoffer agreements to his or her category of provider; or 2) 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, Asotin, Benton, Chelan, Clallam, Columbia, Douglas, Ferry, Franklin, Grant, Jefferson, King, Kitsap, Kittitas, Lewis, Mason, Okanogan, Pierce, Snohomish, Spokane, Stevens, Thurston, Walla Walla, Whitman, 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: (1) the delivery of covered health care services through the use of interactive audio and video technology, permitting real-time communication between a patient at an originating site and a provider, for the purpose of diagnosis, consultation, or treatment, (2) the delivery of health care services through the use of audio-only technology, permitting real-time communication between a patient at an originating site and a provider with which the patient has an "Established Relationship," for the purpose of diagnosis, consultation, or treatment (referred to as "Audio Only Telemedicine"); and (3) use of an asynchronous transmission of a covered person's medical information from an originating site to a health care provider at a distant site (referred to "store and forward technology") which results in medical diagnosis and management of the covered person.

- Audio Only Telemedicine" does not include health care services that are customarily delivered by audio-only technologies and are not customarily billed as separate services by a provider (for example, delivery of laboratory or other test results).
- An "Established Relationship" exists when the treating provider has access to sufficient health care records to ensure safe, effective, and appropriate care services, and:
    - For mental health and substance use disorder services, including behavioral health treatment, the patient: (i) has had at least one in-person or real-time interactive (using both audio and video technology) appointment in the prior 3 years with the treating provider (or with another provider at the same clinic); or (ii) was referred to the treating provider by another provider who has had at least one in-person or real-time interactive (using both audio and video technology) appointment with the patient within the past 3 years and the referring provider has provided the treating provider with relevant medical information.

      For all other health care services, the patient: (i) has had at least one in-person or real-time interactive (using both audio and video technology) appointment in the prior 2 years with the treating provider (or with another provider at the same clinic); or (ii) was referred to the treating provider by another provider who has had at least one in-person or real-time interactive (using both audio and video technology) appointment with the patient within the past 2 years and the referring provider has provided the treating provider with relevant medical information.

Telemedicine does not include the use of facsimile or email. Audio Only Telemedicine services may not be delivered using store and forward technology.

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.

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